Medical Affairs Bulletin

Oxygen policy requirements

The revised HCFA Form 484, included in both this DMERC Medicare Advisory issue and the Summer 1997 Region C DMEPOS Supplier Manual Revisions, asks whether the qualifying blood gas or oximetry test was performed “EITHER with the patient in a chronic stable state as an outpatient OR within two days prior to discharge from an inpatient facility to home.” The purpose of this question is to make sure the reported test result documents the necessity for chronic oxygen use in the home setting.

Patients with pulmonary or cardiac disease who are not on chronic oxygen therapy may be hospitalized with an acute condition, e.g. pneumonia, congestive heart failure, inflammatory and/or reactive airway disease, etc., which results in significant hypoxemia that requires the administration of oxygen. In these situations, specific treatment directed at the acute condition will usually result in improvement of the hypoxemia. If use of oxygen at home following discharge is being considered, an oxygen test obtained early in the course of these hospitalizations does not provide adequate documentation of medical necessity for oxygen at home. Testing as close as possible to the patient’s discharge to home is the best documentation of the necessity for oxygen at home. This is the reason for asking whether the medical necessity for oxygen, which is initially prescribed at the time of discharge from an inpatient facility, has been documented by a test within two days prior to discharge. As has always been the policy, if multiple tests have been performed, the value reported must be the most recent test (prior to the certification date on the form) that assesses the need for chronic home oxygen therapy. For patients who are hospitalized with acute cardiopulmonary conditions, it is common to monitor their response to therapy with tests such as oximetry. The question on the revised HCFA Form 484 is merely a reflection of good medical practice.

Furthermore, in these situations, continued treatment of the acute condition following discharge will likely result in further improvement of the hypoxemia. It is common for the physician to monitor the patient’s progress with oxygen tests during the first one to three months following discharge. This may lead the physician to modify the order or discontinue the oxygen if it is no longer needed. The supplier is encouraged to provide the physician with Medicare coverage criteria for home oxygen therapy.

Similar to situations with hospitalized patients, if home oxygen therapy is initiated on an outpatient basis, i.e. not immediately following a hospitalization, the qualifying test must reflect the patient’s chronic cardiopulmonary state. The test which is submitted must not be one obtained during an acute cardiopulmonary exacerbation, e.g. during an emergency room visit.

For question number 2 on the revised HCFA Form 484, “two days prior to discharge” refers to two calendar days. For example, if the patient is discharged June 4, question number 2 should be answered Yes if the reported test were performed on June 2, 3 or 4. If the answer to question number 2 is No, the supplier can send in additional information from the physician to explain why the reported test was not performed within the defined parameters.
**Support surfaces policy revision**

In the Pressure Reducing Support Surfaces-Group 2 policy, the narrative for code K0413 has been revised and a new code K0454 has been added.

K0413 - Non-powered, advanced pressure-reducing overlay for mattress, standard mattress length and width  
K0454 - Non-powered, advanced pressure-reducing mattress

The revision and addition are valid for dates of service on or after September 1, 1997. Both codes are in the capped rental payment category. A revision of the Pressure Reducing Support Surfaces-Group 2 policy is published in the accompanying Summer 1997 Region C DMEROS Supplier Manual Revisions. Required product characteristics for both of these codes are included in the definition section of the policy. Criterion number 4 in the definition section refers to documented evidence to substantiate the product is effective. In evaluating this criterion, a broad range of available evidence will be considered, and its quality will be evaluated by Palmetto GBA and the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC). Acceptable documented evidence may include: published authoritative studies, scientific data or research studies, consensus of expert medical opinion, or medical opinion derived from consultation with medical associations or other health care experts. Testimonials from physicians, clinicians, patients and limited case studies distributed by sponsors are not sufficient for this criterion to be met.

The ZX modifier should be used for billing these codes only when the criteria for its use, as specified in the documentation section of the Group 2 Support Surfaces policy, are met.

The only products that may be coded and billed using HCPCS code K0413 or HCPCS code K0454 are those products for which a written coding determination specifying the use of these codes has been made by the SADMERC. At the present time, the only products that may be billed to Palmetto GBA using HCPCS code K0413 are the ROHO Dry Flotation Mattress System and the RIK Fluid Overlay. The only product that may be billed using HCPCS code K0454 is the RIK Fluid Mattress. If suppliers or manufacturers think another product meets the definition of either code, they must contact the SADMERC for a written coding determination.

Some examples (not all-inclusive) of products that have not been approved as HCPCS code K0413 or HCPCS code K0454 are as follows (manufacturer and SADMERC approved codes are noted): ISIS (Atlantis Medical, HCPCS code E1399); ZAAM (Atlantis Medical, HCPCS code E0186); Pressure Guard Custom Care (Span-America Medical Systems, HCPCS code E0186); FlexCell (Zephyr Therapeutics, HCPCS code E0186); and Soflex (Crown Therapeutics, HCPCS code E0197).

Suppliers billing the RIK Fluid Overlay or Mattress using HCPCS code E1399 should switch to code K0413 or K0454 beginning with dates of service on or after September 1, 1997. They should bill continuing with the capped rental schedule currently in place. For example, if claims had been submitted for July and August
dates of services using code HCPCS code E1399 with modifiers RR and ZX, the September claim would be submitted as K0413RRKIZX (for the overlay) or K0454RRKIZX (for the mattress) considering it to be the third rental month. The September claim should be accompanied by a statement specifying the initial date the item was furnished. This information should be put in the HA0 record of an electronic claim or attached to a hard copy claim.

**Dynamic joint contracture devices**

Effective for dates of service on or after November 1, 1997, codes L2860 and L3890 for the “concentric adjustable torsion style mechanism” of various joint contracture devices will be invalid for claim submission to Palmetto GBA. These codes have been used along with other L codes to bill for dynamic contracture devices including, but not limited to, those by Ultraflex and Empl. The DMERCs have determined these items are similar to devices coded E1800-E1830 and are considered durable medical equipment.

For claims with dates of service on or after November 1, 1997, codes E1800-E1815, E1825 and E1830 must be used for the device itself, which includes the joints. These codes are in the capped rental payment category, and payment policy and coding guidelines for capped rental items applies, i.e. KH, KI, and KJ modifiers; 10th month rent/purchase option; maintenance and servicing; etc. Code E1820 is used for the interface material. It is in the inexpensive or routinely purchased payment category and is billed in addition to the first month's rental of the device.

Codes L2860 and L3890 will continue to be valid for dates of service before November 1, 1997.

Questions concerning the coding of specific products should be directed to the SADMERC at (803) 736-6809.

**Cold therapy policy**

An interim policy on Cold Therapy was published in the December 1996 *DMERC Medicare Advisory*. This policy was scheduled to take effect on April 1, 1997. A request for comments also was published, with a deadline of March 1, 1997.

Comments were received from a variety of individuals and groups. As a result of the comments received and reviewed, no changes will be made to the policy. The policy became effective on April 1, 1997, as scheduled.
**MEDICAL AFFAIRS BULLETIN**

**Nebulizer administration sets**

The DMERC Regional Medical Review Policy on nebulizers, published in December 1996 *DMERC Medicare Advisory* and revised in the Spring 1997 *DMERC Medicare Advisory*, states HCPCS code K0171 (administration set, small volume filtered pneumatic nebulizer) is covered when used for the administration of the drug pentamidine in patients with HIV infection (ICD-9-Dx 042). However, the HCPCS code appears in a list of codes of small volume nebulizers and related accessories, and could be incorrectly construed as applying to a list of diagnoses including obstructive pulmonary disease, cystic fibrosis or thick, tenacious secretions, as well as HIV.

HCPCS code K0171 is not medically necessary for the administration of medications other than pentamidine. A revision to the policy is enclosed in the Summer 1997 Region C *DMEPOS Supplier Manual* Revisions.

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**Lower limb prosthesis coverage change**

The Lower Limb Prosthesis policy published in the December 1996 *DMERC Medicare Advisory* stated a quick change self aligning unit (HCPCS code L5617) was considered a convenience item and, therefore, noncovered. Additional information presented in response has resulted in a change to the policy. HCPCS code L5617 is no longer considered a convenience item and is now covered.

An update to the policy is enclosed in the Summer 1997 Region C *DMEPOS Supplier Manual* Revisions.

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**Home dialysis supplies and equipment policy correction**

The recently published update to the Home Dialysis Supplies and Equipment policy omitted language in the coding guidelines section. A sentence describing the typical quantities that comprise one unit of service was inadvertently omitted.

The policy should state “For dialysis supply kits (A4820, A4900, A4901, A4905), one unit of service would represent the amount of supplies needed for one month of dialysis.”

An update to the policy is enclosed in the Summer 1997 Region C *DMEPOS Supplier Manual* Revisions.

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**Stocking supporter grips**

Effective for claims with dates of service on or after October 1, 1997, Medicare does not reimburse for stocking supporter grips (HCPCS code L0982). This code will be denied as non-covered when billed to Palmetto GBA.
Dear Physician:

The following is a summary of the Durable Medical Equipment Regional Carrier's (DMERC) Regional Medical Review Policy (RMRP) on seat lift mechanisms. It describes the equipment, its usual clinical indications, and Medicare's coverage criteria for reimbursement. Hopefully it will help you to better understand the criteria Medicare uses in adjudicating these claims.

The DMERC strongly believes that the physician is still the "Captain of the Ship." We require a physician's order before reimbursing any item. Sometimes we require a Certificate of Medical Necessity (CMN) and extra documentation. While this may inconvenience you with additional paperwork, it is only through your cooperation that Medicare can provide beneficiaries with the equipment and supplies they need. You are also helping to protect the Medicare Trust Fund from abusive and fraudulent claims for items that are not medically necessary or physician-ordered.

The following Physician Information Sheet (PHYSIS) is only a summary of the RMRP published in the DMERC Region C DMEPOS Supplier Manual. The definitive and binding coverage policy will always be the RMRP itself, which reflects national Medicare policy, and upon which actual claims adjudication is based. The physician information sheet is intended only as an effort to educate the physician community on conditions of coverage for items of durable medical equipment, prostheses, orthoses, and supplies when ordered for the care of Medicare beneficiaries.
**SEAT LIFT MECHANISMS**

*Physician Information Sheet*

**Indications**

A seat lift mechanism (HCPCS Code E0628, electric or E0629, nonelectric) is covered if all of the following criteria are met:

- The patient must have severe arthritis of the hip or knee or have a severe neuromuscular disease,

- The seat lift mechanism must be a part of the physician’s course of treatment and be prescribed to effect improvement, or arrest or retard deterioration in the patient’s condition,

- The patient must be completely incapable of standing up from any chair in his/her home. (The fact that a patient has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all patients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.),

- Once standing, the patient must have the ability to ambulate.

**Coverage and payment rules**

Coverage of seat lift mechanisms is limited to those types which operate smoothly, can be controlled by the patient, and effectively assist a patient in standing up and sitting down without other assistance. Excluded from coverage is the type of lift which operates by spring release mechanism with a sudden, catapult-like motion and jolts the patient from a seated to a standing position.

Coverage is limited to the seat lift mechanism, even if it is incorporated into a chair (HCPCS Code E0627). Payment for a seat lift mechanism incorporated into a chair is based on the allowance for the least costly alternative.

The physician ordering the seat lift mechanism must be the attending physician or a consulting physician for the disease or condition resulting in the need for a seat lift. The physician’s record must document all appropriate therapeutic modalities, e.g. medication, physical therapy, have been tried and failed to enable the patient to transfer from a chair to a standing position.

**Documentation**

**AN ORDER FOR A SEAT LIFT MECHANISM, SIGNED AND DATED BY THE PHYSICIAN, MUST BE RECEIVED BY THE SUPPLIER PRIOR TO DELIVERY OF THE ITEM TO THE PATIENT.**

The supplier of a patient’s equipment must submit a Certificate of Medical Necessity with the claim in order to obtain Medicare reimbursement. Section B of the CMN contains questions pertaining to the medical necessity of the equipment which may not be completed by the supplier. The physician or another health care clinician may complete Section B, but only the patient’s physician may sign the CMN, indicating he/she has reviewed section B of the CMN for accuracy and completeness.

The physician’s medical record of the patient must contain documentation substantiating that the patient’s condition meets the above coverage criteria and the answers given in Section B of the CMN. These records may be requested by the DMERC to confirm concurrence between the medical record and the information submitted to the DMERC.
Seat Lift Mechanisms
Physician Information Sheet

Prior Authorization

The seat lift mechanism is one of three items of DME which is available for prior authorization (PA). Prior authorization allows a beneficiary and his or her physician to determine, before purchase, whether Medicare will approve reimbursement based upon medical necessity criteria. It is always possible, subsequent to a PA approval, that a claim may be denied for other technical reasons such as Medicare ineligibility, the discovery of Medicare's having paid for duplicate equipment, an invalid supplier number, etc.

In order to participate in the PA process, the physician completes the CMN prior to the supplier's submission of the claim for reimbursement. The DMERC will respond directly to the physician's office and the beneficiary with a decision to pay or deny, or to further develop the claim for information.