Final – to Council Chairs January 25, 2018

Jurisdictions B, C and D Councils Combined A-Team Questions
Jurisdiction D Host
December 2017

Enteral/Parenteral/IV Therapy

1. When a beneficiary is receiving a therapy that requires a DIF and a provider is required to submit records to justify the claim (documentation request) and that provider fails to provide the required documentation, do all DIF's in the patients record change to a denied/non-payable status for ALL providers? This is assuming that there has been more than one provider in the record providing at separate time periods. Does the "deny/non-payable status" apply to all providers or only the provider that received the documentation request?

Response: The response may be dependent on whether this is a pre-pay or post-pay review. When claims are pulled for review by the DME MACs, the reviewer will only look at the claim at issue. If the billing provider fails to secure and submit documentation to support the service(s) billed, that claim will deny. This does not impact claims previously submitted. However, it may impact subsequent claims. When a DIF is placed in denied status it will affect any future claims for that HCPCS code regardless of the supplier. In the case of post payment review, i.e. CERT review, only the date of service being reviewed will be issued a recoupment letter and the DIF on file is not affected.

2. ICD-10 D83.1 - Common variable immunodeficiency with predominant immunoregulatory T-cell disorders became effective Oct. 1, 2017. It's listed as payable in the External Infusion Pump LCD, but not in the IVIG LCD. Will the DME MACs be adding D83.1 to the IVIG LCD?

Response: Code D83.1 is not included in the array of ICD-10 codes that the Centers for Medicare & Medicaid Services (CMS) has deemed covered for IVIG (see CMS Benefit Policy Manual (Internet-only Manual 100-2, Ch. 15, §50.6)). The DME MACs do not have discretion to add ICD-10 codes.

3. On November 22, 2017 the DME MACs released a Joint Publication extending Blinatumomab (Blincyto®) coverage indications to match the expanded FDA approval going back to July 11, 2017. I see the limit on the amount of drug that will be covered per month, is there any limit to the number of cycles covered?

Response: The DME MAC Joint Publication titled "Billing Instruction Blinatumomab (Blincyto® Revised", in November of 2017 does not place any limitation on number of cycles but rather clarifies the billing of Blincyto® to indicate that one unit of service is one microgram of drug and not 1 vial of drug.

4. In light of the recent proof of delivery change request, if we ship to a patient utilizing a courier service (Method 2) and the patient signed our delivery ticket with the date the item(s) was received, would the tracking record from the courier still be required since we are allowed to use the delivery date as our date of service?
Response: Under Method 2 proof of delivery, the beneficiary's signature is not required. Method 2 requires that supplier documentation include some clear method to show evidence of delivery. If the beneficiary's signature is included on the delivery slip, the signature would satisfy this requirement.

Home Medical Equipment

No Questions Submitted

Medical Supplies/Ostomy/Urological/Diabetic Supplies

5. The My CGS portal doesn't look for the K0554 when we inquire about the A4253 and/or E0607. Can this be updated so that the portal will accurately check for same or similar products? The A4253 & E0607 codes are not payable when the K0554 is on file.

Response: CGS has updated the portal information.

Rehab Equipment

No Questions Submitted

Respiratory Care Equipment/Oxygen/PAP/Other

6. There was a period when Noridian interpreted "reasonably treated and under control" as referenced in the LCD and by Dr. Paul Hughes in the February 3rd, 2011 ACT teleconference. The patient had successfully completed the 12-week CPAP trial, an IDTF oximetry, and a CPAP download on the same night. This was done to qualify the beneficiary for nocturnal oxygen.

During this time, other DME MACs were allowing titration studies. This was clarified in joint publications as the required testing in November 2013. For patients who were qualified during this time of different interpretation (February 2011 to November 2013), and they are now starting a new 5-year rental on their oxygen, will this test be appropriate to meet current guidelines, providing the other coverage criteria has been met?

Response: Yes, this would be appropriate. Per the LCD, when replacing oxygen due to the RUL has been reached, suppliers are required to secure a new initial CMN. Repeat blood gas testing is not required. The CMN should include the most recent qualifying value and test date. This test does not have to be within 30 days prior the initial date. It could be the test result reported on the most recent prior CMN. There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment unless the equipment is subject to ACA 6407. Suppliers should note that portable oxygen equipment (e.g., E0431) is included in the list of HCPCS codes subject to ACA 6407.

7. A patient with suspected sleep apnea recently discharged from the hospital with an overnight oximetry on the final night as an in-patient. The physician documented hypoxia related symptoms and the ordering physician ordered oxygen short term pending a sleep consult and polysomnography to qualify the patient for PAP therapy.

Whereas Chronic Stable State is not an inpatient testing requirement, and the Alternative treatment method is the completion/initiation of the PSG/CPAP, would Noridian consider oxygen coverage short term in this scenario.

Response: In the scenario that is described in this question, the patient is described as having suspected OSA and was ordered short term oxygen until he/she could be qualified for PAP therapy. The NCD coverage for home use of oxygen requires a severe lung disease or hypoxia related symptoms expected to improve with oxygen, and that alternative treatments have been tried and failed. OSA is not a severe lung disease, thus there is no qualifying diagnosis. The primary treatment of OSA is not oxygen, but rather CPAP therapy. Additionally, alternative treatments have not been tried and shown to fail. Until further testing can establish the diagnosis, and that alternative treatments (in this case a CPAP trial) have been tried and failed, this patient would not meet Medicare coverage for oxygen.

8. Suppliers are reporting submitting CMN's/prescriptions to the MAC which have a lifetime (99) need indicated by the practitioner. The MAC loads them into their system with the length of need as 12 months. When the 13th month is billed the supplier receives a CO-176 denial. The supplier must then contact MAC to extend the CMN then re-bill the claim.

Is there a way to prevent these erroneous denials?

Response: These denials are not erroneous. For Group 1 initial oxygen CMNs, the mandatory recertification at 12 months results in an expiration of the CMN regardless of the length of need specified by the ordering practitioner. In order to extend certification beyond 12 months, a recertification CMN must be completed. Similarly, for Group 2 initial oxygen CMNs, the mandatory recertification at 3 months results in an expiration of the CMN regardless of the length of need specified by the ordering practitioner. In order to extend certification beyond 3 months, a recertification CMN must be completed.

9. In addition to the above question, we received notice of similar problems from a supplier engaged in a TPE audit. They are being told during the discussion period after the round of TPE's that their CMN's will be entered in for a length of need less than what is originally indicated on the physician's order (example: 3 or 5-month length of need even though the physician specified the length of need as lifetime).

We are unaware if the supplier will receive a CO-176 denial when this happens or how the denial will be relayed to the supplier but it is likely the supplier will have to get a revised CMN so they can bill remaining months. The supplier questioned this and was told by the reviewer, "The rationale is that the medical records did not support long term use of oxygen (in this example)." Suppliers need to be made aware of any changes the MAC is making to the expected length of need.

What specific diagnosis or conditions are indicators for the MAC to determine if a reduced length of need is warranted?

Response: There are no diagnoses which would be indicators for a reduced length of need on a CMN. The length of need is determined by the recertification schedule noted in the policy and by the length of need ordered by the treating physician.

Is there a process that can be implemented to notify any MAC changes to the CMN at the time it is loaded into the system?

Response: No process is required. For discussion of individual claim denials in the TPE process, please contact the TPE case manager.

Documentation/Education/Regulatory/Miscellaneous/Other

10. Medicare New Card /SSN Replacement
The timeline published by CMS regarding the new Medicare card / social security number replacement initiative does not include information regarding form updates.

When will CMS be publishing updated forms (such as CMNS, DIFs) with the new Medicare Beneficiary Identifier (MBI)?

Will the Medicare card transition period (April 1, 2019 through Dec 31, 2109) apply to the use of the new forms (e.g., can the HICN versions of the form continue to be used during the transition period)?

Will suppliers be required to submit revised CMNs / DIFs for patients who were qualified with forms that had the HICN?

Response: All reference materials for the new Medicare Beneficiary Identifier (MBI) can be found on the CMS website. CR 10367 was published with attachments showing the new CMN and DIF forms. CMS will provide further details to the MAC contractors who will pass that information on to the supplier community as this information becomes available. Provider Outreach and Education staff for both CGS and Noridian will conduct webinars on this project throughout the transition period. Please check websites for dates and times.

11. This is a follow-up from the Jurisdiction B/C Meeting. The question was discussed with members presenting their concerns. It was decided it would be taken back for further discussion and clarification. Do you have an update?

Question 15 states that the upgrade process must be started at the time services are rendered and not during the appeals process. We believe the question merits more detail to better solicit guidance from the MACs as this scenario presents fairly commonly. In many cases, an "electric bed" is ordered per the 5EO, and the beneficiary often elects to upgrade to a fully electric bed (E0265). The provider initially reviews the medical record and believes they support a semi-electric bed (E0260). During a prepay audit the E0260 denies, and it is determined the

beneficiary only qualifies for a lesser, variable height bed (E0255). The physician is unresponsive to requests for additional medical records to support the E0260, and the supplier acknowledges that the documentation in their possession will support the lesser E0255 bed. The ABN originally disclosed the upgrade fee between the E0260 and the E0265. The ABN did not disclose the medical necessity defect between the E0255 and the E0260, and the supplier concedes they do not have the authority or documentation to pass on the incremental fee between the E0255 and E0260. However, the supplier believes it is reasonable for Medicare to pay for the bed at the E0255 level of service based on the medical records, and they also believe it is reasonable to maintain the original provision of the upgrade disclosure between the rates for the E0260 and E0265 based on the ABN document that is in their possession.

a) In this case the code can only be changed through redeterminations due to the discovery via claim development and unfavorable audit response. Can the provider change the code to the E0255 and send to redeterminations under the limitation that the beneficiary would only be charged the amount on the original ABN?

Response: This question was addressed and answered in a prior council meeting. The supplier is not able to change the code at the Redeterminations level after a medical necessity denial via a pre-pay review. Because it is a medical necessity issue and relates to patient liability, the supplier is locked into the submitted code for that claim.

b) Going forward, now that the medical necessity is known to the supplier, can it be disclosed to the beneficiary via a newly executed ABN for future services (resulting in a higher charge to the beneficiary)?

Response: Yes, per the Medicare Claims Processing Manual, Pub. 100-04, Chapter 30, section 50.13.4, Suppliers Right to Recover Resalable Items for Refund Has Been Made. If the claim is denied, the effect of the denial cancels the contract for the sales or rental of the item. The supplier may enter a new sale or rental agreement with the beneficiary as long as the beneficiary is informed of their liability. This would include keeping the E0265 and being responsible for all charges by way of a new ABN or the acceptance of the E0255 for which the beneficiary meets the coverage criteria.

c) The beneficiary will continue to use the same equipment as originally delivered. Would execution of an updated ABN and change of billing HCPCS in this scenario necessitate a new delivery ticket, new orders or new F2F (if the original delivery was in excess of 6 months from the original F2F)?

Response: No, a new delivery ticket would not be required (the beneficiary is still in possession of the E0265). A detailed written order or new face to face encounter would not be required per ACA 6407 guidelines.

CEDI
No Questions Submitted

Prosthetics and Orthotics

12. We have received feedback that there is a new medically unlikely edit (MUE) for HCPCS codes L5984 and L5986 when billed together. Can you confirm if this information is correct and the implementation date for the edit? Also, can you provide the logic behind the decision to deny claims with this coding combination?

Based on the components selected for the beneficiary, we believe these two codes can be used in conjunction with one another based upon anatomical consideration (e.g. knee rotation vs. ankle rotation vs. foot rotation).

HCPCS code L5986 (All lower extremity prostheses, multi-axial rotation unit 'mcp' or equal) is generally added to a prosthetic foot or pylon. Standing and walking securely require a good foundation, which in turn demands that the foot adapt to the ground. Thanks to the multiaxial feature incorporated into most feet the patient is able to compensate for surface irregularities. This allows the amputee to maintain a stable standing position on a variety of surfaces and easily handle irregularities while walking.

HCPCS code L5984 (All endoskeletal lower extremity prosthesis, axial rotation unit, with or without adjustability) describes a torsion/rotation feature. While axial rotation is typically added to a foot prosthesis, it may also be added between the knee and socket. When used this way, the prosthesis incorporates an axial rotation feature, this net torque acting about the long axis of the socket is able to rotate the socket externally. The axial rotation tends to relieve the contact pressures that caused the torque and thus reduces pressures in the critical anteromedial region of the brim. With an axial rotation device, the socket is free to respond to the demands of the stump and relieve the pressures and torque caused by cyclic action of the musculature. The rotation adapter is attached above or below the knee joint so that the flexed lower leg can easily rotate in relation to the socket and be conveniently moved out of the way. The rotation adaptor allows amputees to perform activities in confined spaces like small kitchens and walkways which require you to walk in multiple directions. It improves security while driving, enabling the user to swing the prosthesis out of the way. In addition, a rotation adapter eases daily activity like putting on shoes or changing socks because it brings the prosthetic foot within reach.

Response: The feedback that you have received is incorrect. There is not a MUE in place for this issue. These are not contractor edits.