Jurisdictions B, C and D Councils Combined A-Team Questions January 2021

Education/Documentation/Other:

1. The ADR letters indicate, "You must wait for the demand letter from our overpayment recovery department before taking any action regarding the overpayment. Do not request a redetermination prior to receiving the demand letter which will include Redetermination Information." The Demand letters seem to be dated the same date as the decision letter. Recoupment is occurring shortly after the decision letter, usually less than 15 days. CMS MLN MM6183 indicates a provider should have 30 days to submit a redetermination, before seeing a recoup. What is the process to accommodate the 30-day appeal timeframes that would allow a stay on recoupment?

   DME MAC Response: Suppliers are always afforded appeal rights for claims identified as overpayments. For the scenario described above the supplier elected to have their profile updated to place all overpayments into immediate offset at the time of determination. To initiate an immediate offset such as this, the supplier completed the Offset Request Form and selected the option to offset the current overpayment and all future overpayments option. This option is available for all 4 DME MACs. If the supplier would like to discontinue the immediate recoupment of all future overpayments, a new Offset Request form will need to be completed to stop the process.

2. Is coverage of DME in a POS 54 facility dependent on the patient's qualification for the DME being provided regardless of any overarching diagnosis that necessitates the stay in the ICF itself?

   DME MAC Response: DME services that are provided in place of service 54 (Intermediate Care Facility/Individuals with Intellectual Disabilities) require all coverage criteria to be met for any item provided in order to allow consideration of payment. The reason for the beneficiary living in this setting does not by itself lend to any special considerations for qualification for DMEPOS.

Rehab Equipment:

3. The following question was submitted in the February 2018 All Council Q & A's. Please see attachment #1.

   Is it still acceptable for a different ordering practitioner within the same practice to complete the SWO and co-sign the LCMP evaluation for a PMD, if the ordering practitioner who performed the face to face is unavailable for an extended period of time due to vacation, illness, retired, passed away, etc.

Currently we are receiving conflicting answers from the MAC's on the approved process. CGS indicates this would be determined on a case by case basis, but Noridian is stating that a new face to face would be required.

DME MAC Response: The treating practitioner completing the face-to-face requirements must write the Standard Written Order (SWO), as required by SSA 1834(a)(1)(E)(iv). Suppliers should work with their individual DME MAC to resolve these issues.

Respiratory Care Equip/Oxygen:

No Questions Submitted

Home Medical Equipment:

4. The PDAC codes a rollator as E0143 and E0156. When physicians prescribe a rollator, they will use "rollator" on the prescription. Does the SWO need to separately list a wheeled walker + seat? Because it is one item, physicians are not inclined to write beyond a "rollator". In the interest of the reduction of paperwork, can we accept the "rollator" SWO and bill for both the seat and the wheeled walker?

   DME MAC Response: While we understand that both HCPCS codes may be commonly intended for the beneficiary by the practitioner, the code E0143 describes the wheeled walker itself and code E0156 is the walker seat attachment. Suppliers may not bill for the seat in addition to the walker itself unless there is evidence in the medical record that a seat will be needed. Please reference Standard Documentation Article A55426 which states that 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.

Enteral/Parenteral/IV Therapy:

5. On a recent webinar for PEN correct coding under the NCD, it was indicated that home/self-blenderized formulas administered via feeding tube can now be considered covered, allowing suppliers to bill these patients as supply-only when historically they couldn't. Multiple suppliers indicated they have had historic issues in billing supply-only patients, typically receiving CO denials and then potentially even receiving denials through the appeals process because the formula was "not on file." The DME MAC confirmed that suppliers will need to continue to appeal these situations. Is the DME MAC planning to revise their current process or provide education to suppliers on how to bill these patients going forward to prevent unnecessary denials and unfavorable appeals?

   DME MAC Response: Please refer to the joint DME MAC article published in October 2020 "Enteral Nutrition – Correct Coding and Billing" which indicates that self-blenderized formulas are non-covered by Medicare.

6. It was also stated that the LON must be supported in the "ordering physician's" medical records. In the past if the patient was followed by a Nutritional Support Team, their evaluation may clearly document the

LON, and/or the surgeon or gastroenterology consult may document the LON. All of these have been considered as part of the patient medical records. While these other disciplines/professionals may not actually be the ordering physician following the patient or writing the final discharge order, their records were considered part of the medical record and could be used to document LON.

We would like clarification on what can be considered as part of the medical records to support/document LON to support Test of Permanence.

DME MAC Response: All clinical documentation will be utilized in determining the nutritional need and qualification. Per Standard Documentation Article A55426 the medical record is not limited to treating practitioner's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for determining that an item is reasonable and necessary.

7. Can we please confirm that Hizentra J1559 and associated equipment/supplies will continue to be covered under the external pump benefit effective 1.1.2021?

DME MAC Response: Yes, Hizentra (J1559) and associated equipment/supplies will continue to be covered under the DME benefit for dates of service on or after 1/1/2021. Please refer to the External Infusion Pump Local Coverage Determination for additional information on the coding, coverage and documentation requirements.

8. Will the DME MACs be providing follow up information to the many open questions coming out of the 11/23/2020 webinar titled IVIG Demo Conclusion and Next Steps?

DME MAC Response: All questions were addressed during the webinar. The Medicare Intravenous Immune Globulin (IVIG) Demonstration Project was scheduled to end on December 31, 2020; however, the IVIG demo is now extended through December 31, 2023:

- **Beneficiaries enrolled as of November 15, 2020, do not need to re-enroll.**
- **New beneficiaries can continue to enroll, in accordance with the demonstration procedures.**

Medical Supplies:

9. If a bene using urological supplies has a permanent condition (such as paraplegia) that results in a qualifying condition for the supplies; as long as the bene is stable and there isn't a change in the codes/quantities - is a renewed SWO each year sufficient? Or are chart notes from a new office visit needed yearly?

DME MAC Response: From the Urological Supplies Policy Article: (A52521):

CONTINUED MEDICAL NEED

For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered, therefore, beneficiary medical records demonstrating that the item is

reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. Once initial medical need is established, ***unless continued coverage requirements are specified in the LCD, ongoing need for urological supplies is assumed to drain or collect urine for a beneficiary who has permanent urinary incontinence or permanent urinary retention.*** *There is no requirement for further documentation of continued medical need as long as the beneficiary continues to meet the Prosthetic Devices benefit. (emphasis added).*

Prosthetics/Orthotics:

10. Regarding the recently published articles on the roles of Nurse Practitioner and Physicians Assistants in the provision of diabetic shoes for persons with diabetes, there are the following questions:

    a. According to the article, the NP and PA must be "participating in the PCF documentation project." Question: Is there a way to check on participation? A website?

    DME MAC Response: Please note that there are two articles, and that this question is specific to the Primary Care First (PCF) Model Demonstration Project – Nurse Practitioners as Certifying Physicians for Therapeutic Shoes and Inserts . Within the article is a link to CMS Primary Care First Model Options with additional information regarding the program. A Practice Participants list is located in the CMS article.

    b. There are 3 criteria which must be met to meet the "incident to" requirement:
        - The supervising physician has documented in the medical record that the patient is diabetic and has been, and continues to provide, the patient follow-up under a comprehensive management program of that condition; and,
        - The NP or PA certifies that the provision of the therapeutic shoes is part of the comprehensive treatment plan being provided to the patient; and,
        - The supervising physician must review and verify (sign and date) all of the NP or PA notes in the medical record pertaining to the provision of the therapeutic shoes and inserts, acknowledging their agreement with the actions of the NP or PA.

    Question: If the supervising physician is documenting to provide care and follow up under a comprehensive management program and sign and date all the NP or PA notes in the medical records, how are the NP's and PA's involved?

    DME MAC Response: This question relates to the second article, *Nurse Practitioners and Physician Assistants Certifying Physicians for Therapeutic Shoes and Inserts*, which outlines the process for nurse practitioners and physician assistants practicing "incident to." Social Security Act §1861(s)(12) requires that a MD or DO certify that the beneficiary receiving therapeutic shoes and inserts is under a comprehensive plan of care for their diabetes. As a result of the DMD or DO restriction, NPs and PAs may not serve in the role of the certifying physician unless practicing "incident to" the supervising physician's authority.

c. Currently, Medicare has an example of the Statement of Certifying Physician (SCP): https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/33369_4/certifyingphysiciantherapeuticshoesrevised2007.pdf)

Question: Will there be an updated SCP on the Medicare website to have an asterisk stating, "PA's and NP's signatures are allowed"?

DME MAC Response: The form - Statement of Certifying Physician (SCP) - is a suggested form and not an OMB-approved form type. Suppliers may use this suggested form as a model and changes may be made without approval from CMS or the DME MACs, as long as the basic content is retained.

11. On a recent Noridian MAC call, they stated that only two liners per year are allowed for prosthetic patients. The LCD states the following: *No more than two of the same socket inserts (L5654, L5655, L5656, L5658, L5661, L5665, L5673, L5679, L5681, L5683) are allowed per individual prosthesis at the same time.* Can you confirm that coverage of prosthetic liners will not be limited to two per year as long as the medical need for the liners or replacements is documented in the medical record?

DME MAC Response: No more than two inserts may be provided at the same time. These are considered non-consumable supplies where the replacement need would be dictated by the beneficiary's activity level and condition of the insert. The need for replacement must be supported by documentation in the beneficiary's medical record.

CEDI:

No questions submitted