Jurisdiction B, C and D Combined Council Questions

Sorted by A-Team
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Enteral/Parenteral/IV Therapy

1. **Previously we asked a question regarding Enteral Nutrition DME Information Forms (DIF), wanting to know in specific scenarios if we should be submitting Initial and/or revised DIFs. The answers were not consistent among the Jurisdictions, and some were inconsistent with the direction in the Local Coverage Determination (LCD).**

   Scenario – the beneficiary is taking 1500 calories per day via gravity administration, a change in order is received for 2000 calories per day via pump administration.

   The Enteral Nutrition LCD states an Initial DIF is needed when the method of administration changes from Bolus or Gravity to Pump in order to have a payable DIF on file for the PUMP. The LCD states a Revised DIF is needed when the method of administration changes and when the number of calories per day is changed. In the above scenario, if we follow the direction from Jurisdiction C, we would be submitting a DIF to revise a code (the pump) that has not previously been certified. Based on the LCD it would seem we should be submitting 2 DIFs, an Initial for the Pump and a Revised for the nutrition and method of administration.

   We are asking that previous answers be reviewed/revised so all Jurisdictions are consistent with the direction in the LCD.

   Response: While the DME MACs strive to be consistent across all jurisdictions, there are occasionally processing differences between the DME MAC contractors. The answers given during the previous council meeting were in line with how this issue is handled within each Jurisdiction.

2. **On August 4th, Noridian announced that they would be doing pre-payment review on External Infusion Pumps – Code E0781 and E0784.**

The notice identified items that would be requested upon review; those items included the face-to-face (F2F) documentation and written order prior to delivery (WOPD). When referencing the F2F, the notice indicates "if applicable" as the F2F does not apply to the E0781. However, when referencing the WOPD it does not state "if applicable," we are seeking clarification that the WOPD is not applicable to the E0781 healthcare common procedure coding system (HCPCS) code and as such that the physician's National Provider Identifier (NPI) does not need to be included on the detailed written order.

Response: E0781 is not an item that requires a written order prior to delivery and it is not an item included in the list of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) items subject to Affordable Care Act (ACA) 6407.

HCPCS code E0784 does require a written order prior to delivery as it is subject to the ACA 6407 requirements.

Education

3. **Will there be education to the supplier community on the process of escalating to the Medicare Appeals Council from the Administrative Law Judge (ALJ) level of reviews?**

   Response: Several resources currently exist that provide detailed information regarding the Medicare Appeals Council. Sources Include:

   - Jurisdiction C Supplier Manual Chapter 13,
   - Medicare Claims Processing Manual (Pub 100-04 Chapter 29),
   - CMS website: https://www.cms.gov/Medicare/Appeals-and Grievances/OrgMedFFSAppeals/05AppealsMAC.html, and
   - Health & Human Services (HHS) website at http://www.hhs.gov/dab/

4. **We have received information that when a denial has been received we should send to redeterminations only the documentation that relates specifically to the item denied and not to send in the complete documentation that was already sent in? Is this correct?**

   Response: This is correct from a Jurisdiction C standpoint; however, Jurisdictions B and D require that all documentation pertaining to the medical necessity and coverage requirements for the claim in question be sent in.

Home Medical Equipment

5. **Scenario: Patient owns a hospital bed that was purchased by a State Medicaid program. Since the time of bed purchase, the patient becomes Medicare eligible/enrolls in fee-for-service (FFS) Medicare. The patient now needs a new mattress. A replacement mattress (E0271) is not subject to the F2F rule. Based on current documentation of need in the medical record (not specific to any F2F exam), can we append the KX modifier for a replacement mattress for Medicare coverage even though Medicare didn't pay for the bed and the patient didn't have a F2F exam within the previous 6 months?**

Response: As noted in the Program Integrity Manual (PIM) Chapter 5, Section 5.8, Medicare does not automatically assume payment for a DMEPOS item that was covered prior to a beneficiary becoming eligible for the Medicare FFS program. When a beneficiary receiving a DMEPOS item from another payer (including Medicare Advantage plans) becomes eligible for the Medicare FFS program, Medicare will pay for continued use of the DMEPOS item only if all Medicare coverage, coding and documentation requirements are met. Additional documentation to support that the item is reasonable and necessary, may be required upon request of the DME MAC.

Specifically related to hospital beds and mattresses, HCPCS code E0271 does not require a WOPD or F2F within 6 months of the order date. An accessory can be covered for beneficiary-owned base equipment if the base equipment meets the Medicare coverage requirements and if any reasonable and necessary (R&N) requirements associated with the accessory are met. It should be noted that all other documentation requirements would still apply (i.e. dispensing order, modifiers, etc.).

6. **Per the LCD for hospital beds; "a semi-electric hospital bed (E0260, E0261, E0294, E0295, and E0329) is covered if the beneficiary meets one of the criteria for a fixed height bed and requires frequent changes in body position and/or has an immediate need for a change in body position." Would a patient still qualify for a semi-electric hospital bed in the following scenario?**

   Patient with amyotrophic lateral sclerosis (ALS) is in a current rental of a semi electric hospital bed (E0260) under a non-Medicare insurance. The patient's insurance changes to Medicare. There is a face to face documenting medical necessity within the previous 6 months and a new WOPD is obtained. Patient has frequent/immediate need for a change in body position secondary to the progression of ALS but the patient no longer has ability to use the controller and is reliant on their caregiver to operate the bed for the frequent changes in body position. Can the rental of an E0260 be payable based on this justification for frequent changes in body position, or would this scenario only qualify for the lower level of service E0255 requiring an Advance Beneficiary Notice of Noncoverage (ABN) for the upgrade?

   Response: There is no policy requirement that the hospital bed must be operated by the beneficiary in order to meet the coverage requirements in the LCD. The beneficiary would qualify if they meet the criteria for the semi-electric hospital bed outlined in the first paragraph.

7. **Per the Pneumatic Pump LCD; "there must be documentation of the clinical response to an initial treatment with the device." For a patient with diagnosis (DX) of chronic venous insufficiency with chronic ulcer that has failed to heal after six months of conservative treatment, what change in pretreatment measurements would be appropriate? For lymphedema, we understand that to be leg circumferential measurements. For a venous wound, would that mean pre and post treatment wound measurements?**

   Response: Although not effective until 11/1/2014, the revised Pneumatic Compression Device (PCD) LCD contains the following guidance:

The documentation must include careful, detailed records of measurements, obtained in the same manner and with reference to the same anatomic landmarks, prior to, at periodic times during and at the conclusion of the various trials and therapy, with bilateral comparisons where appropriate.

8. **Can pre- and post-treatment measurements of chronic venous insufficiency (CVI) under the Pneumatic Pump LCD be done after the dispensing date of the equipment as long as the ordering physician acknowledges those measurements as part of the patient's medical record by signing and dating? Not all facilities use a pump in their clinic prior to ordering one for home use.**

   Response: Pre and post-treatment measurements and demonstration of effectiveness by a licensed medical professional are a prerequisite to reimbursement eligibility for the pump. Suppliers may dispense the equipment to determine this; however, they must not bill until the coverage requirements have been met.

   Per the current LCD (not the policy effective 11/1/2014):

   The clinical response includes the change in pre-treatment measurements, ability to tolerate the treatment session and parameters, and ability of the beneficiary (or caregiver) to apply the device for continued use in the home.

Oxygen

9. **Does the description "home oxygen continuously" satisfy the "equipment requirement" and "frequency of use" of a detailed written order prior to dispensing for portable oxygen gaseous (E0431)?**

   Response: According to the Oxygen LCD and related Policy Article (PA), a detailed written order must include a detailed description of the item(s) being provided. The detailed description on the order may either be a detailed narrative or a brand name/model number. Regardless of the form of description, there must be sufficient detail to identify the item(s) in order to determine that the item(s) dispensed is properly coded. "Home oxygen" does not satisfy this requirement and would not meet the "equipment requirement" for a detailed written order. The term "Continuous" or "Continuously" would meet "frequency of use" requirements for a detailed written order. Remember that E0431 is subject to ACA 6407 requirements (F2F and WOPD).

10. **Must the added element of "via nasal cannula" or "BNC" be present on an order to satisfy the method of administration requirement for oxygen orders? Due to the fact that the vast majority of beneficiaries default to this method of administration unless a trach is involved, is it possible for a physician to designate in an attestation statement that this is their standing order for non-trach patients unless otherwise specified on an order?**

Response: Method of administration is a requirement of a detailed written order, per the DME MAC LCDs and related PAs and Supplier Manuals. A "blanket order" to use nasal cannula with all patients is not acceptable.

11. **Historically we have not been required to submit new Certificates of Medical Necessity (CMN) for content billing once the base equipment has been established.**

    a. **Is it sufficient to allow content billing based on the necessity of the base equipment?**
    b. **Would listing the oxygen (O2) contents on the initial O2 CMN be sufficient to bill the contents in the 36th month?**
    c. **Will the patient be required to go back to the physician for another FTF visit and new WOPD for billing if it was not originally listed?**

    Response: This question was addressed and answered in the last round of Council questions (Question 6).

12. **Historically the DME MACs have instructed that a change in modality within the oxygen policy necessitates a simple order, and would <u>not</u> require a new CMN as long as base equipment has been certified.**

    a. **Is it sufficient to allow billing for a modality change based on the necessity of the base equipment (e.g. E0431 to E1392)?**

       Response: Yes, as long as a new order is present for the change in modality.

    b. **Will the patient be required to go back to the physician for another FTF visit and new WOPD for billing if the modality switches to an item designated as subject to FTF (e.g. E1392 to E0431)?**

       Response: If the item being ordered is on the list of DMEPOS items that are included in ACA 6407 as outlined in Medicare Learning Network (MLN) Matters (MM)8304 then they would require a WOPD and a F2F visit within six months of the date of the order.

13. **If a patient has a qualifying oximetry test done during a covered Part A skilled nursing facility (skilled nursing facility) stay and the qualifying test was done 3 days prior to discharge to home, how does the physician answer question 2 (below) on the CMS 484 oxygen CMN? Please clarify.**

    "2. Was the test in Question 1 performed (1) with the patient in a chronic stable state as an outpatient, (2) within two days prior to discharge from an inpatient facility to home, or (3) under other circumstances?"*

    *** NOTE: the following Dear Physician letter states 2 days prior to discharge does not apply to nursing facilities.**

https://www.noridianmedicare.com/dme/news/docs/2014/06_jun/home_oxygen_initial_qualification_testing.html

Response: For testing conducted in a skilled nursing facility (SNF), the physician should answer Question 1 if the patient is in a chronic stable state. The "within 2 days of discharge" as a surrogate for chronic stable state is only applicable to hospital scenarios (i.e., inpatient) per the Oxygen National Coverage Determination (NCD).

14. **Regarding oxygen portability and the requirement for the beneficiary to be mobile in the home, will exertion testing suffice to show they are mobile in the home or would you expect to see another note documented within the medical record showing no mobility limitations?**

    Response: According to the LCD, a portable oxygen system is covered if the beneficiary is mobile within the home and the qualifying blood gas study was performed while at rest (awake) or during exercise. During an audit, reviewers would look for evidence in the medical record that the beneficiary was mobile in the home.

15. **In 2011, National Government Services published direction regarding how to bill an oxygen claim for denial. The process enables the claim to go through the front-end CMN edits but does not allow the claim to pay. Utilizing this method ensures that payment is not made when the CMN would appear to qualify even though the patient does not. For example, the patient was tested via overnight oximetry and desaturated to 85% but was only <88% for 2 minutes. Per the LCD, the lowest saturation of 85% would normally be entered on the CMN and the claim would likely pay even though the patient actually did not qualify. Do the other Jurisdictions follow the same practice or can each Jurisdiction provide their direction to address this issue?**

    Response: The DME MACs are discussing this internally and will provide a response in the near future.

Positive Airway Pressure (PAP)/Other Respiratory Care Equipment

16. **The PAP policy includes language that can be interpreted differently and we are seeking clarification.**

    The respiratory disturbance index (RDI) is defined as the average number of apneas plus hypopneas per hour of recording without the use of a positive airway pressure device. For purposes of this policy, respiratory effort related arousals (RERAs) are not included in the calculation of the RDI. The RDI is reported in Type III, Type IV, and Other home sleep studies.

    If the apnea-hypopnea index (AHI) or RDI is calculated based on less than 2 hours of sleep or recording time, the total number of recorded events used to calculate the AHI or RDI (respectively) must be at least the number of events that would have been required in a 2 hour period (i.e., must reach ≥30 events without symptoms or ≥10 events with symptoms).

a. **Is the clarification of "based on less than 2 hours of sleep" simply for patients who are unable to sleep for any length of time, but qualified due to the number of episodes? OR**
b. **Can a block of continuous time be carved out of a longer sleep study to qualify the patient under the criteria "based on less than 2 hours of sleep"? For example, if the patient has a sleep study that has 4 hours of total recorded sleep time with an inflated number of episodes during a 65 minute stretch (sleeping supine versus on their side), can the 65 minute period be used to qualify them for PAP under the second paragraph above?**

Response: No. The "less than 2 hours of sleep time" was added to the policy to address situations where is it readily apparent that, despite not having yet reached two hours of sleep, the beneficiary has experienced enough episodes of apnea and hypopnea to meet the LCD coverage threshold (i.e., has severe enough sleep disordered breathing) that additional testing without a PAP device is unnecessary.

A review of the American Academy of Sleep Medicine (AASM) *Manual for the Scoring of Sleep and Associated Events* requires the reporting of body position – however the manual does not require separate reporting of AHI based on different body positioning. None of the AASM published literature suggests that a diagnosis should be made based on body position-specific AHI.

17. **In the Respiratory Assist Device (RAD) LCD, the policy still references a requirement to procure a signed statement from the physician for billing after the 3rd month of therapy. Is it sufficient to document chart notes stating the patient is using the device 4 hours per day and benefitting from therapy, or is a separate statement truly required?**

Response: In the Continued Coverage section and the Policy Specific section of the RAD LCD it states that a signed and dated statement completed by the treating physician no sooner than 61 days after initiating use of the device, declaring that the beneficiary is compliantly using the device (an average of 4 hours per 24 hour period) and that the beneficiary is benefiting from its use must be obtained by the supplier of the device for continued coverage beyond three months.

18. **If a patient wants to switch to another company for PAP supplies but the documentation is not available because the original setup was done over 7 years ago in 2002:**
    a. **Is it sufficient to document a statement that medical records older than 7 years are not required to be produced in the event of an audit?**
    b. **Are we still required to prove the patient qualified at setup?**
    c. **What is the minimum number of elements necessary to justify in an audit the billing for ongoing supplies for an "archived medical record" patient? (e.g., current office notes documenting DX of obstructive sleep apnea (OSA) along with use and benefit, a new script, a copy of the original sleep study, etc.)?**

Response: The DME MACs are asking CMS for guidance on this issue. In the interim, see MLM Special Edition (SE)1022.

Prosthetics/Orthotics

19. **In some cases (physician closets), other healthcare staff may fit/deliver a device from a supplier's inventory where the supplier is not physically present at delivery. This creates two questions:**
    a. **In cases where another healthcare provider/organization (who is not the provider of record and in many cases, cannot be) delivers the device directly to the beneficiary, can they simply act as a shipping/delivery service? Or should this be treated as a direct delivery?**
    b. **Is a document on the supplier letterhead, executed by the staff/organization which delivered it sufficient, as long as it is signed by the beneficiary and contains the required elements of proof of delivery (POD) (in compliance with direct or shipping service per the above answer)?**

Response: This situation would be considered "direct delivery" in the Proof of Delivery guidelines in the policies. The situation in 19b would be acceptable as long as proof of delivery guidelines were met.

20. **During the last Jurisdiction D DME MAC Advisory Committee (DAC) call it was stated that "orthotic fitters" would not be considered qualified individuals to provide custom fitted, prefabricated orthotics and that only an orthotist could provide these and bill.**
    a. **Do all the Jurisdictions take this position? and**
    b. **Have all the accrediting organizations been informed of this policy?**

Response: Yes, all jurisdictions take this position based on guidance from CMS and the language in the applicable LCDs and related Policy Articles. It is not the function of the DME MACs to notify accrediting agencies of program requirements.

Note that CMS is considering comments to a proposed rule to expand who is a qualified provider of custom fitted items. No decision or changes have been published by CMS at this time.

21. **On July 11, 2014 CMS submitted a proposed rule defining individuals with "specialized training". The comment period ends September 2, 2014, however on Friday, August 15th the Quality Standards were issued with a June date and Appendix C was updated to include a definition of "specialized training." How can the policy be changed prior to the end of the comment period?**

Response: The Quality Standards and the DME MAC LCDs and related Policy Articles were based on existing regulatory language. CMS is considering changing that existing regulatory language by publishing a proposed rule for comment.

Rehab Equipment

22. **Is there any update on receiving power mobility device (PMD) prior authorization (PA) determinations by means other than mail?**

    Response: PMD PA determination letters are currently received only via mail. PMD Prior Authorization status is now available on the Jurisdiction C web portal myCGS under the Claim Preparation Tab. The information given will include the status (either complete or pending), date of receipt of the request, date of decision, action taken (affirmed/non-affirmed), denial reason(s), and the unique tracking number (UTN). In addition, if the PMD PA request was submitted via Electronic Submission of Medical Documentation (esMD), the response would be sent via esMD.

23. **For items that changed from purchase to capped rental effective 4/1/14, specifically items related to repairs and replacement parts, are there any updates or changes that may be made to allow the purchase of those codes that are provided as a repair or replacement and not at initial setup, i.e. actuators on a group 3 and joysticks on standard power?**

    Response: Refer to MLN Matters Article MM8566.There are no exceptions for repair or replacement of the items that changed to capped rental**.**

24. **MM8864 provides clarification on billing and payment for competitive bid (CB) accessories provided on Non-CB bases in Round 2 for claims submitted on or after January 1, 2015. How will claims submitted prior to January 1, 2015 be adjusted to reflect the correct payment of the fee schedule amount based on previous CMS' instructions provided in MM8181?**

    Response: A reopening request will need to be submitted after January 1, 2015. On the request please include the list of Provider Transaction Access Numbers (PTAN) and the HCPC codes needing to be adjusted.

25. **A supplier is providing a complex rehab chair (they are not submitting for advance determination of Medicare coverage [ADMC]). All of the clinical documentation is in place. The detailed product description (DPD) was sent to the physician for signature, but the prescribing physician has left the practice. Can another physician sign the DPD? What are the requirements for another physician to do so? There are references to similar situations that refer to a significant absence, but do not reference a physician who has left the practice.**

    Response: Yes, as long as one of the remaining physicians in the practice becomes the treating physician for the beneficiary. The supplier should also include an explanation of why the physician completing the DPD is not the same physician that completed the 7-element order and face-to-face examination.

26. **Code E2378 - Power actuator replacement has been reclassified. This code is used to bill for a replacement actuator on a power tilt, recline, combination tilt & recline, power**

elevated leg rests (ELR), or power articulating foot platform (AFP). Code E2378 is not one of the codes that when furnished for a complex rehab power chair can be purchased in the first rental month.

a. **Why was this code omitted from the codes for which the supplier can offer the purchase option?**
b. **Will changes be made so that suppliers are able to provide this replacement actuator as a purchase on complex rehab?**

Response: CMS makes these determinations; therefore, the DME MACs recommend that the Councils contact CMS and request that code E2378 be added to the group of codes allowed as a purchase when used on a complex rehab power chair.

27. **When a patient has a wheelchair that was funded by private insurance prior to Medicare entitlement, or by Medicaid while in a SNF stay:**

    a. **What is the proper procedure to follow in order for repairs to be covered by Medicare? Is it necessary for the patient to go through the whole process (face to face, therapy evaluation, 7-element order, DPD, etc.) as if pursuing a new wheelchair, and meet current Medicare coverage criteria for the equipment for Medicare to cover the repairs?**

Response: For items not purchased by Medicare, repairs may only be made to items that are "medically necessary." CMS has not issued final instructions to the DME MAC regarding repairs.

28. **On rented power chairs where there is a change in supplier due to a beneficiary change in residence, can the target supplier use a copy of the original supplier's F2F, 7-element order, and DPD without delaying delivery of a product that meets the same base code definition?**

Response: According to the DME MAC LCDs and related PAs and Supplier Manuals, a new detailed written order is required when there is a change in supplier. The new supplier may use the original supplier's F2F and 7-element order as long as the same base code is being provided. In addition, the new supplier is required to adhere to the timelines of delivery of the PMD specified in the PMD LCD and related Policy Article.

29. **If a beneficiary changes suppliers and the new supplier purchases the original chair from the former supplier, is it possible to simply get copies of the original documentation (FTF, 7 Element, DPD, etc.) without procuring new documentation for billing purposes? Would a change in order suffice for the change in suppliers in this instance?**

Response: When there is a change in suppliers, the new supplier may use the original supplier's F2F and 7-element order; however, the new supplier will need to obtain a new DPD (see Question 28). The new supplier will also need to obtain a new proof of delivery even though they have purchased the chair, since a new supplier is involved. The new supplier is required to adhere to the timelines of delivery of the PMD specified in the PMD medical policy.

30. **Recently we received welcome clarification from CMS on repairs to patient owned equipment, to direct suppliers that if there is a record of Medicare payment, repairs are payable without necessitating the procurement of additional documentation. If we discover that Medicare has recouped monies on a chair that is still in the possession of the beneficiary and is considered patient owned, can the supplier render repairs to the equipment without procuring medical necessity documentation?**

    Response: CMS has not finalized instructions to the contractors; however, CMS is considering the position that for beneficiary-owned equipment paid for by Medicare, medical records are not required to address the medical necessity of the DMEPOS equipment as/when it was originally ordered, but shall address the continued medical necessity of the item and the necessary repair.

Ostomy/Urological/Medical Supplies

31. **A patient with a Urostomy uses a drain bag attached to urostomy pouch with drain tubing for night time use – would A4334 be covered to anchor the tubing?**

    Per Medicare's urological policy:

    "Adhesive catheter anchoring devices (A4333) and catheter leg straps (A4334) for indwelling urethral catheters are covered. More than 3 per week of A4333 or 1 per month of A4334 will be denied as not medically necessary. A catheter/tube anchoring device (A5200) is covered and separately payable when it is used to anchor a covered suprapubic tube or nephrostomy tube. If code A5200 is used to anchor an indwelling urethral catheter, the claim will be denied as not reasonable and necessary."

    Neither applies in this case.

    Response: In the case of a urostomy tube anchor, use code A5200. The LCD will be updated to reflect this guidance.

Diabetic Monitoring and Supplies

No questions submitted.

Documentation/Regulatory/Miscellaneous/Other

32. **Date Stamping documentation – there have been different answers from different regions and in webinars regarding whether WOPD and documentation for items other than PMDs require a date stamp. Many DME providers receive orders and medical records electronically via Epic or have billing software that creates an electronic record of an incoming electronic fax. These records indicate the user/person that received the record and are date and timed stamped electronically within the billing software.**
    a. **Can a supplier utilize these audit trails as an acceptable means of substantiating date of receipt in lieu of printing out a copy of the record, affixing a date stamp**

and then "re-scanning" into a different system If the receipt of the faxed information is recorded electronically in Epic or a billing software system (again user/date/time stamped) would this be acceptable?

b. In regards to faxed documentation, "all documentation received must clearly show that it was faxed to the supplier and who faxed it to the supplier." Will fax cover sheets suffice if there is a clear link between the documents and the cover sheet of company that faxed and company that received?

c. If these are all acceptable, will reviewers be instructed to accept the various formats or will the reviewer deny if a date stamp is not used?

d. What details or discussions are needed to make this an acceptable solution?

Response: For items that require a written order prior to delivery, a date stamp or equivalent is required to indicate the actual receipt date of the completed order. The electronic records of an incoming fax mentioned in 32a would be acceptable in indicating receipt of a completed order, as would printing out the order and physically date stamping it to indicate receipt. When utilizing fax covers sheets to indicate receipt, the reviewer must be able to clearly identify where the cover sheet and the order came from and they must show a date of receipt by the supplier.

33. **Per the joint DME MAC news article entitled Written Order Prior to Delivery – Corrections to Document dated 8/7/14;**

"*…if the (WOPD) error is discovered after submitting a claim, the original supplier can recover their items and a new supplier must complete the transaction after complying with all requirements."*

Please clarify how the term "new supplier" is defined -- company name or NPI number?

Example: If a DME Provider (XYZ Company) has multiple locations/NPI numbers, is the original DME Provider (XYZ Company) able to obtain all required documentation and redeliver under an alternative location/NPI?

Response: New supplier is defined by unique National Supplier Clearinghouse (NSC) number (i.e., Supplier Number). Yes, the beneficiary can be referred to another site. It is important to note that documentation should be present to show the pick-up and re-delivery of the item(s).

34. **In that same document, "Written Order Prior to Delivery - Corrections to Document", the article referenced errors on the WOPD and a section reads as follows:**

"If errors in the WOPD are found after delivery of the item, the supplier has two options:

If the error is discovered prior to claim submission, the original supplier may recover the delivered item(s), obtain a compliant, complete WOPD and then may re-deliver the item(s) to the beneficiary".

Is the original WOPD still considered an order as required (even though it may have errors on it)? Will the PIM 5.2.3.1 be updated to reflect this clarification?

Response: The order would not be considered a valid order until all of the detailed written order requirements outlined in the DME MAC LCDs and related PAs and Supplier Manuals were met.

35. **If a renewal order is procured because the current order expired or is renewed to establish a 12 month continued need requirement, does the patient need a new F2F within 6 months of securing the updated order if that HCPCS is subject to the F2F rule? Is a renewal/updated order the only requirement if the medical record supports continued need?**

    Example: Physician initially orders a rental wheelchair for 7 months. The patient does not progress and continues to need the wheelchair for mobility and mobility-related activities of daily living (MRADL) in the home.

    Response: A face to face exam within 6 months is required each time a new prescription for one of the specified items (ACA 6407 items) is ordered, with the exception of orders that are required by a state regulatory body.

36. **With regard to the PMD prior authorization demonstration: Beginning January 1, 2015, providers will be assessed a 25% reduction on a supplier's payable claim when the first claim was not preceded by a prior authorization request. To avoid the payment reduction, the supplier must include the prior authorization tracking number on the claim." Would the 25% reduction still apply if the provider completed the prior authorization process, but accidentally failed to append the unique tracking number?**

    There are concerns about the timeliness of receiving the PMD Prior Authorization decisions via mail. What methods can a physician/practitioner, supplier, or beneficiary use to receive the PMD prior authorization decision (affirmative or non-affirmative) other than mail? Will the decision be made available on the interactive voice response (IVR) system or online portals? Can customer service release the decision via phone? Can esMD be utilized to receive a PA response?

    JB Response: If the supplier obtains an affirmed prior authorization decision and delivers the PMD but forgets to include the UTN, the supplier may resubmit the claim with the UTN when the supplier realizes they mistakenly omitted it from the claim. If the supplier receives an ADR for that claim (because there was no UTN on the claim) and submits documentation for review (usually because they are unaware they have already obtained an affirmed PA, or because they received an ADR and are unsure what to do), the Medicare reviewer will see that an affirmed PA was already issued for that claim and will call the supplier to inform them to resubmit the claim with the UTN that was previously assigned.

JC Response: If the supplier received an affirmative PAR decision but failed to include the unique tracking number (UTN), the claim will deny.

JD Response: JD is currently researching this issue and will provide a response during their Council Meeting.

See response to question 22 for PMD PA decision receipt methods.

37. **Please clarify: Is it true that if a beneficiary received an orthotic item while in the hospital, if the orthotic is placed on the beneficiary prior to hospital discharge does this automatically render the orthotic item unbillable to the DME MAC?**

Response: According to the Medicare PIM Chapter 4 section 4.26-4.26.2 & Chapter 5 Sections 5.2.5, 5.2.6, and 5.8 which discuss Medicare proof of delivery requirements, a DME supplier may deliver an item of DME, prosthetic, or orthotic to a beneficiary in a hospital or nursing facility for the purposes of fitting or training the beneficiary in the proper use of the item. This may be done up to two days prior to the beneficiary's anticipated discharge to their home. You must bill the date of service on the claim as the date of discharge and the place of service as the beneficiary's home.

38. **The term "Break in Service" is currently used differently by some of the DME MACs. Can the term "break in service" be standardized across the four DME MACs to have the same definition and if so, please clarify which definition is accurate?**

For example:

- **Per slide 45 of a CGS presentation, a *"…a break in medical need is NOT a break in service"*.**
- **NGS published a Break in Service (BIS) flowchart where a break in service and break in medical need appear to be synonymous by stating *"A 'Break in service/medical need' is defined as a change in the patient's medical condition to the point that they no longer need the original equipment (i.e., the patient no longer met medical necessity requirements for the equipment) for a period of 60 days plus the days remaining in the last paid rental month. The patient's condition changed again and the need for the equipment resumed (the patient again met medical necessity requirements for the equipment). It could be for the same or a different diagnosis".***
- **In reviewing published material by all four Jurisdictions; Jurisdiction A appears to be in line with Jurisdiction B in that the break in service is defined the same as a break in need.**
- **Jurisdiction D indicates that a break in service encompasses both a break in need and break in billing.**

See enclosed attachments. Jurisdiction A BIS Claim Submission.pdf, How to Bill for Oxygen Denial.pdf, Jurisdiction C Oxygen 8 12 14.pdf, Jurisdiction D BIS References.pdf

Response: This is a situation in which it is more important to understand the concept rather than some of the terminology that the DME MACs may utilize. The break-in-service rule is not strictly counting days. There is also a component of a change in medical need (not just a temporary discontinuation in the same medical condition). For example, a beneficiary with chronic obstructive pulmonary disease (COPD) uses a nebulizer and in month 3 of billing, has a break in service (e.g., gets admitted to a SNF) that encompasses 90 days. A new capped rental period would not be allowed, even with the >60 days + remaining rental month days, because there was no change in medical need (i.e., COPD was still the reason for the nebulizer use; both pre and post SNF discharge).

Medicare's break-in-service rules are used for the purpose of calculating continuous use and initiation (or resumption) of capped rental payments following an interruption in service and change in medical need. This is outlined in detail in the DME MAC Supplier Manuals and educational materials produced by the DME MACs. Also see Medicare *Claims Processing Manual*, Chapter 20 §30.5.4.

CEDI

No questions submitted

PDAC

No questions submitted