

**Jurisdiction C Council
April 2009 Questions**

Oxygen:

1. Can a supplier bill for contents after the 36mo cap when the supplier had been billing for E13901QG (oxygen flow greater than 4lpm) and no E0431 billing is allowed when billing with the QG modifier. After the E1390 caps out how can we bill for contents?

Answer: In the scenario the supplier was not billing a portable system. In order to bill contents the CMN on file must qualify for portable equipment even if portable oxygen was never billed. When billing for contents attach a narrative statement indicating portable was never billed but the patient qualifies for portable content payments.

2. When billing for replacement oxygen equipment after 60 months from initial issue and the useful life of the equipment has passed; what is the required Claim NTE Note?
 - a. RUL (with original oxygen date) 04/12/2003 new POD & INT CMN attached
OR:
 - b. Request new rental period 03/15/09 new POD & INT CMN attached

Answer: Medicare does not provide specific guidance on the use of appropriate abbreviations. The items required for beginning a new rental period for the expiration of the useful lifetime include: RA modifier for each piece of equipment; a narrative explaining the reason for the replacement; and a new Initial CMN (these are required on the first claim only).

3. When billing for Oxygen Contents after the 36 month payment on the stationary (gaseous or liquid) System; is the supplier required to note the initial date of capped oxygen equipment?

Answer: It is acceptable, but it is not required.

4. Please clarify the correct process to submit 60 month equipment Replacement Initial CMN; is there anything supplier need to do differently than a new initial oxygen patient.

Answer: Indicate the billing is for a new 60 month period by appending the RA modifier on the claim, adding a narrative statement as to the supplier's intentions, and attach the new CMN. CGS has created a new status for these claims so that a Clams Processor can manually set up the new CMN.

5. Please provide clarification for the use of the N370 Remark Code and CO-35 Denial Code

Answer: CO35 and N370 indicate the equipment has capped out, either oxygen or capped rental.

6. Is the N370 Remark Code indicated on the 36 month rental for oxygen?

Answer: No, information message 223 will be received.

7. We have received denials for capped portable oxygen systems with the CO-96' why would a supplier receive a CO-96 instead of the CO-35?

Answer: We need examples - these are two different reasons for denial. CO35 is used when the equipment has capped. CO96 may be used when contents are billed but the related equipment is not on file.

8. What relationship does the CO-96 Denial Reason code have to/with the N370 and CO-35?

Answer: See #7

9. If a patient has had their oxygen equipment for more than 5 years but 36 months has not been paid by Medicare, can replacement equipment be provided and a new 36 month period begin?

Answer: Yes.

Infusion/Enteral/Parental:

1. Please clarify the requirement for WHEN to notify a beneficiary of the rent to purchase option for PEN pumps. Suppliers are reporting that during NSC site visits, they are instructed that the notification has to be with the initial claim. Below is an excerpt from chapter 5 of the Jurisdiction C supplier manual which does **not** indicate suppliers are required to notify the beneficiary of the rent to purchase option with the initial claim, an excerpt from the Jurisdiction B supplier manual which does indicate the beneficiary is notified of the purchase option with the initial claim and the supplier standard related to this topic.

CGS-Parenteral/enteral pumps can be either rented or purchased. When rented, they are processed like capped rental items with two notable exceptions. First, they are not subject to the 25% reduction payment for the fourth rental month and after. Second, a beneficiary may elect to purchase a parenteral/enteral pump at any time, but must be offered the opportunity to do so by the tenth month if he/she has not already done so.

NGS-The beneficiary has the option of purchasing a PEN pump with the initial claim or at any time during the rental period. However, PEN pump suppliers must notify the beneficiary of the option to purchase the pump with the initial claim.

Supplier Standard-# 5- A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.

Answer: Per the IOM: The patient has the option of purchasing or renting the pump from the supplier. Contractors must request written authorization from the patient before or after paying for a pump purchase. If the patient decides to purchase the pump once rentals have been paid, the purchase allowance will consist of the used purchase allowance less the amount allowed to date for rentals.

The instruction does not say it must be in the first month but that they have the option at any time to purchase the pump.

Diabetic Monitoring and Supplies:

1. Where should the KL modifier be listed on a claim or does it matter? We have been getting conflicting answers.

Answer: Effective with dates of service 01/01/2009 KL modifier is a pricing modifier. If more than one pricing modifier is used the VMS system will arrange them in alphabetical order.

DME:

1. We have several patients that are requesting replacement equipment where we are aware the patient has had similar equipment in the past and is not eligible for replacement equipment. We have executed an ABN with these patients to disclose that because of the previous equipment these services will likely be denied by Medicare for medical necessity reasons. However when the claims are

processed, they are not being denied as same or similar equipment, but as having reached a cap (CO-35 versus CO-150). After denial we submit a redetermination request with the ABN and an explanation of the previous equipment history. However our redetermination requests have been unfavorable. This appears to be a system limitation or possible education issue. If we can document the patient had previous equipment, that we advised the patient of their responsibility, and have submitted the claim appropriately, how can we ensure the patient will be held responsible? Same or similar denials are a justifiable medical necessity denial that would be affected by the ABN modifier. This should override a capped out denial. Please see the attached examples:

Answer: CGS reviewed the information sent to Redeterminations and found that the ABN on each example was too vague and therefore deemed an invalid ABN.

2. The TENS Unit policy does not specify a time period for the reevaluation for chronic intractable pain. If the patient receives a one or two month trial, can they still qualify for the purchase if the follow-up visit is 6 months later (assuming the device is providing benefit)? Oftentimes patients are just not compliant in scheduling that follow-up visit, but they continue to use and benefit from the therapy. We understand we cannot bill for the purchase until that follow-up visit takes place.

Answer: No. According to the TENS LCD: For chronic pain... The pain must have been present for at least three months. Other appropriate treatment modalities must have been tried and failed, and the medical record must document what treatment modalities have been used... When used for the treatment of chronic, intractable pain, **the TENS unit must be used by the patient on a trial basis for a minimum of one month (30 days), but not to exceed two months...** The trial period will be paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain. For coverage of a purchase, the physician must determine that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. **The physician's records must document a reevaluation of the patient at the end of the trial period, must indicate how often the patient used the TENS unit, the typical duration of use each time, and the results.**

3. If a patient fails an initial trial with a TENS unit, but then at a later date (say 1 year later), the doctor requests another trial (absent a change in condition).
Will Medicare consider a second trial for the TENS?
Would this be subject to individual consideration, or is there only one trial per lifetime?
Would a change in condition allow for a second trial?

Answer: Medicare will consider a second TENS trial on a claim-by-claim basis.

4. Publication on Supplies and accessories used with beneficiary owned equipment on February 26, 2009 indicates a NTE segment with the HCPCS of base equipment, a notation that this equipment is beneficiary owned and the date the patient obtained the equipment is required for supply claims to be processed.

Providers are starting to see the denials of accessories and supplies when this is missing. Since ALL equipment meets purchase price and becomes beneficiary owned, this information is in the Medicare claims database (if Medicare paid for the item) and the KX modifier on the supplies indicated the provider has documentation that the patient meets medical necessity criteria, is there no way we can modify this edit?

If the contractor paid for the equipment this information would be on file. Please submit examples to James Herren if there are claims where the contractor has the necessary information on file but denied the claim.

As it stands now doesn't a note in the NTE segment cause the claim to pend out for manual processing so it can be reviewed? Won't this cause all PAP supply claims to pend out after 13 months every single claim (as an example)?

[Answer: Notes attached to a claim will not automatically stop all claims for manual processing. We will review submitted notes when necessary \(e.g., RA modifier and new CMN submitted with the claim or if the claim edits for manual review\).](#)

5. Has there been any finalization to the Heating Pads and Heating Lamps LCD?

[Answer: No.](#)

6. Is it acceptable to charge the beneficiary for a service call, for beneficiary **owned** equipment, when the service is performed for the convenience of the beneficiary? For example, the beneficiary believes their power chair isn't functioning properly (or wants air put in the tires) and does not want to bring the chair in to have it evaluated and would rather we go to their home to take a look at it. This "service" is not part of a rental and there is no new delivery. We see this as a service request on customer owned equipment that is outside the scope of the supplier's obligations to a beneficiary and would not be a covered benefit according to Chapter 3 of the supplier manual, but would be chargeable to the beneficiary.

[Answer: No.](#)

7. If a semi-electric hospital bed (E0260) is delivered to the patient and at a later time the physician orders the patient a Group 2 Support Surface (E0277) at which time the standard mattress is picked up and an E0261 is now being billed, do we need to get a new order or can we bill from the existing order for the E0260 and change the HCPC on the claim to E0261?

Answer: No new order would be required.

8. When a payment is recouped due to an "Inpatient Stay" this results in a CO176 denial on additional claims after the CMN Date in Medicare's system has ended. Is there a way for the CMN date to be automatically adjusted when these recoups occur since the CMN is for lifetime and the full rental period has not been paid?

Answer: No. It is necessary to request an extension of the capped rental period through the NTE Segment of the first claim after the expiration of the original capped rental period.

Respiratory:

1. For the new PAP policy we are finding that general practice physicians are typically charting in their notes a minimum of vital signs (heart rate, respiratory sounds, blood pressure, etc) and will include a narrative indication of one or more OSA symptoms (daytime sleepiness, snoring, insomnia, etc). However in these cases, based on these few items, the doctor has made an observation that OSA might be a factor and sends the patient for a sleep study. Will that be sufficient for establishing the initial FTF prior to sleep study? We are not finding routine evidence of an Epworth sleepiness scale, neck circumference or BMI mentioned in the chart. Additionally, cardio pulmonary evaluations typically only take place when a patient visits an ENT.

Answer: The treating physician should document enough elements of an examination to rule out causes of sleep disordered breathing other than OSA that would not be appropriate to diagnose with a home sleep test. Not all of the elements listed in the PAP LCD documentation are required.

2. In December 2008, the DME MACs issued additional PAP FAQs. One of the questions pertained to payer changes (answer copied below) under which a patient received a PAP device paid for by private insurance and the patient is now enrolled in FFS Medicare and needs a replacement PAP device and/or accessories. What is required for medical policy criteria?

Answer: "For beneficiaries who received a PAP device prior to enrollment in FFS Medicare and are now seeking Medicare coverage of either a replacement PAP device and/or accessories, both of the following coverage requirements must be met:

1. *Sleep test - There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare, that meets the FFS Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks a replacement PAP device and/or accessories; and*

2. *Clinical Evaluation - Following enrollment in FFS Medicare, the beneficiary must have a face-to-face evaluation by their treating physician who documents in the beneficiary's medical record that:*

- a. The beneficiary has a diagnosis of obstructive sleep apnea; and*
- b. The beneficiary continues to use the device.*

If either criteria 1 or 2 above are not met, the claim will be denied as not medically necessary. The supplier may hold claims, pending confirmation that the above requirements are met, and then submit claims with the KX modifier beginning with the beneficiary's enrollment in FFS Medicare."

(End of Q and A)

In many instances, we are informed of the payer change many months after the patient became FFS. Oftentimes, the patient does not inform us of their insurance change, and we learn about it through an EOB denial from the private insurance (coverage terminated). If say the patient became FFS Medicare on 1/1/09 and we learn about it only on 4/7/09, we immediately notify the patient to verify the payer change and to inform the patient about the Medicare PAP policy. Say that the earliest that the patient can see their treating physician for a face-to-face evaluation is 4/20/09. Based on this Q and A, we would start our billing to Medicare as of 1/01/09 (date beneficiary became FFS Medicare), not 4/20/09 (date of evaluation). Please confirm that our understanding is correct.

Answer: Coverage begins when the coverage requirements have been met. In the example given, coverage would begin on 4/20/09 when the clinical evaluation is completed and the physician documents that the beneficiary meets the coverage requirements for Medicare's PAP therapy.

If this is correct, does this also mean that for payer changes, if the patient qualifies under criteria 1 and 2 above that we can apply the KX modifier to all rental claims (months 1 through 13)? Since the treating physician is certifying that the patient has OSA and continues to use the PAP device, it is our understanding that there is no longer a need for the objective evidence of compliant usage and another face-to-face re-evaluation between the 61st and 91 day. Using our example, since it was in the fourth month that we became aware of the payer change, we are well past the appropriate time window.

Answer: The physician certification that the beneficiary continues to use the device replaces the requirement for objective evidence of compliant usage;

however, a prudent physician should base his/her assessment of continued use on objective evidence.

3. In reference to a FFS Medicare patient who was set up with a PAP device on 11/01/08. This set up "fell through the cracks" and we had failed to inform the patient about Medicare's policy in regard to continued coverage beyond the first 90 days. Although the patient was using the PAP device regularly since set up, through no fault of their own, the patient was not collecting the usage data nor did he go back to his treating physician for a face-to-face clinical re-evaluation between the 31st and the 91st day. We discovered this oversight on 4/01/09, or at the sixth month of rental. We understand that we can bill the first three months (11/1, 12/1, 1/1) with the KX modifier. Can we now provide the patient with a PAP device with download capability and collect 30 days' worth of data and after the patient goes back to his treating physician for a clinical re-evaluation, can we then submit our claim (month 4) from this point forward with the KX modifier? If not, how do we remedy this situation?

Answer: Yes, per the LCD, If the physician re-evaluation does not occur until after the 91st day but the evaluation demonstrates that the patient is benefiting from PAP therapy as defined in criteria 1 and 2 above, continued coverage of the PAP device will commence with the date of that re-evaluation.

4. Due to the stringent continued use requirements in the PAP policy and the need for the patient compliantly use the CPAP a minimum of 4 hours per night for 20 nights in a 30 day period of continuous use and to follow-up with their treating physician between the 61-91 day; can DMEPOS Suppliers obtain a signed executed ABN from each PAP patient so long as the above reasons are noted on the ABN?

Answer: Yes.

5. If we send a patient-owned PAP machine is to be repaired and the machine is no longer under warranty, the manufacturer sends us a refurbished machine for the patient because it was better to replace the machine rather than repair it. It was repaired, but it was replaced with a refurbished model rather than replace all the parts that needed to be repaired. It is less than 5 years so Medicare will not begin a new capped rental period. How is this to be billed to Medicare? In this case, the DME company is still charged for the "repairs" even though the PAP was replaced with a refurbished PAP.

Answer: According to CMS, Regulations at 414.210(e)(4) – previously (e)(5), is a provision added as part of the DRA rulemaking that requires the supplier of a capped rental item (the one that was paid the 13th rental payment) to replace the capped rental equipment free of charge if it will not or does not last for the entire reasonable useful lifetime (default = 5 years). In the situation described below, the equipment was not

repaired, so a bill for repair cannot be submitted. However, since the equipment was replaced (I assume because it was cheaper than repairing it or this is just the manufacturer's policy), the original item did not last for the entire reasonable useful lifetime and the supplier needs to provide the refurbished item to the beneficiary free of charge and cannot bill Medicare.

The supplier can try to convince the manufacturer to repair the original item rather than provide a replacement, and if the manufacturer will not accommodate such a request, the supplier might want to start purchasing their CPAP devices elsewhere. If the manufacturer will repair the item, but accumulated repair costs exceed 60 percent of the cost to replace the item, the carrier should inform the supplier that they need to replace the item at no charge to the beneficiary or Medicare.

6. Do nebulizer medication claims require the NTE Note in block 19 or NTE segment; if the patient owns their nebulizer equipment?

Answer: No, just on the initial claim for the base equipment.

7. If the patient is renting the nebulizer equipment from the same supplier or a different DMEPOS supplier; is the pharmacy required to indicate the patient is renting a nebulizer from another supplier in the NTE Note or Block 19?

Answer: Helpful but not required.

8. We have an existing CPAP patient set up in 2001 that Medicare has paid rentals and maintenance and service. His original sleep study was done in 2001. The CPAP has been in use but is no longer effective to treat the patient's OSA. The physician is now prescribing E0470. Would this be grandfathered under the old PAP policy? If not, do we need to have a face-to-face evaluation before the sleep study in 2001? The face-to-face evaluation was performed prior to the titration..

Answer: For patients with a change in medical need necessitating a different piece of equipment (E0601 to E0470), the patient must meet the current coverage criteria for the new piece of equipment. The scenario above would not be grandfathered and there must be current documentation proving the medical necessity of the E0470.

Rehab:

1. Updates to ICD9 codes were made effective 10/01/08. The Council requests an update to the seating LCD to allow for additional diagnoses. Peggy Walker has forwarded case studies and information to Dr. Hoover. Council requests an update or opportunity to discuss when the LCD might be updated. (copy these to be brought to the meeting)

Answer: The DMDs received the information and are considering the information provided for an update to the LCD.

2. Review of accuracy of modifier usage:

Power wheelchair replacements -- How should they be billed?

NURBKX99 and the BPKH in the NTE segment?

Answer: The modifier for the replacement of the base equipment is RA. The order of the remaining modifiers is inconsequential as long as the 4th modifier is 99 (99 requires us to manually access the additional modifiers in the notes section.

Manual wheelchair accessories that require NURBKEKXRTL99 - what needs to go on the claim line? RBKEKX99 and the NURTLT in the NTE segment?

Answer: The order of the modifiers is inconsequential as long as the 4th modifier is 99 (99 requires us to manually access the additional modifiers in the notes section.

3. The recently published labor limitations based on type of repair indicates the units per type of repair. If I am repairing a power chair and I do several different repairs, I only bill one line item for labor E1340 with the # of units of combined labor for what occurred. How would CIGNA know what units went with what repair to measure against this new limitation?

Answer: From the February 26, 2009 bulletin article:

Claims for repairs must include narrative information itemizing each repair and the time taken for each repair.

4. Some of the power center-mount elevating legrests have been code verified by PDAC as K0108. It seems that in another region this is paying at the allowable of the E1010. Is this what providers should expect? Or would the allowable be based on more comparable products?

Answer: HCPCS code K0108 is processed under individual consideration. Each claim is evaluated individually taking into consideration information submitted with the claim. Refer to the DME MAC Jurisdiction C Supplier Manual, Chapter 10, for documentation needed for HCPCS codes processed under individual consideration.

5. There are some cases where an end-user is not cognitive enough to safely drive a power wheelchair but does medically need a tilt system, therefore a manual tilt-

in-space (E1161) is prescribed. In few cases, the end-user may weigh too much for a caregiver to tilt back. In such a case would Medicare consider payment of a manual tilt-in-space with a power tilt system added on?

Answer: It is not clear that a manual wheelchair can safely accommodate a power tilt system; however, if it can be fitted safely, we would allow. Alternatively, the Power Mobility Devices LCD allows coverage for a power mobility device with caregiver controls when the beneficiary is unable to operate the device but requires the device to accomplish mobility-related activities of daily living.

6. If a beneficiary requires a repair on a PMD that was funded by another funding source (prior to them qualifying for Medicare), do they actually have to go through the Medicare face to face process for powered mobility as if the chair were a new purchase? If so how does the 45-day rule apply? How does the 120-day rule apply? How does WOPD prior to delivery apply? What initial date should appear on our order (the date of purchase of the chair or the date order was called in for the repair)? We are unsure as to how these issues would apply when the patient already owns the power wheelchair.

Answer: The beneficiary must meet all of the Medicare coverage requirements at the time the accessory, repair or other service is needed.

7. If the provider sold the chair to the beneficiary prior to them having Medicare, would the documentation they have on file from the sale to the private insurance or Medicaid suffice? If they have documentation that clearly shows the need for the power wheelchair, but the patient never had a specific face to face visit, would this be acceptable? The original orders they would have on file from another insurer would also not have the patient's Medicare HIC number. Would these orders be acceptable?

Answer: The beneficiary must meet all the Medicare coverage requirements at the time the accessory, repair or other service is needed, including the 7-element order. The Medicare HICN is not one of the required 7 elements.

8. What kind of documentation is a provider expected to have when Medicare has the patient owned wheelchair on file, but they did not provide the wheelchair? In this scenario the provider conducting the repair normally does not have any documentation justifying the chair. Are they required to have this documentation on file even though Medicare has already approved and paid for the initial purchase of the chair?

Answer: Yes.

9. We are seeing claims where a rental manual wheelchair is denied – after Medicare has been paying the rentals – and a person receives a power wheelchair. Is Medicare not reviewing to see if a pick-up ticket has been received or what, if any, documentation are they reviewing prior to paying the power wheelchair and denying the manual wheelchair?

Answer: When there is a change in medical need necessitating different equipment, Medicare stops paying for the previous equipment (as the previous equipment is no longer medically necessary).

10. There seems to be a prevalent issue with collecting a pick-up ticket from beneficiaries who may have had rental equipment year's prior and now for a different reason needs new equipment. At times Medicare will ask for a copy of the pick-up ticket and the beneficiary has lost it and/or the original provider is closed, will not cooperate, or cannot find a copy. Is there any other documentation that can be used to provide such "proof?"

Answer: CGS will accept a letter signed and dated by the beneficiary or their caregiver detailing what equipment was picked up and when.

11. What is Medicare's coverage policy on foot boxes? There is nothing in the LCD. Do they have to be code verified?

Answer: Coverage decisions regarding foot boxes are made on a case-by-case basis based on medical necessity information in the medical record. Questions concerning code verification should be directed to the PDAC.

12. The next 4 questions are related to a 12/22 PMD Webinar and some information contained on slides from the presentation (attached) as well as some answers to questions provided during the presentation.

- i. For the 7-element order, slide 15 said it must have Detailed description of the item (The type of PMD must be specified). I asked to verify this in the Q&A session since policy states something different, and was told the slide was wrong and would be corrected, that an initial order can still list a general item (i.e. PMD). Someone followed up with the scenario where a POV is initially ordered but the home assessment rules it out, and a PWC is provided. The question asked was 'Does a new order need to be obtained that actually says PWC'? The answer provided was that a new order did not need to be obtained in that situation. Can this be verified?

Answer: There needs to be a new order, in part, to notify the physician that the original device ordered was not suitable for the beneficiary's home.

- ii. Slide 17 states if the supplier receives a written order that does not contain the elements specified on the previous slide, the supplier must clarify this by obtaining another written order. but that the missing elements may be entered by the supplier. In the Q&A session a follow up was asked...if a provider obtained a script and it was missing the date of the face to face, it was stated that the provider could fill in the missing info and just have the physician sign and date the info the provider added. Can this be verified?

Answer: The treating physician must complete the 7 element order, including the date of the face to face. The treating physician should have this information in their records.

- iii. Slide 18 states if the initial order does not have all 7 elements, the revised order does not have to be received within 45 days following completion of the face-to-face examination. Can this be verified?

Answer: Incorrect. The 45 day time limit is tied to the date of the face-to-face evaluation. The regulations make no exceptions on the 45 day timeline; therefore, the order (original or revised) must be received within 45 days of the face to face examination.

- iv. Slide 38 states that if a review by a Medicare Contractor results in a request for additional information, the reviewer will follow the algorithm defined in NCD 280.3 to determine if a claim meets coverage criteria. We have been told repeatedly that a comprehensive assessment is required, not just answers that address the algorithm. Can this be clarified?

Answer: A comprehensive assessment is required. As noted in the PMD Documentation article published in July 2006:

The information that the supplier must obtain before submitting a claim to the DME contractor is described above. However, if the DME PSC [now DME MAC] asks for documentation on individual claims, additional documents (e.g., notes from prior visits, test reports, etc.) shall also be obtained from the treating physician to provide a historical perspective that reflects the patient's condition in the continuum of care, corroborating the information in the face-to-face examination, painting a picture of the patient's condition and progression of disease over time.

- 13. A claim denied in Medical Review for a power wheelchair with a statement from a staff member regarding specificity of physician notes and required elements of the face to face examination. The e-mail states specifically "The physical

assessments listed here should be objective measurements of strength, range of motion, etc. Statements such as "weak", "has difficulty", etc. are subjective and do not give a clear picture of the patient's condition." While such measurements do help paint a clearer picture of a patient's condition, the PMD policy also states the following in the Documentation Section: The [face to face] report should provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation. In this case it can be inferred that the lack of such specific measurements are what triggered the denial, when in fact the policy does not actually state the inclusion of such as a requirement. (The most obvious example of when these measurements would not be included would be for a client that actually was missing one or both upper extremities.) Can this be clarified?

[Answer: While not every element must be addressed, there must be sufficient information in the evaluation of the beneficiary's objective and subjective limitations to make a coverage determination.](#)

14. Are flat free tires separately reimbursable on initial issue of manual wheelchairs? The HCPCS for some of these tires are listed in the LCD but are not included in the bundling table and there is no reference to coverage in the LCD.

[Answer: Flat free tires may be submitted as an upgrade with an appropriately signed Advance Beneficiary Notice \(ABN\). Please visit Policy Article A44196, titled "Downcoding: Use of GK & GL Modifiers on Claims for Upgrades Effective April 2007" for further billing instructions.](#)

Miscellaneous:

1. When submitting a courtesy claim in order to obtain a denial for the secondary payor, are we able to adhere to the secondary payor's requirements for the date of service? Two examples of this would be billing with fill/compound dates for drugs when a state Medicaid plan is secondary and Medicaid requires this date as the "From" date; or billing the usage dates for per diems when the secondary payor is secondary and the secondary payor requires the start of usage (or cycle date) as the "From" date.

[Answer: When filing claims to Medicare, Medicare regulations should be followed.](#)

2. Our office has many denials for clients who are open to home health episodes. Claims are paid and then recouped months later. Is there any way for a provider to verify if a patient is open to home health prior to providing supplies that are included in the episodic rate paid to home health agencies? If a patient is currently receiving supplies from a dme provider and then becomes a home health patient, is there any mechanism for a provider to know this?

Answer: The Jurisdiction C Interactive Voice Response (IVR) provides details of reported Home Health Episodes in the Beneficiary Eligibility section. Please note, the DME MAC's report is limited to the Home Health information submitted by the Home Health Agency to Medicare Part A (this information is not always submitted immediately).