Jurisdictions B, C and D Councils Combined A-Team Questions
April 2017

Enteral/Parenteral/IV Therapy

1. Our question pertains to the written responses given by the DMEMACs for Q.3 on the last round of Q&A, in addition to the January 20, 2017 Joint DMEMAC release of the Revised DME Information Forms(DIFs) usage for enteral and parenteral Nutrition and External Infusion pumps – Revised January 18, 2017.
   https://med.noridianmedicare.com/web/jddme/policies/dmd-articles/difs-usage-for-enteral-and-parenteral-nutrition-and-external-infusion-pumps-revised-2017

   Based on the written answers from the DMEMAC's to Q.3, the expectation for extending LON now becomes a revised DIF, essentially eliminating a Recertification DIF in any situation. This is in direct conflict with the LCD's for Enteral and Parenteral Nutrition. Until the verbiage & instruction in the LCDs are changed and released, many suppliers will likely continue to use Recertification DIFs to extend the LON when expired.

   a. Will this be acceptable until there is new instruction written and released?

   b. Will existing recertification DIFs already on file require any changes?

   c. The TPN LCD states that the beneficiary must be seen by their treating physician 30 days prior to the initiation of TPN, and 30 days prior to the Recertification for TPN. If the recertification requirement is eliminated, will the 30-day requirement be eliminated?

   The January 2017 revised instruction still is unclear and conflicts with the answers given to Q. 3

   a. Under the section for Revised DIF/ Enteral and Parenteral Nutrition: the table does not Contain the reason: extend expired length of need, as it does in the table for the External Infusion Pump.

   b. This elimination then leads one to support the use of a Recertification for Enteral and Parenteral

   Suppliers that have just recently followed this new instruction to submit a revised DIF vs a Recert DIF to extend the LON have received CO-175 Denials for Recert DIF, creating more confusion on what is the expectation.

   DME MAC Response: Please refer to the updated Enteral and Parenteral LCDs. The requirement for a recertification DIF has been removed when LON expires. The DME MACs published a revision to the January 2017 article in April 2017 which further addresses Revised/Recertification DIFs. The link to the article is http://cgsmedicare.com/jc/pubs/news/2017/0417/cope2774.html.

Home Medical Equipment

2. What documentation is necessary to qualify a patient for an E0260 (semi- electric) bed? The LCD states immediate or frequent changes in body positioning are required but how should this be documented by the physician?

    a. Could education on this please be provided to Physicians so they understand that simply saying a bed is needed to reposition or to allow for better positioning will likely not qualify them for a semi-electric bed?

DME MAC Response: The Hospital Beds LCD requires, for a semi-electric bed, that the beneficiary meet the coverage requirements for a fixed height bed AND the requirement that the beneficiary requires frequent changes in body position and/or has an immediate need for a change in body position. As a reminder, the fixed height coverage requirements are:

1. *The beneficiary has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, or*
2. *The beneficiary requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or*
3. *The beneficiary requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration, or*
4. *The beneficiary requires traction equipment, which can only be attached to a hospital bed.*

Medical Supplies/Ostomy/Urological/Diabetic Supplies

3. When a beneficiary places an order for supplies from multiple suppliers (e.g. diabetic supplies, ostomy supplies, etc.), we execute an ABN and submit the claim with the GA modifier. When the claim is billed with the GA modifier some suppliers are reporting receiving CO denials rather than PR denials.

    Per the Supplier Manual, the provider is liable for the dollar amount involved UNLESS a properly executed advance beneficiary notice of possible denial has been obtained. Also in the Supplier, Manual there is a list of examples of reasons for the provider's belief that Medicare is likely to deny payment, one of which is "Medicare does not pay for this many services within this period."

    What (if any) additional steps must providers take to obtain a proper PR denial?

    DME MAC response: The presence of the GA modifier does not guarantee a PR denial. Without claim examples it is impossible to provide any response other than, based on the information provided, an appeal would be the next step.

4. When a beneficiary indicates that supplies that were previously provided by another supplier were returned, how do we determine whether the other provider has properly issued a recoup/refund to Medicare?
    Some customer service representatives will provide that information and others will not. Providers must have a way to ascertain when the previous order from the other supplier was refunded or recouped so we can proceed with a redetermination for the items that were provided by our company as the new supplier.

Is it possible for the DME MACs to make this information accessible via their portal?

DME MAC response: Adjudication of claim information is proprietary to the billing supplier.

Prosthetics/Orthotics

5. Please define and or clarify what you mean by "substantial modification". This verbiage is used extensively in the Knee and Spinal Orthosis policies. Please provide examples of what is considered "substantial modification"?

   DME MAC response: From the definitions in the March 2014 bulletin article titled "Correct Coding - Definitions Used for Off-the-Shelf versus Custom Fitted Prefabricated Orthotics (Braces) – Correction":

   Substantial modification is defined as changes made to achieve an individualized fit of the item that requires the expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthotics such as a physician, treating practitioner, an occupational therapist, or physical therapist in compliance with all applicable Federal and State licensure and regulatory requirements. A certified orthotist is defined as an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification.

   Classification as custom fitted requires substantial modification for fitting at the time of delivery in order to provide an individualized fit, i.e., the item must be trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment.

   The term "minimal self-adjustment" is defined at 42 CFR §414.402 as an adjustment the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist (that is, an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification) or an individual who has specialized training. For example, adjustment of straps and closures, bending or trimming for final fit or comfort (not all-inclusive) fall into this category.

6. The Physician writes a prescription for a certain product to be dispensed. Upon examination prior to fitting the Orthotist/Prosthetist determines that the product needs to be customized before it can be provided to the patient.
   a. Who should own the medical record documentation on this? The Physician or the Orthotist/Prosthetist?

   b. Would a new order be required in this situation? It would be the same product and same HCPC just customized to the patient.

   c. Upon review, what documentation would be expected to be in the patient's medical record?

   DME MAC response: The question is unclear what is intended by "…needs to be customized." Is this custom fitted or custom fabricated?

a. *Medical record documentation is the responsibility of the physician. The medical record must demonstrate that the applicable coverage criteria are met. The supplier is responsible for maintaining documentation related to the justification for the selection and provision of specific products.*
b. *Yes. All items billed to Medicare require an appropriate order*
c. *The Standard Documentation Requirements LCD-related Policy Article (A55426) states that there must be sufficient, detailed information in the medical record to demonstrate that the relevant R&N requirements for the items are met by the beneficiary.*

As a reminder, the definitions for prefabricated and custom fabricated, minimal self-adjustment and substantial modification are found in the March 2014 bulletin article titled "Correct Coding - Definitions Used for Off-the-Shelf versus Custom Fitted Prefabricated Orthotics (Braces) – Correction."

7. The Physician writes a prescription for a custom brace. Upon examination prior to fitting, the Orthotist/Prosthetist determines that an off the shelf product will be sufficient. Is a new order required before we provide the off the shelf brace?

   DME MAC Response: Yes.

Rehab Equipment

8. What is the status of the implementation on prior authorization for K0856 and K0861?

   a. Will the PA program review and consider all HCPC codes on the order, or just the base codes?
   b. If the new PA program only looks at the base codes, can ADMC still be utilized to get approval for all options and accessories?
   c. ADMC approval extends the delivery deadline to 6 months from the date of the F2F. Will the PA program for K0856 & K0861 also allow us the extra time to complete delivery? These can be quite complicated chairs to assemble, with components coming from multiple suppliers.

   DME MAC response: The DME MACs began accepting PAR condition of payment requests on March 6.
   a. *The codes being reviewed are K0856 and K0861.*
   b. *No, both processes can't be utilized. As in other demonstrations, the PAR process will take precedence.*
   c. *Noridian and CGS plan to update the PMD LCD and Policy Article to apply a 6 - month delivery exception for all prior authorization programs. This will include the required and demonstration program.*

9. PMD PAR: Some suppliers have received 'non-affirmed' decisions when requesting a captain's seat chair (i.e. K0823) if the medical records indicate that the patient is susceptible to decubitus ulcers. PA is saying that a K0822 (rehab seat) needs to be provided; but there isn't a qualifying diagnosis for any cushion (other than general use, which will cause both the cushion and the base to deny). How should this be handled?

DME MAC Response: Please provide an example and POE will research.

10. The WC seating policy lists ICD 10 G11.3 as a valid diagnosis for a skin protection cushion and, also for a positioning cushion; but is not listed as a valid diagnosis for a combination skin protection and positioning cushion unless there is also a decubitus code. Is this just an error?

    DME MAC Response: Refer to the recently published revised LCD. ICD-10 code G11.3 is included in the Group 2 diagnosis codes and is a covered diagnosis for a combination cushion. From the ICD-10 section in the LCD:

    For combination skin protection and positioning items (HCPCS codes E2607, E2608, E2624, E2625), use one of the following (either 1 or 2):
    (1) one diagnosis code from Group 1 and one diagnosis code from Group 3 (total of 2 diagnosis codes); or,
    (2) one diagnosis code from Group 2.

Respiratory Care Equipment/Oxygen/PAP/Other

No Questions Submitted

Documentation/Education/Regulatory/Miscellaneous/Other

11. If a customer service representative confirms that a claim was denied in error, can we send that claim to fax reopening?

    We have been receiving mixed information from the MAC's, some say we must send to Redeterminations and others will Re-Open the claim. Which is correct? We do not believe we should have to appeal the decision when it was a contractor error. We need the payer to reprocess the claim correctly.

    DME MAC response: This may depend on the error and where it derives from, as Reopenings staff has some limitations in their ability to change a decision that has been issued.

    DME POE recommends that if a trend in these denials is identified, please contact the DME MAC Provider Contact Center and escalate if appropriate.

CEDI

12. Recently on the electronic version of the provider level adjustments we have had an increase in small recovery amounts. On those lines the reference ID is cut off and we cannot trace the amount to a specific claim. Can this issue be considered so that we can trace these claims? Even though the recoveries are small they add up. (JB-S L)

    POE following up with Stacy McDonald at CEDI for response.

13. We have a concern regarding the CEDI edits that require an LT and RT modifier when a rental is billed with a quantity of two. I think we should introduce the possibility of requesting an exemption from CEDI edits for a dedicated list of HCPCS. Specifically, because this has become problematic on the REHAB side.

    There are several other more pertinent modifiers related to pricing and policy that are necessary for claim processing but we cannot get past the front-end without consuming two of the four modifier slots due to this edit.

    Primarily this affects HCPCS for wheelchair accessories that have recently been reclassified as capped rental. These codes require RR and KH/KI/KJ modifiers in addition to KX, pricing modifiers like KU among others… overflow into the narratives are also becoming more prolific, but the order of modifiers for reimbursement and CEDI are in opposition. We'd like to reduce the need for manual intervention and reduce the likelihood of manual processing errors.

    DME MAC Response: Please refer to question number 6 in the January 2017 council questions.