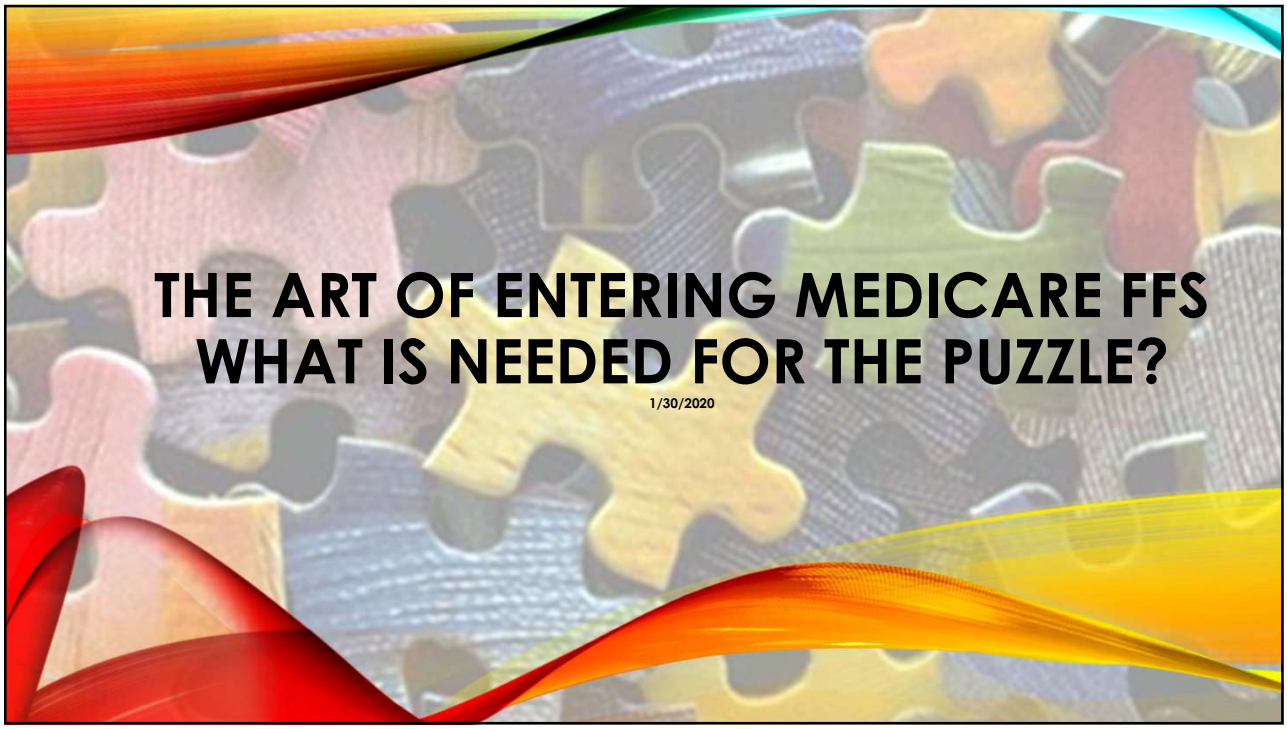


1

PIECING TOGETHER ENTERING FFS FROM ANOTHER PAYOR

When entering FFS from another payor:

- Medicare FFS doesn't know what occurred with other payers
- This is new claim to FFS
- Need to meet FFS coverage guidelines outlined in the current LCD
- For a rental item, it's new to FFS
  - Capped rental starts at month 1 = KH
  - Will get 13 months payment
- Oxygen rental starts from month 1
- RUL starts from FFS date of service (DOS)

2

SWITCHING FROM ADVANTAGE PLAN TO MEDICARE FFS

A beneficiary who was previously enrolled in a Medicare Advantage Plan, returning to traditional Medicare FFS, is subject to the same benefits, rules, requirements, and coverage criteria as a beneficiary who has always been enrolled in FFS Medicare.
Therefore, if a beneficiary received any items or services from their Medicare Advantage Plan, they may only continue to receive such items and services if they would be entitled to them under FFS Medicare coverage criteria and documentation requirements.

For example, a beneficiary who has obtained a capped rental item (e.g., hospital bed) through a Medicare Advantage Plan must, under traditional FFS Medicare, obtain a Certificate of Medical Necessity (CMN), if applicable, and meet FFS Medicare criteria for the item before a new capped rental period would begin.

A partial exception to this rule involves home oxygen claims. If a beneficiary begins taking oxygen while under a Medicare Advantage Plan, you must obtain an initial CMN and submit it to the DME MAC at the time that FFS coverage begins. In this situation, the beneficiary does not have to obtain the blood gas study on the CMN within 30 days prior to the date on the CMN, but the test must be the most recent study the beneficiary obtained while in the Medicare Advantage Plan, under the guidelines specified in LCD.

It is important to note that just because a beneficiary qualified for oxygen under a Medicare Advantage Plan does not necessarily mean that he or she will qualify for oxygen under FFS.

Located in Supplier Manual

3

EQUIPMENT RETAINED FROM A PRIOR PAYER

- When a beneficiary receiving a DMEPOS item from another payer (including a Medicare Advantage plan) becomes eligible for the Medicare Fee For Service (FFS) program, the first Medicare claim for that item or service is considered a new initial Medicare claim.
- Medicare does not automatically continue coverage for any item obtained from another payer when a beneficiary transitions to Medicare coverage.
- For Medicare to provide payment, the beneficiary must meet all Medicare coverage, coding, and documentation requirements for the DMEPOS items in effect on the DOS of the initial Medicare claim.
- A POD is required for all items, even those in the beneficiary's possession provided by another insurer prior to Medicare eligibility

Located in Standard Documentation Requirement (SDR)

4

PROOF OF DELIVERY REQUIREMENTS FOR RECENTLY ELIGIBLE MEDICARE FFS

The supplier record must document:

- A statement, signed and dated by the beneficiary (or beneficiary's designee), that the supplier has examined the item, meets the POD requirements; and
- A supplier attestation that the item meets Medicare requirements.
- For the purposes of reasonable useful lifetime and calculation of continuous use, the first day of the first rental month in which Medicare payments are made for the item (i.e., DOS) serves as the start date of the reasonable useful lifetime and period of continuous use. In these cases, the POD documentation serves as evidence that the beneficiary is already in possession of the item.

Located in Standard Documentation Requirement (SDR)

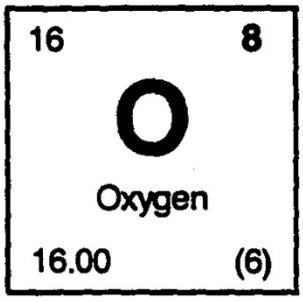
5

SWITCHING FROM MEDICARE ADVANTAGE PLAN TO MEDICARE FSS

Oxygen policy must be met with ALL of the following must be met:

- Severe lung disease or hypoxia related symptoms; and
- May use oxygen test results from the Advantage plan as long as they meeting Medicare FSS criteria; **and**
- Alternative treatments found ineffective considered/tried and ruled out, **and**
- In person visit with the treating physician within 30 days prior to the initial certification (order)
- New initial CMN – this is new to FFS

If patient hops between FFS & MAP, remember coming back to FFS is BIB/BIS



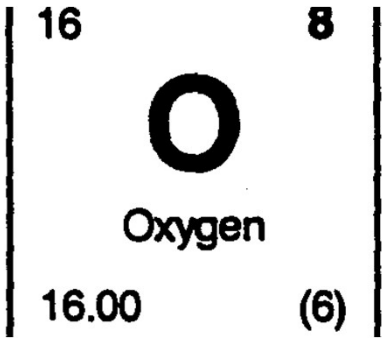
6

SWITCHING TO MEDICARE FSS – FROM OTHER PAYORS

For commercial payers, Medicaid including MCOs, and private pay

Oxygen policy must be met with ALL of the following must be met:

- Severe lung disease or hypoxia related symptoms; and
- New Blood gas or oxygen saturation results meeting specific criteria; **and**
- Oxygenation studies performed physician or a qualified provider or supplier of laboratory services; **and**
- Oxygen testing performed in a chronic stable state or within 2 days prior to discharge from an inpatient facility, and
- Alternative treatments found ineffective considered/tried and ruled out, **and**
- In person visit with the treating physician within 30 days prior to the initial certification (order)
- New Initial CMN



7

BENEFICIARIES ENTERING MEDICARE FFS: CPAP Machine and Supplies

For beneficiaries who received a PAP device prior to enrollment in fee for service (FFS) Medicare and are seeking Medicare coverage of either a new CPAP device and accessories, both of the following coverage requirements must be met:

1. **Sleep test – There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare enrollment, that meets the Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks Medicare coverage of a replacement PAP device and/or accessories; and,**
   - **Make sure hypopnea definition meets FFS criteria (4%)**
2. Clinical Evaluation – Following enrollment in FFS Medicare, the beneficiary must have a face-to-face evaluation by their treating practitioner who documents in the beneficiary's medical record that:
   - ✓ The beneficiary has a diagnosis of obstructive sleep apnea; and,
   - ✓ The beneficiary continues to use the PAP device
3. New capped rental – RRKHKX
4. New order (new to Medicare FFS)

If no sleep study available, a new sleep study (diagnostic) is needed that will meet Medicare requirements, and follow a new 12 week trial period.

8

BENEFICIARIES ENTERING MEDICARE FFS: Needing CPAP Supplies

For beneficiaries who received a PAP device prior to enrollment in fee for service (FFS) Medicare and are seeking Medicare coverage of accessories, the following coverage requirements must be met:

1. **Sleep test – There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare enrollment, that meets the Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks Medicare coverage of a replacement PAP device and/or accessories including; and,**
   - **Including hypopnea index definition (4%)**
2. Clinical Evaluation – Following enrollment in FFS Medicare, the beneficiary must have a face-to-face evaluation by their treating practitioner who documents in the beneficiary's medical record that:
   - ✓ The beneficiary has a diagnosis of obstructive sleep apnea; and,
   - ✓ The beneficiary continues to use the PAP device.
3. New order (new to Medicare FFS)

If no sleep study available, a new sleep study (diagnostic) is needed that will meet Medicare requirements, and follow a new 12 week trial period.

9

PAP (OSA) EXAMPLE

- If the patient is on a BiPAP treating OSA prior to Medicare enrollment
- Sleep study does NOT meet Medicare PAP policy
- Beneficiary needs a new qualifying diagnostic study, Medicare needs a baseline (diagnostic) so a split night study
- During the titration portion it can be warranted for using a BiPAP (E0470) versus CPAP (E0601)
- New trial period, treat like a new setup

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RAD POLICY- FOR BENEFICIARY'S ENTERING MEDICARE

- Qualification test – Documentation that the beneficiary had testing prior to FFS Medicare enrollment, that meets the current coverage criteria in effect at the time that the beneficiary seeks Medicare coverage of a replacement device and/or accessory
- Clinical Evaluation – **Following enrollment in FFS Medicare**, the beneficiary must have a F2F documenting all of the following:
  - Beneficiary has the qualifying medical condition for the applicable scenario
  - Testing performed, date of the testing used for qualification and results
  - Beneficiary continues to use the device
  - Beneficiary is benefiting from the treatment
- New Order (new to Medicare FFS)

11

PATIENT OWNED EQUIPMENT

- Patient enrolled in FFS from another payor
- Just needing supplies/accessories
- Need to make FFS aware of situation
- Claim needs a narrative in NTE section on initial claim:
  - ✓ HCPCS code of base equipment
  - ✓ Add it's beneficiary owned equipment
  - ✓ Date the beneficiary obtained ownership (Month & Year)

Example: *Beneficiary owned E0601 purchased Jan 2018*

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BREAK IN SERVICE

- "Break in service" is defined as break in monthly billing
  - Unable to bill for DMEPOS item due to other circumstances that impact billing the DMAC claim
    - Typically a conflict with Medicare Part A stay or enrollment in a Part A such as inpatient in a hospital, SNF, home health episode, or enrollment in hospice
    - Typically hold billing until beneficiary is released
- "No change in medical condition" means that there is a break in billing but the patient still needed the same equipment. For example, the patient was in a SNF, hospital, Medicare Advantage Plan, or hospice and the DME MAC was not being billed during this time. This could also include situations in which the patient continued to need the equipment, but it was removed from the patient's home.
- If capped rental or oxygen rental, need to add a narrative on NTE section for BIS & "extend rental to XX/XX/20XX" (new date for when rental should be complete 13th or 36th month)

13

BREAK IN NEED

- "BIN" means the medical necessity for the DMEPOS item ends and you discontinue billing and pick up the equipment
- "Change in medical condition" means that the patient's condition changed to the point that they no longer needed the original device. The patient's condition then changed again and the patient needed to resume using the original item. It could be for the same or different diagnosis.

  If same diagnosis, medical records need to be very clear of the change
- Oxygen seems to be the most difficult to get a new rental started

  Would need narrative explanation describing the reason for interruption which shows that medical necessity in prior episode ended (needs to be in medical records from physician)

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BREAK IN NEED EXAMPLE

Here's an example:

A beneficiary in respiratory failure due to COPD, being discharged from hospital needs a BiPAP machine, rents for 4 months, she calls and asks you to pick up the BiPAP because she has been doing well, following pulmonary hygiene treatment from doctor. Physicians writes a d/c order and she doesn't require the use of the BiPAP any longer.

You arrange to retrieve your equipment, provide a pick-up ticket to the beneficiary, and discontinue billing the BiPAP.

If the beneficiary has another need for the BiPAP in the future, new medical records, orders, delivery ticket, etc. would be necessary to begin a new capped rental period. In this scenario, add a narrative to the claim alerting DMAC to the new need and let Medicare know you want to begin a new capped rental.

They can set up the HCPCS code in the system and allow you to get your 13 rental payments.

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ANOTHER EXAMPLE

- Beneficiary gets BIPAP January 2019 for COPD
- Patient uses BiPAP until April 2019
- Doing much better, hasn't needed machine for a few weeks
- Physician and beneficiary decide to discontinue use
- December 2019, beneficiary ends up in hospital in respiratory failure secondary to COPD
- Physician orders BiPAP for home upon discharge to treat COPD
- New capped rental, it's a new need
- RAD policy coverage criteria needs to be met for new need (new DOS)
- Include a claim narrative: alert (claim narrative) the DMAC it's new capped rental, break in need (BIN)

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ONE MORE EXAMPLE

- If a patient has home oxygen rental and they go into the hospital and are there quite awhile. Then they go to a skilled facility for rehabilitation, this went on for about 4 months (in & out of hospital and SNF)
- In this situation, the equipment stayed in the home. We couldn't bill because she had been in and out of a facility. After 4 months, she finally goes home and we can resume our billing. At that point, with it being greater than 60 days break in service, is this a new rental of break in billing?

➢ You would resume billing based on where you left off. At some point in time, you need to ask up to extend the rental so you get your full 36 months. The 60 days is based on break in need, not a break in service. In this scenario, you didn't bill because they were in one type of Part A stay or another (acute care, rehab, skilled). Once she finally gets home, you can resume billing and pick up where you left off.
  ➢ (this applies to capped rental items as well: CPAP, BiPAP, HB, W/C)

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CMS-484 CMN for Oxygen

#	Item	Certification Required	Comments
1	Break in service > 60 days (change in medical condition)	Initial	"BIN" (break in need)
2	Break in service > 60 days (no change in medical condition) none "BIB" (break in billing)	None	"BIB" (break in billing)
3	Break in service < 60 days (change in medical condition) none "BIB" (break in billing)	None	"BIB" (break in billing)
4	Break in service < 60 days (no change in medical condition) none "BIB" (break in billing)	None	"BIB" (break in billing)
5	Change in supplier (no break in service)	Revised	Change in supplier (no break in service) revised in supplier's files In an acquisition, the original may be used if it is available.
6	Initial CMN did not qualify, patient retested and now qualifies.	Initial	Initial CMN did not qualify, patient retested and now qualifies. The initial date should be the date of the qualifying test
7	Group II patient not retested within 61–90th day recertification	Recertification	The recertification date should be the date of the physician visit.
8	Group I patient with a length of need less than or equal to 12 months (but not lifetime) and not retested 30 days prior to revision.	Revised	The revised date should be the date of the physician visit.
9	Group I patient with lifetime length of need, not seen and evaluated by the physician within 90 days prior to the 12 month recert but subsequently seen.	Recertification	The recertification date should be the date of the physician visit.
10	Portable was added after stationary	Revised	
11	Stationary was added after portable	Revised	
12	Change in modality	None	If the physician is requesting this change, a new order is required.
13	Changed billing assignment (non-assigned to assigned)	None	
14	Change in doctor	Revised in supplier's files	Supplier should maintain in their files.
15	Change in liter flow	Revised if change in payment category (e.g. 4 LPM to 5 LPM) None if payment category doesn't change (e.g. 2 LPM to 3 LPM)	Change in liter flow revised if change in payment category, e.g., from 4 LPM to 5 LPM. None if payment category does not change
16	Change from Medicare secondary to Medicare primary none	None	
17	Change from non-Medicare insurance to Medicare initial.	Initial	Change from non-Medicare insurance to Medicare initial. The initial date should be the date of Medicare eligibility if the patient has a Medicare qualifying test within 30 days before their eligibility. If they do not get the qualifying test until after they become Medicare eligible, then the initial date should be the date of the qualifying test.

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Upcoming Webinars:

February 28th @ 11am CST
Protect Your Supplier Number

February 28th @ 1pm CST
Negative Pressure Wound Therapy -What Are the Medical Necessity Requirements

Need training on-site for staff?
Contact me so I can help!

What to schedule a conference call with your team? Let me know so I can get this schedule.

Ronda Buhrmester
Senior Director of Payer Relations & Reimbursement
ronda.buhrmester@vgm.com
217-493-5440

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