Jurisdictions B, C and D Councils Combined A-Team Questions
May 2018
Final to Council Chairs

Home Medical Equipment:

1. Standard Manual Wheelchairs: Some providers have received denials for home assessments for manual wheelchairs when they are documented as done by interview rather than in-person. These Medicare denials cite that a physical in-home assessment with measurements is required. Frequently these chairs are delivered to a facility to facilitate discharge, and the provider is not physically going to the bene's home. The LCD allows for home assessments for manual wheelchairs to be done by interview: "For manual wheelchairs, the home assessment may be done directly by visiting the beneficiary's home or indirectly based upon information provided by the beneficiary or their designee. When the home assessment is based upon indirectly obtained information, the supplier must, at the time of delivery, verify that the item delivered meets the requirements specified in criterion C."

   Please explain what the reviewers are looking for as documentation of a valid home assessment. Is a documented follow-up call, once the bene is home with the chair sufficient?

   Response: Per the policy article for Manual Wheelchair Bases (A52497) the home assessment may be done directly by visiting the beneficiary's home or indirectly based upon information provided by the beneficiary or their designee. The policy article further states that when the home assessment is based upon indirectly obtained information, the supplier must, at the time of delivery, verify that the item delivered meet the requirement specified in Criterion C. The home assessment must include documentation addressing the physical layout of the home, surfaces to be traversed and any obstacles.

   The Medicare program rules include provisions to allow DMEPOS items to be delivered to the beneficiary within 2 days prior to discharge from an inpatient facility solely for the purpose of training and fitting. This provision does not in any way negate the supplier's obligation to conduct an **in-person home assessment** to meet all of the requirements related to criterion C. The supplier is obligated to ensure that the wheelchair provided will provide adequate access to between rooms, maneuvering spaces, and surfaces to allow the beneficiary to perform or participate in MRADLs.

2. We understand that any repair/replacement parts that are under warranty cannot and should not be billed to Medicare. Manufacturer warranties typically do not cover loaner equipment that may be needed while the bene-owned equipment is being repaired. Will Medicare allow for rental of a K0462 when there are no repair parts being billed to Medicare (for warranty repairs)?

Medicare allows payment for temporary replacement (HCPCS K0462) for beneficiary-owned equipment being repaired. When billing temporary replacement equipment under HCPCS code K0462, you must provide information pertaining to both the beneficiary-owned equipment and the temporary replacement equipment. Claims must include a narrative description of the equipment being used as a temporary replacement, with the manufacturer name, brand name, and model name or number of the temporary replacement item, and a statement of why the replacement is needed. In addition, claims must include the HCPCS code and/or manufacturer name, brand name, and model name or number of the beneficiary-owned piece of equipment, and the date of purchase of the equipment. Claims without this information will be denied as not medically necessary.

Response: Yes as long as the beneficiary owns the DMEPOS item being repaired.

3. Are there any specific billing instructions for K0462? Several years ago, NGS asked that K0462 be billed on the same claim as the repair; this was problematic since the rental date is different – earlier than – the final repair delivery date. Will Noridian and CGS accept claims for K0462 that are billed separately than the repair, with the earlier rental date as the date of service?

   Response: It is acceptable to have different dates of services for the temporary loaner rental claim and the repair claim. For example, the supplier bills DOS 04/15/18 for the K0462 when it's provided, then bills DOS 05/01/18 with the repair and labor codes (if applicable) when the beneficiary-owned item is repaired. Suppliers are encouraged to submit one claim for the repair and loaner equipment.

Enteral/Parenteral/IV Therapy:

No questions submitted

Respiratory Care Equip/Oxygen:

No questions submitted

Prosthetics/Orthotics:

4. We are seeing claims denied due to unpublished bundling. A DME MAC representative told us there are unpublished bundling rules. For example, an L1831 (KO) was denied when billed with an L1652 (HO) and the reason given for unpublished bundling rules. Are there unpublished rules? If so, how do we request information on these – or how do we comply?

   Response: These are not DME MAC edits.

5. 13 Section 1834(h) of the SSA was recently amended to state ‘‘(5) DOCUMENTATION CREATED BY ORTHOTISTS AND PROSTHETISTS. - For purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by an orthotist or prosthetist shall be considered part of the individual's medical record to support documentation created by eligible professionals described in section 1848(k)(3)(B)." Is there a timeline or plan by the DME MACs to update policies to reflect this change? What can O & P providers expect related to this change as far as timing and implementation?

   Response: As DME MACs, we are unable to make any changes until we receive instruction from CMS. We have not yet received instruction from CMS on this particular change to the SSA, section 1834.

6. During a Jurisdiction D educational call with a supplier in California, they were told that certified fitters are now considered "qualifying practitioner." Can you confirm this and confirm if Jurisdictions A, B and C will follow the guidance?

   Response: After review of certification material, including the training and educational requirements stipulated by ABC for certification as an orthotic fitter, the DME MAC medical directors have determined that the ABC education, training and other requirements to gain certification as an orthotic fitter are not “equivalent” to the training and education of a certified orthotist. Therefore, provision of a custom fitted orthosis by an orthotic fitter would not meet Medicare’s requirements for reimbursement of those items.

7. During a recent Noridian 200 Level Lower Limb Prostheses webinar, the presenter noted a prosthesis is eligible for coverage during SNF stay only if the prosthesis is provided within two days prior to discharge to home and prosthesis is not needed for inpatient treatment or rehabilitation. (See slide 26 of the presentation). This does not align with the SNF PPS list, which specifically excludes prostheses. Please explain.

   Response: For LLP policy, the following codes cannot be provided during a Part A stay and billed to the DME MAC: L5000-L5020, L5400-L5460, L5987 and L8400-L8480. They must be delivered no less than two days prior to anticipation of discharge. The date of service billed on the claim must be the date of discharge. The other codes in the policy are included on the excluded list which allows billing to the DME MAC when the beneficiary is inpatient. Note: Noridian believes that there may have just been a misinterpretation during the webinar.

Rehab Equipment:

No Questions Submitted

Medical Supplies:

No Questions Submitted

Education:

No Questions Submitted

Documentation/Other:

8. As a pharmacy provider, we understand that in addition to supporting medical documentation, a detailed written order is required for all prescribed medications and related supplies prior to billing. We also know that the DME provider must obtain a valid Written Order Prior to Deliver (WOPD) for the nebulizer prior to the provision of services. However, because the pharmacy is often a separate entity from the DME provider, pharmacies have no way of knowing whether the DME provider has followed all requirements and obtained the valid WOPD prior to delivering the nebulizer and pharmacies are limited in knowing when the DME provider is submitting claims for the nebulizer. We've seen an increase in pharmacy denials for the first dose of respiratory medications, which is often attributed to the delay by the DME provider of filing the initial claim for the nebulizer. Because the DME MACs are basing the reimbursement for pharmacy claims on the rental of the DME company's nebulizer claims, pharmacies are at a loss when the DME provider does not bill the initial claim of the nebulizer.

   The reimbursement of pharmacy claims should not be dependent upon the submission of the DME provider's claim for the nebulizer. So long as all coverage criteria has been met for the provision of the respiratory medications, pharmacies should be reimbursed timely when providing the covered medications so long as the patient qualifies for the medications that are prescribed and all coverage criteria has been met. Realizing that there is a solution for preventing denials of patient owned equipment through the addition of a narrative on pharmacy claims when the patient owns the nebulizer, could a provision also be made for pharmacies to include a narrative describing the relevant rental information on the claim for respiratory medications? If so, what information is sufficient to provide in the narrative section of the claim?

   Finally, will the DME MACs consider revising their practices to adjudicate the DME nebulizer rental claims independent from the pharmacy respiratory medication claims to enable fair reimbursement to pharmacies for prescribed medications that are ordered and dispensed?

   Response: Coverage of nebulized inhalation drugs is afforded under the DME benefit. There is no separate benefit for inhalation drugs which are treated as a supply to the nebulizer compressor (the DME). Review first begins with the medical necessity for the DME. If the DME is not reasonable and necessary or does not meet the benefit requirements, the supplies are denied as well. Pharmacists should work closely with the beneficiary and supplier of the DME to ensure all relevant documentation is present in the medical record to support medical necessity.

It is important to note that MAC audits do vary related to nebulizers and the drugs administered by them. Some may include both the device and the drugs; others may only cover the drugs. This is at the contractor's discretion.

9. Suppliers have reported hearing on recent webinars (Noridian Enteral 3.18) that there will be new DIF's coming out the end of March 2018.

   We assume this is related to the new MBI numbers, however no specific information is being provided to suppliers regarding:
   1. Will there be a transition period? When will the new DIF be mandatory for use?
   2. Will it be for beneficiaries that have received their new MBI cards only?
   3. Will suppliers be required to redo our existing DIF's for current beneficiaries when they receive their new MBI card?
   4. Concern over programing issues with such short notice. Many operating systems will need to upload the new form(s) in their systems.

   Response: CMS added updated CMN and DIF forms during the quarterly update on April 1, 2018, to allow for MBIs. Instead of "HICN," these templates now have "Medicare number" on them. The use coincides with the MBI transition period, which concludes on December 31, 2019. There is no need to submit revised DIFs/CMNs based on when beneficiaries receive their new Medicare cards with the MBI on them.

10. In instances when an ABN is required but not obtained prior to service because there was no indication or notice that the beneficiary applied for SSDI and later becomes retroactively covered by Medicare, how should claims be filed? Is there any exception in these situations so that the supplier isn't held liable for these instances that are beyond their control.

    Response: The Claims Processing Manual, Chapter 1, Section 70 provides guidance to the DME MACs for the adjudication of claims beyond the timely filing limitations with documentation of retroactive entitlement. However, per current Medicare guidelines, no contractor can retroactively apply an ABN.

OTHER:

11. Please provide further clarification on the Reinstating the Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System from CR9911 that is supposed to be resolved by July 2018.

    Response: On October 2, 2017, the Centers for Medicare & Medicaid Services (CMS) implemented CR9911, which incorporates claims processing system modifications to generate Qualified Medicare Beneficiary (QMB) information in Remittance Advices (RAs)

and Medicare Summary Notices. For claims received October 2, 2017, through December 8, 2017, RAs lacked the formatting and specificity that states require to process QMB cost-sharing claims. As a result, CMS temporarily suspended CR9911 claims processing system modifications.

Under CR10494, MACs will initiate a non-monetary adjustment for claims impacted by CR9911 QMB RA changes. The DME MACs will begin reprocessing affected claims in April 2018, and will finish the adjustments by September 2018. Claims will be adjusted in the order in which they were initially received. You will receive a new RA (and beneficiaries will receive a new MSN) as a result of any of your claims which are adjusted. You do NOT need to contact Customer Service regarding these claims.

CEDI:

No Questions Submitted