Final to Council chairs November 9, 2021

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

Home Medical Equipment

No Questions Submitted

Enteral/Parenteral/IV Therapy

1) Part A conflict processing issues: for patient's that discharge from a Part A facility against medical advice (discharge code 07), we are receiving Part A conflict denials on claims with a start date matching the discharge date. We have received conflicting information from the contractors', but specifically, customer service reps have recently advised that because the patient "should not have discharged", the system does not consider this a true discharge and defaults to the Part A denial.

   Does a beneficiary leaving a hospital or SNF against medical advice effect the ability of a DME suppliers to initiate or resume the provision of covered DME services in the patient's home?

   DME MAC Response: No. A beneficiary discharged from a Part A stay against medical advice does not impact the provision of medically necessary DME. Note however that there are two components to consider. One is the actual discharge status and the other is the discharge code. If the patient is discharged and the date of service on the claim is not within the admission/discharge date range, the DME MACs will process the claim.

Respiratory Care Equip/Oxygen

No Questions Submitted

Prosthetics/Orthotics

2) With the current changes effective 10/01 for orthotics, if a DME company dispenses an item with a product code of OR02 state licensure is required. If the item is billed as a miscellaneous code because supplier is simply dispensing as off the shelf and no fitting occurs, is the state licensure required? If it is dispensed as an off the shelf, no licensure is required per the state licensure database.
   ***Please see attachment.

   DME MAC Response: Change Request (CR) 12282 is specifically addressing custom-fabricated and prefabricated (custom fitted) orthotics in 21 states where licensure or

certification is required for the provision of custom fabricated and custom fitted orthotics. Prefabricated off-the-shelf orthotics are not included in the edit associated with this CR. The supplier should refer to specific state licensure requirements for providing off-the-shelf orthotics in the state where the item is being provided.

Rehab Equipment

3) MLN Matters SE1112 - Power Mobility Device Face-to-Face Examination Checklist (published several years ago) is a helpful tool but still references some of the old policy requirements, and the document still appears as a reference in places on the contractor web sites. We know that as a CMS document, the DME MACs can't revise this; but is there anything that can be done to ask CMS to update this information? If not, is it possible for the DME MACs to publish a similar but updated guide that includes the examples and checklist?

DME MAC response: The DME MACs will discuss with CMS an update to the MLN Matters article and checklist; however, note that both CGS and Noridian have published several checklists related to power mobility requirements. If those are not sufficient, we would need specific information on what the supplier community would like . Additionally, there is a joint "Dear Physician" letter incorporating all requirements for the face-to-face encounter on each DME MAC's websites.

Medical Supplies

No Questions Submitted

Education Documentation

4) There are situations where an individual may be in transition or has completed a gender reassignment and assumed a new name. They may be insistent we use the new name even though the Medicare card still has the birth gender and name.
Social security addresses this topic "How do I change my gender on Social Security's records?" at the following link: https://faq.ssa.gov/en-us/Topic/article/KA-01453; but this does not answer the question when a patient is waiting to be discharged and the name does not match the card.

DME MAC Response: Medicare Fee-for-Service requires that the claim and the Medicare Beneficiary Identifier (MBI) match exactly. Suppliers should verify current information using the online portals or IVR to make sure that the information matches.

a. Should an ABN be obtained since as we expect a denial (because the name does not match the beneficiary's name)?

DME MAC Response: This is not a proper use for an ABN.

b. Since It's technically not a medical necessity denial. What should providers do to get the patient serviced in the moment?
DME MAC response: The supplier should work with the beneficiary to help them understand the requirements of their Medicare insurance. If the beneficiary refuses to comply, provision of service would be a business decision on the part of the supplier.

5) For the current ramp up of TPEs, what will be the guidance provided to auditors and providers on how to work through roadblocks of medical record retrieval due to the health pandemic or natural disaster (Hurricane Ida)?

DME MAC Response: Upon the declaration by HHS of a natural disaster, guidance exists to allow for extended deadlines to produce records. When suppliers are selected for review under the TPE program, the letter they receive from the DME MAC provides information for suppliers who may be experiencing hardship and require time extensions for submitting the requested records.

6) What percentage of claim review and approval is considered a passing TPE Round?

DME MAC response: The error percentage that qualifies a provider/supplier as having a high denial rate varies, based on the service/item under review. The Medicare Fee-For-Service improper payment rate for a specific service/item and other data may be used in this determination, and the percentage may vary by MAC. Other factors that determine the need for additional review may include, but are not limited to, decrease in error rate with each round, as well as participation in, and improvement with, education. https://www.cms.gov/files/document/updated-tpe-qas.pdf