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

Education/Documentation/Other:

1. Recently, in Jurisdictions B and C, TPE denials and Educational Events have indicated that because an ADR letter requests, "Relevant medical records that support the medical necessity and continued need for the items provided," that the audit entities expect the supplier to prove that need and this is accomplished by timely medical records. However, despite what the ADR letter requests, the Standard Documentation Policy Article says that medical records or an order dated within the preceding 12 months would suffice to document on-going need. Can you explain why an order alone to document continued need would result in a claim getting denied, considering all other documentation is sufficient, when the policy expressly states an order would satisfy this requirement? References for this would be December 3rd Webinar on diabetic supplies and December 10th webinar on nebulizers in Jurisdiction C and TPE feedback in Jurisdiction B.

   DME MAC response: If any Medicare contractor requests documentation in an ADR, the DMEPOS supplier is expected to provide the documents requested in the letter. If not, the claim may be denied after review of the submitted documentation.

2. If a provider has a valid DWO on file for CPAP supplies with a length of need of 99 and the beneficiary presents in the 13th month with a generic order for "CPAP supplies" can the provider use the generic order to justify continued need? In the event of an audit, will the generic order override the DWO with a length of need of 99, resulting in a denial?

   DME MAC response: It is unclear what is meant by a "generic order." Policy Article A55426 defines what requirements are necessary for a valid Standard Written Order:
   STANDARD WRITTEN ORDER (SWO)

   A SWO must be communicated to the supplier prior to claim submission. For certain items of DMEPOS, a written order is required prior to delivery (WOPD) of the item(s) to the beneficiary (see below).

   A SWO must contain all of the following elements:
   - Beneficiary's name or Medicare Beneficiary Identifier (MBI)
   - Order Date
   - General description of the item
   - The description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number
     - For equipment - In addition to the description of the base item, the SWO may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgraded code (List each separately).
     - For supplies – In addition to the description of the base item, the DMEPOS order/prescription may include all concurrently ordered supplies that are separately billed (List each separately)

•Quantity to be dispensed, if applicable
•Treating Practitioner Name or NPI
•Treating practitioner's signature

As noted above, the description of the item may be general or specific. When the order is general, the DME MACs will look to the medical record(s) to confirm the item(s) ordered.

Rehab Equipment:

3. During the last council meeting in Nov question 9 was asked and answered:

> 9) If a beneficiary weighing 515 lbs qualifies for a power wheelchair with tilt and recline per policy but the mobility limitation is not due to a neurological condition, skeletal deformity, or myopathy; will Medicare allow - during the prior authorization process - a group 3 VHD multiple power base code (K0863) since there is no group 2 VHD multiple power base category?
>
> **DME MAC Response:** The LCD for Power Mobility Devices requires the beneficiary to not only meet the weight requirements for the Group 3 PMD, but to also present with one of the qualifying diagnoses. Meeting the weight requirement alone is not an indication for affirmation. If the Group 3 is provided and the coverage criteria are not met, a non-affirmation decision will be issued. Suppliers may offer the beneficiary an ABN in anticipation of the claim denial and/or submit the claim for a denial and appeal.

However, since there is no group 2 very heavy-duty multiple power category (code) is it possible to give individual consideration at the time of the PA request.

DME MAC response: Individual consideration will not be given during the Prior Authorization process; however as noted in the November 2019 response, there are appeal rights available once there has been a claim denial.

Respiratory Care Equip/Oxygen:

4. Oxygen LCD does not state a requirement for “chronic stable state” when testing oxygen saturation levels if test is completed within two days prior to discharge from inpatient hospital stay. We are receiving conflicting information during the TPE audit process. Please define “chronic stable state” requirements when oxygen saturation tests are completed within two days prior to discharge from an inpatient hospital stay.

   DME MAC response: There are two conditions under which testing may be completed for oxygen qualification:
   1) Within two (2) days of discharge from an inpatient facility; or,
   2) As an outpatient, in their chronic stable state.

   Please address your individual concerns with your TPE nurse case manager for the jurisdiction to which you are billing claims.

Enteral/Parenteral/IV Therapy:

5. The LCD Reconsideration process detailed in Chapter 13 of the Program Integrity Manual states that the effective date of the final LCD is the 46th day after the notice period begins (if notice period is not extended):

13.2.6 - Notice Period
(Rev. 863; Issued: 02-12-19; Effective: 10-03-18; Implementation: 01-08-19)
The date the final LCD is published on the MCD, marks the beginning of the required notice period of a minimum 45 calendar days before the LCD can take effect. If the MAC would like to extend the notice period, they shall seek approval from CMS BFL. If the notice period is not extended by the contractor, the effective date of the LCD is the 46th calendar day after the notice period began.

Can we take from this that if/when specific drug coverage is added to the LCD that the coverage date will not be retroactive, i.e., the FDA approval date, but rather begin on the 46th day after notice?

DME MAC response: For drug coverage, the DME MACs have traditionally designated the FDA approval date as the effective date of the coverage change.

6. What code do I use to bill for Omegaven lipids? Does this change in 2020?

   DME MAC response: Per an article published November 26, 2019, regarding new HCPCS codes for 2020, Omegaven, 10 gram lipids, has a corresponding HCPCS code of B4187.

Home Medical Equipment:
No questions submitted

Medical Supplies:
No Questions Submitted

Prosthetics/Orthotics:
No Questions Submitted

MBI (changed from "CEDI"):

7. At the last Council meetings, suppliers reported billing a number of claims with MBIs but the Medicare remittance returned a legacy HICN causing software logic to update the patient's policy back to the legacy number in the remittance. The MACs confirmed the report and were researching causes and cures. Please provide an update on the findings and system modifications to address this issue ahead of the January 1 enforcement date.

   DME MAC response: This issue was researched, corrected and the "fix" was implemented on December 5, 2019. Since that time, the DME MACs have not had a report of this issue.

8. When suppliers get N382 denials after a CMS MBI change, we are instructed to use the MBI lookup tool on the portals. Many secure portals require two forms of identification. Will the MAC portals always require a social security number to look up a new MBI? Many suppliers have ceased collecting this identifier because of patient privacy concerns, for the same reason the government is moving away from HICNs. Could the MACs petition CMS to permit another identifier as a secondary verification protocol to DOB and Policy number (such as a patient's zip code) if we do not have a social? Ideally, we would like to have more options to verify identity beyond SSN to protect the beneficiaries.

DME MAC response: Suppliers are encouraged to check eligibility prior to filing claims to the DME MAC. Per CMS instruction, the DME MAC portals will provide the MBI in the Lookup Tool if the supplier enters the beneficiary Social Security number. If the beneficiary doesn't have their MBI, they can contact 1-800-Medicare or sign in to their mymedicare.gov account.