Jurisdiction B, C and D Combined Council Questions

Sorted by A-Team
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Enteral/Parenteral/IV Therapy

1. **We would like clarification on how to complete a Total Parenteral Nutrition (TPN) or Enteral Nutrition (ENT) DME Information Form (DIF) when initially the beneficiary did not qualify under the LCD criteria, then later meets the coverage criteria. Scenario:**
   - **We completed the DIF with the answer "No" to question number 1 (ENT) or question number 7 (TPN) regarding; "Is there documentation in the medical record that supports the patient having permanent non-function/disease"**
   - **We understand this puts the DIF in a non-payable status and claims will deny as "not medically necessary'**
   - **Later the documentation to support the coverage criteria is obtained and the patient now qualifies**
   - **We understand we would complete a New Initial DIF for the date the patient meets coverage criteria and answer "Yes" to either question number 1 or question number 7 to now have a payable DIF on file to start the payable monthly pump cycles and payment for TPN/ENT therapy.**
   - **The explanation given was a non-payable DIF cannot be revised for a payable status.**
   - **Recently however, we were advised to complete the DIF as revised versus an initial and change the answer to question number 1 and/or 7.**

   Response: If the answer to question number 1 or question number 7 on the DIF is "No", then this will generate a statutory denial, not a medical necessity denial (i.e., does not meet the prosthetic benefit). If the beneficiary's condition changes and the coverage requirements are met you should submit an initial DIF.

2. **We would like clarification on how to complete a TPN/ENT DIF in the situation where a patient initially meets coverage criteria and length of need, DIF is completed appropriately, and is on file in a payable status; however, later the patient's condition changes and they no longer meet coverage criteria per the Local Coverage Determination (LCD).**

   Response: The answer assumes that the statement "…later the patient's condition changes where they no longer meet coverage criteria per the LCD" means that the patient no longer meets the requirements for the prosthetic benefit. In the scenario provided it would be appropriate to submit a

Revised DIF and if the answers to question number 1 or question number 7 on the DIF are "No", based upon the beneficiary's medical records, this will generate a statutory denial.

3. **We are seeking clarification regarding conflicting information on pump coverage for subcutaneous immune globulin. Section V.H. of the current External Infusion Pump (EIP) LCD states, "Only an E0779 infusion pump is covered for the administration of subcutaneous immune globulin. If a different pump is used, it will be denied as not reasonable and necessary."**

   The Joint Publication detailing the coverage criteria for subcutaneous HyQvia states:

   - **The criteria for Subcutaneous Immune Globulin as specified in the EIP LCD are met, and**
   - **HyQvia is administered subcutaneously through an E0781 pump that is pre-programmed, and**
   - **The E0781 pump is delivered to the Medicare beneficiary in a "locked mode" i.e., the patient is unable to self-adjust the infusion rate.**

   We request the HyQvia coverage criteria detailed in the 7/30/2015 DME MAC Joint Publication be added to the EIP LCD and the language regarding pump coverage to be modified so as to not conflict.

   Response: The External Infusion Pump LCD is currently in the process of being revised to clarify the pump coverage for HyQvia.

Prosthetics/Orthotics

4. **Recently there have been some issues as to how the LCD for Knee Orthotics (including code L1833) has been interpreted. It appears that there are two sets of criteria:**
   1. **Patient qualifies by having surgery and being ambulatory;**
   2. **Patient qualifies by having instability in the knee joint**

   Can you please affirm that there are two clearly separate criterion in which a patient can qualify for a covered knee orthotic?

   Response: Yes, you are correct. For L1833 the LCD describes two separate criteria.

5. **We have seen a recent increase in claim denials as a result of invalid proof of delivery documentation. While we understand that for pre-fabricated items or pre-manufactured components of a device that the best practice is to include a model number, brand name, or serial number on the proof of delivery, there is tremendous confusion regarding how to provide a compliant narrative description of custom fabricated items. We have asked for specific guidance on this issue and have repeatedly been told that. "We cannot tell you what to write as a narrative." When, if ever, will the DME MACs be able to provide additional guidance on what specific criteria is needed in order for a narrative description to be considered compliant as part of the proof of delivery documentation.**

   Response: The DMDs are currently discussing this question and it remains under review.

6. **The current knee orthosis LCD states the following:**

   "A knee immobilizer without joints (L1830), or knee orthosis with adjustable knee joints (L1832, L1833), or a knee orthosis, with an adjustable flexion and extension joint that provides both medial-lateral and rotation control (K0901, K0902, L1843, L1845), are covered if the beneficiary has had recent injury to or a surgical procedure on the knee(s). Refer to the diagnoses listed in the ICD-9 Diagnosis Codes That Support Medical Necessity Groups 2 or 4 section as applicable."

   The LCD continues with the following statement:

   "Knee orthoses K0901, K0902, L1832, L1833, L1843, and L1845 are also covered for a beneficiary who is ambulatory and has knee instability due to a condition specified in the ICD-9 Diagnosis Codes That Support Medical Necessity Group 4 section."

   Finally, the LCD discusses ways to document the presence of joint laxity with the following statement:

   "For codes K0901, K0902, L1832, L1833, L1843, L1845, and L1850, knee instability must be documented by examination of the beneficiary and objective description of joint laxity (e.g., varus/valgus instability, anterior/posterior Drawer test).

   Is it a correct assumption that if a knee orthosis is covered as a result of the first statement in the LCD (recent injury to or surgical procedure on the knee) that there is no requirement to document joint laxity?

   Response: Yes, see response to #4.

   Also, in situations involving a diagnosis of osteoarthritis, there may be established medical need to use an "unloader" brace described by codes K0901, K0902, L1843, L1844, L1845, or L1846 to open the medial or lateral compartment of the knee to provide pain relief. This may or may not manifest with inherent knee instability or joint laxity. Is the objective documentation of joint laxity a requirement of coverage in these circumstances?

   Response: Yes.

7. **While HCPCS codes and descriptors are no longer acceptable by themselves on proof of delivery documentation, they have always been acceptable on detailed written orders. The policy language in the question below was pointed out to one of our team members and reads very close to what is required for proof of delivery. We would like the DME MACs to confirm that HCPCS and descriptors remain valid for detailed written order purposes.**

   Response: The *Medicare Program Integrity Manual,* Chapter 5, Section 5.2.3 states: "The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number." A HCPCS code or HCPCS narrative description is acceptable as the narrative description on the order for the

item. If the item falls under a NOC code, the HCPCS code or narrative description is not acceptable; information to identify that specific product is required.

Rehab Equipment

8. **Some beneficiaries do not have a qualifying diagnosis per the LCD, but may still have a well-documented medical necessity for a skin protection and/or positioning wheelchair cushion. Please explain what the options are for applying individual consideration to qualify for an item that is outside the guidelines of an LCD. Can the DME MACs provide individual consideration at the first level of appeal? Can the Qualified Independent Contractor (QIC)?**

   Response: The appeals process is the correct avenue to request individual consideration where an item does not meet the diagnosis requirement as listed in the LCD. In addition, suppliers may request an LCD reconsideration to have a diagnosis code added.

9. **There is a new HCPCS code E1012 for power center mount elevating legrest/platform. When can we expect to see this code added to the Wheelchair Options LCD?**

   Response: HCPCS code E1012 became valid on January 1, 2016. CMS requires that the Medicare contractors update any new HCPCS code-impacted policies within 120 days of the code effective date.

10. **There is still a lot of confusion regarding counting power functions when determining what base wheelchair code is valid. Do power legrests (E1010 or E1012) count as power functions when coding a base? What about non-covered power functions – power seat elevator and power standing? These did not "count" when the PMD policy was issued in 2006, but there seems to be conflicting decisions being made at times in the PMD PAR demo and with ADMC.**

    Response: If a power wheelchair has an electrical connection device described by code E2310 (electronic connection between wheelchair controller and one power seating system motor) or E2311 (electronic connection between wheelchair controller and two or more power seating system motors) and if the sole function of the connection is for a power seat elevation or power power standing feature, it will be denied as non-covered. The power legrest/power center mount foot platform can be used to determine the need for E2311 versus the E2310.

    Non-expandable controllers can control up to two power seating actuators through the drive control. To meet the coverage criteria for the expandable controller, including all related electronics and mounting hardware (E2377) and the harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware (E2313) the initial issue must include three or more covered power seating systems (which includes power legrests) or an alternative drive control interface. You may refer to the Joint DME MAC publication article "*Power Wheelchair Electronics Clarification*," published in 2010.

11. **What changes, if any, affect the use of the KE, KY and KEKY modifiers for 2016, with the new fee schedule that incorporates expanded bid pricing?**

    Response: The 2016 adjusted fee schedule for non-competitive bidding areas and rural areas does not change how claims should be submitted to the DME MACs and the modifiers required.