Jurisdictions B, C and D Councils Combined A-Team Questions
August 2019

Enteral/Parenteral/IV Therapy

1. With the drug shortage environment today for Immunoglobulin therapy, would it be appropriate to add multiple HCPC codes on the EIP DIF for the drugs that may be substituted?

   For example, the DWO is written to allow for substitutions due to shortages for Gammagard (J1569), and/or Gamunex (J1561). Could both HCPC codes be included on the DIF with the appropriate pump HCPC code to avoid having to get revised DIF's each time the drug is substituted. There could be weekly/monthly drug changes due to shortages.

   DME MAC Response: The LCD states that the exact drug being used must be listed on the DIF. When it is necessary to substitute a different drug with a different HCPCS code due to shortage, it is recommended that a new DIF be obtained.

2. When a claim is submitted for units over the MUE edit in place (more than an average of 5 units per day, 35 per week, or 150 per month) B4185 denies entirely instead of paying the maximum allowed under the edit (35/week). Is it possible to have B4185 pay up to the maximum weekly usage (35 units) and deny only the units over the MUE edit?

   DME MAC Response: The DME MACs do not control medically unlikely edits (MUE). We suggest that the requestor direct their question to the MUE contractor (Capital Bridge) or CMS.

Home Medical Equipment

3. If we have a patient that would like to purchase a capped-rental item (ie; wheelchair, nebulizer, etc.), or an item that is only covered as a rental (portable oxygen concentrator) and bill their secondary insurance for payment, we would obtain an ABN that indicates the item is non-covered by Medicare as a purchase. However, we are not able to get the claim to process through to the DME MAC for a proper PR denial. The claim front-end rejects.

   How do we get the claim to process so we can obtain the proper denial that the secondary insurance is requesting?

   DME MAC Response: Suppliers should inform beneficiaries that in order for Medicare to consider coverage of an item that falls within a capped rental payment category, the item must be billed to Medicare on a monthly rental basis. There is no mechanism for billing Medicare to obtain a PR denial in these cases. Suppliers may also refer to questions answered in Winter 2009, Fall 2011, Winter 2011 and discussed in the past on

multiple occasions.

Medical Supplies/Ostomy/Urological/Diabetic Supplies

4. Please consider publishing the surgical dressing and other current Medically Unlikely Edits (MUEs) that are proprietary.

   Providing the MUE information would give providers a clearer understanding of the reason for the denials and insight as to which denied units may be eligible for appeal. Having the MUE information will also enable providers to know when supplies require an Advance Beneficiary Notice (ABN) prior to dispensing.

   DME MAC Response: See prior response from Summer 2011. The DME MACs are not permitted to publish or provide information regarding the unpublished or confidential MUEs.

Prosthetics/Orthotics

No questions Submitted

Respiratory Care Equipment/Oxygen/PAP/Other

5. The PAP LCD says the desaturation should be 4% for hypopneas but does not indicate that for apneas. If the apneas have a AHI of 15 or greater and then hypopneas are not used to calculate the AHI, can this sleep test be used to qualify the patient?

   DME MAC Response: Per the LCD, the apnea-hypopnea index (AHI) is defined as the average number of episodes of apneas and hypopneas per hour of sleep without the use of a positive airway pressure device. Therefore apneas, hypopneas or a combination of both may be used in the calculation of the AHI.

6. If a sleep test scores hypopneas using both 3% and 4% (listing each result in a separate table) but the interpretation only acknowledges the 3% scoring results (due to patient not being enrolled in Medicare at the time), can the sleep study results be used to qualify the patient if the 4% scoring meets Medicare criteria?

   DME MAC Response: **Yes, assuming an interpretation is provided utilizing the 4% Medicare metric.**

   Documentation/Education/Regulatory/Miscellaneous/Other

7. Will you please add the monetary values back to TPE review results letters? These fields are

almost essential for a provider to see how the error rate was calculated.

Though we are keeping track of the dollar amounts, sometimes these values are off, especially for partially favorable, Medicare secondary claims, or when a claim contains a code without an assigned fee and it is at the MAC's discretion to determine an allowed amount, e.g., A6213.

DME MAC Response: Provider-specific questions should be directed to the supplier's individual DME MAC.

Rehab Equipment

8. If we receive a denial for a replacement wheelchair seat or back cushion, because of a RUL same/similar situation; can this be appealed with evidence that (a) the original cushion was out of warranty, (b) the cushion is no longer intact or effective due to "specific reason", and (c) the original cushion cannot be made effective through a repair?

   We would generally have medical necessity documentation from the physician or a therapist/LCMP that would explain why the original cushion is no longer intact or effective and the need for a replacement; the supplier or manufacturer would provide the warranty and repair vs replacement info. We are asking for guidance for both suppliers and claims reviewers, hoping for more consistency in the process.

   DME MAC Response: When claims deny because the payment history includes payment for equipment that is the same or similar to the item billed, appeal rights are afforded.

   Medicare's definition of reasonable useful lifetime (RUL) is separate and distinct from a manufacturer's warranty. Payment for replacement prior to the expiration of the 5-year RUL may be considered for items that have been lost, stolen, irreparably damaged (single incident) or for a change in medical necessity. There must be documentation in the supplier's records describing the circumstances prompting the billing of a new item prior to the expiration of the 5-year RUL. Normal wear and tear does not meet the requirement for replacement prior to the 5-year RUL.

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No Questions Submitted