EDUCATION

1. Company closes one location and continues to bill the patients from main office are they required to get a revised CMN? Same tax ID/same name/different PTAN and NPI - when they asked if they had to revise all their CMNs they were told no but now when they go to reconsideration they are told they have to have a revised CMN even if it is with the same company.

Response: The second location is considered a separate entity since there is a different PTAN and NPI; therefore, a revised CMN is required, similar to the guidance outlined in the 2003 DMERC Dialogue article for Common CMN Scenarios for an acquisition.

2. Can the KE modifier be used on power complex rehab accessories? We have received the payment in the past but are now receiving denials (DCN 11220829814010 06/29/11).

Response: KE is a CB modifier. For this example, supplier appended the KE modifier to a competitive bid item and we denied the claim correctly. The previous claims paid in error as the narrative was not followed.

3. Patient transfers from a Medicare HMO to traditional Medicare and has already been billed for 5 months. He does not want us to bill past the total of 13 months. We billed the 8 months and stop billing. Can he get paid for supplies as needed without Medicare paying the full 13 months?

Response: Beneficiary movement between a Medicare Advantage (MA) plan and fee-for-service (FFS) Medicare can follow 2 possible scenarios:

Scenario 1 - Payment for item started in FFS, beneficiary then moves to MA then returns at some point to FFS Medicare.
   a. If item in continuous use throughout the MA episode, FFS payment resumes at the month it stopped in the MA plan. Suppliers should indicate “patient-owned equipment” in HAO record. The tracking CMN will need to be updated to reflect 13 payments using the Reopenings process.
   b. If item use was stopped during the MA episode, Medicare break-in-service rules apply.

Scenario 2 - Payment for item started in MA then beneficiary moves to FFS Medicare.

For items started in the MA episode then the beneficiary moves to FFS Medicare, Medicare treats this situation like a new item to FFS and all applicable Medicare rules apply, similar to a beneficiary becoming newly eligible for Medicare.

4. Patient has suppliers’ equipment but refuses to go back for a follow up evaluation. Patient refuses to sign an ABN and will not give the supplier his equipment. Can the supplier use the GA modifier after notifying the patient via certified mail and then bill the patient?

   a. Can the supplier use the GA modifier and notate refusal to sign the ABN as per the instructions in the Medicare Carriers Manual on refusal to sign ABNs?

Response: Please use existing instructions in the IOM.

5. Patient abuse of capped rental equipment. To whom does a supplier report patient continued abuse of equipment (i.e. Repeated bug infestation of concentrators/CPAPs/Bi-paps/abuse of power mobility that is being rented etc.)?

Response: The supplier should report to written correspondence malicious damage (as defined by IOM, Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 110.2.C) to the contractor. CGS, in consultation with CMS, will make a determination about the beneficiary’s liability for the cost of repairs.

6. An error is made on original date of a CMN and a wrong date was keyed in. This was paid for over 12 months and was found when a CERT contractor requested information on a claim within the last 6 months. The person keyed in the date of the order intake rather than the actual date of billing.
Delivery ticket and all other information is good. How can this be corrected within the system?

**Response:** Use the Redeterminations process – document what happened and show proof of such and analyst should correct CMN on file.

7. An electronic data company is selling a DME ordering program to DMEs stating the clinical criteria put in electronic format with a check off format sent to physicians would be acceptable as documentation for any DME item? Would this be acceptable?

**Response:** The Program Integrity Manual, Chapter 5.7 provides additional information regarding medical necessity documentation requirements. Each supplier is responsible for ensuring that the documentation to support their claims are valid.

8. What recourse is there for an HME company when a patient sells the oxygen concentrator which is being rented by Medicare?

**Response:** Suggest supplier contact an attorney knowledgeable in healthcare matters.

9. Will CGS be updating/revising their forms with their new name and/or logo?

**Response:** Please provide examples of out of date forms. A quick review of the website as of 10/25/11 shows current brand and format.

10. When Medicare is the secondary payer on a Group 2 PWC, they are denying the claim if the primary payer treats the transaction as a purchase. The denial code states that billing guidelines were not followed and makes it the provider’s responsibility. Providers then have no recourse to collect the remaining balance from the patient. Can that code be changed to deny as patient responsibility? Will the claim process if it is billed to Medicare with the RR modifier?

**Response:** Medicare is required to follow the payment guidelines established for PMDs which requires rental of equipment. Medicare cannot change the payment liability.

11. The Assignment of benefits (AOB) guidelines were revisited in 2005 to identify situations in which an AOB does not HAVE to be specifically assigned to the provider via the following change request: http://www.cms.gov/Transmittals/downloads/R643CP.pdf. For audit purposes, can we assume that DME providers are not required to procure a signed AOB from patients in two scenarios: 1) when the provider has signed a participation agreement with Medicare and is listed as “participating” by indication of the green participation icon on the www.medicare.gov website, and 2) in the case of Medicare covered drugs where the program mandates that providers must file those claims on an assigned basis only? Are there any other cases where providers do not have to obtain an AOB?

**Response:** The question addresses the two specific situations where an AOB is not needed. Refer to IOM 100-4, Chapter 1, 30 and 100-8, Chapter 4, 4.24 for the exact language.

12. A provider has received two CO-184 denials. According to the provider, the physician’s office has indicated that they do prescribe DME. She has orders for both claims from the physician. Medicare is telling her that the physician may not be set up in PECOS to order DME. Can you tell us what these claims may be editing against, and what suppliers can do to verify physician eligibility?

**Response:** It may be a ZPIC issue where they have a letter that the physician does not order DME. Given an example, we can check the NPI registry.

**RESPIRATORY**

1. After reviewing the LCD effective 10/01/11 for oxygen, there is a new section that states: “In the case of OSA, it is required that the OSA be appropriately and sufficiently treated such that the patient is in the chronic stable state before oxygen saturation results obtained during sleep testing are considered qualifying for oxygen therapy”.

We understand that in the case of obstructive sleep apnea (OSA), it is required that the OSA be appropriately and sufficiently treated such that the patient is in the chronic stable state before oxygen saturation results obtained during sleep testing are considered qualifying for oxygen therapy. Based on this directive, it is our interpretation that a patient undergoing a diagnostic polysomnography (sleep study) for the purposes of diagnosing OSA would not be considered to be in a chronic stable state until he/she is being treated for the OSA and that sleep study could not be used to qualify the patient for home oxygen therapy. Physicians have expressed frustration at being unable to use the titration study for patients who require supplemental oxygen.
Please address the following questions so that we may provide physicians with appropriate direction.

a. Please clarify chronic stable state to qualify for oxygen therapy in the context of OSA and Polysomnography.

Response: “Chronic stable state” – Not during a period of acute illness or other condition that impacts the pulmonary status of the patient.

b. During testing it is frequent that one disease is found while diagnosing another; would this not be the case during Polysomnography (where the patient is found to have OSA and COPD, or nocturnal hypoxemia, etc)?

Response: It could be; however, other diseases impacting oxygen saturation that are treated by other means, such as PAP therapy for OSA, must be addressed first.

c. Can the titration study be used to qualify the patient if it shows the AHI was controlled but the patient still desaturates while a PAP is applied?

Response: CMS’ NCD and the LCD for oxygen require that in order to qualify for oxygen therapy, the patient must be in the chronic stable state. If, after titration and appropriate treatment for OSA, the patient remains hypoxemic AND the other criteria for qualification for oxygen are met, the values from the titration oximetry would be acceptable.

d. If the patient must first be treated with a PAP, is there a time frame for how long the OSA has to be treated to achieve chronic stable state?

Response: See above.

e. Is the patient required to wait until he/she meets the 30 day compliance period? Physicians are concerned that the 30 day compliance period will likely not be met if oxygen is not administered in order to prevent the patient from desaturation.

Response: No, the patient is not required to wait until the 30 day compliance period is met. That is not a policy criterion.

2. Unfortunately, 90% of the people diagnosed with OSA have gone undiagnosed and/or untreated for several years; even after the individual has undergone a Polysomnography. A large number of patients are unable to tolerate the PAP device and choose not to use and/or continue PAP therapy. Considering that PAP devices are not considered life support devices, we have the following questions:

a. If a patient is never able to tolerate the CPAP for treatment of OSA, is he or she ever considered in a chronic stable state to qualify for oxygen?

Response: For patients that are unable to tolerate PAP therapy or other therapies for OSA, oxygen is a substitute to treat the hypoxemia; however, this situation must be well-documented by the treating physician.

b. We have seen patients where they cannot tolerate a PAP device at all and the physician discontinued the PAP order and prescribes nocturnal oxygen. Would an overnight oximetry showing a desaturation > 5 minutes ever be considered in a chronic stable state?

Response: See above (a). For those patients who are unable to tolerate PAP therapy or other therapies for OSA, substitution of oxygen is acceptable; however, the patient must meet the coverage requirements in the oxygen LCD and related PA. Specifically, the coverage criteria for qualification under nocturnal testing must be met.

3. Scenario: The treating physician orders a sleep test to evaluate the patient for possible OSA. During the diagnostic portion of the test, the patient’s AHI is over 15, confirming a diagnosis of OSA. Additionally, the patient’s O2 saturations are below 89% during this portion of the test. A PAP device is subsequently applied, properly titrated, and the patient’s AHI is reduced to within normal limits, (this shows that the patient’s OSA is being treated and controlled, and the patient is now in a chronic stable state). The patient’s O2 saturations, however, remain below 89%. Oxygen is added to the PAP device and the patient’s AHI is reduced to within normal limits, (this shows that the patient’s OSA is being treated and controlled, and the patient is now in a chronic stable state). The patient’s O2 saturations, however, remain below 89%. Oxygen is added to the PAP device with oxygen added.

a. Would the above scenario qualify the patient for both the CPAP and the O2 therapy? If not, please advise?

Response: See above.
oxygen order in April 2011. The order came to us from the North Florida Sleep Disorders Center. The physician wrote in his report: “Results of the study reviewed with the patient who will utilize home oxygen at 2 liters per nasal cannula at bedtime and a prescription was written. The patient’s AHI was borderline for positive pressure titration and if she is not keen on using C-PAP, positional therapy will be helpful avoiding the supine position.”

The patient heeded the latter recommendation but did not want a CPAP, therefore, only the oxygen equipment was delivered.

Our questions are the following:

a. Please confirm that it is acceptable for us to bill Medicare for the oxygen equipment based on the oxygen saturation result from the attached sleep study.

Response: Yes, as long as the coverage criteria for oxygen therapy are met.

b. For future referrals (such as this example) where the outcome of the polysomnography would result in an oxygen referral, can we continue to accept them and bill Medicare for oxygen?

Response: Yes, as long as the coverage criteria for oxygen therapy are met, including testing in the chronic stable state.

5. In the Oxygen LCD it states: For patients who qualify for oxygen coverage based only on a sleep oximetry study, the oxygen saturation value reported in question 1b of the Oxygen CMN must be the *** lowest value *** (not related to artifact) during the 5 minute qualifying period reported on the sleep oximetry study. A report of the sleep study documenting the qualifying desaturation must be available upon request.

a. Question: **** does this mean that if a patient sat is 78% for 1 minute but were at 88 for the rest of the qualifying 5 minutes would the doctor document the sat as 78% even though it was not a full 5 minutes?

Response: The lowest value during the 5 minute qualifying time frame was 78%. That is the value to list on the CMN.

b. Question: if the patient spends greater than five minutes at multiple saturations below 88%, but none of the values were present for five minutes, would the patient still qualify for oxygen (e.g. 4 minutes at 88%, 1 minute at 87%, 3 minutes at 86%, 4 minutes at 85%)?

Response: In the example given, the patient spent a total of 12 minutes at or below 88%. The lowest value was 85% which is what would be listed on the CMN.

6. We have been told by a couple of the physicians who specialize in sleep medicine that they have received letters from Medicare regarding possible overutilization of sleep studies. We have not actually seen a copy of the letter, but it is making the physicians shy away from repeat studies. Additionally, with the recent changes to the BiPAP criteria and the recent advances to CPAP (auto-titrating), the physicians are leaning toward trying the Auto-CPAP as a replacement when the patient is eligible for a replacement unit at the 5 year mark of using a BiPAP. However, they want to do this without performing a re-titration study. Please review the following scenario and advise:

Scenario A: patient qualified for and received a BiPAP device for OSA in January 2005. He met the compliance guidelines in place at the time and continued to see his physician for follow-up. He returns to the physician in October 2011 for a standard follow-up and communicates to the physician that his machine is malfunctioning (shutting on and off at times) and that he is not tolerating the machine, even though his usage is an average of 7 hours/night. The patient is eligible for a replacement unit based on the 5 year reasonable useful lifetime provision. The patient was on a relatively low pressure (Ipap 10, Epap 5) and the physician feels that, with the advancements made in PAP device and the low pressures prescribed, the patient’s apnea could be adequately corrected with an Auto-CPAP device (lower cost) as opposed to a Bipap device. We realize this is a change in equipment from E0470 to E0601.

a. Can the E0601 be provided as a 5 year replacement for an E0470?

Response: No. Reasonable useful lifetime rules apply to like/same items (i.e., devices within the same code). Coverage for E0470 requires that the E0601 be ineffective; therefore, how can you justify replacing an effective device with an ineffective one?

b. Can the replacement be justified with only the F2F evaluation?

Response: Because of the difference in the R&N criteria between the E0470 and E0601, the patient would need...
to qualify for the E0601 by meeting all of the coverage criteria (i.e., face-to-face evaluation, trial period, adherence to therapy metric, follow-up evaluation).

c. Is a new sleep study required to step down from the E0470 to an E0601?

Response: Yes, at least a new titration study to determine that the E0601 device is adequately treating the OSA.

d. Would there be new compliance requirements?

Response: Yes, see above.

7. Regarding AutoSV devices and the coverage criteria:
In the policy it states Central sleep apnea (CSA) is defined as:

An apnea-hypopnea index (AHI) greater than 5, and
Central apneas/hypopneas greater than 50% of the total apneas/hypopneas, and
Central apneas or hypopneas ≥ 5 times per hour, and

According to the sleep tech they have to score most centrals as mixed. She stated that according to the AASM that a central apnea starts out as a hypopnea then if the patient does not take a breath and the hypopnea continues then it is considered to be a central apnea. She stated they have to report mixed apneas not just central. If this is the case then how do we get an AutoSV covered if the physician’s dictation states the patient has mixed apneas/hypopneas greater than 50% of the total apneas/hypopneas?

Response: CGS has no comment on the AASM scoring rules. The coverage criteria and definitions for CSA are included in the local coverage determination. If there has been a change in the diagnostic criteria for CSA, an evidence-based LCD reconsideration request should be submitted.

8. Are hospitals eligible to get paid for a sleep test if the physician does not do a face to face? It seems like that should be a requirement for them to get paid. If Medicare mandates this as a condition for coverage for the equipment should it also be the same for coverage of the test itself? We have had several patients qualified for PAP based on the test results, but absent the face-to-face the results are nullified. The patient is caught in the middle. We have educated the physicians and we still have problems. Are there any means to hold the hospitals accountable on this point?

Response: CGS has numerous educational documents on the CGS website and we encourage you to provide them with those and copies of the LCD.

9. I have 3 documented SAT tests during exercise as follows:
   a. At rest on room air of 91%
   b. 87% while walking and standing on room air
   c. Recovery Sat while walking of 92-93% on 2.5 liters

The physician is to report the 87% while exercising off of oxygen on the CMN 484. However; because the physician put a range for the exercise SAT while on oxygen – would this qualify?

Response: Yes, assuming the 87% is the value obtained with exercise.

REHAB

1. Payment rates for K0108 Articulating Foot Platform (AFP) have been inconsistent. What would prevent CGS from considering these items for payment under normal K0108 pricing methodology? Example is available.

Response: This item does fall under the pricing methodology used for K0108. Please provide the examples.

2. Providers have received Group 4 ADMC denials. With the removal of the LCA provision, what should providers do in cases where a Group 4 product is being provided as an upgrade in an ADMC situation?

Response: Suppliers should follow the upgrade rules outlined in the numerous articles published in February and March 2011. For ADMC, the supplier would submit a claim for the medically necessary item and the upgraded Group 4 product, both claim lines with the appropriate upgrade modifiers.

3. Now that standard power wheelchairs are rental only, is the Rent/Purchase Option letter or modifiers (BR, BP and BU) still a requirement?

Response: No, they are not.

4. A provider received an ADMC denial stating that a single power option chair could not accommodate both a power tilt and power ELRs. It is our understanding that power options in this capacity refer to power tilt and power recline only and that power ELRs are not a factor in the determination of whether a chair is a single or multiple power option. Please clarify. Example is available.
Response: Please provide an example. A single power option chair should be able to accommodate a power tilt and power ELRs. Per the PMD Policy Article:

Single Power Option - A category of PWCs with the capability to accept and operate a power tilt or power recline or power standing or, for Groups 3, 4, and 5, a power seat elevation system, but not a combination power tilt and recline seating system. It may be able to accommodate power elevating legrests, seat elevator, and/or standing system in combination with a power tilt or power recline. A PMD does not have to be able to accommodate all features to qualify for this code. For example, a power wheelchair that can only accommodate a power tilt could qualify for this code.

5. The wheelchair options/accessories policy states “Adjustable arm height option (E0973, K0017, K0018, K0020) is covered if the patient requires an arm height that is different than that available using nonadjustable arms and the patient spends at least 2 hours per day in the wheelchair.” However, K0020 is still listed in the Policy Article bundling chart as being included with a power mobility base. Can this chart be updated and K0020 removed?

Response: DME MAC medical directors will discuss.

6. The following was recently received as a Draft item from the Jurisdiction D Council:

78. How can a K0822 power base be provided with an E2601 upgrade? This cannot be billed as an upgrade situation. NAS is researching to see if an ABN and GA modifier for the general seat cushion (E2601NUGA) will allow the K0822. Hard coded system logic may not allow.

Does Jurisdiction C have the same processing issues?

Response: Yes, there is a similar processing issue across all four DME MACs. There is no systematic way for a K0823 (Group 2 PMD with captain’s seat) to be “upgraded” to three codes – K0822 + E2601/E2602 + E2611/E2612.

7. If a patient is in a facility and has a PMD evaluation during his stay, what would be the FTF date? Is it the discharge date? Is it the date of the actual PMD evaluation during his stay? Or is it the signature date on the evaluation (if different than the actual evaluation visit date - but before discharge)?

Response: The FTF date is the date of the evaluation if conducted by the treating physician. If referred to PT/OT for evaluation, it is the date the physician signs and dates concurrence with the findings.

8. Is a Physician’s Order required for replacement parts, if the parts are the same as the original item (i.e. tires)? I understand if it is a modification, a new Order is required. (Assume that the original supplier of the base is replacing the parts where Medicare covered the initial wheelchair and the patient still qualifies). Will the original order for the base be sufficient in an audit?

Response: Yes

9. The PMD LCD states a FTF visit is not required when replacing a PMD with the same code as previously billed. How does this affect the 7-Element order... what would the FTF date be? What day does a supplier count from for the 45 & 120 day requirements?

Response: The statement about the lack of need for a new face-to-face visit is in the Power Mobility Device (PMD) Policy Article. The PA states:

If the POV or PWC is a replacement during the 5 year useful lifetime of an item in the same performance group that was previously covered by Medicare, a face-to-face examination is not required. Note: Replacement during an item’s useful lifetime is limited to situations involving loss or irreparable damage from a specific accident or natural disaster [e.g., fire, flood, etc.]. [Emphasis added]

The replacement requires a new order but not a new FTF. The supplier should list the original FTF date on the order. Since this is not a “do-over,” the 45 and 120 day requirements are not applicable.

For replacements following the 5 year RUL, different rules apply. As noted in a 2007 PMD FAQ and republished again in November 2009.

Reminder - Replacement of Power Mobility Devices

Suppliers are reminded that replacement of power mobility devices (PMDs) under reasonable useful lifetime rules differ from other types of durable medical equipment. As detailed in Final Rule for Power Mobility Devices (Federal Register, Vol. 71, No. 65, April 5, 2006) and published in the September 2007 Frequently Asked Questions - Power Mobility Devices article:

Question 7. If a new PMD is needed after 5 years of use, what documentation must be obtained? Must we start the complete process or just obtain a new order?
Answer 7. All new PMD requirements must be met. Many new products are available, the codes have changed, and a patient’s functional status must be assessed through a face-to-face evaluation in order to establish need.

When replacing a PMD after the 5 year reasonable useful lifetime is met, the beneficiary must meet all of the coverage requirements outlined in the local coverage determination (LCD) for PMDs, including a new 7-element order and face-to-face evaluation. Claims that do not meet the coverage, coding or documentation criteria will be denied.

10. What is Medicare doing regarding the reasonable useful life of wheelchair cushions and backs? The PDAC coding verification requires the manufacturer warranty for these items to be 12-18 months (dependent on the code). Is Medicare recognizing this and the fact that these products do not last for 5 years?

Response: DME, by statute, has a 5 year reasonable useful lifetime, based on continuous use by the beneficiary. Medicare’s RUL does not take into account manufacturer warranty lengths.

11. We received a denial from Medicare based on the fact that the span of time between the date the physical therapist signed the LCMP and the date the doctor signed the same document was too long. A search of the current LCD’s shows no written time span limits. A leader at a seminar stated it was 6 months based on an old MedLearn Matters article. Is there an official limit that reviewers/auditors are using, and where can we find that documentation?

Response: Progress notes, test results or evaluations by other healthcare providers should be within a reasonable timeframe, relative to the date of service in question. This is to ensure that the patient’s medical condition is appropriately treated and has not changed between the time of the test or evaluation and the provision of DMEPOS or other therapy.

12. Can an ATP write the mobility documentation for a therapist and then have the therapist sign off on it?

Response: No. The therapist must conduct and document the evaluation; however, the ATP may be present.

13. Does the K0108 code require a KK modifier?

Response: Yes, if required by the LCD.

DME

No questions submitted.

DOCUMENTATION

1. This past summer a supplier received a “Corrective Action Plan” document from a DME MAC Jurisdiction C Medical Review Nurse that were not consistent with the requirements of the Program Integrity Manual. Specifically, the nurse highlights as a concern under “Education Comments” that “Medical records include verbal orders that were not co-signed and dated by the physician.”

Guidance in the Program Integrity Manual 100-8 Chapter 5 Section 5.2.2 “Verbal and Preliminary Written Orders” require preliminary written orders to contain four elements: a description of the item, the beneficiary’s name, the physician’s name and the start date of the order.

Where is the requirement published that requires verbal and preliminary written orders to be signed and dated by the physician? Is a claim invalid if the supply was shipped without having the physician’s signature and date on the verbal and preliminary written order?

Response: Please provide an example. According to the Jurisdiction C Supplier Manual, Chapter 3, the physician’s signature is not required for a dispensing order.

2. During a recent Ask the Contractor teleconference, we were apprised that legally, physicians are only required to respond to supplier requests for documentation when the supplier is under an audit request. We are in desperate need for CMS to provide clear definitive guidelines for the time frames and parameters that meet “continued need and ongoing medical necessity” so suppliers have a reference to provide to the physician.

a. If the instruction on the Ask the Contractor call holds true, how can suppliers be held responsible to obtain continued need documentation on an ongoing basis when often the physician does not want or feel it necessary to see the patient on a regular basis?

Response: The requirement does not state that suppliers have to obtain documentation on a regular basis, only when asked to present by CMS or a contractor. From an education standpoint, CGS suggests developing
relationships with referral sources that make it possible to respond to the DME-MAC or other contractors within a given timeframe.

b. Secondly, we have heard differing answers to continued need requirements being 6 months, 12 months, and whatever documentation we have from the beneficiary’s last contact with the physician (no time frame given). If CMS is not holding the physician accountable to follow the patient and/or provide ongoing need, how can they hold the supplier liable for continued need?

Response: Since it is the supplier submitting the claim to Medicare, it is the supplier’s responsibility for demonstrating that the claim is reasonable and necessary.

c. We are already required to meet the Refill requirements each month, which validate the patient’s continued use and need. For example, for patients that have a lifetime functional impairment which is supported in our initial documentation, a lifetime order, and a lifetime DIF, would the annual RX renewal suffice if the physician signs and dates another prescription for another extended period?

Response: No, a new order by itself is not sufficient documentation of continued medical need. The refill requirements do not focus on medical necessity but rather on the actual amount of supplies that the beneficiary has on-hand. The goal is to avoid overstocking the beneficiary with unnecessary/unused supplies. This requires constant and ongoing monitoring of the beneficiary’s utilization; therefore, the requirement to confirm that the supply is “nearly exhausted” prior to sending additional supply refills.

Medicare is launching a Pilot Project for Electronic Submission of Medical Documentation (esMD) of which CGS will be participating. Can you share any insights on how this may affect DME claims?

Response: Not at this time. Details for this pilot are pending.

The Nebulizer policy states: Administration instructions must specify the amount of solution and specific frequency of use. As noted in the Program Integrity Manual (Internet-Only Manual, Pub. 100-8), Chapter 5, Section 5.9 “…do not accept ‘PRN’ or ‘as needed’ utilization estimates for supply replacement, use, or consumption.” For orders that include “PRN” or “as needed”, reimbursement will be based on the specified frequency of use on the order only”.

It is common practice for physicians to write orders for BiD & PRN, TID & PRN, and QID & PRN/as needed; to ensure necessary therapy is administered during acute situations or if the first dose does not resolve the patient’s acute scenario.

Please clarify: If a physician writes the order to administer “Albuterol 083% QID & PRN” the pharmacy would only be reimbursed for the QID amounts.

a. How should the physician write the order to ensure the patient has and can administer additional nebulizer treatment(s) when they have an asthma attack or exacerbation of their COPD, etc.?

Response: See below.

b. Is it acceptable for the order to be written for “Albuterol 083% QID and 10 Rescue Treatments”?

Response: It is acceptable to write a specific amount for “rescue” treatments as long as the scheduled frequency and the rescue amounts do not exceed the usual maximum outlined in the LCD.

With the changes that are coming with the ICD-10 project, will providers have to obtain revised CMNs/RXs with the ICD-9 codes listed?

a. Can we crosswalk to the most appropriate ICD-10 code for the purposes of filing a claim based on information in our files without securing a written order?

b. How about if I am resubmitting a claim and or appeal after October 2013 for a date of service prior to that date, how will those claims be handled?

Response: Details are still being worked out. Will advise when available.

For pre-payment review, re-opening, reconsideration or redetermination appeals, what date range of information, specifically physician orders, physician, speech therapy or dietary notes, need to be submitted to support coverage?

a. Are there different date ranges acceptable for different types of medical documentation? See below.
b. Currently there is no requirement for a supplier to routinely update its documentation other than to gather documentation when enrolling or when a patient’s need changes. Can guidelines be published so that suppliers can periodically collect updated supporting documentation?

Response: In cases where timelines are specified in the LCD or PA, those should be followed (e.g., monthly evaluations for NPWT). In cases where there is not a specific timeline in an LCD, medical records should contemporaneous with the DOS in question.

7. A beneficiary is insured with a Medicare HMO and receives a power wheelchair. A few years later, the beneficiary changes back to traditional Medicare and subsequently needs repairs on the power wheelchair. Because the PWC was purchased by a Medicare HMO, has medical necessity been established in Medicare’s databases for traditional Medicare to pay for the repairs?

Response: No. Moving from a Medicare HMO or any private insurer to Medicare is considered like “new” to Medicare and all coverage criteria must be met.

**ENTERAL/IV**

1. Are daily enteral feeding kits covered when no enteral formula has been supplied during the same period of service? For example, the patient has plenty of nutrient on hand for the month but is out of feeding supply kits, can the supplier send just the daily feeding supply kits and be reimbursed? Nothing in the enteral medical policy precludes this, however, this supplier has encountered denials on the feeding supply kits as “not medically necessary” and when we’ve inquired with the DME MAC we are told that without billing the formula at the same time, there is no need for the plastics. Response: The LCD states the supply kit must correspond to the method of administration. It does not indicate that nutrition be billed at the same time; however, suppliers should not bill for enteral supply kits on days when no enteral nutrition is provided to the patient. Generally the number of kits provided should match the number of days that nutrition is administered.

2. In regard to home infusion therapy for IV anti-infectives NOT delivered via an external infusion pump, (which are statutorily non-covered, i.e. there is no defined Medicare benefit), we must bill for denial in order to move to the beneficiary’s secondary payer. We are instructed to use the GY modifier in this situation to produce a PR patient liability denial. Most state pharmacy board rules and regulations, allow us to dispense based on a verbal order given to a licensed pharmacist. Often, the verbal is accompanied by a written order, but it may not necessarily meet all the requirements of a “detailed written order” as defined by Medicare.

Detailed Written Orders Social Security Act Sections 1834(a)(11)(B) and 1861(s)(2)(K)(iii); Title 42 C.F.R. Section 410.38; CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, Sections 5.2 & 5.3 &Chapter 3, Section 3.4.1.1.B.)

a. Would this be a scenario where we would HAVE to bill with the EY modifier as well? It would seem to us that the EY modifier would not be required in this situation of “statutorily non-covered therapy” since Medicare has no jurisdiction over non DMEPOS services.

b. If the direction is that we must use the EY modifier when we do not have a complete detailed written order, would we get a PR denial or a CO denial?

Response: It is appropriate to bill with EY and will be PR denial. Medicare requires that detailed written orders comply with the PIM requirements outlined above.

3. The fourth quarter DME MAC Drug fee schedule now shows Hizentra J1559 100mg at ASP rates 7.285, under policy it states all biological and other drugs infused through DME would be reimbursed at AWP -5% . Was this a correct published rate?

We incorrectly listed the ASP fee instead of the 95% of first available AWP fee. The information was corrected and ListServ notification was sent out on 10/14/2011.

4. What is the standard regarding additional medical documentation needed to support specialty nutrients? At this time a resident’s diagnosis typically supports specialty nutrients (i.e. IDDM for Diabetic formulas due to Blood Sugar fluctuations etc.) Will other data need to be provided to assure payment? For example, lab values etc.

Response: The Enteral Nutrition policy is not diagnosis driven; therefore, diagnoses alone are not sufficient to support medical necessity. It is expected in an audit situation that documentation from the treating physician’s notes would justify the need for the item ordered/provided. This documentation must justify why
a specialty nutrient is needed based on that unique beneficiary's medical conditions and need for the type of nutrient ordered.

5. Is the pump automatically denied if a resident is receiving bolus feedings sporadically during the day? For example, there are some residents that have supporting medical documentation for the pump but intermittently receive bolus or gravity feedings during the day. Would payment automatically be paid for the least costly method, despite medical documentation for the pump, and when the majority of the enteral feeding is supplied via pump?

Response: No, it is not automatically denied; however, the documentation must justify the need for the beneficiary to use a pump. If a patient can tolerate bolus or gravity feedings then a pump would not be medically necessary and would be considered a convenience.