FINAL to Council Chairs – November 9, 2018 – Post-Council Updates

Jurisdictions B, C, and D Councils Combined A-Team Questions
November 2018

Prosthetics/Orthotics:

*Question removed by POE as it is contractor specific. Association managers notified.

Education/Documentation/Other:

1. In a recent article pushed by Forbes, CMS Administrator-Seema Verma called upon doctors' offices to completely eliminate fax machine usage by 2020. The link to the article is: https://www.healthcareitnews.com/news/cms-administrator-seema-verma-calls-end-physician-fax-machines-2020

*Please see attachment #1 for print out.

Some of the documentation guidelines require practitioners to sign/date or initial medical records, causing HME providers to heavily rely on faxed documents. Have you been advised by CMS of any action taken to pursue this goal?

Would the Medical Directors keep this in mind when communicating with CMS to see if there are steps that the contractors need to make this goal attainable for HME services?

DME MAC Response:

THE DME Medical Directors are aware of this goal established by CMS. At this point, there have been no additional instructions or proposed actions presented to us, but we will be prepared to provide input when further direction from CMS is received.

Home Medical Equipment:

No questions submitted

Enteral/Parenteral/IV Therapy:

2. We are seeing discrepancies in the standard documentation language regarding proof of delivery. In reviewing the Enteral policy/article the standard documentation language comes up as "super-ceded", but there has been no update published. Is there a super-ceded policy we are not aware of?

The EIP (External Infusion Pump) policy/article comes up as super-ceded, but the proof of delivery language has been updated. Is there something additional to be published?

**Please see attachments 2-16.

***Additional Note: The screen shot is from the Enteral LCD # L33783 and the External Infusion Pump LCD # L33794. When you try to access the Standard Documentation Article at the bottom of both of these individual LCD's. Date of inquiry was 9.27.2018.

The Standard Documentation Article in the TPN LCD #33798 is just fine. If you go to the CGS website... all 3 of these LCD's noted above allow you to access the Standard Documentation Article, so appears the "Superseded" Message is with Noridian website only at this time.

DME MAC Response:

Noridian identified that an omission had been made in website update where a Standard Documentation Article A55426 hyperlink remained at the end of the policy article and had not been updated. Noridian is working to make this correction.

*Attachments removed from this document as unnecessary.

Respiratory Care Equip/Oxygen:

3. PAP Question - Supplier received a denial on a pap claim stating the sleep study was signed by the physician after the pap device was set up. Claim was appealed to redetermination and denial upheld stating "interpretation signed by physician after the set-up date therefore unable to determine if patient met the criteria on or prior to the initial date". Appealed this denial to C2C who upheld the denial reason. Must a supplier wait until a signed sleep study has been obtained prior to set up of a pap device? Why is a signature the determining factor for medical necessity rather than the clinical data obtained during testing?

DME MAC Response: Per the PAP LCD, for all PAP devices the sleep test must be interpreted by a practitioner holding one of four certifications. Draft interpretation can be utilized at the discretion of the supplier, however appropriately authenticated documentation must be provided at the time of response to a request for records. All medical records must be authenticated by the author. When a signature is missing it is possible to utilize signature attestation as defined in the Medicare Program Integrity Manual, Publication 100-08, Chapter 3.

Rehab Equipment:

*Question removed by POE as it is related to a Modifier tool that is under review by both contractors at this time. Association managers notified.

4. Diagnosis code I69.341 (monoplegia of lower limb following cerebral infarction affecting right dominant side) is listed as a Group 3 code in the Wheelchair seating policy but I69.342 (monoplegia of lower limb following cerebral infarction affecting left dominant side) is missing. Was this the intention of the policy, or was it an inadvertent omission?

DME MAC Response:
This was an omission due to a clerical error. I69.342 was added to the Group 4 codes, but inadvertently was not added to Group 3. Thank you for bringing that to our attention.

5. Code E0952 is available with KE allowable in Alaska and Hawaii as the instructions note but why not in the rural areas for the other states? It's on the KE list but there is $0 fee in all other states with a KE.

DME MAC Response:
The KE modifier is a competitive bid modifier, and is not tied to rural areas for this particular HCPCS code. The competitive bid fees are established by CMS.

Refer to MLN10707:

Because the revised rural and non-contiguous fee schedule amounts are based in part on unadjusted fee schedule amounts, the fees for certain items included in the 2008 Original Round One CBP, denoted with the HCPCS pricing modifier, are added back to the fee schedule file only for items furnished in rural and non-contiguous areas. Background information and a list of the applicable KE HCPCS codes was issued in Transmittal 1630, CR 6270, dated November 7, 2008. Beginning June 1, 2018 through December 31,

2018, the rural and non-contiguous KE fee schedule amounts will be based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted KE fee schedule amount updated by the covered item updates specified in sections 1834(a)(14) and 1842(s)(B) of the Act. The non-rural fees for these KE codes will be populated with zeros on the fee schedule file since KE is not a valid option for areas without blended fees.

If you look back at the fee schedules for each quarter for the E0952, E2624, E2622 and K0038 since the Rural Fees came into play (CR 9431 - CY 2016 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule), these codes have not had a Rural designation or Rural Fee. There is no designation of Rural on these codes, so the KE modifier would only be applicable for non-contiguous areas (i.e., AK, HI, PR, VI). Where the fee schedule has a zero amount listed in the HCPCS code and KE modifier combination, the combination is considered invalid and should be return/rejected.

6. This question is specific to the expanded "Condition of Payment" (Prior Authorization) process. During the review process, is the medical reviewer auditing the records for any technical errors or is the reviewer only looking at the medical records to determine medical necessity? For example, for coverage and payment of a PMD, a 7-element order is required. If there is an error on the 7- element order such as a missing date stamp, will this result in a non-affirmed prior auth?

DME MAC Response:

All documentation will be reviewed as outlined in the Operational Guide. If any required document is missing elements or non-valid in some way, the PAR submission will receive a non-affirmation.

*POE staff did make the council managers aware that this question should probably have been answered by the A-teams.

Medical Supplies:

7. What are the documentation requirements when a beneficiary receives a Continuous Glucose Monitor (CGM) K0554 and it is covered by Medicare? The patient later changes back to regular diabetes testing. When submitting claims for the A4253 Test Strips and A4259 Lancets they will deny once a CGM K0554 is on file.

When we call customer service about how to appeal these since the beneficiary is no longer using the CGM, we are told that diabetes supplies are no longer covered once a beneficiary receives a CGM K0554.

DME MAC Response:

Per the Glucose monitor LCD, a therapeutic CGM device replaces a standard home blood glucose monitor. Claims for a BGM and related supplies billed in addition to an approved CGM device and the associated supply allowance will be denied. Since the CGM is in the inexpensive and routinely purchased category, if purchase has occurred, a return to BGM cannot be allowed inside the five-year reasonable useful lifetime unless a change in medical condition has occurred. The supplier may appeal the claim to show the need for change in therapy as it is recognized that CGM may not be the correct testing method for everyone.