



**Questions from: Additional Emergency and Disaster-Related Policies
and Procedures That May Be Implemented**

Only With a § 1135 Waiver

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

1135I-1 Question: How can people with Medicare who have been displaced and who are without access to their usual suppliers get access to durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) such as wheelchairs and therapeutic shoes?

CMS Answer: Beneficiaries who have access to a telephone may contact 1-800-Medicare for information regarding suppliers serving their current location. Alternatively, if beneficiaries have access to the Internet, they go to the following medicare.gov website to obtain a directory listing suppliers by geography, proximity and name: <http://www.medicare.gov/supplier/home.asp>.

AAH Comment: I-800-Medicare may not know which suppliers are open and have power and able to assist. Can the CMS Regional Offices in the area of the country be tasked with creating a listing of which suppliers in specific geographic areas are open and available to assist? They could use the supplier database that CMS publishes to research and create a reference that is local to the beneficiaries in the area.

1135I-2 Question: Can the face-to-face requirement for certain DMEPOS be waived in an emergency?

CMS Answer: Absent an 1135 waiver, no. In the event that 1135 waivers are authorized for a particular emergency, specific waivers could be granted to waive the face-to-face requirement. Each request for such a waiver would be evaluated to determine if the particular circumstances warranted such a waiver.

AAH Comment: No additional comments.

**Questions From: Emergency-Related Policies and Procedures
That May Be Implemented Without § 1135 Waivers**

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

I-1 Question: If a beneficiary's durable medical equipment, prosthetic, orthotic, or supply (DMEPOS) is lost, damaged, destroyed, or otherwise rendered unusable due to a circumstance related to an emergency, can the beneficiary obtain a replacement item and if so how would the supplier bill for such item?

CMS Answer: See the Medicare Claims Processing Manual, Chapter 20, Section 50, regarding Medicare's customary payment policy for replacement of DMEPOS. This policy is also applicable in an emergency, but the following discussion restates the policy in that context and also discusses the associated billing issues.

Except as noted below, Medicare will pay for the replacement of equipment which the beneficiary owns or is purchasing, is oxygen equipment, or is a capped rental item – when the equipment/item is lost, destroyed, irreparably damaged, or otherwise rendered unusable due to circumstances relating to an emergency declared by the President. This includes inexpensive or routinely purchased items, customized items, and other prosthetic and orthotic devices.

Medicare does not pay for replacement of rented equipment (except, as noted above, oxygen equipment or capped rental items). Medicare also does not pay for replacing items that require frequent and substantial servicing. For oxygen equipment and capped rental equipment other than complex rehabilitative power wheelchairs, payment for the replacement of the equipment is made by starting a new 36-month rental period for oxygen equipment or a new 13-month rental period for capped rental equipment. Payment for replacement of complex rehabilitative power wheelchairs (K0835 thru K0864) can be made on a lump sum purchase or rental basis.

In all cases for which Medicare payment of a replaced item is available, the replacement item must be furnished by a Medicare-enrolled supplier. Moreover, a new physician's order/certificate of medical necessity would still be required, regardless as to whether the circumstances are emergency-related or not.

The "RA" modifier is always required on the claim for a replacement item. If the beneficiary is displaced from the Federally-declared disaster/emergency area, the beneficiary may obtain the replacement item from a Medicare-enrolled supplier located outside such area. If the supplier is aware that the item is a replacement, the supplier should annotate the claim with the RA modifier.

If the beneficiary is displaced from a Federally-declared disaster/emergency area that is, or that encompasses, a competitive bidding area (CBA), and the replacement item is a competitive bid (CB) item, in addition to billing with the "RA" modifier, the out-of-CBA, Medicare-enrolled supplier must also annotate the claim with the "KT" modifier. In this circumstance, payment for the CB item will be made at the CB rate. For replacement of a standard power wheelchair (K0813 thru K0831), payment can be made on a lump sum purchase or rental basis for items furnished on or before December 31, 2013, to beneficiaries residing in a Round 1 CBA. Payment can only be made on a rental basis (i.e., starting a new 13-month rental period) for standard power wheelchairs furnished outside the nine Round 1 CBAs on or before December 31, 2013, or for any standard power wheelchair furnished in any area after December 31, 2013.

As in non-emergency circumstances, if the claim requires more than four modifiers, the supplier must include the "99" modifier on the claim to indicate to the Medicare claims administration contractor that one or more additional modifiers are applicable.

AAH Comments: Suppliers will not be able to obtain documentation and written orders as referenced above. The previous supplier and prescribers may be destroyed and no longer a viable option to obtain documentation. CMS should issue guidance that the requirement for all documentation is waived when a supplier is replacing DMEPOS due to a federally recognized disaster. In addition, it needs to be clear that all CB items can be obtained from any Medicare enrolled DMEPOS supplier. In addition, the CR modifier that has been created for disaster situations should be required in addition to other required

modifiers. This modifier should exempt all documentation requirements and prevent future audits against these claims for the period of medical necessity they are used by the beneficiary.

I-2 Question: If a beneficiary, living at home and using a stationary oxygen unit, has to be transported to another location, can Medicare pay for any portable oxygen necessary to transport the beneficiary?

CMS Answer: Yes. Medically necessary oxygen in connection with and as part of the ambulance service would be included in Medicare's payment to an ambulance supplier when a beneficiary is transported by ambulance and such transport is a Medicare-covered service. In addition, separate payment under Part B can be made to a DME supplier for portable oxygen when medically necessary to transport the beneficiary if the transport itself is not covered by Medicare.

AAH Comments: AAH recommends information is added to this answer to indicated how to bill. Recommend to indicate CR modifier applied to indicate due to disaster efforts and KT modifier if providing to a CBA residing beneficiary and the supplier is non-contracted. This modifier should exempt all documentation requirements and prevent future audits against these claims for the period of medical necessity they are used by the beneficiary.

I-3 Question: Will Medicare cover and pay for a surgical mask to prevent the spread of infectious diseases, if prescribed by a physician?

CMS Answer: No. There is no Medicare benefit category that would allow for separate coverage of a surgical mask.

AAH Comment: No additional comments.

I-4 Question: Will CMS cover the cost of a generator for medical needs?

CMS Answer: Although a generator may be used to power durable medical equipment, it is not, nor can it be considered to be, medical equipment. By law, Medicare does not have the authority to pay for generators.

AAH Comment: No additional comments.

I-5 Question: A supplier has been dispensing portable oxygen tanks to beneficiaries per day because power is out in their area and their oxygen concentrators do not function without power. Can CMS provide reimbursement in addition to the fee schedule amount that the supplier is already receiving for that patient? That is, due to the above-normal amount being dispensed can payment be higher than the usual monthly oxygen payments? If so, would there be any particular billing requirements other than the "CR" modifier?

CMS Answer: No, the supplier would not receive any additional payments in these situations. Medicare payment for stationary oxygen equipment, stationary oxygen contents, and portable oxygen contents is included in the supplier's monthly fee schedule payment amount. A supplier may receive an "add on" amount as payment for portable oxygen equipment in certain situations if a beneficiary receives portable oxygen after a finding of medical need. Other than this "add on" for patients found to have a medical need for portable oxygen, the monthly payment amount for oxygen and oxygen equipment does not vary depending on the modality of oxygen that is furnished. If a beneficiary's concentrator does not work due to a power outage, the supplier may meet the beneficiary's stationary oxygen needs by furnishing gaseous or liquid stationary equipment until the power is back on in the beneficiary's home.

If a supplier chooses to provide portable oxygen equipment in lieu of stationary equipment during this time, the supplier will not receive an additional Medicare payment. The supplier may also choose to pick up the concentrator while the beneficiary is using other stationary oxygen modalities.

AAH Comment: This is one of the biggest issues for beneficiaries in disaster areas. CMS need to consider allowing a per tank payment when there is a disaster. Suppliers cannot cover costs to assist beneficiaries in disaster areas based on the current reimbursement. As CMS needs the supplier community to provide numerous tanks when there are disasters that result in no electricity, it behooves all to find a mechanism to allow suppliers to cover costs to be able to assist. In addition, often it maybe an emergency supplier and not the original oxygen supplier that is able to service Medicare beneficiaries and they should be able to cover their costs to go out of their way to service all Medicare beneficiaries in a disaster area. The CR modifier should be used and the systems should be setup to allow a per tank allowable when it is present. This modifier should exempt all documentation requirements and prevent future audits against these claims for the period of medical necessity they are used by the beneficiary.

I-6 Question: Can the face-to-face requirement for certain DMEPOS be waived in an emergency?

CMS Answer: Absent an 1135 waiver, no. In the event that 1135 waivers are authorized for a particular emergency, specific waivers could be granted to waive the face-to-face requirement. Each request for such a waiver would be evaluated to determine if the particular circumstances warranted such a waiver.

AAH Comment: In the presence of an 1135 waiver, all documentation requirements should be waived and the CR modifier should be used. This modifier should exempt all documentation requirements and prevent future audits against these claims for the period of medical necessity they are used by the beneficiary.

I-7 Question: Can medical necessity documentation requirements for DMEPOS be waived in an emergency?

CMS Answer: No. However, in a particular emergency, specific waivers could be granted to permit DME suppliers additional time to comply with medical necessity documentation requirements. But the requirement to submit such documentation cannot be waived altogether. See the CMS' Medicare Program Integrity Manual, Publication 100-08, Chapter 3, Section 3.2.2, Administrative Relief in the Presence of a Disaster at: <http://www.cms.gov/manuals/downloads/pim83c03.pdf>.

AAH Comments: In the presence of an 1135 waiver, all documentation requirements should be waived and the CR modifier should be used. This modifier should exempt all documentation requirements and prevent future audits against these claims for the period of medical necessity they are used by the beneficiary.

I-8 Question: How can people with Medicare who have been displaced, without access to their usual suppliers, get access to durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) such as wheelchairs and therapeutic shoes?

CMS Answer: Beneficiaries who have access to a telephone may contact 1-800-Medicare for information regarding suppliers serving their current location. Alternatively, if beneficiaries have access to the Internet, they go to the following medicare.gov website to obtain a directory listing suppliers by geography, proximity and name: <http://www.medicare.gov/supplier/home.asp>.

AAH Comment: I-800-Medicare may not know which suppliers are open and have power and able to assist. Can the CMS Regional Offices in the area of the country be tasked with creating a listing of which suppliers in specific geographic areas are open and available to assist? They could use the supplier

database that CMS publishes to research and create a reference that is local to the beneficiaries in the area.

I-9 Question: Could CMS summarize Medicare's payment rules regarding payment for oxygen services in an emergency, especially with regard to changes in delivery modalities (portable versus stationary) made necessary by the emergency?

CMS Answer: The Medicare monthly payment amount for oxygen and oxygen equipment includes payment for all of the different oxygen modalities (concentrator, liquid, gaseous) and also includes payment for portable oxygen contents. If there is a power outage and suppliers have to switch patients to a different modality (i.e., from concentrator to gaseous or liquid stationary or portable equipment), the Medicare payment already factors those costs into the monthly payments. Therefore, no additional payment for switching to a different modality can be made in these situations as the Medicare payment includes payment for all modalities.

The monthly portable equipment add-on payment includes an additional payment (added on to the monthly payment for oxygen and oxygen equipment) when portable equipment is used and necessary. This is only an add-on payment to the monthly payment amount for oxygen and oxygen equipment and should not be confused with a monthly payment for furnishing portable oxygen equipment and oxygen contents. Again, the Medicare monthly payment for oxygen and oxygen equipment includes payment for all modalities of stationary oxygen and payment for any necessary oxygen contents, both stationary and portable oxygen contents.

Because the Medicare statute has mandated a modality-neutral payment method for oxygen since 1989, suppliers have not received increased payments or decreased payments depending on the type of system furnished except for the additional add-on payment for portable equipment. Most suppliers have elected to furnish the least expensive modality over the years, an oxygen concentrator, but the Medicare payment is not a payment for this modality alone. Therefore, the statute would not allow an increased payment for situations where one modality is furnished as opposed to another other than the add-on payment for portable equipment.

The portable equipment add-on payment can be made in disaster situations in cases where the patient was not already using portable oxygen equipment and needs to be furnished with portable oxygen equipment during a disaster. However, if the patient was already receiving portable oxygen equipment, additional payments beyond what the supplier is already receiving for furnishing portable oxygen equipment on a monthly basis cannot be made because this amount includes the monthly payment amount and the add-on payment .

Finally, if oxygen equipment is lost as a result of a disaster, the supplier can follow the normal process for submitting a claim for replacement of the lost equipment in disaster situations. Medicare begins the 36-month payment period over in situations where lost oxygen equipment must be replaced and proper documentation describing the need for replacement and the required medical necessity documentation is furnished. The DME MACs will process the claims for replacement of lost oxygen equipment using the process established for processing disaster claims.

AAH Comments: The allowable per modality is not the issue here, however the need for many portable tanks needs to have additional consideration. Suppliers cannot cover costs to assist beneficiaries in disaster areas based on the current reimbursement. As CMS needs the supplier community to provide numerous tanks when there are disasters that result in no electricity, it behooves all to find a mechanism to allow suppliers to cover costs to be able to assist. In addition, often it maybe an

emergency supplier and not the original oxygen supplier that is able to service Medicare beneficiaries and they should be able to cover their costs to go out of their way to service all Medicare beneficiaries in a disaster area. The CR modifier should be used and the systems should be setup to allow a per tank allowable when it is present. This modifier should exempt all documentation requirements and prevent future audits against these claims for the period of medical necessity they are used by the beneficiary.

I-10 Question: Due to the limited utilities; phone, power and internet, beneficiaries have sought a secondary provider to support their respiratory needs during the state of emergency. We respectfully request CMS allow the secondary provider to bill for life sustaining respiratory services rendered to a patient residing in the Hurricane Sandy-affected area.

CMS Answer: The temporary supplier of oxygen and oxygen equipment needs to seek payment from the supplier that received the Medicare monthly payment amount for the remainder of the paid month during which the beneficiary relocated or needed to obtain services from an alternate supplier. The Medicare fee-for-service program does not authorize a duplicate payment for the same month. Once the month for which the initial supplier received payment is over, the alternate supplier can bill for the next continuous month, but the supplier of the equipment left behind in the patient's home cannot be paid.

AAH Comments: CMS must find a way to compensate a supplier who is rendering emergency services in disaster areas to Medicare beneficiaries. The use of the CR modifier can be used to indicate services in a disaster area. CMS can allow a duplicate payment for a HCPCS codes that have the CR modifier. This modifier should exempt all documentation requirements and prevent future audits against these claims for the period of medical necessity they are used by the beneficiary.

I-11 Question: Due to the emergency situation, patients required the use of two oxygen dispensing modalities; portable oxygen tanks and oxygen concentrator. Due to the lack of electricity, patients who typically utilize concentrators are requiring the use of cylinders until power is restored. In many cases, providers may already be billing for some form of portability code, whether it be K0738 for the filling station or the E0431 for the portable gas system. It is essential to maintain both modalities in the home environment until power is completely restored. Based upon the factors outlined, we request CMS to reimburse providers for both modalities.

CMS Answer: If a supplier supplies liquid or gaseous cylinders in lieu of an oxygen concentrator due to a power outage, the supplier is not eligible for additional payment during this time beyond the monthly oxygen payment amount. The Medicare monthly payment amount for oxygen and oxygen equipment includes payment for all of the different oxygen modalities (concentrator, liquid and gaseous) and also includes payment for portable oxygen contents. Therefore, no additional payment for switching to a different modality can be made in these situations as the Medicare payment includes payment for all modalities.

The portable equipment add-on may be made in disaster situations in cases where the beneficiary was not already using portable equipment but now has a need for portable equipment. However, if the beneficiary was already receiving portable oxygen equipment, additional payments beyond what the supplier is already receiving for furnishing portable oxygen equipment on a monthly basis cannot be made because this amount includes the monthly payment amount and the add-on payment.

AAH Comments: CMS must find a way to compensate a supplier who is rendering emergency services in disaster areas to Medicare beneficiaries. The use of the CR modifier can be used to indicate services in a disaster area. CMS can allow a duplicate payment for a HCPCS codes that have the CR modifier. This

modifier should exempt all documentation requirements and prevent future audits against these claims for the period of medical necessity they are used by the beneficiary.

I-12 Question: Due to the beneficiary's complex needs, requiring the use of respiratory devices from mechanical ventilators (E0450 & E0463) and Respiratory Assist Devices (RAD), a number of patients have chosen to remain at home without power. To support these life-sustaining devices requires supplemental external batteries to maintain the respiratory devices to continue to function and support the respiratory needs of the patients. Based upon the factors outlined here, we request CMS to allow providers to bill for supplemental batteries to support these devices for patients residing in the Hurricane Sandy-affected area.

CMS Answer: There is no authority under the Medicare fee-for-service program to make separate payment for supplies used with items that require frequent and substantial servicing (ventilators) or for items that are being rented (RADs). The statute does not allow payment for power generators or alternative power sources needed in the event of power outages.

AAH Comments: CMS must find a way to compensate a supplier who is rendering emergency services in disaster areas to Medicare beneficiaries. Suppliers who are providing accessories outside the covered amounts and/or those that are typically not reimbursed separately must be given a mechanism to be able to cover their costs in taking care of Medicare beneficiaries. CMS should allow the use of E1399 to represent items that are not normally reimbursed outside of a disaster area. The CR modifier can be appended to the HCPCS code and a narrative included with the claim to explain the item provided. This modifier should exempt all documentation requirements and prevent future audits against these claims for the period of medical necessity they are used by the beneficiary.

I-13 Question: Due to lingering flood waters and environmental destruction to Medicare beneficiaries' homes, their existing medical supplies were destroyed, e.g. Positive Airway Pressure (PAP) masks, tubing and head gear, oxygen tubing, ventilator/trachea cuffs, etc. Due to limited utility coverage in the stricken areas, DMEPOS suppliers have been unable to verify patient eligibility with the DME MAC contractors. Also, there are situations where the now-servicing supplier (caused by patient displacement from the storm or other reasons) is not the primary DMEPOS supplier originally on record. Also, we are closely monitoring the situation and may find that we will need to request that CMS and its contractors allow for emergency replacement of certain supplies (e.g., PAP masks/supplies) that may be otherwise not allowed by Medicare due to frequency limitations (e.g., if an item is only allowed to be provided quarterly, but a quarter has not yet elapsed since the last replenishment). With the urgent needs of the patient being addressed by the provider we request CMS to allow the replacement provider to bill for these needed medical supplies for patients residing in the Hurricane Sandy affected area.

CMS Answer: Medicare will pay for the replacement of accessories used in conjunction with a nebulizer, CPAP or RAD in the event that the accessories were lost, destroyed, irreparably damaged, or otherwise rendered unusable due to circumstances related to a disaster. The replacement accessories may be furnished by a new supplier if the supplier on record is unable to provide the replacement accessories to the beneficiary.

AAH Comments: CMS must allow for the replacement of any and all supplies needed by a Medicare beneficiaries to include diabetic, infusion, enteral supplies and formula, ostomy, urological, wound care and any other covered benefit where there is an accessory or supply limitation in the policy. The supplier should be able to use the CR modifier to indicate the provision of supplies and accessories in a disaster area and the quantities should be allowed. This modifier should exempt all documentation

requirements and prevent future audits against these claims for the period of medical necessity they are used by the beneficiary.

I-14 Question: Due to flash flooding, beneficiaries needed to leave their homes quickly and were unable to transport their hospital bed to the new location. These beneficiaries' medical needs require the support and position from a hospital bed. Based upon the factors outlined here, we request CMS allow the provider to bill for both the primary hospital bed and the secondary temporary replacement hospital bed until the beneficiary is able to return to their home.

CMS Answer: The temporary supplier of the hospital bed needs to seek payment from the supplier that received the Medicare monthly rental payment amount for the remainder of the paid month during which the beneficiary relocated or needed to obtain services from an alternate supplier. The Medicare fee-for-service program does not authorize a duplicate payment for the same month. Once the rental month for which the initial supplier received payment is over, the alternate supplier can bill for the next continuous month, but the supplier of the equipment left behind in the patient's home cannot be paid.

AAH Comments: CMS must find a way to compensate a supplier who is rendering emergency services in disaster areas to Medicare beneficiaries. The use of the CR modifier can be used to indicate services in a disaster area. CMS can allow a duplicate payment for a HCPCS codes that have the CR modifier. This modifier should exempt all documentation requirements and prevent future audits against these claims for the period of medical necessity they are used by the beneficiary.