

DME MAC Jurisdiction A

Ask-the-Contractor Teleconference (ACT) Q&A - December 16, 2009

Posted January 15, 2010 ([GEN](#))

The last quarterly ACT call for calendar year 2009 was conducted by Jurisdiction A on December 16th as a teleconference/webinar. DME MAC A began by providing general updates followed by 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, many questions were also obtained during the registration process which enabled staff to provide verbal responses to everyone 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: Can we bill for a partial month rental if a patient is in a SNF for part of the month? Do we use the KR modifier for this situation?

A1: As long as the patient is at home on the date of service/anniversary date, you are eligible to receive a full month payment; however, you may bill a partial month if you choose. Use of the KR modifier would be applicable when billing for a partial month.

Q2: We continue to receive duplicate claim denials for E1028 (wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory) when more than one is provided on a new wheelchair at the same time. As a result, we have to make multiple redetermination requests. What information can we provide during initial claim submission that will assist us in getting these claims paid correctly the first time?

A2: When submitting a claim for any number of claim lines for code E1028, the following instruction must be applied:

1. Each different item that is billed as an E1028 must be on a separate claim line.
2. Each E1028 claim line must include a narrative description of the item, the brand name, the make/model and the part number.

For additional information, please refer to the article [Guidance on Billing Claims for E1028 When Used for Multiple Items](#) that was posted to our Web site on May 16, 2008.

Q3: Can a supplier bill a patient for lost or misplaced medically necessary equipment that is currently under maintenance and service and also within the reasonable useful lifetime?

A3: No; however, replacement due to stolen or lost equipment may be covered by Medicare. Documentation identifying the situation must be available upon request. This could include a police report for stolen items or a beneficiary statement for items that have been lost. All other applicable documentation rules apply. For additional information, refer to the article [Billing Reminder: Submitting Claims for DME Replacement Items Broken Beyond Repair](#) posted December 4, 2009.

Q4: What is the proper way to bill E0218?

A4: A water circulating cold pad with pump (E0218) will be denied as not medically necessary. If it is necessary to submit a claim to Medicare the RR, NU or UE modifier must be included. To ensure that the patient fully understands liability and to receive a patient responsibility denial the supplier must properly execute an ABN and bill with the GA modifier as well. For additional information, refer to the [LCD for Cold Therapy](#).

Q5: Can a signature stamp be used on an order?

A5: No. Signature stamps are not acceptable on an order.

Q6: Do you need new oxygen testing done during the 90 day re-evaluation period or just an office visit?

A6: For patients initially meeting Group I criteria, the most recent qualifying blood gas study prior to the thirteenth month of therapy must be reported on the Recertification CMN. This may be the same test result reported on the Initial CMN.

For patients initially meeting Group II criteria, the most recent blood gas study that was performed between the 61st and 90th day following Initial Certification must be reported on the Recertification CMN. If a qualifying test is not obtained between the 61st and 90th day of home oxygen therapy but the patient continues to use oxygen and a test is obtained at a later date, if that test meets Group I or II criteria, coverage would resume beginning with the date of that test.

For patients initially meeting Group I or II criteria, the patient must be seen and re-evaluated by the treating physician within 90 days prior to the date of any Recertification. If the physician visit is not obtained within the 90-day window but the patient continues to use oxygen and the visit is obtained at a later date, coverage would resume beginning with the date of that visit.

Please refer to the [LCD for Oxygen and Oxygen Equipment](#) for the recertification requirements for replacement oxygen equipment.

- Q7:** When dispensing oxygen based on Group I qualifications, can an ABN be provided to a patient up front to notify them that if they fail to be seen and re-evaluated by the physician within 90 days prior to the date of recertification that they will be held responsible for the charges for the thirteenth month and all months thereafter until the physician visit is obtained?
- A7:** No. Providing an ABN up front for a “just in case” situation would be considered a blanket ABN.
- Q8:** Are treating physicians who prescribe oxygen to Medicare patients made aware of the fact that the patient must be seen and re-evaluated within 90 days prior to the date of any Recertification? What type of documentation should we request from the treating physician to make sure the patient has met this requirement?
- A8:** It is the supplier’s responsibility to inform the treating physician and the patient of the recertification requirements. In order to determine if the patient has met these requirements, you would need to confirm that the patient’s chart notes document the re-evaluation and include information to specifically support the ongoing need for the oxygen equipment.
- Q9:** If a patient signs an ABN resulting in a Medicare denial, what is the reasonable price to charge the patient for that item? Is it Medicare’s allowable?
- A9:** You can bill the patient responsibility amount listed on your Remittance Advice (RA).
- Q10:** Do you know when you are going to create the tool for DME providers to verify if the physician has updated their information with PECOS?
- A10:** CMS is currently working on this tool and it should be available to the public prior to the Phase II implementation. Suppliers will be notified of the availability via the CMS Web site, ListServe and Open Door Forum (ODF) calls.
- Q11:** Is DME MAC A planning to publish a list of crosswalk HCPCS codes for the discontinued codes that were effective with the 2010 HCPCS Update?
- A11:** Yes. Refer to the [2010 HCPCS Update](#) article posted December 31, 2009.
- Q12:** What medical documentation would you expect a supplier to have on file for a patient that meets the coverage criteria of an E0770 (functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified) listed under the *National Coverage Determination (NCD) Manual*, section 160.12?
- A12:** It is expected that the patient’s medical records will reflect the need for the care provided. Per the NCD, you should have documentation that indicates that the item is being provided to a spinal cord

injury patient (ICD-9 diagnosis codes 806.00-806.9, 907.2, 952.00-952.9) with ALL of the following characteristics:

1. Persons with intact lower motor neuron units (L1 and below)(both muscle and peripheral nerve); and
2. Persons with muscle and joint stability for weight bearing in their upper and lower extremities who can demonstrate balance and control to maintain an upright support posture independently; and
3. Persons who demonstrate brisk muscle contraction to neuromuscular electrical stimulation and have sensory perception of electrical stimulation sufficient for muscle contraction; and
4. Persons who possess high motivation, commitment, and cognitive ability to use such devices for walking; and
5. Persons who can transfer independently and can demonstrate independent standing tolerance for at least 3 minutes; and
6. Person who can demonstrate hand and finger function to manipulate controls; and
7. Persons who are at least 6 months post spinal cord injury and restorative surgery; and
8. Persons with hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and
9. Persons who have demonstrated a willingness to use the device long term; and
10. Persons who have completed a one-on-one training program with a physical therapist which consists of at least 32 physical therapy sessions with the device over a period of 3 months. The training program must be conducted in an inpatient hospital, outpatient hospital, or outpatient rehabilitation facility.

Note: *The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports.*

For additional information, refer to the article [Functional Electrical Stimulators - New Code](#) posted December 4, 2008.

Q13: When billing a claim that requires a date span can the date span from one year to the next (i.e. December 2009 - January 2010)?

A13: Yes. It is acceptable to have a claim with dates of service that span years.

Q14: When a customer is not compliant with the PAP policy and an ABN can't be done at set up how do we bill the customer?

A14: The supplier may, after day 60 following the dispensing of the PAP device, present an ABN to the beneficiary if the supplier has knowledge that the beneficiary has not yet met the policy criteria for continued coverage. This ABN should advise the beneficiary that if, by the 90th day of therapy, they do not meet the policy criteria for continue coverage (e.g., adherent to therapy and obtain a follow-up face to face evaluation), Medicare may deny their subsequent claim(s) and that the beneficiary will be liable for payment.

Q15: Must suppliers furnish their patients with CPAP or BIPAP machines that have the capability to report AHI, RDI or mask leaks?

A15: This is not a Medicare requirement.

Q16: Will a patient ever qualify for a CPAP device (E0601) after qualifying for a BIPAP (E0470/E0471)?

A16: No. Since the patient already qualified for a BIPAP (E0470) that means that the CPAP device (E0601) was already proven to be ineffective and ruled out for coverage during the therapeutic trial that was conducted in a facility or home setting prior to receiving the E0470.

For additional information, refer to the [LCD for Positive Airway Pressure Devices for Treatment of Obstructive Sleep Apnea](#).

Q17: What are the proper modifiers that need to be used when billing E1390 and E0431?

A17: Since oxygen equipment is paid on a rental basis, the RR modifier applies throughout the rental period. This includes replacement equipment as well.

If oxygen equipment is replaced because the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or is lost, stolen, or irreparably damaged, the patient may elect to obtain a new piece of equipment. Claims for the replacement of oxygen equipment for the first month of use only are billed using the HCPCS code for the replacement equipment and the RA modifier.

The MS modifier is appropriate for maintenance and service of oxygen concentrators and transfilling equipment after the 36 month rental period has capped. **Note:** maintenance and service is billable for E1390 but not for E0431.

Lastly, when appropriate be sure to use the liter flow modifiers (QE, QF, or QG) and the oxygen conserving device modifier (QH).

For additional information, refer to the [LCD for Oxygen and Oxygen Equipment](#) and the article [Medicare Billing Requirements and Policies for Replacement of Oxygen Equipment and Oxygen Contents](#) posted January 30, 2009.

Q18: How do we handle an oxygen patient that was not seen and re-evaluated by the physician within 90 days prior to the recertification date?

A18: If the physician visit is not obtained within the 90-day window but the patient continues to use oxygen and the visit is obtained at a later date, coverage would resume beginning with the date of that visit.

For additional information, refer to the [LCD for Oxygen and Oxygen Equipment](#).

Q19: What documentation needs to be present in the provider's files regarding the face-to-face evaluation that is required within 90 days of the Oxygen?

A19: Physician visits are required as part of the initial certification process and as part of the recertification process. The initial visit must be within 30 days of the initial certification date and the re-evaluation must be within 90 days of any recertification date. The provider must have access to the patient's medical records, more specifically the physician chart notes documenting that the patient was evaluated and re-evaluated for oxygen. The records must also indicate that all of the coverage criteria in the oxygen LCD are met. These records must be documented in the same manner that the physician would use to document any other patient chart notes.

For additional information, refer to the [LCD for Oxygen and Oxygen Equipment](#).

Q20: Will PECOS be delayed?

A20: The Centers for Medicare & Medicaid Services (CMS) has delayed the implementation of Phase 2 of CR 6421 (*Expansion of the Current Scope of Editing for Ordering/Referring Providers for DMEPOS Supplier Claims Processed by Durable DME MACs*) and CR 6417 (*Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B MACs*) until April 05, 2010. The delay in implementing Phase 2 will give physicians and non-physician practitioners who order items or services for Medicare beneficiaries or who refer Medicare beneficiaries to other Medicare providers or suppliers sufficient time to enroll in Medicare or take the action necessary to establish a current enrollment record in Medicare prior to Phase 2 implementation.

Q21: Has CMS and/or the DME MAC started the process of updating PECOS with NPIs?

A21: Prior to the implementation of Phase 2, CMS will systematically add the NPIs to the PECOS enrollment records of all physicians and non-physician practitioners whose enrollment records are in PECOS but do not contain their NPIs. Suppliers will be notified via the CMS Web site, ListServe and Open Door Forum (ODF) calls.

Q22: Will the PECOS date be changed in light of the fact that most doctors have not complied yet?

A22: Phase 2 implementation has been delayed until April 05, 2010 which will give physicians and non-physician practitioners sufficient time to enroll.

Q23: Is there a more efficient process to get physicians to enroll in PECOS?

A23: If you receive a rejection you can contact the physician or non-physician practitioner and direct them to the [CMS Internet-based Pecos Web page](#) where they can access three easy steps to update their PECOS enrollment.

Q24: When do you use the KX modifier?

A24: The exact use of the KX modifier is based on each LCD and may be used differently. It is in your best interest to review the specific LCD related to the items you are billing.

For additional information, refer to the [Jurisdiction A DME MAC LCDs](#).

Q25: Is the GY modifier being removed from all LCDs or is it just for AFO/KAFO?

A25: No. The GY modifier is not being removed from all LCDs. There has been an update to most LCDs regarding the KX, GA GZ and GY modifiers. It is in your best interest to review the specific LCD related to the items you are billing to verify how each of these modifiers are used.

For additional information, refer to the [Jurisdiction A DME MAC LCDs](#).

Q26: When will the 2010 Fee Schedule be available?

A26: The DMEPOS fee schedule for each new year is usually posted to our Web site within the first few weeks of January. Refer to the Jurisdiction A [1st Quarter 2010 DMEPOS Fee Schedule](#) for the most current fee schedule.

Q27: In what payment category is the IV pole for enteral feeding?

A27: The IV pole for enteral feeding is listed within the Prosthetic Device Category.

Q28: How do we get a CO-57 denial for same/similar equipment instead of the CO-18 denials we have been receiving?

A28: The CO-57 denial was discontinued as of 6/30/2007. For additional information, refer to the [Claim Adjustment Reason Code List](#) maintained by the Washington Publishing Company.

Q29: Can a nurse practitioner sign an order instead of a physician?

A29: Per the [Medicare Program Integrity Manual, Publication 100-08, Chapter 5, Section 5.5](#), a nurse practitioner or clinical nurse specialist may give a dispensing order and sign the detailed written order in the following situations:

- They are treating the beneficiary for the condition for which the item is needed
- They are practicing independently of a physician
- They bill Medicare for other covered services using their own provider number
- They are permitted to do all of these things in the state in which the services are rendered

Q30: Is a stamped signature acceptable on an order?

A30: No. A stamped signature is not acceptable on an order.

Q31: What type of narrative documentation is needed in the NTE segment of an electronic claim if a customer has a patient owned manual wheelchair and is now getting a power chair?

A31: Higher level equipment that is medically necessary does not require additional documentation to be entered in the NTE segment; however, the medical record must reflect the need for the higher level equipment and must be available upon request.

Q32: Why is the patient's specific jurisdiction not provided when eligibility is verified via the IVR?

A32: It is the supplier's responsibility to obtain the beneficiary's correct address upon initial visit and to verify the specific jurisdiction that the beneficiary resides in before checking eligibility.

Q33: When will the zip codes for Round 2 of the Competitive Bidding Program be published?

A33: Specific zip codes affecting Round 2 will be published on the [CBIC Web site](#) once the information is available.

Q34: Is HCPCS Code E2399 being discontinued for dates of service on or after January 01, 2010?

A34: Effective for dates of service on or after January 01, 2010, E2399 is discontinued. E2399 will continue to be valid for claims with dates of service on or before December 31, 2009, regardless of the date of claim submission. For additional crosswalk information, refer to the [2010 HCPCS Code Update](#) posted December 31, 2009.

Q35: What constitutes a valid HIPAA release that a DME supplier must obtain from the beneficiary in order to receive test results for an overnight oximetry conducted by an IDTF?

A35: A valid release would be one that complies with HIPAA privacy standards in which the beneficiary is granting permission for the DME supplier to receive the report.

Q36: Why is a new PO2 test needed before the recertification date for a patient who had an initial sleep oximetry study which qualified them for nocturnal oxygen?

A36: A new test would only be required for patients initially meeting Group II criteria. The most recent blood gas study that was performed between the 61st and 90th day following Initial Certification must be reported on the Recertification CMN.

For patients initially meeting Group I criteria, the most recent qualifying blood gas study prior to the thirteenth month of therapy must be reported on the Recertification CMN. This could be the same test result reported on the Initial CMN.

For additional information, refer the [LCD for Oxygen and Oxygen Equipment](#).

Q37: How do we get an appropriate denial for an oxygen claim that does not have a qualifying O2 saturation and the CMN keeps rejecting if we are not permitted to change our method of claim submission to paper?

A37: The claim can be appealed with a copy of the non-qualifying CMN.

Q38: What is the maximum number of records that NHIC may request from a provider at any given time?

A38: There is no maximum.

Q39: Can we continue to bill for a CPAP device if the patient is compliant; however, the physician has not sent supporting documentation to us after we have requested it several times?

A39: Yes. You can continue to bill as long as you are able to confirm (prior to billing) that the LCD requirements for continued coverage are met. Keep in mind, the documentation in the patient's medical record does not have to be routinely sent to the supplier or to the DME MAC. However, in the event of an audit/claim review you may be requested to provide this information. If this occurs and the requestor does not receive the information or if the information in the patient's medical record does not adequately support the medical necessity for the item, then an overpayment demand will be initiated.

Q40: What type of documentation do I need on file in order to bill for the first three months of a CPAP device?

A40: For a CPAP device and related accessories to be covered by Medicare, a written signed and dated order must be received by the supplier prior to claim submission. Once you receive the written order you may submit a claim; however, in order to apply the KX modifier to the claims for the first three months of coverage you will need to obtain proof to verify that the patient meets the basic coverage criteria for the CPAP device. The method you choose to use to obtain this proof is a business decision. It would be in your best interest to collect this information up front.

For additional information, refer to the [LCD for Positive Airway Pressure Devices for the Treatment of Obstructive Sleep Apnea](#).