Jurisdiction C Council
October 2012 Questions

EDUCATION

1. **We are seeing denials for detailed order not complete with oxygen when the nocturnal or continuous is not written on the CMN BUT the LCD states:**

   If no frequency or duration of use is specified "continuous use" is assumed. Duration of need may be specified on the CMN in the "Length of Need" field.

   We would like to clarify this statement. If the patient is receiving continuous flow of oxygen and it is not written in part C of the CMN then it would be "assumed" that the Oxygen is continuous.

   Why are denials being given when this statement is part of the LCD policy.

   Response: Please provide examples.

2. **Is this statement still true? (from Medical review FAQ 07/28/10)**

   Is it acceptable to accept an illegible signature on the bottom of a form or order as long as the physician's printed name is noted on the top of a form or order, such as a letterhead?

   Yes; however, if there is more than one printed name on the form or order (e.g. a group practice) then the name of the author of the document must be circled.

   Response: Yes, still true.

RESPIRATORY

1. **If a patient is evaluated for oxygen by a pulmonary physician on 08/01/12 and has an overnight pulse oximetry done on 08/03/12. But because the test was over looked or physician practice was busy the dispensing (initial CMN) for providing the oxygen was not ordered until 09/05/12 which is 5 days more than the 30 day limit.**

   Does the patient have to go back for another physician visit, have another overnight and initial CMN date within the 30 day LCD limit, or are there any exceptions in a medical review audit?

   Response: LCD requires physician visit within 30 days of the initial date of the CMN.

2. **Patient is set-up on a PAP device through Medicare 3 years ago. We have a detailed written order that is for lifetime for supplies and meets all medicare requirements for DWO. Patient walks into your office and request a new mask because his is 1.5 yrs old mask has a large crack and no longer can keep a seal.**

   Can we bill Medicare with only the 3 year old lifetime detailed written order or does patient have to have a new face to face and new dispensing order?

   Response: While technically the old order will suffice to dispense the new mask, it is highly recommended that the beneficiary return to their physician for evaluation and a new order. This helps ensure the supplier that documentation of continued use and continued need are met.

3. **The FUTURE O2 LCD (effective 10/01/12) seems to say that for overnight pulse oximetry they have to have demonstrated above criteria room air @ rest. Does this mean that we will now be required to have two studies for an overnight as we do the three studies for pulse oximetry testing with exercise?**

   Response: The LCD states:

   > Home sleep oximetry is limited solely to stand-alone overnight pulse oximetry performed in the beneficiary's home under the conditions specified below. Overnight oximetry performed as part of home sleep testing or as part of any other home testing is not considered to be eligible under this provision to be used for qualification for reimbursement of home oxygen and oxygen equipment even if the testing was performed in compliance with the requirements of this section.

   Response: No other reference to testing requirements is changed.

4. **Do oxygen CMNS automatically get end dated for 36 month cap?**

   Response: Yes

5. **A patient completes a facility based sleep study and titration and is prescribed PAP therapy. The PAP therapy demonstrates that it corrects all desaturation issues during the titration. During the scheduling of PAP therapy, the patient refuses set up. The physician orders an overnight oximetry and based on the results (taken at room air without PAP), prescribes oxygen, but the only diagnoses listed is OSA. Will the oxygen be covered by Medicare?**

   Response: Coverage of home oxygen therapy requires that the beneficiary be tested in the "chronic stable state" and that all co-existing diseases or conditions that can cause hypoxia must be treated before oxygen therapy is considered eligible for payment. In addition, the beneficiary must have a severe lung disease, such as chronic obstructive pulmonary disease, diffuse interstitial lung disease, cystic fibrosis, bronchiectasis, widespread pulmonary neoplasm, or hypoxia-related symptoms or findings that might be expected to improve with oxygen therapy (see Oxygen LCD for additional information).

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Non-adherence to PAP therapy does not meet these requirements for coverage.

6. **If the medical records cannot be obtained to satisfy an oxygen audit, can the beneficiary return to the physician and obtain qualifying testing, with a face to face office visit, that meet Medicare guidelines, and use this date to begin billing once again? If so, would we need to get a revised or an new initial CMN using the date from that office visit? If this is not an option, please advise what can be done so we can start getting paid. We are very familiar with the Medicare criteria for oxygen, however, some of the audit dates of service, go back several years and it is next to impossible to obtain records.**

   Response: All Medicare providers are required to maintain records for 7 years following the date of treatment or service. If a supplier is unable to obtain records to support that oxygen therapy is reasonable and necessary, there is no method for "recreating" the medical record. Additionally, any CMN that is on already on file with the Medicare contractor will need to be addressed before a new CMN is loaded. Consequently, for past payments for which documentation is not available to support that the claim(s) were reasonable and necessary, the supplier should make a voluntary refund.

   Going forward the beneficiary can return to the physician and if all of the coverage requirements are met for oxygen therapy, payment can be made/resume.

7. **Pertaining to the revisions that were made to the oxygen LCD: Are face to face physician's evaluations (initial and re-evaluation) required for a patient diagnosed with cluster headaches? If so, what is the time frame in which these visits must take place since a CMN is not required?**

   Response: No. The requirements for oxygen use with cluster headaches are outlined in detail in the LCD. Suppliers should not try to apply rules for oxygen used to treat other conditions (like COPD) to the oxygen used to treat cluster headaches requirements.

8. **In reference to the oxygen LCD revision effective 10/01/12: "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 beneficiary is on 4 or more LPM meets Group I or II criteria." Previously, it stated that the test should be conducted while the beneficiary is on 4 LPM, in other words, the test for high liter flow cannot be taken greater than 4 LPM. This is a welcome change.**

   Will the CMN verbiage be changed accordingly to reflect the oxygen LCD revision? Currently, question #6 of the oxygen CMN reads: "If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).

   If the patient was tested on 5 LPM, how should the physician complete question #6?

   Response: It is not likely that the CMN will be changed, given the complexity and length of time it takes to make changes to a CMN. The physician should complete Q6 in accordance with the instructions in the LCD.

9. **During our last meeting with CGS, we had discussed with Dr. Hoover about the Ballard closed system tracheal suction catheter (A4605) as not covered when used with a ventilator. We would like to respectfully ask for reconsideration of this direction. This is reimbursement neutral whether we provide 100 standard suction catheters at $2.00 each or 10 Ballard closed suction catheters at $20.00 each. It is also our understanding that the Ballard is not really part of the circuit but inserted "in-line" with the circuit. Many patients find it more convenient to use the Ballard over the standard suction catheters. Patients using a Ballard are less prone to the risk of infection. What do we need to do as the council to open discussion on this?**

   Response: The DME MAC medical directors have reconsidered this position. Codes A4624 and A4605 are separately payable. Code A4605 is still only payable for ventilator-dependent beneficiaries.

10. **The following question and answer was included in the Summer 2012 Medical Review Q & A:**

    Q5. We received a denial for an oxygen claim because the reviewer found no documentation to support that the beneficiary had a lung condition. The beneficiary was in the hospital with a primary diagnosis of pneumonia and the beneficiary's arterial oxygen saturation at rest on the day of discharge was 88%. Why would this claim deny as not meeting the oxygen policy's reasonable and necessary criteria?

    A5. Without reviewing the actual records, it is not possible to explain this specific claim denial. However, the NCD limits oxygen coverage to beneficiaries with a severe lung disease (COPD, diffuse interstitial lung disease, cystic fibrosis, bronchiectasis, widespread pulmonary neoplasm) or a condition that results in hypoxia-related symptoms that might be expected to improve with oxygen therapy (pulmonary hypertension, recurring CHF due to chronic cor pulmonale, erythrocytosis, impairment of the cognitive process, nocturnal restlessness, morning headache, etc.). Furthermore, coverage is only available if the qualifying test reveals significant hypoxemia while the beneficiary is in the chronic stable state, i.e. not during a period of acute illness or an exacerbation of their underlying disease.

    It is true that a test conducted within two days of discharge is deemed to be an acceptable substitute for the usual chronic stable state requirement. However, hypoxia related to a purely acute condition, like pneumonia, would not qualify for payment because

pneumonia alone is not a chronic lung condition. Coverage criteria would only be met if, in addition to the pneumonia, the beneficiary had a chronic underlying lung disease or other condition that produced hypoxia.

There seems to be a contradiction in the response to the question due to the following: In the first paragraph, the response states that the NCD limits oxygen coverage to beneficiaries with a severe lung disease OR a condition that results in hypoxia-related symptoms that might be expected to improve with oxygen therapy. In the second paragraph, the response states that hypoxia related to a purely acute condition, like pneumonia, would not qualify for payment because pneumonia alone is not a chronic lung condition.

The standard is EITHER a severe lung disease OR a condition that results in hypoxia-related symptoms that might be expected to improve with oxygen therapy. The response seems to require BOTH a severe lung disease AND hypoxia-related symptoms that might be expected to improve with oxygen therapy.

We submit that pneumonia is a condition that results in hypoxia-related symptoms that might be expected to improve with oxygen therapy. We find no documentation in the NCD or LCD which excludes the provision of oxygen for a patient discharging from a hospital with the diagnosis of pneumonia who is still exhibiting hypoxia-related symptoms.

NCD

In reviewing the NCD, we find the following statements under "Indications and Limitations of Coverage:"

Under Section C – Laboratory Evidence: "For those patients whose initial oxygen prescription did not originate during a hospital stay, blood gas studies should be done while the patient is in the chronic stable state, i.e., not during a period of acute illness or an exacerbation of their underlying disease."

(Our question relates to patients whose prescription DID originate during a hospital stay – they are not subject to the chronic stable state requirement)

Under Section D – Health Conditions: Conditions for Which Oxygen Therapy May Be Covered:

Hypoxia-related symptoms or findings that might be expected to improve with oxygen therapy.

Note: Under this Section D, there is also a narrative on conditions for which oxygen therapy is not covered.

It reads:

Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments; Breathlessness without cor pulmonale or evidence of hypoxemia. Although intermittent oxygen use is sometimes prescribed to relieve this condition, it is potentially harmful and psychologically addicting; Severe peripheral vascular disease resulting in clinically evident desaturations in one or more extremities.

There is no evidence that increased PO2 improves the oxygenation of tissues with impaired circulation; or Terminal illnesses that do not affect the lungs.

This section does not exclude oxygen for use with the diagnosis of pneumonia.

LCD: In reviewing the LCD, we find the following statements:

Home oxygen therapy is reasonable and necessary only if all of the following conditions are met:

1. The treating physician has determined the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
2. The patient's blood gas study meets the criteria stated below, and
3. The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services, and
4. The qualifying blood gas study is performed under the following conditions: If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one closest to, but no earlier than 2 days prior to the hospital discharge date, or if the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease, and
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

Please rule on the coverage/non-coverage of oxygen in the following scenario:

A patient has been hospitalized and has been evaluated and treated for pneumonia by her treating physician. The treating physician feels that the patient is now stable enough to go home. The patient is still exhibiting hypoxia-related symptoms and the physician documents that this is due to the lingering pneumonia. Blood gas/oximetry studies are performed in the hospital within two days of discharge and they meet the Medicare guidelines for qualification (88% on room air at rest or the 3-test qualification for exercise). The physician has treated the patient with appropriate medications in the hospital and has prescribed continuing medications AND home oxygen for the continuing hypoxia-related symptoms. Would this be covered by Medicare and, if not, why?

Response: To fully understand the Medicare policy for oxygen, suppliers must know the context in which Medicare's oxygen policy was written. Coverage is for long-term oxygen therapy, based on the Nocturnal Oxygen Therapy Trial (NOTT) results. This seminal study of oxygen treatment's impact on mortality in patients with COPD demonstrated improved mortality with continuous (as opposed

to nocturnal-only) oxygen. The study only included patients with chronic lung conditions. Furthermore, the coverage criteria reflected in Medicare's oxygen policy are the entry criteria for the NOTT study. Consequently, while there is an "or" in the two coverage statements, they are intimately related i.e., you must have a chronic, severe lung disease OR signs/symptoms of hypoxia related to that chronic, severe lung disease. This becomes quite evident when one examines the examples associated with each coverage statement. All conditions associated with the first statement in the NCD are chronic, severe lung conditions. All signs and symptoms associated with the second statement result from hypoxia as a consequence of the chronic, severe lung condition(s).

In light of this history, suppliers should remember that there is more to oxygen coverage than just a qualifying test value. There must also be a chronic underlying lung condition for which oxygen is expected to improve the hypoxia and hypoxia-related symptoms. In addition, the beneficiary must be in the "chronic stable state" and not during a period of acute illness or exacerbation of their underlying disease when the qualifying test is conducted. In the scenario described, there is no description of an underlying chronic, severe lung disease or hypoxia-related signs and/or symptoms related to that chronic, severe underlying lung disease; therefore, oxygen coverage is not allowed.

REHAB

1. **1.800.Medicare is telling providers to bill place of service 12 for patients in nursing facilities (31 or 32) if the patient needs a high end power chair and the patient or their family is paying private for their stay. Provider did this and then had money recouped. How should they proceed to get payment for the chair? The family member did sign an ABN but the provider billed it with a KX and no GA. Can they go ahead and bill the family since it was really a non-covered item? Can this issue be addressed with the 800 call center?**

   Response: Place of service should always represent where an item is delivered for patient use (the "two days before discharge" being the lone exception) Billing POS 12 when a beneficiary is in an inpatient stay would be considered program fraud or abuse. The provider can use the appeals process to attempt to fix the modifier issues. The ability to bill the patient would depend on the denial type obtained from Medicare.

2. **Denials for the PA brought up some interesting clarifications.**

   a. 7 element orders - Dr wrote diagnosis instead of using diagnosis codes, does the 7 element order have to have ICD - 9 codes or can physician just write the diagnosis out?

      Response: Either one

   b. DPD - denials because the DPD was signed on same date of 7 element order, does the DPD have to be signed after date of 7 element order in all cases?

      Response: No sooner than the same day.

   c. DPD - denied because the denial was the day after signature of 7 element order? How many days after the signature of the 7 element order does the signature on the DPD have to be?

      Response: No sooner than the same day.

   d. Denial because the information was not date stamped on receipt but the fax date was clearly legible on top of documentation. Rule says date stamp OR equal, is this a valid denial?

      Response: Suppliers are strongly encouraged to apply a date stamp to all documentation rather than rely on a fax header or footer date/time stamp. Often it is hard for reviewers to discern which is the most recent faxed time/date stamp or the information is illegible or missing/cut off following duplication or scanning.

3. **In the May 3rd minutes, it was stated that Dr. Hoover will take back and clarify the safety equipment on POVs. Is there any update on this?**

   Response: No. The LCD and related Policy Article for POVs has the most up-to-date requirements for safety equipment.

4. **Can suppliers use the IVR to obtain the status of PARs? If a PAR has been processed, and the PAR is decision is affirmative, is the Unique Tracking number available via the IVR?**

   Response: Not at the present time; however, CGS is investigating this possibility. There is however, a dedicated group of CSR's for this workload. The menu on our CSR line has change to reflect this.

5. **Due to the updated Quality Standard for K0005's effective March 1st, 2013 are we to expect a revised LCD for manual wheelchairs due to some of the requirements (i.e. FTF visit)?**

   Response: The DMDs are considering this issue.

6. **On the PMD PA call held on 09/18, a question was asked regarding the replacement of a PMD under 5-years due to irreparable damage (i.e. flooding or fire) and if a PA was required since based on policy a new FTF is not required. It sounded like the answer was "no" and PA is not required, but how can a provider be assured that they would not be hit with the 25% penalty.**

   Response: A PA would not be required in this situation. CGS has safeguards in place to avoid the 25% penalty.

7. **Modifiers - Do modifiers have to be in a specific order for proper payment, if so, what is it? If there are more than 4 modifiers and a 99 is required, should the KX modifier be in the initial 3 spots?**

   Response: Modifiers do not have to be in a particular order.

8. **It appears that CGS has been systematically denying claims with CO4 (missing required modifier) whenever a KX is not appended. There are circumstances where an ABN is used and a KX modifier is not appropriate. A claim would be billed with**

a NUGA (or NUGY or NUGZ) - a denial is expected and in many cases a secondary insurance will pay, however a PR denial is necessary. This issue was raised on an August 7th webinar for "Frequent Claim Errors" conducted by CGS. Michael did confirm the MACs position stating CGS's Medicare system is set up to look for the KX modifier first. If their system does not detect the KX modifier, the claims edit stops and the claim automatically denies. Their system will only look for the GA or GY modifier after the KX modifier is detected. He agreed that this billing method doesn't seem logical and stated, "Unfortunately the KX modifier is a system requirement and claims that have an ABN or that are non-covered should be submitted as stated to pass all edits." - How can we append the KX if we know that the claim would not meet the criteria?

Response: Please provide examples. Suppliers should NOT append the KX modifier unless the criteria for KX use are met, based on the applicable policy or claim submission situation. Claims for which the supplier believes an incorrect denial was received may appeal the claim determination.

9. **On the 09/26 PMD PA Demo call a questions was asked regarding the following:, but an answer could not be provided: A provider forgets to place the affirmed PA # on the claim when initially submitted. How is this to be handled - can it be re-opened or does it have to be appealed? Do you have any information on such a situation?**

   Response: No, the claim must go to appeals.

10. **In the latest PMD PA Demo Guide (09/26) it states the following:**

    Transferability of an affirmative PA Decision
    An affirmative PA decision follows the beneficiary. It is the beneficiary's choice as to which supplier will deliver the PMD and bill Medicare. *In the event a beneficiary changes suppliers after an affirmative decision is made a new 7 element order (see PIM section 5.2.4) is required. The newly selected* supplier must comply with all Medicare documentation and claim submission requirements (e.g., number of days between the order and the delivery, etc.) as outlined in the PMD LCD.

    What would make the 7-Element different in this situation? Provider name is not normally on the 7-Element. Would a new face-to-face visit be required?

    Response: PIM 5.2.4 states, in part, that a new order is required when there is a change in suppliers. A new F2F would not be required.

DME

1. **Is there a way to get sale items such as pap supplies added to the IVR or CSI for CMN information?**

   Response: Not at this time

2. **We have a claim denial for CO50 due to the initial claim being in prepay. We do not file to redeterminations within the 120 day timeframes. We have been told that even though a redetermination had not been filed that re-openings will always be able to reprocess these if the initial claim pays within the one year. What if the claims go to reconsideration or ALJ? Do the same rules apply?**

   Response: If the CMN (real or dummy) is currently in a payable status, ReOpenings will be able to process the claim.

3. **Is In May 2012 the following question was posed to Jurisdiction C through the Council on upgrades within a code (with the answer):**

   Q: A supplier was told that you can't do an upgrade for bras just because a patient wants a more feminine type of product. One with lace etc. Why if this is patient choice couldn't they do an upgrade?

   A: Upgrades are not determined by an item's price or the Medicare fee schedule. Upgrades within the same code are allowed only if the functions/features that define the upgrade are not included in the coding and pricing for the covered item. L8000 (Mastectomy bras) is all inclusive; therefore there are no features/functions that would justify an upgrade.

   It was also suggested that suppliers provide these items on a non-assigned basis, thereby allowing beneficiaries to obtain items that they chose to receive regardless of price with relation to the allowable.

   There are several references in various manuals/regulations regarding this topic. Following are relevant portions with regards to upgrades:

   - Change Request 1893 - General Instructions for the Use of the ABN for Upgrading DMEPOS Items states: ***"1. An upgrade may be from one item to another within a single HCPCS code, or may be from one code to another. When an upgrade is within a single code, the upgrade is from the item or service which the beneficiary may be furnished as medically necessary, within the range of items or services included in that code, to the more costly item or service which the beneficiary wishes to have furnished."***
   - Change Request 5367 states *"Under existing policy, suppliers may collect from a beneficiary a payment amount greater than Medicare's allowed payment amount if the beneficiary, by signing an ABN, agrees to pay extra for a DMEPOS item because the beneficiary prefers an item with features or upgrades that are not medically necessary. The instructions in this section apply to situations where the ABN is being used for upgrades and applies to both assigned and unassigned claims.* ***An upgrade is an item with features that go beyond what is medically necessary. An upgrade may include an excess component. An excess component may be an item feature or service, which is in addition to, or is more extensive and/or more expensive than the item that is reasonable and necessary under Medicare's coverage requirements."***

- According to the SSA Section 1834: *"(19) Certain upgraded items.— (A) Individual's right to choose upgraded item.—Notwithstanding any other provision of this title, the Secretary may issue regulations under which an individual may purchase or rent from a supplier an item of upgraded durable medical equipment for which payment would be made under this subsection if the item were a standard item. (B) Payments to supplier.—In the case of the purchase or rental of an upgraded item under subparagraph (A)—(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and (ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i). In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item. (C) Consumer protection safeguards.—Any regulations under subparagraph (A) shall provide for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for— (i) determination of fair market prices with respect to an upgraded item; (ii) full disclosure of the availability and price of standard items and proof of receipt of such disclosure information by the beneficiary before the furnishing of the upgraded item…"*
- Medicare's Claims Processing Manual Chapter 20 Section 90 indicates: *"The payment amount for a given service or item, whether rented or purchased, must be consistent with what is reasonable and medically necessary to serve the intended purpose (See the Medicare Benefit Policy Manual, Chapter 15). Additional expenses for "deluxe" features, or items that are rented or purchased for aesthetic reasons or added convenience, do not meet the reasonableness test. Thus, where a service or item is medically necessary and covered under the Medicare program, and the patient wishes to obtain such deluxe features, the payment is based upon the payment amount for the kind of service or item normally used to meet the intended purpose (i.e., the standard item.) Usually this is the least costly item. Carriers may, of course, determine that the payment amount for a more expensive service or item is reasonable when the additional expense is for an added feature that is medically necessary in a given case. For example, a more expensive item may be medically necessary where a patient in a weakened condition needs a power-operated wheelchair or a power-operated vehicle that may be appropriately used as a wheelchair since the patient is not strong enough to operate a manual wheelchair." Finally* ***the provider may not charge the beneficiary for features not medically required by his/her condition and which cannot be considered in determining the provider's allowable costs unless the beneficiary or her/his representative has specifically requested the excessive or deluxe items or services with knowledge of the amount s/he is to be charged. An Advance Beneficiary Notification (ABN) is required as documentation that the beneficiary has made such an informed request.*** *See Chapter 30 for ABN requirements." while Section 120 states: "Under existing policy, suppliers may collect from a beneficiary a payment amount greater than Medicare's allowed payment amount if the beneficiary,* ***by signing an ABN, agrees to pay extra for a DMEPOS item because the beneficiary prefers an item with features or upgrades that are not medically necessary. An upgrade is an item with features that go beyond what is medically necessary.*** *An upgrade may include an excess component."*
- Finally the MCM Chapter 30 states ***"Excess component" means an item, feature, or service, and/or the extent of, number of, duration of, or expense for an item, feature, or service, which is in addition to, or is more extensive and/or more expensive than, the item or service which is reasonable and necessary under Medicare's coverage requirements. For example, a deluxe or aesthetic feature of an upgraded item of medical equipment is an "excess component."*** *Charge increases on the basis of purported premium quality services are not considered to be "excess components" since that would constitute circumvention of payment limits and applicable charging limits (e.g., limiting charges in the case of unassigned claims for physicians' services and fee schedule amounts in the case of assigned claims). The "excess component" definition for partial denials, with respect to an item, feature, or service that is "more expensive" refers to increased charges attributable to furnishing something that is clearly more extensive, that is, more in number, more frequent, for a longer period of time, or with added features;* ***it does not suffice to claim that an item or service is "better" or "higher quality."***

(**Note:** For all references italics and bold added)

Recent discussions with Jurisdiction C and other DME MACs have indicated that while upgrades within a code are technically allowed, the practical application of doing so is virtually non-existent.

We would ask that this be reconsidered by the DME MACs, or request that the issue taken up with CMS if the DME MACs believe necessary to do so. There are a number of items that are obvious upgrades from what would be considered a "base" item within a code; a group 1 POV for example that has one or more group 2 characteristics (speed threshold for example) but is still classified as a group 1 product since it doesn't meet all the group 2 thresholds.

The Local Coverage Determination (LCD) for Refractive Lenses (L11532) contains code V2025 which simply refers to "deluxe frames". The policy article (A23658) simply states that "When billing claims for deluxe frames, use code V2020 for the cost of standard frames and a second line item using code V2025 for the difference between the charges for the deluxe frames and

the standard frames." The policy does not further define "deluxe frames" but simply allows them to be charged in addition to the standard frames.

The fact that this exists in a Medicare policy speaks to the fact that the intent of the rules listed above are to allow a patient to have a choice as to the item that they receive under the Medicare benefit,

Additionally, the workaround of billing claims as non-assigned is not a viable option for beneficiaries in the 9 current Competitive Bidding areas, and will not be an option in the 91 additional CBAs once Round 2 of the program begins.

While aesthetic enhancements or higher quality items may not be considered upgrades, there are many cases where code specifications indicate a base level of equipment. In those cases where the code may be all inclusive, based on the examples given and the citations referenced that the beneficiary should have a choice in what product they obtain as long as they are given an option for a "baseline" product in a code. All things considered, can the Jurisdiction C DME MAC allow for upgrades within a code or should the Council seek further guidance from CMS?

Response: Initial response is unchanged. The ability to upgrade within a code is dependent upon Medicare's determination about the extent of the features included in the code (i.e., code narrative, coding guidelines, bulletin articles, predicate product(s), etc.). When a code is created and priced, all features considered as included in the code are included in the pricing array. Virtually all codes are defined inclusively such that if a similar item has features not included in the existing code, a new code or different code is often assigned. As a result, there is rarely (if ever) the ability to upgrade within a code.

4. **The Medicare LCD states that the patient must be room and/or floor confined with no toilet facilities. We have situations that patients may suffer from urgency issues and/or other medical issues that could result in urinary or fecal accidents without the use of the commode. With proper documentation would a commode be covered even if a walker or other ambulatory item is ordered?**

   Response: The LCD statement is clear and unambiguous.

DOCUMENTATION

1. **When a prepayment audit is denied we often get very vague reasons for the denial from the CGS customer service example: One or more elements of the dispensing order are missing.**

   Why can't CGS pre-pay review and redetermination give us the exact reason for the denial like we get from reconsideration? If the purpose of all of these audits is to educate the providers so they do it right the next time, this does not work.

   Response: Thanks for the feedback.

2. **If a prepayment audit is denied for missing information example: no delivery ticket or oxygen testing report, but the CGS customer service rep. can see that you did send all the required documents.**

   Can that customer service rep inform the review nurse that that document was sent and send back to the review nurse instead of the supplier having to do a redetermination appeal when they were not at fault.

   Response: In the case of visible contractor error, CSR's have a process to re-open the case internally.

3. **Per the LCD, we understand that precise, quantitative wound measurements are required to be included with the documentation prior to a patient being set up with a negative pressure wound therapy (NPWT). Are there minimum measurements that the DMEMAC expects to see to justify NPWT? If so, what are these and where is this information published?**

   Response: There are not minimum wound requirements; however, there are practical requirements associated with inserting the sponge and tubing into a wound bed in order for the NPWT to be effective. The treating physician should provide detailed documentation for any wound, including very small wounds (e.g., <1x1cm), to justify the necessity of NPWT therapy vs. other advanced wound therapies.

4. **In today's electronic age, more and more people including physicians are turning to video conference technology as a means of interacting with one another. Does CGS consider a video conference (aka "Skype") between the patient and the physician (whereby the physician documents the evaluation performed via video conference), evidence of an in person evaluation so long as the interaction is documented in the patient's medical record and meets the minimum requirements outlined in the Medicare Benefit Publication 100-2 chapter 15 section 270 which states that "The use of a telecommunications system may substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other physician fee schedule (PFS) services"?**

   Response: As long as the encounter meets all the requirements for a telemedicine visit. In addition to the citation above, also see the Claims Processing Manual, Chapter 12, Section 190.

5. **In instances where the physician's signature on one document is illegible (i.e. medical record chart note) with no identifier, but we do have a signed corresponding CMN or prescription for the same patient which does have the physician's printed identifying information, will the DME MACs accept the matching signature on the corresponding Rx/CMN in lieu of obtaining a signed signature log or attestation from the physician so long as the signatures are an obvious match?**

   Response: No. Suppliers should follow carefully the signature requirements outlined in the Supplier Manual and various publications from Medical Review.

6. **DME MACs have published guidelines on electronic signatures for providers. We are unable to find any published information on electronic signatures for suppliers. Today when we sign a DIF for enteral, we fill it out electronically and print it to paper so that we can manually sign it. We would like to eliminate this step and sign it electronically. Please advise on the requirements necessary for the electronic signature to be valid.**

   Response: Signature requirements apply to all providers.

7. **Jurisdiction B Supplier Manual states the following: "When changes are made to an initial DIF, a revised DIF must be completed. A revised DIF is required whenever there is a change in supplier, beneficiary information, item dispensed, or medical need. When the only change to the DIF is a change in supplier, the revised DIF must be completed and kept on file. It does not need to be submitted to the DME MAC. Otherwise, submit a revised DIF with the first claim affected by the changes."**

   Is this true for claims submitted to Jurisdiction C as well?

   Response: Yes

8. **Is a revised DIF required to be completed and submitted to the DME MAC when the only change is a change in physician?**

   Response: No

9. **If a beneficiary is transferred from one servicing location to another (same company) would this constitute a change in supplier and therefore require a revised DIF and a new detailed written order?**

   Response: Yes it is considered a change in supplier and thus a new DIF is required. If the "new" company is able to obtain the original detailed written order (DWO) from the "old" supplier, no new DWO is required. If the "new" supplier is unable to obtain the DWO from the "old" supplier, a new DWO would be required.

10. **Is a provider required to initiate a revised DIF when the lipid volume decreases? For example, the lipid volume initially is 250ml 20% per day and subsequently is decreased to 240 ml 20% per day.**

    Response: Yes

11. **If a patient changes from an ambulatory pump (E0781) to a stationary pump (E0791), would a revised DIF be required, or a new initial DIF?**

    Response: Revised

12. **The Medicare Program Integrity Manual, (Section 5.3 "Certificate of Medical Necessity (CMNS) and DME Information Forms (DIFS)" does not provide suppliers with guidance on when a revised DIF is required. The External Infusion Pump LCD states the following"**

    "If a patient begins using an infusion for one drug and subsequently the drug is changed or another drug is added, a Revised DIF must be submitted for use of the pump with the new or additional drug. In the case of an additional drug, all drugs for which the pump is used should be included on the Revised DIF."

    It would appear based on the above guidance and the lack of direction provided in the PIM, that the only time a supplier is required to complete a revised DIF when providing services covered under the EIP policy is for the above reason. Is this correct?

    Response: No. The DIF connects the drug to the pump. If you change to a different pump code, the DIF is needed to associate the drug with the new pump code in order for payment to occur.

ENTERAL/IV

1. **The Medicare Program Integrity Manual, (Section 5.3 "Certificate of Medical Necessity (CMNS) and DME Information Forms (DIFS)" does not provide suppliers with guidance on when a revised DIF is required. The Parenteral Nutrition LCD states the following:**

   A revised DIF is required when: Nutrients billed with a different code are ordered, or The number of days per week administered is changed

   Would you please clarify if the number of days applies to just the parenteral solution (i.e. B4189 – B4199) or does this apply to other HCPCS as well, (i.e. B4185)?

   Response: Yes, it applies to all nutrients.