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

Home Medical Equipment:

1) When submitting a claim for supplies for patient-owed equipment such as a CPAP, nebulizer, etc., is it necessary to include a claim narrative indicating the patient-owned information even when Medicare paid 13 months of rental for the item? We understand the need for a patient-owned narrative the first time a patient receives supplies under Medicare if another insurance purchased the base equipment, but if Medicare paid for it, that information should already be in Medicare's system.

   DME MAC Response: When Medicare FFS originally pays the 13- month cap for DME, it is not necessary to include a narrative on the claim for the replacement of related supplies and accessories. If the supply or accessory has additional and/or separate criteria, these must also be met in order for coverage to be considered.

Education/Documentation/Other:

2) There are numerous entities that have developed web-based programs that claim to be CMS approved for ordering DME. They are marketing to physicians that their program guides the ordering physician through the LCD requirements ultimately creating a Letter of Medical Necessity, lessening the burden of creating medical documentation in the traditional manner. The concern that the supplier community has is regarding utilization of a program such as Express Scripts, Parachute, or similar entity are twofold:
   a. This type of documentation must be mandated for all prescribers to use this EMR documentation and
   b. Whereas CMS is currently establishing the "Patients over Paperwork – Burden Reduction" initiative, and whereas CMS has encouraged providers to comment as well as utilize templates for DMEPOS that are currently on the CMS website and referred to as "Draft" templates for DME, suppliers need to be reassured that CMS will accept this document as the only required documentation and eliminate the need for face to face or other medical records to prove need for the device, and at the same time guide both the MACs and all other auditing entities (such as SMRC, CERT, UPIC, etc) to accept this as the be-all and end-all required documentation.

   DME MAC Response: CMS and the DME MACs do not approve forms or templates. CMS provides the following guidance on medical record documentation in the *Program Integrity Manual, IOM 100-8* (Ch. 5, Section 5.7): *However, neither a physician's order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable).*

   Similarly, templates are addressed in the *Program Integrity Manual, IOM 100-8* (Ch. 3, Section 3.3.2.1.1):
   B. Guidelines Regarding Which Documents Review Contractors Will Consider
   The review contractor shall consider all medical record entries made by physicians and LCMPs. See PIM 3.3.2.5 regarding consideration of Amendments, Corrections and Delayed Entries in Medical Documentation.

   The amount of necessary clinical information needed to demonstrate that all coverage and coding requirements are met will vary depending on the item/service. See the applicable National and Local Coverage Determination for further details.

   CMS does not prohibit the use of templates to facilitate record-keeping. CMS also does not endorse or approve any particular templates. A physician/LCMP may choose any template to assist in documenting medical information.

Some templates provide limited options and/or space for the collection of information such as by using "check boxes," predefined answers, limited space to enter information, etc. CMS discourages the use of such templates. Claim review experience shows that that limited space templates often fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met.
Physician/LCMPs should be aware that templates designed to gather selected information focused primarily for reimbursement purposes are often insufficient to demonstrate that all coverage and coding requirements are met. This is often because these documents generally do not provide sufficient information to adequately show that the medical necessity criteria for the item/service are met.

If a physician/LCMP chooses to use a template during the patient visit, CMS encourages them to select one that allows for a full and complete collection of information to demonstrate that the applicable coverage and coding criteria are met.

Certificates of Medical Necessity (CMN), DME Information Forms (DIF), supplier-prepared statements and physician attestations by themselves do NOT provide sufficient documentation of medical necessity, even if signed by the signed by the ordering physician. See PIM §5.7 for additional information on documentation.

3) For certain geographical areas, Medicare denies DMEPOS items CO-184 citing the physician signed an attestation with the ZPIC that they will not order a particular item.

   More often than not the physicians claim they are not aware of the attestation and they have no interest in contacting the ZPIC to get the attestation updated. We have heard physicians also complain that it is almost impossible to get someone at the ZPIC who can resolve the issue. If we appeal these, even with a signed letter or statement from the physician that they are authorized to prescribe the items, the appeal denies all the way to the ALJ.

   Here is the typical scenario: Provider received an order and supporting documentation from the physician. The supplier determines the LCD requirements are met and the physician is showing active in PECOS. The provider delivers the item and submits the claim. Upon submission of the claim the discovery is made that the physician has a signed attestation on file with the ZPIC. There are examples of wheelchair bases being paid for, but the accessories are not because the physician didn't check the box that they are prescriber's of wheelchair accessories even though they checked the box for wheelchair bases.

   Would the MAC, CMS and/or the ZPIC make a database available to providers so we can verify the physician's prescribing ability for specific items? Certainly, this will reduce the amount of denials on the MAC error rate and the volume of claims sent to the ALJ unnecessarily.

   DME MAC Response: The DME MACs do not have the authority to provide a database for UPICs activities. Suppliers are encouraged to contact the UPICs associated with the beneficiary's state of residency for more information.

Enteral/Parenteral/IV Therapy:

4) When can home infusion suppliers expect education regarding the Temporary Transitional Payment for Home Infusion Therapy Services that goes into effect on January 1, 2019? There are many questions that remain unanswered, for example: Are delivery tickets required for billing nursing visits with this new CMS Cures Act Transitional Rule? Do these new codes G0068, G0069 and G0070 need to be listed on the DIF?

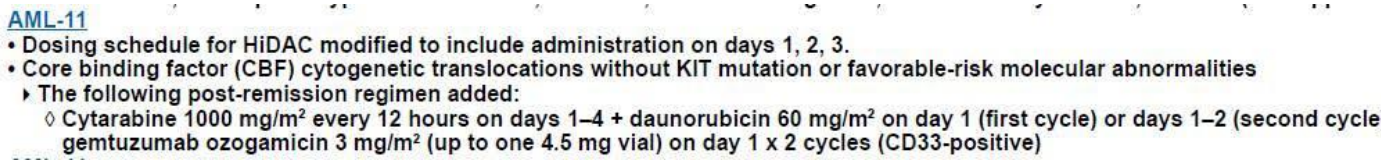
   DME MAC Response: The DME MACs are working on a series of Frequently Asked Questions to provide information about the new Home Infusion Therapy Services G-codes. Additional information may also be found in the CMS CR10836 and Medicare Learning Network (MLN) article accompanying CR10836 on the CMS web site.

5) There is a common cytarabine AML regimen that calls for a 3-hour infusion every 12 hours (intermittent) over 3 days. Does the EIP LCD allow for coverage of cytarabine for intermittent infusions (less than 8 hours), where the intermittent regimen is proven or generally accepted?

LCD reference:
Criteria set 2:
- Parenteral administration of the drug in the home is reasonable and necessary
- An infusion pump is necessary to safely administer the drug
- Administered by intermittent infusion which does not require the bene to return to the physician's office prior to each infusion?
- Adverse effects of the drug are unavoidable without infusing it at a strictly controlled rate as indicated in the Physician's Desk Reference or the U.S. Pharmacopeia Drug Information

Coverage for the administration of other drugs, based on criteria set (1) or (2), using an external infusion pump is limited to the following situations (A) - (J):

A. Administration of the anticancer chemotherapy drugs cladribine, fluorouracil, cytarabine, bleomycin, floxuridine, doxorubicin (non-liposomal), vincristine (non-liposomal) or vinblastine by continuous infusion over at least 8 hours when the regimen is proven or generally accepted to have significant advantages over intermittent administration regimens.
See documentation attached. Specific drugs therapy that many look to do in the home environment is on page 11, excerpt below...


AML-11
- Dosing schedule for HiDAC modified to include administration on days 1, 2, 3.
- Core binding factor (CBF) cytogenetic translocations without KIT mutation or favorable-risk molecular abnormalities
  - The following post-remission regimen added:
    - Cytarabine 1000 mg/m² every 12 hours on days 1–4 + daunorubicin 60 mg/m² on day 1 (first cycle) or days 1–2 (second cycle
      gemtuzumab ozogamicin 3 mg/m² (up to one 4.5 mg vial) on day 1 x 2 cycles (CD33-positive)

DME MAC Response: No. HiDAC (High-dose Ara-C) for consolidation therapy of Acute Myeloid Leukemia (AML) is generally not considered safe for home infusion and requires administration in the hospital setting due to toxicity and side effects. The DME MAC medical directors would be open to reconsideration of this response if provided with clinical literature demonstrating that home infusion of this regimen is safe.

Prosthetics/Orthotics:

6) There continue to be reports of claim denials for L5984 when used in conjunction with other codes that describe multi-axial rotation features. CMS has provided guidance that L5984 describes axial rotation features at or near the ankle and therefore is redundant coding when that feature already exists and is described using a different code. A common reason to bill L5984 is to describe axial rotators that are used just below the prosthetic socket to allow the prosthesis to be rotated temporarily to accommodate specific environmental situations. When an axial rotator is used for this specific reason, and is not used to provide ankle rotation, is it acceptable to be billed as L5999?

DME MAC Response: Yes. L5999 is the appropriate code to bill when axial rotation is medically necessary to accommodate specific environmental situations such as (not all-inclusive): Performing activities in confined spaces like small kitchens and walkways; while driving, enabling the user to swing the prosthesis out of the way; putting on shoes or changing socks because it brings the prosthetic foot within reach.

7) The DME MACs have provided informal guidance that claim denials due to same or similar edits may be overturned through Redeterminations when a documented change in patient condition exists. There have been reports that even when there is excellent documentation of the change in patient condition, claims continue to be denied at Redeterminations. The Medicare Claims Processing Manual, Chapter 20 Section 50 states: "Replacement of equipment which the beneficiary owns or is purchasing or is a capped rental item is covered in

cases of loss, or irreparable damage or wear, and *when required because of a change in the patient's condition* subject to the following provisions. Expenses for replacement required because of loss or irreparable damage may be reimbursed without a physician's order when, in the DME MAC's judgment, the equipment as originally ordered, considering the age of the order, still fills the patient's medical needs. However, claims involving replacement equipment necessitated because of wear or a change in the patient's condition must be supported by a current physician's order." Do the DME MACs have any guidance on what must be documented to support coverage due to a change in patient condition?

DME MAC Response: Please provide examples. Payment may be considered for a DMEPOS item that is the same or similar to an existing DMEPOS item when there is a change in the patient's medical condition and there is documentation to support why the existing equipment is no longer meets the beneficiary's medical needs.

Rehab Equipment:

8) The following question was submitted and answered by Trust Solutions in October 2007. When a Noridian Rep was asked if this is still applicable, she stated that the Q&A was published by another contractor (not Noridian) and could not say that this was correct.
We would appreciate a consensus answer from CGS and Noridian!

Oct 2007 Answer from Trust Solutions:
If a doctor involved in a practice is on vacation, another doctor within the practice can sign the OT/PT assessment; however, there should be a notation in the patient chart indicating why a different physician is completing the info rather than the prescribing physician.

For PMD documentation:

a) If Dr. A performs a face-to-face assessment and orders a PT/OT evaluation and the PT/OT evaluation is sent back to Dr. A for concurrence; but Dr. A is on vacation for two weeks - must we wait for Dr. A to return, or may another physician (Dr. B) within the same practice sign for the original ordering physician? Can Dr. B also create the 7-element Order and sign the DPD?

DME MAC Response: The Power Mobility Devices LCD (L33789) states, "…referred to as the 7-element order that the supplier must receive within 45 days after completion of the face-to-face examination… The treating practitioner completing the face-to-face requirements must write the 7-element order." Thus, in the scenario presented, Dr. A must create and sign the 7-element order and Dr. A must also sign and date the DPD. Of course there are exceptions to the rule in extreme cases where a physician leaves a practice, death occurs and/or extended medical leave. A scenario such as this one would be handled on a case-by-case basis. If the physician (Dr. B) who is signing in absence of another physician is in the same practice and there is documentation to substantiate why the (Dr A.) physician could not complete both portions of the face to face, it would not be an issue. The supplier should get an attestation statement explaining the unique situation.

b) If Dr. A performs a face-to-face assessment and orders a PT/OT evaluation and signs it in concurrence and creates a valid 7-element order; but then Dr. A goes on vacation for two weeks - must we wait for Dr. A to return, or may Dr. B sign the DPD?

DME MAC Response: The Power Mobility Devices LCD (L33789) states, "…referred to as the 7-element order that the supplier must receive within 45 days after completion of the face-to-face examination… The treating practitioner completing the face-to-face requirements must write the 7-element order." Thus, in the scenario presented, Dr. A must create and sign the 7-element order and Dr. A must also sign and date the DPD. Of course there are exceptions to the rule in extreme cases where a physician leaves a practice, death occurs and/or extended medical leave. A scenario such as this one would be handled on a case-by-case

basis. If the physician (Dr. B) who is signing in absence of another physician is in the same practice and there is documentation to substantiate why the (Dr A.) physician could not complete both portions of the face to face, it would not be an issue. The supplier should get an attestation statement explaining the unique situation.

c) Does it matter how long Dr A is unavailable – 3 days off, 2 week vacation, extended maternity leave, or retired…?

DME MAC Response: The Power Mobility Devices LCD (L33789) states, "…referred to as the 7-element order that the supplier must receive within 45 days after completion of the face-to-face examination… The treating practitioner completing the face-to-face requirements must write the 7-element order." Thus, in the scenario presented, Dr. A must create and sign the 7-element order and Dr. A must also sign and date the DPD. Of course there are exceptions to the rule in extreme cases where a physician leaves a practice, death occurs and/or extended medical leave. A scenario such as this one would be handled on a case-by-case basis. If the physician (Dr. B) who is signing in absence of another physician is in the same practice and there is documentation to substantiate why the (Dr A.) physician could not complete both portions of the face to face, it would not be an issue. The supplier should get an attestation statement explaining the unique situation.

9) Medicare is denying Headrests (E0955) when provided on a complex rehab PWC when the chair is a Captains Style Seat w/ Power Tilt and/or Power Recline (e.g. K0836, K0842 & K0857). There are two conflicting statements in the WC Seating LCD:

Excerpt A: a headrest (E0955) is also covered when the beneficiary has a covered manual tilt-in-space, manual semi or fully reclining back on a manual wheelchair, a manual fully reclining back on a power wheelchair, or power tilt and/or recline power seating system.

Excerpt B: If the beneficiary has a POV or a power wheelchair with a captain's chair seat, a headrest or other positioning accessory will be denied as not reasonable and necessary.

Standard, non-adjustable headrests common to Captain's Style Seats do not provide the full necessary support or flexibility when power positioning is medically needed. To meet the needs of the users, suppliers need to provide more appropriate add-on headrests that accommodate the patient's support and positioning needs (i.e. multi-axis headrest).

Is it possible to consider potential coverage for a complex Headrest when provided on a Captains Style Seat PWC when power seating is justified – per the coverage criteria in Excerpt A?

DME MAC Response: Please provide examples. Almost all the items that are PDAC code-verified and listed as a Captains chair with power options, such as the PWC base codes listed in the examples, have been discontinued.

The Power Mobility Devices LCD-related Policy Article Coding Guidelines for Captain's-style seat describes this component as follows:

Captain's chair - A one or two-piece automotive-style seat with rigid frame, cushioning material in both seat and back sections, covered in cloth, vinyl, leather or equal as upholstery, and designed to serve as a complete seating, support, and cushioning system for the user. It may have armrests that can be fixed, swingaway, or detachable. It may or may not have a headrest, either integrated or separate.

Generally speaking, a Captain's-style seating system is a type of seat that is replaced with a separate power tilt and/or recline product (i.e., E1002 – E1012) for beneficiaries in need of a complex rehab PWC and meet the

requirements in the Wheelchair Options and Accessories LCD and related Policy Article. Moreover, for beneficiaries in need of a specialized headrest, it is unlikely that they would be appropriately fitted with a Captain's seating system rather than a specialized seat/back system.

10) Is there any guidance on Suppliers billing for labor when modifying a patient owned PWC? We consider modifications to be adding something new to a chair, with appropriate documentation and usually from a change in condition. Modifications can require a substantial amount of labor. Some examples are:
    a) Adding power seating (tilt and/or recline) to a 'no-power' base
    b) Adding head control or some other alternative control
    c) Adding power elevating leg rests
    d) Changing from Captain seating to Rehab seating

    DME MAC Response: The fee schedule established for wheelchair accessories, options and seating is calculated to include labor. Reimbursement for labor is limited to customized items and repairs.

11) On December 6th, a joint article was published that will, effective 03/01/19, require WC Options Accessories to be billed on separate claim lines when there is more than one unit and the item might need the RT and/or LT modifiers. We have concerns about claims processing this way:
    a) This will add more claim lines to claims that can already be several 'pages'; we often have trouble with multi-page claims being split and inappropriately pending and denying.
    b) We are concerned that we may see more denials for 'duplicate' claim lines if the modifiers are not properly recognized.
    c) We know we will see a substantial number of denials on Secondary claims as duplicates – few other payers require or recognize the RT and LT modifiers.
    d) Adjustable hardware, E1028, can sometimes be a right/left situation (for example, when used with lateral pads), but can also be used where there is no right or left – headrest hardware, swing-away hardware for joystick mounts – how will these lines be edited?
    e) Is there any distinction between options billed with a new chair vs options billed as replacement parts?

    Is it possible to identify a limited set of WC Option codes that must be billed with RT/LT? And is there any possibility of allowing 2 or more units to continue to be billed on one line?

    DME MAC Response: If an item or accessory has laterality, the RT and LT modifier must be used and billed on separate lines. The combination RTLT and 2 UOS is no longer appropriate. The change was made to accommodate claim editing requirements of the DME MACs.

Medical Supplies:

12) If a beneficiary is requesting more supplies than what is allowed and reimbursed by Medicare, how is the claim submitted? The medical record does support the standard allowed amount and does meet the coverage criteria in the medical policy. The medical record does not support the over-utilization that is being requested. The beneficiary is willing to sign an ABN, choosing option 1, and will pay for the extra supplies that he/she wants.

    For example, for HCPCS code A4351, the order is for 200 per month which is the allowed amount. The medical record support and meet the requirements in the medical policy for 200 catheters. The beneficiary is requesting an additional 10 catheters of HCPCS code A4351, which the medical record does not support. The beneficiary is willing to pay out of pocket and sign an ABN with option 1 chosen. When the supplier submits the claim, how should the claim be submitted?

    DME MAC Response: Suppliers must bill 2 line items for upgraded/excessive DMEPOS items where the beneficiary requests an upgrade. Suppliers must bill both lines on the same claim in the following order:

Line Instructions:
Line 1:
Bill the appropriate HCPCS code for the upgraded item the supplier actually provided to the beneficiary with the dollar amount of the upgraded item. If the supplier has a properly obtained ABN on file signed by the beneficiary, use the GA modifier. If the supplier did not properly obtain an ABN signed by the beneficiary, use the GZ modifier.

Line 2:
Bill the appropriate HCPCS code for the reasonable and necessary item with the actual charge for the item. Use the GK modifier.

Suppliers should bill their full submitted charge on the claim line for the upgraded item (Line 1) and the full amount for the reasonable and necessary item (Line 2). If the upgrade is within a code, suppliers still bill 2 line items, using the same code on both lines, but Line 1 would have the higher dollar amount.

Suppliers must bill both lines on the same claim in sequential order. Line 1 and the associated Line 2 should follow each other.

13) Can consideration be made for companies that are under TPE for a specific HCPCS under one NPI number to wait until that audit is complete before placing another location under audit for the same HCPCS? For example, a company is under TPE for the A4253 for 3 different locations at the same time and it is hard to track which CCN numbers are complete for which audit. It also makes it a challenge to track which Medical Review person to send the questions back to.

DME MAC Response: Yes, supplier burden and the timing of audits can be taken into consideration for suppliers involved in the TPE process. We encourage suppliers to work with their case managers should there be an issue related to the timing of audits**.**

CEDI:

No Questions Submitted