Jurisdiction B, C and D Combined Council Questions

Sorted by A-Team
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Enteral/Parenteral/IV Therapy

1. **Medicare states that when we use a shipping service to deliver, the shipping date must be used as the date of service. It is also required that the date of service not precede the start date on the detailed written order (DWO). When a physician specifies a start date on the dispensing order, we are required to use the physician specified start date as the start date on the DWO. In order to stay compliant with Medicare requirements, we are unable to ship enteral formula prior to the start date, even though it sometimes takes 2-3 days between shipment and patient receipt of delivery. We believe that this creates an unnecessary hardship for the supplier community, and may jeopardize a patient's ability to receive their enteral formula in time to start administering on the physician specified start date. Can you provide guidance on how we can ship soon enough to ensure that the patient receives the enteral formula by the start date, while also staying compliant with Medicare rules so that we can receive payment? (C)**

   Response: The date on the DWO is the date the supplier received the dispensing order from the physician (for verbal dispensing orders) or the order date indicated on the written dispensing order. It is not correct to use the "start date" listed on the dispensing order as the date of the written order. The supplier may deliver the item, based on the dispensing order (assuming it is not an item that requires a written order prior to delivery) prior to the start date indicated on the dispensing order; however, the beneficiary should be instructed not to begin using the item until the physician-indicated start date.

2. **Often times a hospitalist will provide a dispensing order for enteral nutrition. However, when approached to sign the DWO the hospitalist refuses to sign, as they are not following the patient for the length of time the patient will require the enteral nutrition therapy. Can suppliers have a dispensing order from the hospitalist and a corresponding DWO from the patient's primary care physician for the initial treatment? If this is acceptable, which National Provider Identifier (NPI) would be reported on the DME Information Form (DIF) and subsequently billed on the claim?**

   Response: The primary care physician may write the DWO. The NPI reported on the Medicare claim and DIF should be the primary care physician's NPI.

3. **The question has been previously asked if suppliers will need to submit a revised DIF and/or Certificate of Medical Necessity (CMN) with the ICD-10 codes on existing patients where there is already a payable DIF or CMN on file with an ICD-9 code for any dates of service on or after 10/1/05. The previous response was that the DME MACs were still awaiting guidance from CMS; can you confirm that you have received this guidance? Will CMN/DIF validity be enforced or driven by the latest of the initial, revision or recertification date and the diagnosis set that corresponds to the set in effect for that same time?**

   There have been various publications or FAQs which speak to the question, however the wording is not clear and consistent – please see below:

   - **Jurisdiction B – "The revised version of the CMN/DIF forms must be used on all claims for services provided on or after 10/1/2015."**
   - **Jurisdiction C – "New CMNs completed on or after 10/1/2015 will require the use of ICD-10 codes in the diagnosis field."**
   - **Jurisdiction D – "Medicare is not requiring that all CMNs or DIFs on file have the ICD-9 cross walked to an ICD-10 code. The CMN or DIF will stay on file as originally submitted."**

   Response: CMS is not requiring suppliers to submit updated CMNs or DIFs for claims submitted on or after the ICD-10 implementation date of 10/1/2015; however, these claims must contain a valid ICD-10 diagnosis code. CMNs and DIFs created after the transition to ICD-10 must use ICD-10 codes. Suppliers should ensure that the diagnosis code(s) billed on the claim are supported by documentation in the medical record. The URL for the document published by CMS can be found at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ICD-10BillingandPaymentFAQs.pdf

4. **Quantity to be dispensed: There has been an increase in enteral prepayment audit denials related to missing information on the Detailed Written Orders (DWO), specifically the Quantity to be dispensed per Fill.**

   As a community of suppliers who have gone through many prepayment reviews, audits, appeals, etc. over the years this has never before been an issue with DWOs, and we have never included a specific quantity per fill on our DWOs. The DWOs identify a quantity per day (either number of cans or number of calories); this has been acceptable and the claim reviewers made the appropriate calculations based on the date span that was billed.

   We have been advised that if we have multiple shipments in a 30 day period that equal the quantity on the DWO that would be acceptable. In the instances where our claim quantity is less than the quantity on our DWOs will the supplier be required to obtain a new DWO in these cases and have to provide a Revised DIF with the claims – and then be required to provide another Revised DIF once the patient returns to the monthly schedule?

   Does the quantity to be dispensed per fill requirement apply to all DMEPOS items, or is it specific to Enteral?

Will there be a limit on the "look back" period? As previously mentioned, this seems to only recently have become an issue and as such suppliers have not been obtaining DWOs with the per fill quantity; can there be a date set to say "anything prior to this date (xx/xx/xx) the more strict interpretation will not apply"? And finally, can we expect any supplier education that specifically addresses this issue so we may do our part in reducing the claim error rate? (C)

Response: Quantity to be dispensed has been an element of a DWO for many years. The fact that the DME MACs recently began to enforce the requirement is irrelevant and not subject to a limited "look back" period or grace period. Quantity to be dispensed is not a requirement unique to enteral nutrition and applies to any item, particularly products that are refilled on a periodic basis.

Multiple shipments in a 30-day period that equals the quantity on the DWO are acceptable. If based on monitored usage, the amount of product consumed is less than the DWO, the supplier can adjust their shipping/refill timing or obtain a new DWO to reflect the new utilization quantities if this is expected to be an ongoing pattern.

5. **DME Information Forms (DIFs) Usage for Enteral and Parenteral Nutrition and External Infusion Pumps: In reference June 11, 2015 REVISED LCD policy article on DME Information Forms (DIFs) Usage for Enteral and Parenteral Nutrition and External Infusion Pumps.**

   We understand that a NEW Initial DIF is also appropriate for TPN and EIP if there has in fact been a BIN/BIS with patient being off the therapy for a period of 60 days or greater, and then their condition changes to warrant restarting the therapy again, along with the documentation of the medical condition being justified. However it only refers to Enteral formula and pump and there is no mention for TPN or EIP.

   We would like to see in the instruction included for a New Initial DIF for TPN and EIP when there has been a 60 day or greater break in service due to a break in need (C).

   Response: The DME MACs appreciate the suggestion.

Education

6. **The DME MAC CMN and DIF forms attached to LCDs reflect a form revision date of 11/11 at the bottom of the forms. The updated forms reflect a generalization of diagnosis references, removing the ICD-9 specific terminology to make way for universal use for ICD-9 or ICD-10 diagnoses. Can you provide the specific CMS transmittal where these forms were launched? What is the effective date for use of these new forms, when will the old forms be discontinued? How has CMS directed the MACs to enforce the implementation of these newer versions? (C)**

   Response: The DME MACs published an article in June 2015 with information about the new CMNs/DIFs and the implementation date. The new forms are for use on or after 10/1/2015 and are available on the CMS web site.

No questions submitted.

Home Medical Equipment

7. **For temporary loaner equipment (K0462) that is provided in a competitive bidding area (CBA), will payment amounts be based on the single payment amount (SPA) or the fee schedule amount for the equipment being repaired? (C)**

   Response: Per CMS, reimbursement is based on one KH rental month of either the loaner equipment or the beneficiary-owned equipment, whichever is less. For loaner equipment (K0462) provided in a CBA, these are individually priced at the competitively SPA for the item being repaired.

8. **The Group 2 future LCD lists the acceptable ICD-10 codes which are much more specific than that prior ICD-9 code set. The ICD-10 equivalents include a staging of ulcers. How will suppliers be expected to report diagnoses for these products? Will the diagnosis at onset of the equipment order be permitted to follow the claims without modification until the ulcer heals, or will suppliers be expected to update the stage of the ulcer every month? (C)**

   Response: There is no change in the way suppliers report diagnosis with the implementation of ICD-10 (other than using and ICD-10 code). The DME MAC policy does not "reverse stage" meaning the beneficiary is able to remain on the Group 2 support surface, once qualifying coverage conditions have been met, until the ulcer is healed. The supplier should continue to report on the claim the ICD-10 code that was appropriate at the time the initial claim was submitted.

Oxygen/PAP/Other Respiratory Care Equipment

9. **There have been several recent discussions of denials for oxygen prescribed for patients coming out of the hospital with a diagnosis of pneumonia. The reasoning is that pneumonia is an acute condition, so the patient is not in a chronic stable state (CSS). It is our understanding that the in-patient discharge from the hospital is the exception to the CSS rule. If a patient has a diagnosis of pneumonia and the physician has ordered discharge from the hospital with oxygen, will this qualify the patient under the oxygen policy? According to the oxygen LCD:**

   Home oxygen therapy is reasonable and necessary only if all of the following conditions are met:

   1. **The treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and**
   2. **The beneficiary's blood gas study meets the criteria stated below, and**
   3. **The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services, and**
   4. **The qualifying blood gas study was obtained under the following conditions:**
      - **a. If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than two days prior to the hospital discharge date, or**

b. If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the beneficiary is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease, and

5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

****Criterion 1 notes a severe lung disease or hypoxia related symptoms that are expected to improve with oxygen therapy. Pneumonia would fall under the second clause in this requirement. Criterion 4 also differentiates the two types of testing: within two days prior to discharge from an inpatient facility or an outpatient in the CSS.**

The Dear Physician letter regarding oxygen testing appears to support that these are two separate criteria.

Chronic Stable State:

All qualification testing must be performed while the beneficiary is in the CSS. CSS requires that all of the following be met:

- **Other forms of treatment (e.g., medical and physical therapy directed at secretions, bronchospasm and infection) have been tried, have not been sufficiently successful, and oxygen therapy is still required.**
- **Each patient must receive optimum therapy before long-term home oxygen therapy is ordered.**
- **It is expected that virtually all patients who qualify for home oxygen coverage for the first time under these guidelines have recently been discharged from a hospital where they submitted to arterial blood gas tests. If more than one arterial blood gas test is performed during the patient's hospital stay, the test result obtained closest to, but no earlier than two days prior to the hospital discharge date, is required as evidence of the need for home oxygen therapy. (Note: this is the only exception to the CSS requirement.)**
- **For those patients whose initial oxygen prescription did not originate during a hospital stay, blood gas studies should be done while the patient is in the chronic stable state (i.e., not during a period of an acute illness or an exacerbation of their underlying disease).**

**** This statement clearly differentiates the two types of studies, noting the inpatient testing is an exception to the CSS requirement, and patients whose initial prescription did not originate as an inpatient would require testing in a CSS.**

Response: The foundation of Medicare coverage for home oxygen is that the beneficiary must have a chronic lung condition. Therefore, we would not cover home oxygen for someone who needed short-term support strictly due to an acute illness such as pneumonia. However, coverage is available for a beneficiary with an acute exacerbation of a chronic condition IF the qualifying test is done on an inpatient basis within two days of discharge and is the last test prior to discharge. In this situation, coverage is not dependent on the medical records indicating that the acute component has been resolved.

10. **If the face to face (F2F) prior to the sleep study becomes too old, can we get another <u>after</u> the sleep study but before we provide service, and must we provide documentation**

of both F2F examinations in this scenario and can the second F2F serve as the F2F for the PAP/RAD under the Affordable Care Act (ACA)?

For example, we had a patient have his F2F in October. Due to the sleep lab average scheduling out 4-5 months for sleep studies, he didn't have his sleep test until April (just within the 6-months). The secondary insurance required a prior authorization, which took it into May. Now the F2F in October is too old. So, the patient is going to see his PCP in June, if the doctor writes up a new F2F and WOPD in the second visit, would Medicare accept this documentation? Or does the sequence have to be F2F, sleep study, WOPD and delivery all within six months? (B)

Response: In order to meet LCD requirements for PAP the beneficiary has to have a clinical evaluation prior to the sleep study. In order to meet ACA requirements they have to have a F2F within 6-months of the writing of the WOPD. The clinical evaluation prior to the sleep study can meet the F2F requirement for ACA, but if for some reason that visit occurs more than 6-months prior to the WOPD being written the beneficiary could go back to the doctor for another F2F to meet the ACA requirement but a new sleep test would not be required.

11. **We have several sleep physicians that have their own Detailed Written Order forms that list the PAP equipment they are prescribing (E0601 or E0470 or E0471) and all available supplies. Most of the sleep physicians are ordering both a Full Face Mask & Nasal Mask on the detailed written order. They order both masks so the patient can choose the mask that will work best for them to ensure fit and compliance. They do not want DME suppliers calling them multiple times for new orders every time the patient wants to try a different mask type. DME Suppliers are only billing for one mask; even though we are required to switch out the mask multiple times during the 3 month trial period to ensure fit and compliance.**

    Based on recent conversations on this protocol we have received some information that the MACs may have modified earlier positions. As long as the provider does not bill for multiple masks, will Medicare accept and validate an order for both masks and related cushions on the Detailed Written Order? (B)

    Response: No. If a DWO has more than one type of mask "checked" or ordered, it will be considered a blanket order and that particular HCPCS would deny. If the beneficiary needs to switch to a different mask, a new detailed written order would be required. Further guidance was provided in a detailed article published in April 2010 entitled *Detailed Written Orders.*

12. **If a patient has received a CPAP and had their F2F visit completed on day 57 but was not showing 70% compliant but became compliant on day 88, does the patient need to go back to have another F2F visit or can the physician sign and date the download showing the compliance report has been reviewed? (D)**

    Response: Per the LCD, adherence therapy is defined as use of PAP $\geq$ 4 hours per night on 70% of nights during a consecutive (30) day period anytime during the first (3) months of initial usage. If the beneficiary meets the adherence requirement on day 88, there is no need for a new F2F encounter or sleep test.

13. **Regarding the CAHI requirement for qualification of the bi-level devices, if the CAHI is not listed on the sleep study report, can suppliers obtain the data and calculate the CAHI or does this have to be done by the sleep lab? (D)**

    Response: The information must be provided by the interpreting physician at the sleep testing facility.

14. **The PAP LCD requires objective evidence of adherence to the use of the PAP device, which must be reviewed by the treating physician. Please explain the expectation. Does the physician have to document the specific numeric results of the download or just say that it was reviewed and compliant? (D)**

    Response: The LCD states, for continued coverage beyond the first 3-months, that the objective evidence of adherence to use of the PAP device must be reviewed by the treating physician. The DME MACs do not prescribe how this review and confirmation of adherence is documented however, it must be clear in the beneficiary's medical record that the physician reviewed the results and that the beneficiary met the adherence requirements for continued coverage.

Prosthetics/Orthotics

15. **In reference to the recent Joint DME MAC revision of the article previously published on March 27, 2014, the bulletin instructs on the use of a miscellaneous HCPCS when the definition is not met. If a supplier provides and bills for a custom fitted, pre-fabricated orthosis using a specific custom fitted, pre-fabricated HCPCS, if the MAC reviewed the claim and determined that the documentation does not justify a custom fit code (even though these codes are ONLY for custom fitted products) and/or the supplier did not meet the definition for "individual with specialized training," will the MAC deny the claim or down code the claim to L1499 miscellaneous code? If you down code the claim to L1499, may the supplier appeal?**

    Response: The claim would deny as DME MAC claim approvers would not change the HCPCS code billed on the claim to the comparable off-the-shelf HCPCS code.

Rehab Equipment

16. **HCPCS K0835 is eligible for both PMD PAR and for ADMC. Recently a representative from provider inquiry stated that we should not be submitting for both PMD PAR and ADMC, although nothing is stated in policy to that effect. As a supplier we need the PMD response in order to avoid the 25% reduction in payment. We need the ADMC response to know if the accessories are medically necessary. If we do not have the ADMC response, we must rely on our judgment to decide if an accessory will be medically necessary and potentially paid for. If we provide the equipment and it is not covered then we must write it off. If we decide up front that the item may not be covered and obtain an ABN from the beneficiary, the beneficiary may decide not to receive something they really need. What is the best way to assure that the patient meets the medical necessity requirements for BOTH the base and accessories without inconveniencing Medicare or the beneficiary? Depending on the outcome, can we secure updated instructions and**

educational material to guide suppliers on how we can secure a review of both the bases and accessories on items that are eligible for both? (B)

Response: This question was answered in the April 2015 Combined Council Questions:

Question submitted: How is a file reviewed for a K0835 (in PAR) base, or a base with a sling/solid/seat/back, when the medical reviewer isn't looking at the accessories necessary to pay this specific base? If the request is for a K0835, can it be submitted for Advance Determination of Medicare Coverage (ADMC) as well?

Response: When a Power Mobility Device Prior Authorization Request (PMD PAR) is submitted, all the coverage criteria for the power wheelchair base are reviewed. In addition, the nurse reviewing the documentation would determine if the following criteria are also met.

1. The beneficiary requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control).

2. The beneficiary meets coverage criteria for a power tilt or a power recline seating system; and the system is being used on the wheelchair.

The ADMC process is voluntary, and the PMD PAR process is not mandatory; however should the supplier choose not to participate in the PAR program, there will be a 25% reduction in payment that would apply if the power wheelchair is found to be payable. The PMD PAR decision is for the power wheelchair base; however in the event the decision is affirmative and a UTN is provided, when the claim is submitted for the PWC base, then the accessories should be paid. In this setting, the accessories remain subject to future audits for being reasonable and necessary.

17. **Under the current Wheelchair Seating policy, some cushions (E2603-E2604, E2622-E2623) are covered if the bene has a current ulcer or a history of pressure ulcers (ICD 9 codes 707.03 - 707.05). In the future ICD10 LCD, codes are listed for 'unstageable' pressure ulcers, in addition to Stages 2, 3, and 4. Would a history of pressure ulcers be appropriately coded as 'unstageable'? What about Stage 1 pressure ulcers? Is there a policy/coverage change hidden in the conversion to ICD 10? (B)**

Response: "History of pressure ulcers" must not be coded as unstageable since that wound category has a specific definition. From the LCD:

Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Under ICD-10 coding, use of a cushion listed above for a stage 1 ulcer is not reasonable and necessary.

18. **When wheelchair accessory HCPCS are subject to audits such as E1002 and E1007, will claims that go through the ADMC/PMD Demo processes be subject to review or**

scrutiny? If the accessory is found to be not medically necessary, will the base subsequently be denied in cases where the accessory such as the E1002 and E1007 affect what base code the beneficiary qualifies for? (C)

Response: If documentation is reviewed in ADMC or via a PMD PAR request, the claim will bypass the E1002/E1007 edit. The base will not be denied if the power seating system is denied. Review the news item on the CGS website dated 4/28/2015; neither the seven-element order nor the F2F examination will be requested.

19. **The PMD PA Demo project is scheduled to conclude on September 1st 2015. Are there any insights that can be provided to the councils on the future of this program? Overall providers have found it to be beneficial and would like to see it continue and expand. (C)**

Response: CMS has not provided any updated instructions to the DME MACs regarding extension of the PMD PAR demonstration project; however, CMS published a notice in the 7/15/2015 *Federal Register* announcing the intent to extend the PMD PAR demonstration through 8/31/2018. The DME MACs will publish additional information when official instructions are received from CMS. A present, the PMD PAR demonstration is scheduled to end on 8/31/2015.

20. **PMD PA demo project question: If the provider is offering a free upgrade to the beneficiary, how should this be submitted for PA? Example: provider will supply a K0856 Group 3 single-power wheelchair, but the beneficiary only qualifies for a Group 2 single-power chair (K0835). Since this is a free upgrade, there will only be one billing line for the base and in most providers' software systems, one base code line on the DPD Rx. Should the DPD Rx show the actual item provided (K0856) or the item the bene qualifies for (K0835)? If K0856 is listed, will the PA request be rejected since K0856 is not included in the demo project? Original upgrade instructions stated the item the bene would be receiving should be the one listed on the DPD – is that still true? (B)**

Response: The DME MACs published a detailed article on the use of upgrade modifiers in August 2011 entitled Use of Upgrade Modifiers. From the article:

If a supplier wants to provide the upgraded item without any additional charge to the beneficiary, then no ABN is obtained. If it is the supplier's decision to provide the upgraded item at no additional charge to the beneficiary or if physician ordered the upgraded item and the supplier decides to provide it at no additional charge to the beneficiary, the supplier bills with a GL modifier the HCPCS code that describes the item that is covered based on the LCD. In this situation, the supplier does not bill the HCPCS code that describes the item that was provided.

If the request for the upgraded item is from the beneficiary and the supplier decides to provide it at no additional charge, no ABN is obtained. On one claim line the supplier bills with a GZ modifier the HCPCS code that describes the item that was provided. On the next claim line, the supplier bills with a GK modifier the HCPCS code that describes the item that is covered based on the LCD. (Note: The codes must be billed in this specific order on the claim.)

Additional information is also available in the PMD Demo Operational Guide.

Finally, From the April 2013 Question set…Rehab #3:

Jurisdiction B has published the following in March 2013 in a document titled “Tips for Completing a Detailed Product Description Correctly”:

The PMD on the DPD is considered an upgrade when a beneficiary meets the coverage criteria per the medical policy however, requests a different PMD to be delivered, suppliers are able to provide a different PMD as an upgrade. The DPD should have the PMD that is being delivered to the beneficiary, not the PMD that meets coverage criteria. The medical records should support the PMD that the beneficiary meets per coverage criteria. It is suggested that the PMD PAR clearly advise that the request contains an upgrade situation by specifying the HCPCS code of the PMD being requested for PAR and the HCPCS code of the PMD that will be delivered.

Does Jurisdiction C follow the same guidelines?

Response: CGS agrees that the DPD should reflect the PMD being delivered to the beneficiary. Note that the upgrade policy specifies that when an item that is more than is medically necessary (as determined by the policy criteria) is provided; an upgrade is possible from the medically necessary item to the desired item. Since many items, especially in the PMD policy, have the same coverage requirements, changing to a different item or code is not automatic evidence that an upgrade is appropriate. The DME MACs verified that the system corrections outlined in MM8864 have been implemented and based upon examples reviewed are working correctly. The DME MACs have reopened claims that were incorrectly paid and or denied in error prior to the implementation of MM8864. If you have additional claims that you believe were not adjudicated correctly, contact the Jurisdiction that processed the claim to have the issue resolved.

21. **MM8304 has several wheelchair accessories (e.g. E0973 and E0990) that have the description of "manual wheelchair accessory". However, the formal description of these codes does not include the reference to manual wheelchairs. In these cases, will the DMEMACs only apply the ACA requirements to these accessories when used on manual chairs? (C)**

    Response: No

22. **Is an ADMC request based on the HCPCS code or the beneficiary’s Medicare number? Does Medicare permit two attempts in six months per HCPCS or per Medicare beneficiary number? (C)**

    Response: The ADMC request follows the Medicare beneficiary HICN. The supplier may rebut the initial decision from ADMC and file another request with corrected/additional information. After the second submission, the supplier must wait six months before submitting another ADMC for that beneficiary.

23. **We sometimes will provide a rehab (sling/solid) seat power wheelchair to a customer who will be using a seat cushion that they already own on their new chair. Will it cause any problems with PMD prior authorization, ADMC or an audit if we are requesting or billing for a sling/solid seat base when there is no cushion on the DPD, prescription or**

claim? How would the DME MACs prefer suppliers communicate these details effectively for claims processing?

Response: The beneficiary-owned seat cushion has no bearing on the PAR or ADMC request submitted to the DME MAC.

Ostomy/Urologicals/Medical Supplies/Diabetic Monitoring and Supplies

No questions submitted.

Documentation/Regulatory/Miscellaneous/Other

24. **We would like to get clarification on the proper use of the RA modifier. We have previously been told to use the RA modifier if replacing equipment that Medicare paid for initially (i.e., starting a new PAP capped rental after 5-year RUL). In the Modifier Madness webinar, I believe the presenter indicated that RA modifier was only to be used (first month rental claim) when starting a new 36-month oxygen capped rental after the 5-year RUL. (B)**

    Response: The RA modifier should be appended for replacement of equipment prior to the end of the RUL due to loss, theft or irreparable damage. The RA modifier is also required for replacement of Oxygen equipment that is less than 5-years old or if the RUL is met.

25. **ICD-10 transition: If a non-specified ICD-9 such as 496 (COPD) was accepted for oxygen and nebulizers, will the 1:1 ICD-10 code J44.9 be accepted – both are unspecified codes? The oxygen LCD is not diagnosis driven and therefore will not list compliant diagnoses. Will the new J44.9 be equally acceptable and compliant as its predecessor 469 for the purposes of claim processing? (B)**

    Response: Yes, per CEDI.

CEDI

No questions submitted.

PDAC

No questions submitted.