Jurisdiction B, C and D Combined Council Questions

Sorted by A-Team
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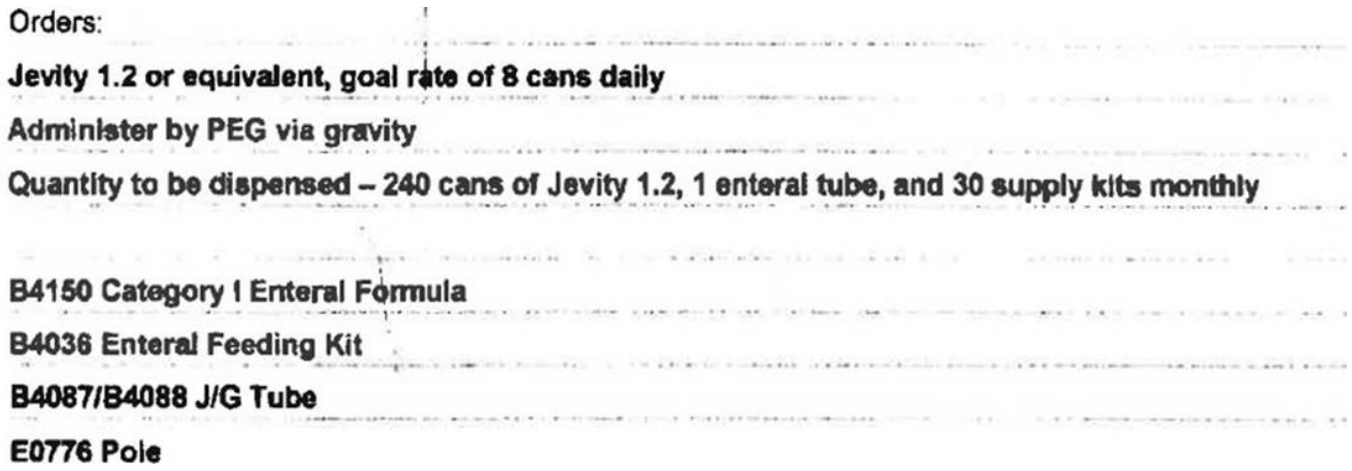
Enteral/Parenteral/IV Therapy

1. **The new External Infusion Policy (EIP) policy article provides clarification on the E0781 pump for subcutaneous infusion of HyQvia; however, it doesn't reference coverage for the first three ramp-up doses. Has coverage for the ramp-up dosing changed from the latest guidance that was provided in the Joint Publication on 7/30/15?"**

   Response: The guidance on HyQvia has not changed since the joint publication in July 2015.

2. **Does an enteral nutrition detailed written order (DWO) have to specify both the number of calories to administer per day and the quantity to be dispensed monthly in order to satisfy documentation requirements?**


Orders:
Jevity 1.2 or equivalent, goal rate of 8 cans daily
Administer by PEG via gravity
Quantity to be dispensed – 240 cans of Jevity 1.2, 1 enteral tube, and 30 supply kits monthly

B4150 Category I Enteral Formula
B4036 Enteral Feeding Kit
B4087/B4088 J/G Tube
E0776 Pole

   Response: Enteral detailed written orders must meet the standard documentation language for detailed written orders outlined in the LCD. Per the LCD:

   DETAILED WRITTEN ORDERS (PIM 5.2.3)

A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Physician's name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Physician signature and signature date

For items provided on a periodic basis, including drugs, the written order must include:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills

For the “Date of the order” described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

Frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed. Reimbursement shall be based on the specific utilization amount only. Orders that only state “PRN” or “as needed” utilization estimates for replacement frequency, use, or consumption are not acceptable. (PIM 5.9)

The detailed description in the written order may be either a narrative description or a brand name/model number.

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The DWO must be available upon request.

Prosthetics/Orthotics

3. If a patient has been diagnosed with a Charcot condition and also has diabetes, is it a correct assumption that a Charcot Restraint Orthotic Walker (CROW) orthosis described by L4631 remains eligible for Medicare coverage as long as the primary diagnosis is one of the ICD-10 codes that are indicated in policy as eligible for coverage?

Response: The Ankle-Foot/Knee-Ankle-Foot Orthosis Local Coverage Determination L33686 states that a Medicare beneficiary must have a weakness or deformity of the foot or ankle that requires stabilization for medical reasons and has the potential to benefit functionally can be considered for the L4631. ICD-10 diagnoses are listed in LCD L33686 under “Group 2 Paragraph: For HCPCS L4631.” In the example noted above, the L4631 would be considered for coverage per the LCD.

4. **Is it correct to assume that the diagnosis code of E11.610 = Type 2 diabetes mellitus with diabetic neuropathic arthropathy does <u>not</u> allow for coverage of a Charcot Restraint Orthotic Walker (CROW) orthosis, described by HCPCS L4631, since that ICD-10 code is not included in the policy?**

   Response: Please see the response provided in the preceding question. In the example noted above, the L4631 would not be considered for coverage per the LCD.

Rehab Equipment

5. **What are the correct pricing modifiers (KE/KY) for the follow scenarios and the correct fee schedule for each scenario assuming all other modifiers are appropriately appended? Are there changes now or coming in the future (7/1/2016) to these modifier scenarios?**

   Beneficiary does NOT reside in a CBA:

   - **Mobility accessories (i.e., E0973) used in conjunction with a non-bid base (K0005, E1161);**
     - This accessory was bid in Round 1 and Round 2. In this scenario append the KE modifier and the accessory will be paid at fee schedule.
   - **Mobility accessories (i.e., E0973) used in conjunction with a non-bid base Group 2 power wheelchair (K0835-K0843)**
     - This accessory was bid in Round 1 and Round 2. In this scenario a modifier is not required and the accessory will be paid at the fee schedule.
   - **Mobility accessories (i.e., E0973) used in conjunction with a non-bid base Group 3 power wheelchair (K0848-K0864)**
     - This accessory was bid in Round 1 and Round 2. In this scenario a modifier is not required and the accessory will be paid at the fee schedule.

   Beneficiary does reside in a CBA:

   - **Mobility accessories (i.e., E0973) used in conjunction with a non-bid base (K0005, E1161);**
     - This accessory was bid in Round 1 and Round 2. In this scenario you must append both the KE and KY modifiers and the accessory will be paid at the fee schedule.
   - **Mobility accessories (i.e., E0973) used in conjunction with a non-bid base Group 2 power wheelchair (K0835-K0843)**
     - This accessory was bid in Round 1 and Round 2. In this scenario you must append the KY modifier and the accessory will be paid at fee schedule
   - **Mobility accessories (i.e., E0973) used in conjunction with a non-bid base Group 3 power wheelchair (K0848-K0864)**
     - This accessory was bid in Round 1 and Round 2. In this scenario you must append the KY modifier and the accessory will be paid at the fee schedule.

Response: Proper uses of the pricing modifiers (KE/KY) are detailed in the Medicare Learning Network Matters Article MM8864 and are also included in the DME MAC supplier manuals.

The DME MACs are unaware of any upcoming changes from CMS related to the use of these modifiers.

6. **Congress exempted wheelchair options used on Group 3 Power Wheelchairs from the reduced bid-related regional pricing for one year. CMS posted that correct fee schedules would not be available until 7/1/2016; until then, submitted claims will pay at the reduced regional allowables.**

    a. **How are the DME MACs identifying these adjustments and how will the adjustments be processed come 7/1/2016? Will there be an option for mass adjustments vs. resubmission of single claims lines?**
    b. **Will this pricing adjustment also include repair/replacement parts billed with the "RB" modifier for Group 3 bases?**
    c. **CMS also instructed in their announcement (https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html) that suppliers who are largely impacted by the underpayments would be afforded the option to seek "advanced payment" in writing through the MACs. In qualified cases, payments could be issued no more frequently than every two weeks (https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-sec421-214.pdf), but we have not seen any follow-up education on this concept. Please provide guidance on what this process looks like and how eligibility is determined.**

Response: CMS has not provided the DME MACs with additional information at this time. Suppliers should watch the DME MAC Listservs for notifications when they become available.

7. **We were pleased to see the rescission of the announcement that directed footboxes to be coded as E0995. As you work through your additional review of the topic, may the Councils offer education on the differences between calf pads and footboxes and the different types of footboxes that are available?**

Response: Thank you for the offer; however, the Medical Directors are working with several manufacturers to obtain additional product information. A revised article on footboxes will be forthcoming.

8. **Replacement parts used in conjunction with non-bid base items, and billed with modifiers KE/KY/RB modifiers continue to be paid incorrectly at the single payment amount (SPA) rather than the full allowable. Is there an update from CMS on when these will be fixed? We have been improperly paid since Round 2 started on 07/01/2013.**

Response: At this time the DME MACs are paying claims as instructed by CMS. The DME MACs have received no further instructions from CMS.

9. **We have been seeing denials for the new center mount foot platform code (E1012) when submitted as a purchase on a K0835-K0864. The denial code is listed as CO-108; rent/purchase guidelines were not met. When a provider called Medicare to ask why, they were told "this code is a capped rental and it doesn't have the first month purchase option". CR9431 provided an update to CR8566 stating that "Code E1012 is eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair, effective January 1, 2016". What is the best way to get this issue resolved?**

   Response: This was a system issue in early 2016 (the E1012 was omitted from a pricing table). CMS has resolved the problem and claim lines should be paying correctly now. Suppliers having claims with the E1012 that denied based on the system issue can contact their DME MAC Reopenings department for claim adjustment.

10. **In 2008, the four DME MACs published a Frequently Asked Questions (FAQ) document regarding PMDs and Supplier ATP involvement that was revised in 2009 and 2011, and Question 17 reads:**

    If the sATP participated in the evaluation by means of a live video feed, would that be acceptable?

    Yes. Involvement of the sATP in the evaluation of the patient by means of a live video feed is acceptable for beneficiaries who reside in remote locations as long as the evaluation is conducted in accordance with the Telehealth requirements outlined in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 270.

    Is this answer still valid and acceptable in all 4 DME MAC Jurisdictions?

    Response: Yes.

Respiratory Care Equipment/Oxygen/PAP/Other

11. **If a supplier has all required elements in the Written Order Prior to Delivery (WOPD), with a non-specific-modality order for "portability" for the portable oxygen system:**

    a. **Does the order have to be specific to compressed gas, portable concentrator, etc. or will "portability" suffice?**
    b. **If the physician documents via an attestation statement that their standard protocol for ordering portability shall be compressed gas portables unless otherwise specified, would Medicare accept the attestation in lieu of a modified order?**

Response: See response to Question 2 above for information about what is required for a detailed written order. Generally speaking, detailed written orders must contain a detailed description of the item ordered. Simply stating "portability" is not specific and a general blanket attestation for all patients is not acceptable.

12. We are seeing a CO-234 denial code when providing disposable and non-disposable nebulizer kits. In Jurisdiction C, when calling about these denials, we are being referred to CR9345; however we have been unable to locate any such Change Request. Where can we access this CR, and what guidance does this provide to explain this denial?

Response: The CO-234 denials are the result of CMS-mandated "same or similar" edits.

13. Patients living at higher altitudes may not be able to secure testing in a facility at a comparable altitude which would render different results compared to their home setting.

a. Will Medical Review consider payment of oxygen therapy for a beneficiary that demonstrates significant desaturation at high altitudes?

Response: Altitude is not a factor for determining oxygen qualification. Oxygen qualification requires that the qualifying testing be done in compliance with the LCD testing requirements by a qualified lab.

b. Would Medical Review accept any other testing in the home to justify portable oxygen beyond an overnight oximetry which would preclude portable oxygen?

Response: Testing in the home setting can be done at rest, with exercise or with overnight oximetry. Specific rules related to each type of test are detailed in the Oxygen LCD. There is NO extra or special testing required for coverage of portable oxygen beyond the overall oxygen testing requirements. From the Oxygen LCD:

PORTABLE OXYGEN SYSTEMS:
A portable oxygen system is covered if the beneficiary is mobile within the home and the qualifying blood gas study was performed while at rest (awake) or during exercise. If the only qualifying blood gas study was performed during sleep, portable oxygen will be denied as not reasonable and necessary.

c. Would the provider have to request individual consideration for these cases and what documentation would be expected?

Response: Neither question appears to describe a scenario that requires special consideration. Individual consideration is available for any LCD-based requirement that resulted in a claim denial. Such consideration is available at the Redetermination level. There must be sufficient detailed information in the medical record to explain and justify the need for waiving the policy requirements.

Medical Supplies/Ostomy/Urological

14. Per policy, surgical dressings are covered for as long as they are medically necessary. Dressings over a percutaneous catheter or tube (e.g., intravascular, epidural, nephrostomy, etc.) are covered as long as the catheter or tube remains in place and after removal until the wound heals (per the coding guidelines in the associated Policy Article).

a. What is the documentation requirement for dressings used in this manner?
b. Since the tube is in for longer durations, and is quite different than traditional wound care protocols, is it still necessary for monthly evaluations and new orders every three months?

Response: The medical record must demonstrate the presence of a qualifying tube, based on medical necessity and benefit category. Note that not all catheters and tubes qualify for separate payment of surgical dressings. In some cases (enteral, infusion, for example) dressings are included in catheter maintenance allowances and are not separately billable.

15. Is it acceptable for USPS to ship supplies to a PO Box if they have a ship date and a delivery date? All other requirements are met including name, contents of package, etc. In some instances, we've been told that it must be a physical address and in other cases it was stated that a PO Box is considered valid if they have a city, state, and zip code as well as all the information on what was shipped.

Response: Yes, a PO Box may be used for deliveries as long as all of the proof of delivery requirements for Method 2 are met.

16. We frequently have orders for PAP machines orders that list specific accessories and supplies along with quantity and frequency of use. They commonly have a designation for "lifetime length of need", but no separate indication for "number of refills". We have received education that lifetime length of need on the detailed written order is sufficient for the supplies as long as quantity and frequency are stipulated.

a. Can we confirm that all four DME MACs educate according to the above direction?

Response: Jurisdictions B, C and D would consider these orders sufficient. Suppliers should verify with state regulations as well, to verify compliance with state requirements.

Documentation/Education/Miscellaneous

17. With the effective date of the new Prior Authorization rule being 2/29/2016, can you offer a status update on the implementation of the program?

Response: CMS has not provided the DME MACs with any additional information at this time. Suppliers are urges to watch the DME MAC ListServs for updates and notifications.

18. It has always been our understanding that reopenings are at the discretion of the MACs and they aren't always aligned with what they will reopen. With the effective date of the new Prior

Authorization rule being 2/29/2016, can you offer a status update on the implementation of the program?

a. **Would each DME MAC provide a list of denial codes that they would allow to be reopened?**
b. **Do each of the DME MACs permit reopening of related service dates after an unfavorable audit determination is reversed on a single claim?**

Response: Reopenings are available for clerical errors only and each Jurisdiction has been given the ability by CMS to use their own discretion in granting a reopening. Contact your DME MAC for additional information.

19. From a CEDI perspective, will suppliers have to make any changes related to Jurisdiction A or Jurisdiction B claim transactions to ensure that claims continue to be processed and delivered to the appropriate contractor post transition?

CEDI Response: CEDI response: Today and after the transitions, the DME MAC contractor code submitted on inbound claims files (837 and NCPDP) only has to be one of the four valid DME MAC contractor codes. CEDI will perform front end editing and determine which DME MAC Jurisdiction will receive the claim based on the beneficiary state code submitted on the claim in the beneficiaries address. CEDI will apply the correct DME MAC contractor code for the destination of the file.

For example, today a file can be submitted to CEDI with two claims and one of the valid DME MAC codes. One has a beneficiary address with the state code “ME” and the other is “CA”. Both claims pass the CEDI front end edits. The claim for beneficiary who resides in Maine will be put into a file with the contractor code 16003 and delivered to NHIC. The claim for the beneficiary who resides in California will be put into a file with the contractor code 19003 and delivered to Noridian.

For inbound claims transactions (837 and NCPDP), suppliers will need to coordinate with their Software Vendor to make changes to ensure the old contractor codes (16003 for JA and 17003 for JB) are no longer submitted.

For inbound 276 Claim Status Request transactions, files must be submitted with the contractor code FOR THE JURISDICTION WHERE THE CLAIM IS BEING PROCESSED. The 276 does not have beneficiary address fields so CEDI must rely on the contractor code submitted to determine where the 276 request will go.

Suppliers will need to coordinate with their Software Vendors to make changes to ensure the old contractor codes (16003 for JA and 17003 for JB) are no longer submitted for 276 Claim Status Requests transactions.

CEDI will notify PCAce users when the updated version of the software is available with the new JA and JB contractor codes. We will include instructions and helpful hints for a smoother upgrade.

Inbound files (837, NCPDP and 276) will be accepted by CEDI up until 3:00 pm on June 30, 2016 with the current contractor codes for JA (16003) and JB (17003).

CEDI will then apply the necessary changes for the transition and when we re-open the CEDI Gateway, the only valid codes that will be accepted are 16013 (JA), 17013 (JB), 18003 (JC) and 19003 (JD).

NHIC and NGS will run their last cycles as a DME MAC on June 30, 2016 and produce the outbound files that CEDI will return to our Trading Partners via our CEDI Gateway. This includes the RPT files, 835s and 277s. These will have the current DME MAC codes (16003 for JA and 17003 for JB).

The transition changes will then be applied to the DME MACs and the next cycles will produce outbound files for CEDI with the new codes for JA and JB and the current codes that are not changing for JC and JD.

20. Will providers continue to use the same payer IDs in claim transactions for the existing DME MACs (JA = 16003, JB = 17003, JC = 18003, and JD = 19003) From a CEDI perspective, will suppliers have to make any changes related to Jurisdiction A or Jurisdiction B claim transactions to ensure that claims continue to be processed and delivered to the appropriate contractor post transition?

Response: The only valid codes that will be accepted are 16013 (JA), 17013 (JB), 18003 (JC) and 19003 (JD).

21. Currently each Jurisdiction requires separate enrollment for CSI/VPIQ access. Regarding the upcoming MAC transitions, will existing CSI/VPIQ enrollments JA/JB remain intact without separate enrollment for same and similar inquiries that are performed through third party applications?

Response: CGS and Noridian plan to keep current enrollments intact for Jurisdiction A and B CSI/VPIC inquires.

22. If a supplier already operates in multiple jurisdictions and has access to JC or JD CSI systems, will the CMN data migrate from JA and JB and aggregate with JC and JD data to permit a single query that will return data on file from both jurisdictions (A/D and B/C), or will these inquiries still have to be performed individually to check Jurisdiction B CMN data separate from Jurisdiction C, and Jurisdiction A CMNs separate from Jurisdiction D?

Response: CMN data from one jurisdiction will NOT migrate and aggregate with CMN information in another jurisdiction. The processing systems will remain separate while being administered by one contractor which will be Noridian or CGS, respectively.