

# Jurisdiction C Council

## July 2011 Questions

### EDUCATION

1. Pricing for miscellaneous codes: How is pricing defined for any NOC code? We were told by an ALJ that Medicare has to pay at 80% of the MSRP for all NOC codes? Is this true?

The CMS defines the Pricing Category for each HCPCS code, including NOC codes. The pricing category can be found on the HCPCS file.

There is no regulation that Medicare pay 80% of the Manufacturer Suggested Retail Price (MSRP) for NOC codes.

For NOC codes, there are multiple factors that must be taken into consideration in calculating the reimbursement.

- Is the item provided, correctly coded under the NOC code?
- Is there a coverage benefit for the item?
- Is the item provided, medically necessary for the beneficiary for whom it is billed?
- What pricing category is assigned by the CMS to the NOC code?
- What instructions from the CMS are applicable for the pricing category?

For example, HCPCS code K0108 is in pricing category 46, which is defined as "Carrier priced (E.G., Not otherwise classified, individual determination, carrier discretion, gap-filled amounts)". If the carrier determines to use the gap-fill methodology in calculating the reimbursement amount, they would follow the instructions in the IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 23, Section 60.3. Under this methodology, the carrier can use the fee schedule amounts for comparable equipment, fee schedule amounts from neighboring carriers, or supplier price lists with prices in effect during the database year. There are additional instructions in this section for different situations, including when the price information is not from the database year.

2. Error Rate: What is the process to have error rate adjusted to reflect when an initial development request is denied and then over turned during redetermination?

**Dr. Hoover:** Assume the question relates to probe and prepayment review activities conducted by CGS MR. CGS MR conducts periodic edit effectiveness reviews for both supplier-specific and service-specific prepayment edits and takes into account redetermination decision. Due to the timing of redeterminations and the common practice of

providing additional documentation at the redeterminations level, CGS MR does not routinely take into account redetermination reversals in the original probe review error rate.

3. Removal from Audit Process: What is required from a supplier to be removed from a prepay review audit, and where is this information documented?

**DR. Hoover:** There is no single criterion for removal from prepayment audit. CGS MR staff take into account a variety of factors including (not all inclusive): Reduction in errors compared to initial probe review results; type of errors found in probe review; quality of corrective action plan and progress of supplier in meeting CAP goals; supplier understanding of errors encountered in probe review; willingness to accept or pursue education.

4. Education: What education should a supplier expect to receive from CGS while in the audit process and should a supplier have to seek out this education or is it provided at certain intervals or only when requested by the supplier?

**Dr. Hoover:** CGS has a variety of educational offerings for suppliers under audit including webinars, in-person seminars and information on the CGS web site. In some cases, depending on the initial probe review error rate, teleconference education is mandatory. In others, it is anticipated that the supplier will review the probe review findings and, in conjunction with the development of a



corrective action plan, independently seek education from CGS MR or POE.

5. Is there anything that states that a supplier can't use a prescription that is completed by the physician but has the suppliers header on it as an original order? Companies are supplying physicians' with script pads that has the companies' name and address and contact information on top of the prescription. Can this be done? One is a blank form: One has check boxes for specific products by manufacturer.

**Dr. Hoover:** There is no prohibition on a prescription written on a supplier's letterhead; however, the information contained therein must comply with the Supplier Manual and/or Program Integrity Manual requirements for an order. Also note that there are specific rules for orders for power mobility devices (PMDs). Suppliers should ensure that any orders with "check boxes" comply with the educational guidance provided in the article entitled "Detailed Written Orders" in the Summer 2010 DME Insider (pg. 12).

6. Do the DME MACs publish a HCPCS List with Description like they did in the past? Pricing Includes a complete listing of the codes with prices; however the listing does not include a description.

*Appendix A of the Supplier Manual*

[CMS website at http://www.cms.gov/HCPCSReleaseCodeSets/02\\_HCPCS\\_Quarterly\\_Update.asp](http://www.cms.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp)

## RESPIRATORY

1. On April 27th in the ask the contractor session, Q1: Regarding the answer to the question in which the patient was trial on a CPAP with a DX of OSA but was unable to tolerate the CPAP. The physician then ordered O2 for the patient due to low O2 sats. The documentation in the patient's chart stated the they did not tolerate the PAP therapy in the question. The answer given stated the patient must receive therapy from the PAP device and have that condition under control then have them tested. If the patient is unable to tolerate the CPAP, how do we get them to qualify and what would you consider a chronic, stable state if they have a DX of OSA?

**Dr. Hoover:** Chronic stable state is a requirement of the

National Coverage Determination (CMS Internet-only Manual, Pub. 100-3, Section 240.2) and is one of the key criteria when considering coverage of home oxygen therapy. The NCD describes chronic stable state as "...not during a period of an acute illness or an exacerbation of their underlying disease." Based on this NCD definition, all other hypoxia-inducing co-existing diseases or conditions must be addressed before oxygen therapy is considered. In the case of OSA, it is expected that the OSA be appropriately treated such that the patient is in the chronic stable state before oxygen saturation results are considered qualifying for oxygen therapy. For patients who are unable to tolerate PAP therapy, the documentation must demonstrate that all measures to encourage compliance with PAP have been considered (e.g., mask changes, consideration of bilevel use, nasal decongestants, etc) and/or consideration of other accepted treatments for OSA (e.g., weight loss, lifestyle changes, smoking cessation, surgical intervention, oral appliances, etc).

2. Regarding replacement of O2 equipment: the policy states an initial CMN is required "when the equipment is replaced because the reasonable useful lifetime of prior equipment has been met". The policy also states for initial CMN's for replacement equipment: Repeat blood gas testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN. There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment. We have several pre-pay audits that are being denied due to lack of physician documentation the patient still needs the equipment. The auditors are looking for a 6 month window in which the patient has seen the physician even though the policy states the patient does not need to be seen. What is your recommendation how to handle these since the policy states "there is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment"?

**Dr. Hoover:** The issue of seeing the physician for completion of the CMN for replacement equipment is a separate issue from documentation of continued need. Continued need is a medical necessity issue wherein the

physician documents that the oxygen equipment or other DME item remains medical necessary.

3. Change Request 7235 announced that effective for claims with DOS on after 1/4/11, Medicare will allow for the coverage of home use of oxygen to treat Medicare beneficiaries diagnosed with Cluster Headaches (CH) when these beneficiaries are enrolled in clinical studies that are approved by CMS for the purpose of gaining further evidence. The claims for these services must contain ICD-9 code for CH (339.00, 339.01, 339.02) and HCPCS E1399 and a clinical trial procedure code modifier Q0. CR7235 also stated that currently, there are no clinical trials approved or pending approval for the home use of oxygen for CH.

CMS issues quarterly HCPCS updates. Among the new HCPCS codes that are effective as of 7/1/11 are:

K0741 Portable gaseous oxygen system, rental, includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing, for cluster headaches

K0742 Portable oxygen contents, gaseous, 1 month's supply = 1 unit, for cluster headaches, for initial month's supply or replace used contents

Our question is – When would we use E1399 and when would we use K0741 and K0742? The Policy Article for Oxygen and Oxygen Equipment states: “When oxygen is supplied as part of a CMS approved clinical trial for cluster headaches, equipment must be coded using E1399 (durable medical equipment, miscellaneous).”

**Dr. Hoover:** After 7/1/11, suppliers should use the specific K codes K0741 or K0742, in conjunction with the clinical trial modifier, for patients with cluster headaches enrolled in a clinical trial.

4. Re: PAP, we had discussed this during the last meeting with CGS in April (see Q#1 under the ‘Respiratory’ section). A number of physicians are questioning our company’s insistence that the word “obstructive” be on the clinical evaluation notes following a beneficiary entering Medicare. On the clinical evaluation notes, the physician had written “sleep apnea” not “obstructive sleep apnea.” Our billing center is rejecting the office visit

notes stating that per the PAP policy, the diagnosis on the clinical evaluation should state “a diagnosis of obstructive sleep apnea.” The physician, on the other hand, pointed out that the rest of the documentation we have on this patient all state “obstructive sleep apnea” – (1) the original sleep study, the original prescription where the physician first prescribed the PAP and now the new written order following the beneficiary’s enrollment in Medicare FFS. It should be evident from all of these that the patient has OSA. Should we be fixated with the word “obstructive” in the current office visit notes when we have other medical records that state OSA?

**Dr. Hoover:** From the entirety of the record it must be clear that the diagnosis is OSA (ICD-9 327.23) to qualify for a PAP device.

5. If a patient fails the initial trial period for a PAP (but had a valid sleep study, etc to qualify for the initial to begin with), what does Medicare expect to see to start a new trial period over? The LCD lists 2 things that are required: beneficiaries who fail the initial 12 week trial are eligible to requalify for a PAP device but must have both: face-to-face clinical re-evaluation by the treating physician to determine the etiology of the failure to respond to PAP therapy; and repeat sleep test in a facility-based setting (Type 1 study). This may be a repeat diagnostic, titration or split-night study. Can we get clarification, that if a titration is used, what elements need to be present, as Medicare will not cover a new baseline PSG for the sleep lab to perform.

**Dr. Hoover:** The elements of a facility-based type 1 study are defined in the LCD.

6. Medical Records? Does the LCD or NCD for Oxygen services provide a distinction for medical records and what information needs to be documented on each “type” of medical record, if there is a distinction?

**Dr. Hoover:** There is no way to specify what information is documented in each “type” of medical record because the content of each type of record varies, depending on the disease condition, the type of record, etc. Medical records are defined in PIM 5.7. It says, in part, “The patient’s medical record is not limited to the physician’s office records. It may include hospital, nursing

home, or HHA records and records from other health care professionals." In general, Medicare does not specify what document type should be the source.

7. Group 1 patient, tested on 10/21/10, with resting saturation of 75. Doctor indicated length of need was only one month, and the patient switches to new company. Do they need a revised CMN using the old test values? Or a revised CMN with new test values? Or initial CMN with new testing? First provider was paid for one month.

**Dr. Hoover:** According to the Oxygen LCD and Chapter 4 of the *Supplier Manual*, both extending the length of need and switching companies are reasons to obtain a revised CMN. Any break in service or break in medical need issues could change this.

### REHAB

1. If the LNP (who has their own NPI) sees the patient and does the complete evaluation for a power chair but the physician in the office also reviews and signs off on her progress note, can the LNP do the 7 element order and sign off on detailed product description? It is her patient just the physician signed off on the original progress note. He did not do the evaluation, the LNP did it.

**Dr. Hoover:** The authority of a nurse practitioner is dependent on state law and the scope of practice outlined in the state statutes. Assuming the state law allows, it is acceptable for the NP to complete the face-to-face evaluation, 7-element order and other documentation components required for a PMD.

2. Could a swing away joystick be considered for coverage if need is to swing away to be able to reach table and feed themselves?

**Dr. Hoover:** Swing away joysticks are considered for coverage if the documentation demonstrates that the swing away joystick is reasonable and necessary to accomplish the beneficiary's mobility-related activities of daily living (MRADLs).

**Dr. Hoover Follow-up:** Will discuss with the other medical directors the apparent contradiction between the response to this question and the statement in the

Wheelchair Options and Accessories Policy Article: Swingaway, retractable, or removable hardware (E1028) is noncovered if the primary indication for its use is to allow the patient to move close to desks or other surfaces. If it ordered for this indication, a GY modifier must be added to the code.

3. What is the process a supplier should use to provide an upgraded positioning seat and back cushion for a patient who only qualifies for a power wheelchair with a captain's seat, K0823? This requires the patient to be given a K0822 wheelchair base to accommodate the positioning seat and back cushions. Additionally the patient does not have one of the specific qualifying diagnoses but based on professional clinical opinion the positioning products will better meet the needs of the patient than a captain's seat.

**Dr. Hoover:** Positioning seat and back cushions may be billed as an upgrade when the patient does not meet the coverage requirements outlined in the Wheelchair Seating and Positioning LCD.

4. New DPD requirements – Is it still advised to include make and model but no longer a requirement to include Medicare fee schedule amount and provider charge?

**Dr. Hoover:** The new detailed product description requirements no longer include listing the Medicare fee schedule allowance and provider charge. In addition, the new DPD requirements give the supplier the option of using either a narrative description or make and model number; however, whatever description is used it must be sufficiently detailed to allow a correct coding determination. CGS recommends the description be as specific as possible and that is most often accomplished by listing a specific make and model.

5. We have a dealer who received word from a CSR (no name unfortunately) that they received an overpayment on a G3 wheelchair because it should have not been paid as a purchase but rather as a rental. We have also heard this about Group 2 POVs (for which I do have a specific claim reference – provider was told 3 times that as of Jan.1 scooters had to be rentals; resubmitted and received same info on denial). Can education be provided to prevent this from happening?

**Dr. Hoover:** Please provide examples so CGS can research.

6. There appears to be mixed messages regarding replacements of wheelchairs (or other DME) that were received (Delivery date) over 5 years prior. Beneficiaries are being told they can just get a new prescription and get a new wheelchair and providers are told that the 5 years RUL rule should be all that is needed, however that is not what is happening in claims processing or reviews. Providers are being asked for repair breakdowns. What are the documentation requirements?

**Dr. Hoover:** Please provide examples. Note that the PMD policy requires a complete redo of all requirements to replace a PMD.

7. With the latest PMD revised policy, the wording of the DetailedProductDescriptionforPMDshaschanged.Itstates:

*This detailed product description (DPD) must comply with the requirements for a detailed written order as outlined in the Supplier Manual and CMS' Program Integrity Manual (Internet-Only Manual, Pub. 100-8), Chapter 5. Regardless of the form of the description, there must be sufficient detail to identify the item(s) in order to determine that the item(s) dispensed is properly coded.*

When the requirements are pulled from the PIM, it states:

*All orders must clearly specify the start date of the order . . . The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number... Someone other than the physician may complete the detailed description of the item. However, the treating physician must review the detailed description and personally sign and date the order to indicate agreement. The supplier must have a detailed written order prior to submitting a claim. For items listed in chapter 5 section 5.2.3.1 (this includes PMDs), the detailed written order must be obtained prior to delivery. If a supplier does not have a faxed, photocopied, electronic or pen and ink signed detailed written order in their records before they submit a claim to Medicare (i.e., if there is no order or only a verbal order), the claim will be denied... Medical necessity information (e.g., an ICD-9-CM diagnosis code, narrative description of the patient's condition, abilities, limitations) is NOT in itself considered to be part of the order although it*

*may be put on the same document as the order.*

Based on this information would the DPD require a start date? Or since the Face-to-Face date is required on the 7-element order, will that fulfill the requirement?

**Dr. Hoover:** The signature date on the 7-element order serves as the start date and is considered the "order" for a power mobility device. The DPD is confirmation of that order. Suppliers may simply restate the signature date from the 7-element order as the "start date" on the DPD.

8. When working with complex rehab PMDs (Group 3's and above or Group 2's with powered seating) the common process is:  
**End-user has physician office visit**  
**Physician writes an RX for a Seating/WC evaluation by a specialized seating therapist**  
**During this evaluation, which normally includes a provider ATP, a WC (and seating) is recommended and documentation is completed.**  
**Based on policy - evaluation documentation is sent to physician for review and concurrence.**

The question is, because of this process the physician may receive the completed evaluation with all recommended equipment, a home assessment, and a Detailed Product Description at the same time (the provider is able to create this after the seating evaluation). He/She will also complete a 7-Element order at this time since the final wc evaluation is now completed. If the Home Assessment and/or the Detailed Product Description is signed & dated the same day as the evaluation signature & completion of the 7-element, would that be considered valid? In essence, the face-to-face date would be the same as the signature date on the Home Assessment and DPD.

**Dr. Hoover:** It is unclear from the "common process" at what point the home assessment is conducted. The home assessment cannot be conducted until there is a recommendation or order from the physician for the appropriate type/size of wheelchair, based on the assessment of the beneficiary. Only after the physician makes their clinical assessment of the beneficiary's equipment needs can the appropriate piece of equipment be selected. AND only after the appropriate piece of equipment is selected can the home environment be assessed for accommodation of this equipment.

### DME

1. We are receiving CO96 denials on claims and when inquiring with customer support at CGS, we are being told a development letter had previously been sent and documentation not supporting the medical necessity of the claim had been received. Upon further research, it was determined that this documentation was received from a previous provider. Should these claims not pend out for prepayment review in this case instead of denying outright? The new provider should have information on file supporting the medical necessity. This would eliminate the need to go to Redetermination. If the claims cannot pend for prepayment review, is CO96 the most appropriate denial? Should you not receive a medical necessity denial CO50 instead?

**Dr. Hoover:** Please provide some examples, there are many possibilities here that need to be defined so that a correct answer can be given. Indications from our tech team are that a claim in this situation would normally receive a medical necessity denial.

### DOCUMENTATION

1. No questions.

### ENTERAL/IV

1. We have recently heard that one of the other DMEMAC regions is now stating that effective 4/1/2011 all claims for patients receiving greater than 2500 calories per day will deny and providers will be required to submit claim through the Redetermination process with additional documentation to support the need for this caloric intake to receive payment. Is Region C planning any such action, and if so can this be enforced without any notification to suppliers?

**Dr. Hoover:** Please provide examples. This may not be a DME MAC-specific issue as there are a number of Medically Unbelievable Edits (MUEs) that took effect for claims with dates of service on or after April 1, 2011. The MUE is likely based on contractor instructions in the Medicare Claims Processing Manual (Internet-only Manual CMS Pub. 100-4, Chapter 20, Section 100.2.2.2 which state:

*Generally, daily enteral intake of 750 to 2,000 calories is considered sufficient to maintain body weight. Patients with*

*medical complications may require an intake outside the range. The attending physician must document the reason for prescribing less than 750 calories per day or more than 2000 calories per day.*

2. Is it acceptable for a provider to deliver equipment / drug and supplies to a facility versus the patient's home to allow for initiation of a continuous infusion that will be continued in the home? For example, shipment of drug/supplies delivered to a Cancer Center. The patient met the courier at the Cancer Center and signed paperwork upon receipt. The patient was hooked up at the Cancer Center and returned home for the remainder of the 72-hour infusion. The patient returned to the Cancer Center to be disconnected. How should we bill this to the DME MAC?

**Dr. Hoover:** Delivery of the equipment/drug to a facility for use by facility staff to initiate the infusion would not qualify for billing to the DME MAC based on a place of service (POS) that qualifies as home. In the scenario described, the provider would bill the A/B MAC or legacy Part B local carrier.

3. For enteral supplies that are supplied as refills to the original order, the DME provider is allowed to deliver product no sooner than approximately 5 days prior to the end of usage for the current period. Let's say that the end of the usage period is June 15 and 6 cases of enteral formula (equivalent to a 30-day supply) were shipped on June 12. On June 15, the patient was admitted to the hospital and was discharged on June 25. How do we bill this claim to be properly reimbursed?

**Dr. Hoover:** Date of service (DOS) is considered date of shipping for supplies that use a commercial shipping service. In this case, the DOS is June 12 and payable. Since there are 10 days where the patient was in-patient, the next date of service and/or the amount would need to be adjusted to account for the excess supplies due to non-use during the 10 inpatient days.

Note that this question was received in mid-July. Effective for dates of service on or after August 2, 2011 the Centers for Medicare and Medicaid Services revised the timelines for refills. The new rules, located in the *Program Integrity Manual*, Chapter 5 specify that contact with the beneficiary or designee regarding refills must take place no sooner than

14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized.

The DMDs will be updating the applicable LCDs in the near future to reflect this new guidance.

4. Medicare does not pay consistently on HCPC K0552. When Medicare is contacted we are told the only way they will pay this HCPC is if it is billed with an insulin type pump. We have sent the claims to redetermination and it appears the code will deny dependant on the pump we provide.

**Dr. Hoover:** HCPCS code K0552 (Supplies for external infusion pump, syringe type cartridge, sterile, each) is an accessory for a syringe-type infusion pump. It is not specific to insulin infusion pumps. Please provide examples.

5. Do you foresee Cardiac ECHOs being accepted as a way to obtain cardiac index for testing for the EIP inotrope policy with the hospitals facing problems with readmissions for CHF after October 1<sup>st</sup>?

**Dr. Hoover:** The DMDs have not been asked to consider cardiac echocardiography or other non-invasive tests as acceptable for justification of inotropic therapy.