Jurisdictions B, C and D Councils Combined A-Team Questions
August 2020 final

Education/Documentation/Other:

No questions.

Enteral/Parenteral/IV Therapy:

1. In light of paperwork reduction, if a patient's caloric change for enteral formula or parenteral amino acids or lipids match a previous order where the matching DIF is still on file (and there's no other changes that would warrant an initial or revised DIF), is it sufficient to bill claims without attaching the revised DIF and keeping one on-file for our records only? It is common for the previous DIFs to remain on file with the DME MAC.

   For example:
   Enteral: B4150 2100 cal/day via gravity DIF on-file for 99, patient increases to B4150 2300 cal/day via gravity for 99, and then reverts back to B4150 2100 cal/day via gravity. Instead of attaching another revised DIF to go back down to B4150 2100 cal/day, can the supplier keep the SWO/DIF on-file for our records only and not attach to the claim?

   Total Parenteral Nutrition: B4199 100 grams with 20 gram lipids for 7 days/week DIF on-file for 12 months, patient decreases B4197 75 grams with 20 grams lipids 7 days/week, but reverts back to the original order, can the supplier keep the SWO/DIF on-file for our records only and not attach the claim?

   DME MAC Response: A revised DIF will need to be attached for both of the examples provided. A revised DIF is required for the enteral example since the number of calories per day is changed. The parental example requires a revised DIF because of the change in HCPCS code for the current nutrient provided. Please refer to the Local Coverage Article: Enteral Nutrition - Policy Article (A52493) and Local Coverage Article: Parenteral Nutrition - Policy Article (A52515) for detailed information on when a new initial or revised DIF must be submitted.

2. During a recent POE outreach webinar sponsored by NHIA on June 11, it was discussed that with the non-enforcement of the ambulatory infusion pump policy that there may be drug coverage for antibiotic and hydration therapy through the DME benefit during the PHE. We are seeking clarification from the DME MAC that if the therapy was not covered prior to the non–enforcement, that it is not covered during this PHE.

   DME MAC Response: During the COVID-19 Public Health Emergency (PHE), CMS has suspended enforcement of the clinical indications of coverage for external infusion pumps. Services must still be reasonable and necessary. Suppliers are reminded that this is a DME benefit, not a drug benefit. Drugs are paid as a "supply" to the durable external infusion pump. Infused drugs that are not administered with a durable pump are non-covered (i.e., do not meet the Medicare DME

benefit). This requirement to meet the DME benefit for external infusion pumps is unchanged by the COVID-19 PHE waivers and regulatory changes. Additional information may be found in the DME MAC publication *Drugs Used With External Infusion Pumps – Coverage and Billing Reminders* found at:

CGS: https://protect2.fireeye.com/url?k=1d71af70-4124a663-1d719e4f-0cc47adb5650-b7a4cf8434a4ed1f&u=https://cgsmedicare.com/jc/pubs/news/2011/0601/cope15146.html

Noridian: https://protect2.fireeye.com/url?k=15bae54c-49efec5f-15bad473-0cc47adb5650-8ba995de128b189e&u=https://med.noridianmedicare.com/web/jddme/dmepos/external-infusion-pumps/drugs-used-with-external-infusion-pumps

Home Medical Equipment:

3. Recently, suppliers report that they are only receiving payment for an E0705 transfer device board when it is used with a wheelchair. If E0705 is used with anything else, like a drop arm commode, it is denied CO16/M124 stating it is covered only for use with a wheelchair. While E0705 is included in the wheelchair policy, the description does not specify that the item is for wheelchairs only (as most other codes in the policy do): the E0705 is in a grouping of HCPCS codes related to safety equipment. The WC Options and Accessories LCD does not specify any specific coverage criteria or limitations for coverage. Transfers can and often do occur between medical devices other than wheelchairs. Please provide clarification how the determination of the transfer device is only covered with use with a wheelchair.

   DME MAC Response: The DMDs agree that a transfer board could be paid without a wheelchair on file and are investigating edits which may preclude this coverage.

Prosthetics/Orthotics:

4. We provide LVAD care kits for patients that are discharged from the hospital and are taking care of the device at home. MLN Matters MM7888 seems to indicate these are coverable. We have been trying to bill Q0508 -Miscellaneous Supply or Accessory For Use w/ an Implanted Ventricular Assist Device to no avail. The transmittal indicates this code clarifies the supplies and replaces Q0505 as of 3/31/2013. Please advise as to how DMEPOS suppliers bill for these kits.

   DME MAC Response: Implanted devices and their associated accessories and/or supplies do not fall under DME MAC jurisdiction. Claims for these must be submitted to the A/B MACs for consideration of payment.

5. In February 2019 the following question and DME MAC response was included in the combined **DME MAC Advisory Council Q&A.**

   Q: There continue to be reports of claim denials for L5984 when used in conjunction with other codes that describe multi-axial rotation features. CMS has provided guidance that L5984

describes axial rotation features at or near the ankle and therefore is redundant coding when that feature already exists and is described using a different code. A common reason to bill L5984 is to describe axial rotators that are used just below the prosthetic socket to allow the prosthesis to be rotated temporarily to accommodate specific environmental situations. When an axial rotator is used for this specific reason, and is not used to provide ankle rotation, is it acceptable to be billed as L5999?

DME MAC Response: Yes. L5999 is the appropriate code to bill when axial rotation is medically necessary to accommodate specific environmental situations such as (not all-inclusive): Performing activities in confined spaces like small kitchens and walkways; while driving, enabling the user to swing the prosthesis out of the way; putting on shoes or changing socks because it brings the prosthetic foot within reach.

Suppliers are reporting that claims for axial rotation units that are not part of the foot and ankle complex continue to be denied when billed with L5999, even when supported by documentation in the patient's medical record. Can you provide any guidance on the type of documentation the DME MACs require?

DME MAC Response: The response to the original question is correct. Suppliers must be mindful that the (NTE) claim narrative should be descriptive enough to show the component is separate from the ankle rotation features that are included in other components. If requested, the medical record must include information to support that the item is required to accommodate a specific environmental situation. In cases where the claim is denied as not reasonable and necessary, appeal rights will be afforded.

6. Patients often call the 1-800 Medicare number and ask about foot orthotic coverage (L3000-L3020) and are told, yes, they are covered. The patient tells the CSR that their podiatrist, orthotist or pedorthist is telling them that it is not. The CSR tells them that their podiatrist, orthotist, pedorthist doesn't know how to bill. Is there any way the DME MACs can educate the 1800 Medicare CSR, the notion that foot orthotics are only covered if the patient is wearing a leg brace which is attached to a shoe? Patients will understand that.

DME MAC Response: This issue has been elevated to the 1-800-Medicare to identify areas of need for training to respond to questions concerning foot orthotic coverage.

Rehab Equipment:

7. CMS has clarified that during the COVID-19 PHE, an ordering practitioner can conduct the PMD mobility exam ('face-to-face') using telehealth, with both audio and video components. Is it possible to have a valid mobility exam conducted only by telephone? For example, if the patient is established

with that practitioner, needs a replacement chair, and the beneficiary does not have access to a video app?

DME MAC Response:

The face-to-face requirement includes examinations conducted via the CMS-approved use of telehealth examinations, which must meet the requirements of 42 CFR §§ 410.78 and 414.65 for purposes of DMEPOS coverage. This is not new information and is included in the Standard Documentation Requirements for All Claims Submitted to DME MACs Policy Article (A55426). However, CMS has broadened access to Medicare telehealth services during the COVID-19 Public Health Emergency and published information regarding these flexibilities for virtual services on their web site. *It is up to the discretion of the treating practitioner to conduct the evaluation in a manner that allows documentation to assure that coverage criteria are met.*

8. KE & KU modifier for options used on manual wheelchairs: CR 11635 (May 7, 2020) informs us to start using KU on the relevant codes starting in July, to receive the adjusted fees that result from the Further Consolidated Appropriations Act, 2020. The basic instruction is the same as using KE for CARES ACT adjustments for allowable for wheelchair options used on complex manual bases. KU, under this FCAA provision, applies across the board - all zip codes (rural, non-rural, former CBA); We will start using this in July but retro back to January 1 dates of service. Since KE and KU are both pricing modifiers that will most likely pay at different rates there is an overlap of these two adjustments. How will we know whether to use KE or KU - or both?

DME MAC Response: MLN Matters article MM1178 https://www.cms.gov/files/document/mm11784.pdf informs suppliers that Section 3712(b) of the CARES Act increases the non-rural fee schedule amounts for HCPCS codes for DMEPOS items that are adjusted based on payments determined under the DMEPOS Competitive Bidding Program (CBP). Medicare will use these schedules to pay for these items provided on or after March 6, 2020 through the end of the COVID-19 Public Health Emergency (PHE). The KE modifier (non-rural fee schedules for items bid in the initial Round 1 CBP) has been added back to the fee schedule file for the length of the PHE. See Attachments A and B of CR 11784 https://www.cms.gov/files/document/r10116otn.pdf for a list of HCPCS codes and modifiers impacted by these changes. No immediate action is needed for suppliers to receive the increased fee schedule amounts. For dates of service from March 6, 2020, through April 22, 2020, the DME MACs will automatically reprocess affected claims to pay the higher blended 75/25 non-rural fees if the following is true:

- **The FROM date of service is between March 6, 2020, through April 22, 2020**
- **The HCPCS/Modifier combination is on the list in Attachment A of CR 11784**
- **The claim line was previously paid**

After the DME MACs have completed the automated adjustments, the DME MACs will adjust claims for the KE modifier with dates of service beginning March 6, 2020, through April 22, 2020, when

brought to the attention of the DME MACs by suppliers for HCPCS/Modifier Combination in Attachment B of CR 11784. Suppliers must notify the DME MACs by requesting claim reopenings/adjustments. The DME MACs must complete the automated adjustments before suppliers may begin sending reopening/adjustments. The DME MACs will notify suppliers via listserv once the automated adjustments are completed.

CARES ACT Modifier Important points:

Use of the KE modifier for specific option codes on manual wheelchairs (K0001 through K0009) remains in effect for beneficiaries living in rural zip codes.

The KU and KE modifiers must not be billed together. The KU modifier should be billed on certain manual wheelchair accessories to receive the unadjusted fee amount.

Additionally, in reference to wheelchair modifiers, the KY modifier remains a requirement on certain option codes used with complex rehab manual and power wheelchair bases for beneficiaries in former competitive bid areas (CBAs).

9. The DME MACs' documentation training for PMDs no longer includes any reference to the need to have the beneficiary sign a 1st month purchase option letter when delivering a complex power chair as a purchase. The sample Purchase Option Letter has disappeared from the Supplier Manuals and Policies, although it can still be found, with some digging, in the PIM. What is the current expectation for informing the beneficiary and documenting their purchase vs rental choice, before or on delivery, when the beneficiary is getting a Complex PWC and for capped rental accessories that can also be done as purchases when used/delivered with a Complex power base?

DME MAC Response: **Supplier standard number 5 requires the supplier to advise the beneficiary that they may rent or purchase inexpensive or routinely purchased DME and of the purchase option for capped rental equipment. This requirement must be met in order to obtain and retain DME billing privileges. A copy of the template for the purchase option can be located on the National Supplier Clearinghouse website under *Suggested Templates for Compliance with Certain Supplier Standards.* The template is titled "Capped Rental Inexpensive or Routinely Purchased Items".**

https://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~National%20Supplier%20Clearinghouse~Supplier%20Enrollment~Standards%20Compliance~Additional%20Information~7GLS7E7278?open

Note: This form is also located on each jurisdictional DME MAC's website under forms.

Respiratory Care Equip/Oxygen:

10. The QH modifier (conserver is being used) is informational only and does not affect pricing- can you give us any insight as to what it is used for internally and could it result in changes for the providers at some point in the future?

DME MAC Response: The DME MACs do not have additional information about the description of this code or plans for changes in the use of the modifier.

CEDI:

No questions.