

DME MAC Jurisdiction A

Ask-the-Contractor Teleconference (ACT) Q&A - September 30, 2009 [\(GEN\)](#)

Posted October 29, 2009

The September 2009 ACT call was conducted as a teleconference and Webinar. DME MAC A provided general updates and then conducted an open Q&A chat session. As questions were submitted via the Webinar chat mechanism staff responded by sharing both the question and the answer with the entire audience. In addition, questions were solicited in advance during the registration process and addressed during the call. **Note:** *Individual claim specific questions are not included below. As advised during the call, please contact Customer Service to address these types of questions.*

Q1: Under the PAP guidelines, if a patient is not compliant in the first 3 months and as a result has a new sleep study performed and is still not compliant after the next 3 months is another sleep study necessary?

A1: Yes, a new sleep study would be required if attempting to re-qualify the patient.

Q2: What is the current ruling on consignment closets?

A2: Please refer to the MLN article [Compliance Standards for Consignment Closets and Stock and Bill Arrangements](#) (MM6528).

Q3: If a pharmacy sends an assigned claim for diabetic supplies with a GA modifier will the claim adjudicate for the allowed supplies and then return a PR responsibility for anything above Medicare's guideline?

A3: The GA modifier (ABN on file) will result in an over-utilization denial changing from a contractual obligation (CO) to a patient responsibility (PR) denial.

- Q4:** Is it a requirement to give the patient the option of renting or purchasing a power mobility device (PMD) at the time of setup? Can we make it company policy to only sell PMDs and not offer the rent option?
- A4:** Giving the beneficiary the option to rent or purchase a PMD is a requirement; however, if you choose only to sell these items then you can advise the beneficiary that they could go to another supplier if they want to rent these items.
- Q5:** Can you clarify if it is acceptable to bill a 90 day supply for PAP supplies? If so, is a date span necessary with a note in the NTE field?
- A5:** Yes, it is acceptable to bill a 90 day supply. A date span must not be used on the claim line; however, you are required to document the appropriate dates for which the supplies are for in the NTE field.
- Q6:** Where can I find the published utilization limits for tracheostomy tubes (A7520/A7521) and other tracheostomy supplies?
- A6:** If there are specific utilization guidelines for an item it would be specified in the LCD. If parameters are not listed, utilization is based on individual consideration and may vary from patient to patient.
- Q7:** Are the upcoming pre-payment audits for oxygen going to involve only the first claim selected for a particular beneficiary or on each subsequent claim for the same beneficiary as well?
- A7:** The upcoming widespread prepayment probe audits will be conducted on a random sample of claims from multiple suppliers. For additional information on the Medical Review process access [The Medicare Medical Review Program](#) brochure available on the CMS *Medicare Learning Network* Web site.
- Q8:** If a claim is submitted for an item that requires the KX modifier to indicate coverage criteria is met but the KX is missing; is the claim denied or rejected? Can the KX be added accordingly and the claim resubmitted?
- A8:** In the past, absence of a KX modifier always caused the claim to deny and required a reopening or an appeal. The DME MACs are currently implementing new system edits that will now reject a claim line if not billed with the KX, GA, GY or GZ modifiers. If a claim line is rejected, the supplier may correct the claim and resubmit. These system and policy changes are being phased in and will be implemented for all LCDs with the KX modifier over the next few months. For additional information, refer to the DME MAC Jurisdiction A article: [IMPORTANT CHANGE - KX, GA, GZ and GY Modifiers - New Uses](#)

Q9: If a supplier has voluntarily revoked their NPI number due to non-completion of accreditation requirements; however, they have claims that need to be sent to reopenings, redetermination, etc. for dates of service prior to 09/30/09, can they still do so?

A9: Yes, as long as the date of service is prior to the deactivation of their NPI number.

Q10: If a patient requests to purchase a portable concentrator to have in addition to their stationary system, can we get an ABN and sell them the unit?

A10: It is expected that if the patient qualifies for the portable system that you would provide the portable and follow the rental guidelines; however, if the additional piece of equipment is a patient preference then an ABN can be obtained and the appropriate option selected. **Note:** *An item that is required to be billed as a rental cannot be billed to Medicare as a purchase.*

Q11: What is the Web site for the *CERT Physician Letter for Oxygen and Supplies*?

A11: http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml

Q12: Can we bill the patient for the purchase price of a CPAP when they are not compliant and they refuse to sign the ABN but won't return the machine?

A12: No.

Q13: For the CPAP requirement of 30 consecutive days, does this mean 30 days in a row?

A13: Yes.

Q14: Is something being considered to come up with a way for O&P providers to check for same/similar by calling the IVR?

A14: Currently, there is no way for suppliers to check for same/similar O&P items on the IVR. The supplier may initiate a 3-way call with the beneficiary and a customer service representative to verify if same/similar items are on file. NHIC is currently researching this issue for possible resolutions.

Q15: Have you ever considered splitting Webinars into categories? For example, have one for oxygen and then one for O&P so the information is specific to those specialty providers?

A15: We do offer specific Webinars for specific policies. This ACT call was intended for all supplier types to ask general questions pertaining to their particular business needs. The winter Webinar schedule is currently available by accessing the "[Events & Seminars](#)" section of the DME MAC A Web site.

- Q16:** If the beneficiary did not return the ABN should I use the GZ modifier or still use the GA modifier?
- A16:** If you have not received a signed ABN back from the beneficiary you must bill with a GZ modifier; however, you may hold your claims until you receive the valid ABN.
- Q17:** Is testing on 4-LPM required if a patient is prescribed 6-LPM of oxygen? Is this also required to be reported on the CMN?
- A17:** Yes. To be considered for payment for higher liter flow, the patient must be tested on 4-LPM in order to comply with the high liter flow guidelines. This test result must be reported on question 6 of the CMN.
- Q18:** If we are billing as non-assigned for the PMD, are we still required to give the rent or purchase option to the patients receiving the PMD?
- A18:** Yes. For both assigned and non-assigned claims, the patient must be given the option to rent or purchase an item. A suggested form can be found on NSC Web site at <http://www.palmettogba.com/nsc>
- Q19:** If a patient is prescribed > 4-LPM of oxygen but we are not billing Medicare for the increased rate on the concentrator is it a requirement to have the patient tested on 4-LPM? Is it a requirement to report the testing on 4-LPM on the CMN if we are not billing for the increased rate?
- A19:** The supplier should be billing for what they are providing to the beneficiary. If basic oxygen coverage criteria have been met, a higher allowance for a stationary system for a flow rate of greater than 4 liters per minute (LPM) will be paid only if a blood gas study performed while the patient is on 4-LPM meets Group I or II criteria. If a flow rate greater than 4-LPM is billed and the coverage criterion for the higher allowance is not met, payment will be limited to the standard fee schedule allowance.
- Q20:** If we are not billing for the increased rate on the stationary system, does the patient need to be tested on the 4-LPM?
- A20:** The supplier should be billing for what they are providing to the beneficiary. If basic oxygen coverage criteria have been met, a higher allowance for a stationary system for a flow rate of greater than 4 liters per minute (LPM) will be paid only if a blood gas study performed while the patient is on 4-LPM meets Group I or II criteria. If a flow rate greater than 4-LPM is billed and the coverage criterion for the higher allowance is not met, payment will be limited to the standard fee schedule allowance.

- Q21:** If an ABN is mailed to a customer after the 31st day of treatment on a CPAP/BiPAP and the customer refuses to sign and mail the ABN back to the DME supplier, can the provider document the patient's refusal to sign the ABN in their records and then bill the claim with the GA modifier?
- A21:** No. You may not bill with the GA modifier unless you have received a valid ABN back from the patient.
- Q22:** I have a patient who received a CPAP at the ER and a face-to-face was not done before the sleep study. Per the LCD, this patient does not qualify since the face-to-face was not done prior to the sleep study and not done by the treating physician. Now the patient's primary physician is doing a face-to-face and ordering a new sleep study. Will Medicare cover the CPAP if the patient meets the criteria with the new face-to-face and the new sleep study, or will the first order done incorrectly always make this patient noncovered for PAP therapy?
- A22:** Medicare will consider the CPAP for coverage once all of the coverage criteria are met.
- Q23:** Can we file Medicare secondary payer claims by paper if we are submitting primary claims electronically?
- A23:** If you do not fit any of the current Administrative Simplification and Compliance Act (ASCA) exceptions, you are prohibited from submitting paper claims. To review these exceptions, refer to the [Administrative Simplification Compliance Act Self Assessment](#).
- Q24:** Do we have to accept assignment for diabetic supplies even if we are a non-participating provider?
- A24:** No. Mandatory assignment only refers to drugs and biologicals.
- Q25:** We are a non-participating provider and are not required to accept assignment. Can we bill assigned and non assigned claims on the same dates of service for different HCPCS codes as long as they are on a separate delivery sheet?
- A25:** You must either accept assignment or not accept assignment for all items delivered on the same day. Suppliers should remember they may **not** attempt to "fragment" their bills. Fragmenting is defined as accepting assignment for some services and then billing the enrollee for other services performed at the same place and on the same occasion. There is an **EXCEPTION**. In situations where assignment is mandatory, i.e., where a supplier must accept assignment for certain services as a condition for any payment or for full payment to be made he/she may accept assignment for those conditional services without accepting assignment for other services furnished by him/her for the same enrollee at the same place and on the same occasion.

- Q26:** Can you access same/similar information for diabetic shoes via the CMN status option in the IVR?
- A26:** No. Providers must speak directly with a customer service representative to obtain same/similar information on HCPCS codes beginning with the letters A, L or V. A three-way call with the beneficiary is necessary to obtain this information.
- Q27:** What options, if any, does the supplier have for noncompliant CPAP patients who refuse to sign an ABN?
- A27:** As the owner of the rented equipment, you can pick up your equipment if the patient does not meet compliance.
- Q28:** It was stated that DME has a 5 year useful lifetime rule and that an O&P items' useful lifetimes are in the LCDs. The question comes about when the LCD doesn't have a useful lifetime stated. The example we used was of a previous service for an L0627 that we were denied on for a 2009 date of service. Medicare stated that the patient already had same/similar equipment in use from 2007. We appealed the decision and showed the reason why she needed a different service, based on medical necessity. But again, there is no statement of useful lifetime within 5 years in the spinal LCD. So why would a provider get a same/similar denial on a spinal service within 2 years?
- A28:** Unless otherwise specified in the policy, all durable medical equipment (DME) and most O&P items will follow the 5 year useful lifetime rule.
- Q29:** The knee brace and the shoe policy include the useful lifetimes. Why wouldn't the system be able to give us same/similar information if Medicare is obviously keeping track of that when the claims come in? If a customer service representative can look that information up wouldn't there be a way to have the IVR give that information to us?
- A29:** Unfortunately, the IVR cannot provide same/similar information for O&P items. The mechanism used to track capped rental and inexpressive routinely purchased items is different than what is used for orthotics and prosthetics and is not accessible from the IVR. Providers must speak directly with a customer service representative to obtain same/similar information on HCPCS codes beginning with the letters A, L or V. A three-way call with the beneficiary is necessary to obtain this information.

Q30: We have been unable to locate information specific to mail order DME in relation to obtaining a signature for Assignment of Benefits (AOB). The *Medicare Claims Processing Manual* states, “*If it is impractical to obtain the patient’s signature because a home health agency does not make a visit to his home (e.g., the physician certifies that the patient needs a certain item of durable medical equipment but no visits are certified), the agency may furnish the equipment and need not obtain the patient’s signature. An agency representative should sign on behalf of the patient and indicate in the provider record “Patient not visited.”*” ([Medicare Claims Processing Manual](#), Publication100-04, Chapter 1, Section 50.1.3 A).

Does this same principal apply to a DME supplier that furnishes mail order DME via a delivery service such as Federal Express or UPS? Please note that the mail order DME does not involve any type of diabetic supplies.

A30: Please refer to the “*Signature Requirements*” section of Chapter 10 of the [DME MAC A Supplier Manual](#) for assignment of benefits signature requirements.

Q31: How do you re- enroll with the NSC as a result of deactivation due to lack of claim submission?

A31: The reenrollment process allows the NSC to determine if the supplier is in compliance with the supplier standards.

The reenrollment process takes approximately 60 days, which includes a site visit, if required. Also, workload and the time spent requesting any additional information required to complete the reenrollment package play a part in determining the processing time. Be sure to respond to requests for information from the NSC timely to avoid having your supplier number inactivated and having to begin the process again.

The NSC has several tools available to assist suppliers through the reenrollment process. These include:

- [Helpful hints](#) for completing the CMS 855S
- Numerous [FAQs](#) regarding the enrollment process
- Additional [helpful hints](#) regarding the reenrollment process

You may also visit <http://www.palmettogba.com/nsc> for further information on reenrollment.

Q32: When will DMEPOS suppliers from the states of NY and NJ have to enroll in the Competitive Bidding Program?

A32: Certain NY and NJ providers will be affected for Round 2. Competition for Round 2 begins in 2011. On January 08, 2008, CMS announced the metropolitan statistical areas (MSAs) for Round 2. A list is available on the CMS Web site at: <http://www.cms.hhs.gov/DMEPOSCompetitiveBid>

Q33: When will Round 2 of the Competitive Bidding Program be announced and what will be the Competitive Bidding Areas (CBAs)?

A33: MIPPA provides that the delayed Round 2 competition will occur in 2011. Round 2 CBA specific zip codes are not yet available.

Q34: Are wheelchairs and transport chairs considered same/similar equipment?

A34: Yes, wheelchairs and transport chairs are considered to be same/similar equipment. You can retrieve same/similar information on these items via the Interactive Voice Response (IVR). Select option 7 from the IVR menu.

Q35: How is a CBA segmented? City, County or State?

A35: A CBA is segmented by counties and zip codes.