National Government Services

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A CMS Contracted Agent

Medicare

Jurisdiction B Council A-Department Questions
Sorted by A-Department
July 2007

Home Medical Equipment
No questions submitted

Enteral/Parenteral/IV Therapy

1. We received a remittance advice with the code B4035 downcoded to B4036. When National Government Services, Inc. was called, we were told that we needed documentation to support the need of the pump. There is not a place on the new DIF for this information. Previously, the information to support the need for the pump and extra calories was indicated on DMERC 10.02B - question #15 (Additional information when required by policy.) How can we get this information to the DME MAC without having to review the claims to have codes B9002 and B4035 processed correctly?

   The Local Coverage Determination for Enteral Nutrition states in pertinent parts:

   If a pump (B9000-B9002) is ordered, there must be documentation in the patient's medical record to justify its use (e.g., gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload, gastrostomy/jejunostomy tube used for feeding). If the medical necessity of the pump is not documented, the pump will be denied as not medically necessary.

   The feeding supply kit (B4034-B4036) must correspond to the method of administration indicated in question 5 of the DME Information Form (DIF). If it does not correspond, payment for the billed code will be based on the allowance for the code relating to the method of administration specified on the DIF or the billed code, whichever is less. If a pump supply kit (B4035) is ordered and the medical necessity of the pump is not documented, payment will be based on the allowance for the least costly medically appropriate alternative, B4036.

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Claim examples provided for the scenario indicated gravity as the method of administration, resulting in the pump supply kits (B4035) being downcoded to least costly medically appropriate alternative gravity supply kits (B4036).

Suppliers may exercise his/her appeal rights and request a redetermination. Redetermination requests should be submitted to the following address:

Redeterminations
P.O. Box 50403
Indianapolis, IN 46250-0403

Respiratory Care Equipment/Oxygen Therapy

2. Is there, can there be, new modifiers to help with the new capped rental of oxygen systems? IE KM for first month, KN for months 2-12, KO for 13-24 and KP for months 25 through 36. There is definitely a need for an ability to tell Medicare of break in service changes as well as ways to notify providers what stage of payment an oxygen patient is at.

   This suggestion has been referred to the Program Safeguard Contractor, TriCenturion. Suppliers are encouraged to utilize the Break in Service (BIS) process in the event that there is a change in the patient's medical condition for a period of 60 days or more. To determine whether a Break in Service or a Break in Billing has occurred, please refer to the Break in Service Flow Chart and Break in Service Form on the Forms page of the National Government Services Web site at: http://www.adminastar.com/Providers/DMERC/Forms/forms.html

3. We have had several long term patients who have recently been granted retro active Medicare benefits, some up to 5 or more years. Two of our customers are on oxygen therapy and we do not have the required qualifying test results at the beginning of therapy which is now during a Medicare covered period, nor do we have an ABN as patient was not Medicare when we took them on service but now are and retroactively to the initial date of service. What is our responsibility in these situations?

   Medicare provisions will allow for the untimely submission of claims for retro-active benefits. However, qualifying test results are required in order to determine if the coverage criteria has been met.

For additional details regarding administrative errors, please refer to the CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 1, §70.7.1 Administrative Error at: www.cms.hhs.gov\manuals

Prosthetics/Orthotics
No questions submitted

Rehab Equipment

4. Claims for E2399, E2377 and K0040 have been denied inappropriately. Will there be any DME MAC generated re-processing of incorrectly denied claims? Examples have been provided.

   The Jurisdiction B DME MAC Provider Outreach and Education department has requested and received claim examples to research this issue. A response will be provided to the council upon receipt of a resolution.

Ostomy/Urological/Medical Supplies
No questions submitted

Diabetic Monitoring and Supplies

5. Claims for supplies that are delivered by mail, UPS, etc (not picked up by the bene or delivered directly by the provider) must be billed with a KL modifier effective July 1, 2007.

   (a) What is the purpose of this modifier?
   Per Change Request 5641, the purpose of the KL modifier is to identify diabetic supplies that are ordered remotely by the beneficiary and delivered via mail with dates of service on or after July 1, 2007. When submitting the following HCPCS codes, A4233-A4236, A4253, A4256, A4258 and A4259, the KL modifier (DMEPOS item delivered via mail) must be included on the claim when they are delivered via mail.

   (b) Will there be any difference in reimbursement?
   No, the addition of the KL modifier does not change the fee schedule for any of the codes listed. However, suppliers are reminded to include the KS or KX modifier with their claim as instructed by the Local Coverage Determination for Glucose Monitors.

   (c) Any difference in processing?
   No, processing guidelines will remain the same.

Documentation/Regulatory/Miscellaneous

6. In reference to capped rental equipment set up after the Deficit Reduction Act, we have noticed that the DME MACs are loading our prescriptions and CMNs with a length of need as 12 months even though the length of need on the hard copy document is lifetime. The claim for the thirteen month rental is then denied as "no CMN/Prescription on file". Why is the DME MAC loading these CMNs/Prescriptions with a length of need of 12 months? (Examples furnished upon request)

   The Jurisdiction B DME MAC Provider Outreach and Education department has requested examples of the claims described above.

7. In reference to the article published by National Government Services titled 'Downcoding - Use of GK and GL Modifiers on Claims for Upgrades', this is different from the previous guidance which was to bill for what the physician actually ordered. The recent article now instructs to bill for what the patient qualifies for. If a supplier wants to provide the upgrade without any additional charge to the beneficiary, and if the physician has ordered, for example, a K0003 but the beneficiary only qualifies for a K0001, the supplier only bills the HCPCS code for the item that meets coverage criteria with a GL modifier; in this example, bill using K0001GL. Our question is in reference to existing claims that you already have on file.

   (a) If we had been billing for a K0003 all along (using the previous guidance) and Medicare has our prescription and historical claims on file, and midway during the rental period, we now change the HCPCS code to a K0001GL, will we not receive a 'same and similar' denial?

   Please see response to May 24, 2007, Ask the Contractor Teleconference Question #6 below:

   If the supplier had previously billed with a K0003 and is now billing with a K0001GL, the K0001GL will process in our system for payment. The supplier will not receive a same/similar denial. Any amount that was paid towards the K0003 will be applied to the K0001. The K0001 will continue to pay for the remainder of the rental period.

   For additional information, you may refer to the following articles located on the CMS Web site at:

   http://www.cms.hhs.gov/Transmittals/Downloads/B03009.pdf or to the

Jurisdiction B DME MAC May 24, 2007, Ask the Contractor Teleconference Q&A document at:

http://www.adminastar.com/Providers/DMERC/Workshops/TeleconferenceMaterials.html

(b) If so, how do we prevent this denial from occurring?

Please see response to part (a) of this question.

(c) In the event that we receive such a denial, how do we overturn it?

In the event of a denial, the supplier should exercise his/her appeal rights and request a redetermination. Redetermination requests should be submitted to the following address:

Redeterminations
P.O. Box 50403
Indianapolis, IN 46250-0403

8. We would like to access the list of Health Care Common Procedure Code System (HCPCS) affected by the Medically Unlikely Edits (MUEs) but have been unable to locate it. Change Request 5603 indicates a supplier cannot obtain an Advance Beneficiary Notice or send a denied claim to appeal; suppliers need to know which codes are affected. Please advise where the list is published?

Change Request 5603 announced the release of the next version of the Medically Unlikely Edits, which went into effect July 1, 2007. The Medically Unlikely Edits are made available only to the CMS contractors to ensure implementation of the appropriate sets of Medically Unlikely Edits developed for this particular quarter. However, suppliers are encouraged to follow the units of service parameters set forth in each of the Local Coverage Determinations to ensure that items or services being provided are not deemed excessive by the policy.

For additional details regarding the Medically Unlikely Edits please refer to the CMS IOM Publication 100-08 Medicare Program Integrity Manual, Chapter 3, §3.5.1, Automated Prepayment Review at www.cms.hhs.gov/manuals

9. Medicare Learning Network Matters Number MM5603 "Medically Unlikely Edits (MUEs) states "Excess charges due to units of service greater than the MUE may not be billed to the beneficiary. Is it possible to provide us how "greater than MUE" is determined since we cannot bill for these items even with an ABN?

   Per the Medically Unlikely Edits (MUE) Project, CMS stated:

   "The Centers for Medicare and Medicaid Services will develop MUE criteria based on data for past periods, clinical judgment of CMS health care professionals, and comments from the health care community."

   For additional details regarding the Medically Unlikely Edits, please visit the CMS Web site at http://www.cms.hhs.gov/MedicalReviewProcess/

10. When we need to put more than 4 modifiers on a claim line, please explain the use of KB and 99 to indicate modifier overflow. I know that KB is to be used strictly on claim lines for bene waiver upgrades. Is "99" also restricted, or can it/should it be used in all other circumstances?

    The KB modifier is used strictly for upgrade situations and the 99 modifier should be used in all other situations where there is a need for more than four modifiers on one detail line. Please see response to May 24, 2007 Ask the Contractor Teleconference Question # 4 below:

    Additional modifiers are reported on electronic claims in the NTE line segment and on paper claims in box 19 of the 1500 form. For example: If the supplier needs to report the following six modifiers RR, KH, LT, BR, KX and the GK or GL. The supplier would put the pricing modifier RR first, followed by KH, LT and then the KB. The KB modifier should go in the fourth two-digit place to indicate there are more than four two-digit modifier sets being billed. The supplier then places the remaining two-digit modifier sets (BR, KX and GK or GL modifier) in Box 19 for paper claims and in the NTE line segment for electronic claims. For additional information, you may refer to the following article located on the CMS Web site: http://www.cms.hhs.gov/Transmittals/Downloads/B03009.pdf

    You may view the entire Ask the Contractor Teleconference May 24, 2007 Q&A document at:
    http://www.adminastar.com/Providers/DMERC/Workshops/TeleconferenceMaterials.html

11. Replacing referring physician UPINs with NPIs: we have been able to use surrogate UPINs in certain circumstances, i.e. RES000 if the referring physician is a resident and does not yet have an individual UPIN. Will there be an equivalent surrogate NPI to use in these circumstances (once referring IDs must be switched to NPIs, May 2008)? If not, what options are available for a DME provider to submit a claim if the referring physician does not have an NPI?

    National Government Services cannot answer this question at this time as we are waiting for further instructions from CMS.

12. Based on responses to Questions 10 and 18 of the last Medicare Jurisdiction B Council meeting, can you please clarify how suppliers are to handle these situations, without liability, when we know Medicare will deny the claim? According to Chapter 30 of the Medicare Claims Processing Manual, Section 50.5.5 ABN-G Customizable Boxes, we are allowed to customize with the following 3 reasons: 1) Medicare does not pay for this item or service for your condition, 2) Medicare does not pay for this item or service more often than the frequency limit and 3) Medicare does not pay for services which it considers to be experimental or for research use. Don't both these situations fall under situation number 2? Doesn't this, in essence, taking away the patient's right to choose to receive more supplies than Medicare allows?

    When billing for replacement equipment prior to the reasonable useful lifetime of 5 years, suppliers have the right to execute an Advance Beneficiary Notice (ABN). If an ABN has been obtained, suppliers should submit their claim with a GA modifier. In the event that the supplier is held liable and receives a CO denial, suppliers must request a redetermination and submit a copy of the ABN.

    Redetermination requests should be submitted to the following address:

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    With respect to services that are denied due to units of service greater than the Medically Unlikely Edits suppliers can not utilize an ABN or bill the beneficiary. Suppliers will need to make a business decision as to whether or not they will provide the beneficiary with the excessive units of service.

13. What specific information is required on the transfer of title to the beneficiary (13 months for capped equipment and 36 months for oxygen)? Does the provider have to create a Title Transfer form letter similar to the Capped Rental Purchase Option Letter providers previously used?

    According to Change Request 5370 suppliers must follow applicable state and federal laws when transferring the title for an item to the beneficiary. This transfer must occur on the first day after the last rental month. The provision applies to items for which the first rental month occurs on or after January 1, 2006.

    To review Change Request 5370 in its entirety please refer to the CMS Web site at: http://www.cms.hhs.gov/Transmittals/01_Overview.asp

14. Medicare secondary billing is not being processed. We have submitted claims many different ways and they continue to reject on the front end for invalid posting codes from primary payment. We have used the PR and 2, DED and 1, still can't get claims processed for secondary payment.

    The Jurisdiction B DME MAC Provider Outreach and Education department has requested additional information and/or examples to research this issue.