Jurisdictions B, C and D Councils Combined A-Team Questions
August 2017- Final to Council Chairs

Home Medical Equipment:

1. In cases where a PSG and/or titration study was performed prior to a beneficiary's Medicare enrollment, and one or both studies are unsigned, but the patient does meet the RDI/AHI requirement. Will these studies be denied in an audit for an attestation statement?

   DME MAC Response: Regardless of when the study was performed, all PSG test results must be signed by the provider interpreting the test as required by the CMS *Program Integrity Manual* (Internet-only manual 100-08), Chapter 3, §3.3.2.4. This section states, in pertinent part:

   For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

   a. What's the expectation/option if the physician who interpreted the study is deceased and/or no longer available to complete the attestation statement(s)?

      DME MAC Response: The answer is dependent on whether or not the original physician providing the interpretation billed the Medicare program for the service. Suggest that you contact your local A/B MAC for guidance.

   b. Prior to Medicare enrollment, if PSG studies (2008/2009) were calculated based on a 3% decrease in oxygen saturation vs 4%, and the patient meets the current AHI/RDI index, is this acceptable in the event of an audit?

      DME MAC Response: Medicare's definition of hypopnea requires interpretation based on a 4% desaturation. For PSGs based on 3% desaturation, the study may either be rescored or the test repeated using the 4% criterion.

Enteral/Parenteral/IV Therapy:

2. What if any steps are CMS and/ or the DMEMACs taking to notify participating beneficiaries of their options to continue service prior to the cessation of the IVIG Demo?

   DME MAC Response: Providers and Beneficiaries should refer to the Noridian IVIG Demo web page at https://med.noridianmedicare.com/web/ivig for guidance concerning the IVIG demonstration.

3. If we have a TPN patient with LON on the DIF of 6 months and in the second month the MD decides at an office visit that the patient will need the TPN for lifetime can we revise the DIF with the next shipment to 99 or do we have to wait for the initial DIF to expire?

   a. From an audit documentation perspective, what revision date on the DIF should the supplier use, the date the prescriber extended the LON or the date the original prescription ends (assuming there are no other changes made)?

   DME MAC Response: In order to accomplish this change, a revised order from the physician is needed, and then a revised DIF would be appropriate. The supplier should report the date of the revised order in the "Revised "date section of the DIF.

4. What avenue does the PDAC use to correct pricing for drugs that are no longer on the market? For example, Foscarnet, current drug pricing is pulling off of Redbook compendia (WAC pricing) for the discontinued NDC's for Foscarnet (J1455) NDC#00409-3863-02 and NDC#00409-3863-05. These two drugs have not been on market since 2012 and are also not in the FDA National Drug Code Directory.

    a. Is it possible when such instances are identified by suppliers to utilize the Councils IV/PEN A-Team to notify the DME MACs? If so, what information would need to be provided to substantiate the updates?

DME MAC Response: NDC 00409-3863-02 and 00409-3863-05 are not listed as discontinued in the Red Book drug compendia. The Current Pricing Information section lists the ASP as effective 10/01/2011, the WAC as effective 10/01/2011 and the DIR as effective 11/01/2013. The effective date of 11/01/2013 for the DIR (Manufacturer's Direct Price) is after the May 10, 2013 article that the supplier is referencing. If the NDC numbers have been discontinued by the Manufacturer, the Manufacturer needs to report that information to Red Book.

Respiratory Care Equip/Oxygen:

5. A patient had a qualifying PSG and did not go on therapy. Two years later they underwent a titration study and the study indicated they needed to be set up on BiPAP. Will the PSG from two years ago be sufficient for meeting the requirement or will a new PSG be required? What exactly is the time frame that a PSG is valid? It has been referenced as a 'reasonable time frame' however a more definitive answer would be helpful in educating our referrals.

DME MAC Response: While there is no published timeframe for which a PSG remains valid, good medical practice suggests that the testing upon which a diagnostic or therapeutic decision is based should be within a reasonable time frame (e.g., 12 months or less, depending on the underlying condition). A beneficiary's medical condition can change and the testing should be proximate to the time of intended therapy to ensure that the test accurately reflects the current state of the beneficiary's medical condition.

Prosthetics/Orthotics:

6. We are seeing audits deny stating "there is no mention of the orthosis that was billed in the medical records" or "the medical documentation does not demonstrate the orthosis was ordered to treat a covered indication". The supplier received a valid DWO for the bracing from the practitioner and the medical records clearly state the patient's qualifying condition, joint laxity testing, etc. Is it a "requirement" that the medical records specifically state the practitioner has ordered the brace? Wouldn't the valid DWO serve this purpose?

DME MAC Response: A DWO is not sufficient to justify medical necessity. As noted in the *Program Integrity Manual* (Internet-only manual 100-08), Chapter 5, §5.7 (in part):

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.

7. Related to the issuance of Noridian's Same or Similar guidelines for L codes (https://med.noridianmedicare.com/web/jadme/topics/same-or-similar). As you can see, the chart has grouped all knee braces together as "same". Our concern with this approach is that these knee braces have different reasonable useful lifetimes (RUL) per the LCD. For example an L1830 is a knee immobilizer without joints. However per this

chart, it is considered the same as an L1833 with adjustable knee joints. The RUL for L1830 is one year and the RUL for L1833 is 2 years. Does this mean that a patient who receives an L1833 would not be eligible for an L1830 for 2 years? Similarly, does it mean that a patient who receives an L1851 which has an RUL of three years would not be eligible for an L1812, L1820, L1830 or L1833 for three years? We would like to obtain clarification on how the RUL factors into the same and similar chart as well as whether these criteria apply to the other MAC regions.

Scenario: Medicare beneficiary has been injured and requires knee immobilizer. Medicare beneficiary has healed enough to come out of immobilizer but still requires some support. Physician has now ordered a KO with adjustable joints, will this device be covered? Will the beneficiary be responsible for paying for this device?

Our concern is that Medicare will say – yes, we may cover the brace in this situation if the need is appropriately documented in the medical records. The problem is that the MAC will initially deny the claim based on their adjudication rules and the supplier would then have to appeal for coverage.

DME MAC Response: We recommend you direct this concern to Noridian.

Rehab Equipment:

8. Occasionally, a provider may want to or need to sell a Complex Group 2 or a Group 3 PWC as used. Even though these codes (K0835 – K0864) are capped rental, they do have the 1st month purchase option. If we offer a used purchase to the bene, and they are agreeable with this, would the valid modifier sequence be "UEKHBPKX"? Will all 4 MACs accept and pay for a used PWC as a purchase?

   DME MAC Response: Yes, this process is correct for billing used equipment.

9. Code E1028, swing-away hardware, is used with several other accessories. When used with lateral positioning pads, it seems reasonable to add RT and/or LT. When used with a joystick mount, there would only be one unit, but RT or LT could indicate on which side of the pwc the control is mounted. When used with a headrest, there isn't any right or left. When E1028 is billed as an accessory on the same claim as a new chair, are the RT/LT modifiers required for claim processing? This is a capped rental code but allows 1st month purchase option when provided for use on a Group 3 PWC.

   DME MAC Response: The RT and LT modifiers are used to identify accessories which have laterality and which may be billed simultaneously (i.e., medically necessary bilateral accessories). In the case of the joystick mount example where there is only one (1) UOS billed, there is no need to use the RT or LT modifiers to indicate which side of the chair that the joystick is mounted. For code E1028 (WHEELCHAIR ACCESSORY, MANUAL SWINGAWAY, RETRACTABLE OR REMOVABLE MOUNTING HARDWARE FOR JOYSTICK, OTHER CONTROL INTERFACE OR POSITIONING ACCESSORY), it is not necessary to use RT or LT modifiers.

10. If a DME/rehab supplier is hospital owned, if one individual is both a therapist and a RESNA-certified ATP, and works for both the hospital and the supplier; can that individual perform both the specialty therapy evaluation and the supplier's ATP assessment? There is some confusion about the two separate requirements and the financial relationships. Would you clarify what is acceptable for a hospital owned provider?

    DME MAC Response: Response: This is allowed for PT and OT working for hospital-owned DME supplier. From the Power Mobility Devices LCD-related Policy Article:

    "The practitioner may refer the beneficiary to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), who has experience and training in mobility evaluations to

perform part of the face-to-face examination. This person may have no financial relationship with the supplier. (*Exception: If the supplier is owned by a hospital, PT or OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination.*)" [Emphasis Added]

11. Codes E2201 – E2204 nonstandard seat widths and depths for manual wheelchairs. Medical necessity is justified by the bene's physical measurements: hip width, upper leg length, weight. Generally it is the supplier, not the physician, who will document these measurements. Is it acceptable for the body measurements to be provided in the supplier documentation only, as these details will rarely be in the physician's office or chart notes?

    DME MAC Response: Yes, the DME MACs will accept measurements from the supplier; however, suppliers are also reminded that there must be information in the treating practitioner's medical record that supports the need for the non-standard seating. As noted in the *Program Integrity Manual* (Internet-only manual 100-08), Chapter 5, §5.7 (in part):

    For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.

Medical Supplies:

12. In the LCD for Ostomy Supplies, if there is no specific quantity listed for a supply, how many are covered? We would like to inform the beneficiary what may be considered over quantity to secure the proper documentation.

    DME MAC Response: Irrespective of utilization guidelines in LCDs, the ordering physician's medical records must always support the frequency of usage and amount ordered.

Education:

13. For the Improvements to the Adjudication Process of Serial Claims, MLN Matters Number: SE17010, released April 26, 2017 (effective April 7, 2017), how are claims identified and overturned through the serial claim initiative and what recourse do suppliers have to resolve claims that are not reprocessed? Will the DME MACs POE consider hosting a joint serial claim webinar to provide education and clarification on the initiative?

    DME MAC Response: Please note that the MLN states: "Suppliers do not need to take any action and should not reach out to the DME MAC within their jurisdiction to request that their appeal be considered for this initiative." However, the suggestion for a joint webinar will be referred to the DME MAC POE Collaboration workgroup for consideration.

Documentation/Other

14. Is a beneficiary signed AOB required for assigned claims, when the claim can ONLY be paid on an assigned basis (i.e...participating providers and dual eligible patients)?

    In reading from the Jurisdiction B&C supplier manual regarding beneficiary authorizations, it states "For *all claims submitted on or after January 1, 2005, payment shall be made to physicians and suppliers **even without** a beneficiary-signed assignment of benefits (AOB) form when the service can only be paid on an assignment related basis. This includes any mandatory assignment situations and participating physician or supplier situations."*

Disclaimer: This Q&A document is not an official publication of the DME MACs. The official guidance documents from the DME MACs are CMS manual instructions, national coverage determinations, local coverage determinations, bulletin articles and supplier manuals.

The same language does not seem to exist in Jurisdictions A & D.

DME MAC Response: The DME MAC Outreach teams will research this guidance.

15. Upgrade Modifiers In cases where a semi-electric hospital bed is billed and denied during an audit (Medicare ADR) as not medically necessary (CO 50), can suppliers request a redetermination for the denied claim and bill the least costly alternative and/or append upgrade modifiers (if beneficiary agrees) for the denied claim and all other claims subsequently billed after that? Can this practice only happen when the initial claim has been denied or can the same principle apply if a claim was denied later in the capped rental process? Can this same principle apply to RAC audits?

    DME MAC Response: The upgrade process must be initiated at the time the services are rendered and not during the appeals process.

16. Suppliers are experiencing problems signing up for the Noridian Portal and the MyCGS portal. Within the sign up process, it is asking for the EFT/Check # of the most recent check. It allows up to 10 digits to be entered. When suppliers are paid via ACH, the actual check number (11 digits) is converted to an EFT number (15 digits). The portal is not accepting the EFT numbers. If paid via ACH, suppliers are forced to call the IVR to check claim status to get the actual check number.

    Can the number of digits allowed be expanded to 15 and can Noridian and CGS work to also accept the EFT numbers?

    CGS Response: The myCGS registration for a DA/End User no longer requests a check amount. This requirement was removed in 2016. The process now requires the DA to utilize the authorization code that would have been sent to them by email once the supplier's Authorized Official's request has been approved. This information can be found in the myCGS Registration guide at:

    https://cgsmedicare.com/jb/mycgs/pdf/mycgs_registration_guide.pdf

    Noridian Response: At this time, the Noridian process has not changed and requires the check number which can be obtained through the IVR. This council question has been forwarded to the Noridian team managing the portal for review and consideration.