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

Enteral/Parenteral/IV Therapy

1. Code B4187 (Omegaven 10gms) now has a published allowable. This allowable is the same allowable as HCPCS code B4185 (Lipid 10gms). If the allowables are the same, why was there a new code established to distinguish this kind of lipid/IV fat emulsion? The current allowable for B4187 covers only ~20% of the cost of the Omegaven. How was the pricing established for this code? Since this lipid is primarily utilized in the pediatric patients and most commercial and Medicaid plans follow Medicare pricing, the impact to possible patient access is the primary concern with the understanding how pricing was established for this code.

   DME MAC Response: Effective January 1, 2020 the description of HCPCS code B4185 was changed to "Parenteral nutrition solution, not otherwise specified, 10 grams lipids" and new HCPCS B4187 "Omegaven, 10 grams lipids" was added. Information about the request to establish the new code and change the description of code B4185 was published by CMS in the Application Summaries for Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS) discussed in the June 12, 2019 HCPCS Public Meeting. CMS recommended that the Medicare fee schedule amounts for code B4185 for lipid solutions would apply to any codes for any type of lipid solution. https://www.cms.gov/files/document/2019-hcpcs-application-summary-june-12-2019-dmepos.pdf

2. The Medicare IVIG Demonstration Project is set to expire 12/31/2020. Previously the demonstration was extended. Does CMS have plans to extend legislation for the demonstration or will it officially cease on December 31, 2020? Will notification go out directly to the Medicare beneficiaries currently enrolled? If plans to not continue, when should suppliers and beneficiaries cease to apply into the project?

   DME MAC Response: The DME MACs are not aware of any plans by CMS to extend the demonstration, and CMS published that the demonstration is ending December 31, 2020, in MLN Matters Number MM11877. https://www.cms.gov/files/document/mm11877.pdf

Home Medical Equipment

No questions submitted

Medical Supplies/Ostomy/Urological/Diabetic Supplies

3. We have many patients nationally who switch from Diabetic Test Strips (DTS) to a Continuous Glucose Monitor (CGM). They later decide they don't like it and want to return to DTS even though there is no documented problem with the CGM. Often, it is a matter of patient preference or the fact that DTS is much cheaper than a CGM and patients want to go back to the less expensive co-pay option. How can the supplier justify a patient who wants to go back to DTS?

DME MAC Response: Suppliers, beneficiaries and treating practitioners should be aware that CMS considers standard glucose monitors (BGM) and CGM to be same or similar equipment and thus subject to the 5-year reasonable useful lifetime regulation. Replacement sooner than 5 years is only available if the item is lost, stolen, irreparably damaged or there is a change in medical necessity. There must be documented reasons in the medical record why the CGM is no longer medically necessary and the physician is now ordering a BGM to replace the CGM. Patient preference would not be sufficient justification and the beneficiary could be offered an Advance Beneficiary Notice of Non-coverage (ABN).

Prosthetics/Orthotics

No questions submitted

Rehab Equipment

No questions submitted

Respiratory Care Equipment/Oxygen/PAP/Other

No questions submitted

Documentation/Education/Regulatory/Miscellaneous/Other

4. Page 9 of the Medicare ABN Booklet ICN MLN006266 February 2020 states, "*If you cannot issue the notice in person, you may issue it via direct phone, email, mail, or secure fax machine (according to HIPAA policy). The beneficiary should not dispute the contact. You should document the contact in the beneficiary's records and keep a copy of the unsigned notice on file while you wait for the signed notice. You must follow phone contacts immediately by either a hand-delivered, mailed, emailed, or faxed advance written notice of non-coverage. The beneficiary or the beneficiary's representative must sign and retain the notice and send you a signed copy for their beneficiary record. If the beneficiary fails to return a signed copy, document the initial contact and subsequent attempts to get a beneficiary's signature in their records or on the notice*."
    a. Which modifiers are to be appended on a bill for denial claim where an ABN is properly executed to the beneficiary and/or authorized representative, the supplier has documented the verbal consent and made several documented attempts to obtain the signed version back, but remains unsuccessful? As long as the supplier has done its due diligence, has properly documented the conversation and attempts with the unsigned form on-file and the beneficiary and/or authorized representative does not dispute, is the use of the GA modifier appropriate?

       DME MAC Response: The supplier will need to make a business decision on whether or not to proceed with providing the item and billing the GA modifier. If the beneficiary disputes the contact, documentation will be requested and CMS will determine if the beneficiary may be held liable based on the information obtained.

    b. Secondly, if the refusal to sign is due to COVID, would it be appropriate to use the GA modifier alone or would we need to use the GA and CR modifier on each line and each claim thereafter?

DME MAC Response: CMS has provided the following guidance for beneficiary notice delivery guidance in light of COVID-19:

In light of concerns related to COVID-19, current notice delivery instructions provide flexibilities for delivering notices to beneficiaries in isolation. These procedures include:

- Hard copies of notices may be dropped off with a beneficiary by any hospital worker able to enter a room safely. A contact phone number should be provided for a beneficiary to ask questions about the notice, if the individual delivering the notice is unable to do so. If a hard copy of the notice cannot be dropped off, notices to beneficiaries may also delivered via email, if a beneficiary has access in the isolation room. The notices should be annotated with the circumstances of the delivery, including the person delivering the notice, and when and to where the email was sent.
- Notice delivery may be made via telephone or secure email to beneficiary representatives who are offsite. The notices should be annotated with the circumstances of the delivery, including the person delivering the notice via telephone, and the time of the call, or when and to where the email was sent.

Specifics of notice delivery are set forth in Chapter 30 of the Medicare Claims Processing Manual. EXT

c. Same scenario but pertaining to the AOB: What guidance is there for situations where a supplier has made numerous attempts, has properly documented the conversation and attempts with the unsigned form on-file and the beneficiary and/or authorized representative does not dispute? Is it appropriate to file claims with documented verbal consent.

DME MAC Response: CMS has not waived the claim signature requirements at 42 CFR 424.36(a). The DME MACs are working with CMS to provide further guidance, which will be shared as soon as it is available.

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No questions submitted