Jurisdiction B, C and D Combined Council Questions

Sorted by A-Team
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Disclaimer: *This Q&A document is not an official publication of the durable medical equipment, Medicare Administrative Contractors (DME MAC). The official guidance documents from the DME MACs are Centers for Medicare & Medicaid Services (CMS) manual instructions, national coverage determinations, local coverage determinations, bulletin articles, and supplier manuals.*

Enteral/Parenteral/IV Therapy

1. **When obtaining an Advance Beneficiary Notice of Noncoverage (ABN) for antibiotic therapy (statutorily excluded) that is infused via external infusion pump, is it acceptable to complete the ABN using the phrase "Antibiotic" instead of the specific drug name and total daily dose (in section D?) All antibiotic drugs are statutorily excluded, and the ABN is required for the pump and supplies, not the antibiotic drug. Would the 2 examples below be considered valid ABNs?**
    a. **Scenario #1: Antibiotic ordered via external infusion pump – Medicare billed for denial/Secondary payer will cover the therapy**
        I. **Under Section D: Antibiotic, Infusion pump, administration supplies /cassette/bag, & catheter supplies ordered to administer statutorily excluded antibiotic therapy.**
        II. **Under Section E: Medicare Part B DMEPOS will not cover antibiotic therapy in the home; therefore there is no benefit for the pump or supplies to deliver the antibiotic.**
        III. **Under Section F: Estimated range from $160-$200/day based on drug co-pays**
        IV. **Under Section H: Your secondary insurance will be billed after Medicare denial. You have a $500 deductible and 20% co-pays due on drug/supplies per your secondary insurance.**

    Response: This question is phrased incorrectly. It is important to recognize that drugs are considered supplies to the pump. Drugs billed without a pump will be denied as statutorily non-covered. The statutory exclusion is not applicable when drugs are billed with the pump. An ABN is needed for the drug as this situation represents a medical necessity denial. ABNs need to be detailed and specific. "Antibiotic" is not sufficiently detailed.

    b. **Scenario #2: Antibiotic ordered via external infusion pump – Medicare billed for denial on pump/supplies. Medicare Part D benefit for drug.**
        I. **Under Section D: Infusion pump, administration supplies/cassette/bag, catheter supplies to administer statutorily excluded antibiotic drugs.**
        II. **Under Section E: Medicare Part B DMEPOS will not cover antibiotic therapy in the home; therefore there is no benefit for the pump or supplies to deliver the antibiotic. Drug is billed to Medicare Part D.**

III. **Under Section F: Estimated range for pump and supplies per day.**
IV. **Under Section H: Part D will cover your antibiotic drugs with co-pays for each dispense. The pump and other supplies will be billed to you.**

Response: For DME billing purposes there is no difference between the two scenarios presented. The pump and drugs should be billed together to the Medicare contractor. If drugs are not billed with the pump then the claim will be denied as not medically necessary and an ABN should be executed.

2. **Question regarding date of the DIF for Enteral Nutrition. Further clarification/instruction is required related to question one from the last round of questions and answers; the previous question and answer are as follows:**

"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 written order. 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 written order. 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 the 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 written order 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 a WOPD item) 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."

The DME MAC supplier manuals state that the Initial DME Information Form (DIF) states that the initial date reported on the DIF should be the "specific date the physician gives as a start date of medical necessity or if the physician does not give a specific start date, the 'initial date' would be the date of the order". The instruction given in the Q & A above is contradictory to the instruction in the DME MAC supplier manuals. Here is the scenario:

1/1/2015 – Verbal order received for enteral nutrition. The order is for five cans of enteral nutrition per day, for a 30-day supply, refill 12-months. The order indicates the patient is to start using the enteral on 1/3/2015.

The supplier ships the enteral nutrition on 1/1/2015 (rural area, using shipping service), the DWO is created by the supplier and sent to the physician for signature on 1/1/2015. The DWO has 1/1/2015 as the order date, and 1/3/2015 as the start date indicated in the body/label text of the order. 1/1/2015 is the date of service submitted on the claim as that is the shipping date.

If we follow the instruction in the DME MAC supplier manuals, our claim will deny due to the date of service preceding the initial date on the DIF.

What should the supplier use on the DIF, the order date or the physician indicated start date of therapy?

Response: The DME MAC Medical Directors are currently reviewing this follow-up question and will provide a response in the future.

Home Medical Equipment

3. **When a supplier elects to provide equipment as a free upgrade (examples: beneficiary qualifies for a semi-electric hospital bed, supplier delivers a full-electric bed; beneficiary qualifies for a standard K0001 wheelchair but supplier delivers a K0003 lightweight wheelchair); which item should be in the WOPD? The item the beneficiary qualifies for, or the item that will be delivered?**

   Response: In May 2007, the DME MACs published an article titled "Downcoding – Use of GK and GL Modifiers on Claims for Upgrades", which indicates the following: "In order to use the GK or GL modifier, the supplier must have a physician order for one of the items. An order for either the covered or upgraded item is acceptable".

   The physician or non-physician practitioner may write a prescription (order) for the medically necessary item or for the upgraded item. If the item does not require a WOPD the prescription (order) may be written for either the item ordered or the upgraded item, either is acceptable. However, if either item requires a WOPD, then the prescription (order) must be for the item that requires the WOPD. In addition, all other associated documentation requirements must also be met.

4. **How can we provide a capped rental item as a cash sale item to a beneficiary?**

   Response: The Social Security Act (Section 1848(g)(4)) requires that claims be submitted for all Medicare patients for services rendered on or after September 1, 1990. This requirement applies to all physicians and suppliers who provide covered services to Medicare beneficiaries. You may ask the beneficiary to sign an ABN and select Option 2, and indicates the beneficiary would like to obtain the item and they do not want you to bill Medicare.

   I. **Would it be a different scenario if we remove the product from our National Supplier Clearinghouse (NSC) list of items that we provide to Medicare beneficiaries?**

      Response: No.

Oxygen/PAP/Other Respiratory Care Equipment

5. **Once the ICD-10 implementation is complete, will CMS accept and consider the CMS-484 Oxygen CMN version 0905 valid for recertification/renewals if completed before 10/01/2015, if the ICD-10 diagnosis code and questions are completed correctly?**

Response: Beginning with date of service on/after 10/1/15, use of the revised CMN/DIF forms will be mandatory for all claims which require Initial, Revised or Recertification documents. If a CMN or DIF is already on file, a new one is not required for the sole purpose of updating for these revisions or to add an ICD-10 diagnosis code to a CMN or DIF. Additional information regarding ICD-10 can be found on the CMS ICD-10 web site at: http://www.cms.gov/ICD10.

6. **Per the LCD for High Frequency Chest Wall Oscillation (E0483) "It is not reasonable and necessary for a beneficiary to use both a HFCWO and mechanical in-exsufflation device" (E0482). So if a beneficiary starts with mechanical in-exsufflation device and uses the device for 5 months and returns the device and changes therapy to HFCWO (no break in service) shouldn't a new Cap Rental start for HFCWO?**

   Response: Only one capped rental can occur at a time. If there is a change in equipment, there must be a new capped rental initiated. This applies to items included in the capped rental payment category.

7. **In contrast if a beneficiary starts therapy on HFCWO (E0483) and changes therapy in rental month 5 (with no break in service) to mechanical in-exsufflation (E0482) shouldn't a new Cap Rental start for mechanical in-exsufflation?**

   Response: The answer to this question is the same as the response provided in question 6 – a change in equipment requires a new capped rental.

Prosthetics/Orthotics

8. **In states that license orthotic fitters, may a licensed 'orthotic fitter' provide and bill for prefabricated custom-fitted orthoses for Medicare beneficiaries? The response from the council referred us to revised joint publication published March 27, 2014. This publication does not provide the information needed to answer our question. Please clarify.**

   Response: Please refer to the joint publication article that discusses this: "Correct Coding – Definitions Used for Off-The-Shelf Versus Custom Fitted Prefabricated Orthotics (Braces) – Revised" which was published March 27, 2014. Substantial modification is defined as changes made to achieve an individualized fit of the item that requires the expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthotics such as a physician, treating practitioner, an occupational therapist, or physical therapist in compliance with all applicable Federal and State licensure and regulatory requirements.

9. **Will the DME MAC's allow a certified/licensed Orthotic fitter to be supervised by a certified/licensed Orthotist in order to provide and bill for prefabricated custom-fitted orthoses?**

Response: Issues of supervision are typically governed by state regulation and scope of licensure/certification rules. Our recommendation is that you contact the state board in the state you practice.

Rehab Equipment

10. **If an Advance Determination of Medicare Coverage (ADMC) is denied due to a technical error (example: date issue) and not due to medical necessity can the provider appropriately have the error fixed, then provide the product and submit the claim? If they do, will the claim automatically deny because there is a denied ADMC on file? Would it be best for the provider to submit a second ADMC request after the errors were appropriately corrected before delivering the product? This however delays the delivery of the medically necessary equipment by approximately 30 days.**

    Response: In the scenario provided, a non-affirmed decision would be on file and any claim filed for that power mobility base will deny. Once the claim is submitted and the claim is denied the supplier must follow the appeals process for the denied claim. The decision to file a claim to the Medicare program versus submitting a subsequent ADMC request is up the supplier.

11. **For a standard power chair, the Physician is performing the complete face-to face (F2F) exam (no specialty therapy evaluation). If the doctor sees the beneficiary, completes the F2F and dictates notes but does not review, sign off and date the chart note until sometime later, which date should be listed as the F2F date on the 7-element order? The actual date of the visit or the date the dictation is reviewed and signed?**

    Response: The required Power Mobility Device F2F examination has two components. These components are:

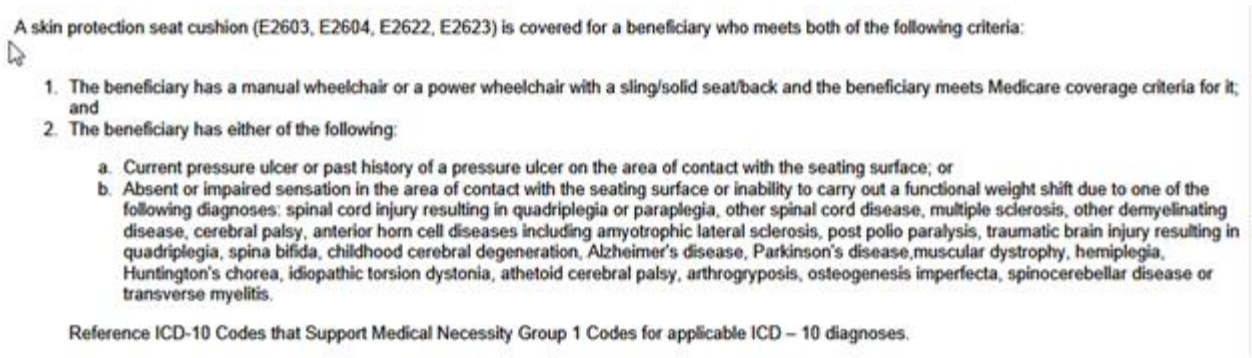
    I. Decision component – An in-person visit between the beneficiary and the ordering physician to document the decision to order a PMD; and,
    II. Medical evaluation component – A medical examination to document the beneficiary's mobility and functional condition.

    Both components are required and must be documented in the prescribing physician's records.

    If the ordering physician completes the entire F2F examination (both components) as indicated above, during the initial, in-person encounter with the beneficiary the date of the F2F examination is the date of that in-person encounter. The medical record documentation that supports the date indicated on the 7-element order would not be considered valid until the medical record entry is signed by the author.

12. **The updated Wheelchair Seating LCD with ICD-10 codes, effective 10/ 01/2015, now has a contradiction between the narrative statement of coverage for skin protection cushions, and the designated list of qualifying diagnosis codes.**

    The policy says:



A skin protection seat cushion (E2603, E2604, E2622, E2623) is covered for a beneficiary who meets both of the following criteria:

1. The beneficiary has a manual wheelchair or a power wheelchair with a sling/solid seat/back and the beneficiary meets Medicare coverage criteria for it; and
2. The beneficiary has either of the following:
   a. Current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; or
   b. Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, post polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease,muscular dystrophy, hemiplegia, Huntington's chorea, idiopathic torsion dystonia, athetoid cerebral palsy, arthrogryposis, osteogenesis imperfecta, spinocerebellar disease or transverse myelitis.

Reference ICD-10 Codes that Support Medical Necessity Group 1 Codes for applicable ICD – 10 diagnoses.

Coverage criteria 'a' allows for coverage for either a current pressure ulcer – with no mention of any degree or stage minimum – or history of a pressure ulcer. However, the ICD-10 codes listed do not include any stage one pressure ulcers or have any way to indicate a history of ulcers. There are some beneficiaries who have very fragile skin who are reliant on the support of a skin protection cushion – and who may very well NOT have a pressure sores due to long term use of that cushion. When they need a replacement cushion, they will no longer qualify for anything other than a general use cushion, which puts them at a huge risk of developing sores. How do the medical directors explain the contradiction that the policy retains coverage criteria 'a' but does not include qualifying codes to support this criteria?

Response: Stage one ulcers were never covered under the previous Wheelchair Seating policy. Conversion of the LCD from ICD-9 to ICD-10 does not change the coverage requirements. If requestor feels that coverage for Stage one pressure ulcers should be added, they will need to file a formal reconsideration request and submit literature to support their positions.

Note that the list of covered Wheelchair Seating LCD ICD-10 diagnosis codes was recently expanded to encompass subsequent visits and sequelae.

13. **Any update on CMS' proposal to split codes E1399 and K0108 into 6 new codes with different pricing and payment logic?**

Response: No comment.

14. **Any update on the expansion of bid pricing to no-bid areas thru Regional Single Payment Amounts (RSPAs)? Specifically, will claims still be allowed at the full fee schedule amount, for wheelchair options when used in non-bid bases, for beneficiaries who live in bid areas? Items currently billed with KY and KEKY?**

Response: The DME MACs do not have any information regarding this topic. However, CMS published an MLN Connects Provider e-News-Special Edition on Monday, October 5, 2015 which included an article titled; "DMEPOS Fee Schedule PUF Formats and Rural Zip Code File".

Documentation/Regulatory/Miscellaneous/Education

15. **Guidance has been issued to suggest that physician claims for dates of service after 10/1/2015 will be allowed some "flexibilities" with using ICD-10 codes that are within the "same family" (not requiring the greatest specificity). We understand that certain LCD's require specific diagnosis to be considered for coverage. However, for claims without specific diagnosis within the LCD, will this flexibility be available for DME providers, since they rely on physician documentation and prescriptions for their mutual patients?**

    Response: Claims must always include at least one diagnosis code and the diagnosis code(s) used must accurately reflect the beneficiary's medical condition as closely as possible, regardless of whether or not an LCD lists covered diagnosis codes. If an LCD lists specific ICD-10 diagnosis codes that are eligible for coverage, then only those codes will be eligible for consideration of coverage.

16. **Many rural providers are concerned and seeking information regarding the 2016 roll out of the RSPA that will mimic the Competitive Bid Rates for competitive bid products. Although, this may be outside the scope of the CBIC, we would like to recommend that the CBIC reference this on their website with a link to where providers can go to seek additional guidance. We would also like to recommend the contractors also provide additional education regarding the upcoming changes with regards to RSPA and what providers should expect to see and when.**

    Response: The DME MACs do not have any information regarding this topic. However, CMS published an MLN Connects Provider e-News-Special Edition on Monday, October 5, 2015 which included an article titled; "DMEPOS Fee Schedule PUF Formats and Rural Zip Code File".

17. **Do you have any updates to provide regarding the new Regional SPA's?**

    Response: The DME MACs do not have any information regarding this topic. However, CMS published an MLN Connects Provider e-News-Special Edition on Monday, October 5, 2015 which included an article titled; "DMEPOS Fee Schedule PUF Formats and Rural Zip Code File".

Documentation/Regulatory/Miscellaneous/Other

18. **Is there a difference in the turn-around time for audit determinations when the supporting audit documentation is submitted via ESMD (or another electronic method) vs. audits that are submitted via paper(e.g. via fax/mail)?**

    Response: The DME MAC Medical Review departments work additional documentation request (ADR) responses on a first in, first out (FIFO) methodology. Transmissions received via esMD will be added to the day's workload in which they were received, processed into the system, and added to the queue.

19. **PECOS denials – several providers are reporting increasing denials for (rental) claims submitted when the ordering physician is now retired, or deceased. CMS had stated that these claims would be 'grandfathered' and should be paid thru the end of the capped rental period. Can the MACs explain what must happen for these claims to be paid? Or what isn't happening that is causing these denials? And do we have any avenues for updating the PECOS file or whatever needs done to allow claims to be processed?**

Response: To clarify, CMS did not establish any "grandfathering" provisions when the PECOS edits were implemented. The assumption is the submitter of this question is referencing guidance provided in MLN Matters Special Edition article SE1305 On page 10, question J states the following:

> "A Medicare beneficiary was ordered a 13-month DME capped rental item. Medicare has paid claims for rental months 1 and 2. The equipment is in the 3rd rental month ***at the time the Phase 2 denial edits are implemented***. The provider who ordered the item has been deactivated. How will the remaining claims be handled? Claims for capped rental items will continue to be paid for up to 13 months from the physician's date of deactivation to allow coverage for the duration of the capped rental period.
>
> Answer: Claims for capped rental items will continue to be paid for up to 13 months from the physician's date of deactivation to allow coverage for the duration of the capped rental period."

Since more than thirteen months have passed since the Phase 2 edits were implemented, this exception no longer applies. The supplier must inform the beneficiary that the ordering physician on file is no longer eligible and they will need to see a physician who is eligible to order, and obtain a new detailed written order from the new physician. The supplier can resume billing claims using the NPI of the new physician.

20. **Liability information: We are hearing that the MACs will no longer be able to verify diagnosis code/liability after 10/01 (ICD 10). We have really appreciated being able to call, when we see other liability insurance primary on a Medicare eligibility (worker's comp, auto accident, etc); and find out whether the liability coverage is for the same diagnosis as is the need for the equipment we are trying to provide. Is it true that Customer Service will no longer be able to provide this information? If so, is this temporary – while other ICD 10 actions are implemented? Or is it permanent?**

Response: The implementation of ICD-10 does not change the type of information that will be provided by the DME MAC Provider Contact Center representatives, and representatives will continue to provide diagnosis code information related to MSP records. However, if the record contains only ICD-9 diagnosis codes, the PCC representatives will not provide ICD-10 crossover codes to the caller.