Final to Council Chairs

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

Enteral/Parenteral/IV Therapy

1) The newly added Parenteral Nutrition code, B4187, Omegaven Lipid, is not on the Q1 2020 fee schedule. Home Infusion Pharmacies are starting to receive payment for B4187 that is significantly below acquisition cost. When will the allowable for B4187 be available on the fee schedule?

   Response: As noted in CR11570 (*MLN Matters* MM11570), there are no fees added to the DMEPOS fee schedule file for new HCPCS codes effective January 1, 2020. The Medicare coverage and payment determinations for these items are made based on the discretion of the DME MACs and A/B MACs Part B processing claims for these items, until national Medicare coverage and payment guidelines have been established for these codes. Fee schedule amounts for new HCPCS codes for items and services without a fee schedule pricing history are established using existing fee schedule amounts for comparable items when items with existing fee schedule amounts are determined to be comparable to the new items and services. CR 11570 also makes changes to the gap-fill and continuity of pricing instructions in Chapter 23, Sections 60.3 and 60.3.1 of the "Medicare Claims Processing Manual."

Home Medical Equipment

2) When a beneficiary changes their supplier before the equipment has reached its capped period and a pick-up ticket is unable to be obtained, what are the new suppliers' options for documentation that the beneficiary no longer has the previous providers equipment?

   Response: It is the responsibility of a supplier assuming service to determine that there is no other same or similar equipment in the beneficiary's possession prior to initiating service. The method of establishing this information is not the purview of the DME MAC, however the DME MAC portals offer contact information for previous supplier through their same and similar functionality.

Medical Supplies/Ostomy/Urological/Diabetic Supplies

3) New HIGLAS Recoup FCN numbers do not show the invoice number of the paid invoices. This information is critical to ensure that payments/recoupments are properly applied.
   To obtain this information, providers must call the financial department for assistance which is time consuming and labor intensive. In addition, providers have reported that the information is showing the old HICN number and not the current MBI number. When calling to inquire, providers are told "this is just the way it will be".

   Can the DME MACs please give providers more information to identify the recoupment (i.e. invoice number and correct MBI) in addition to what is currently provided so that we can properly apply the recoupments to the appropriate invoices?

   Response: Receivables created by claims adjustments occurring after the February 2020 transition to HIGLAS can be identified on the remittance advice by the Adjusted Claim Number, Accounts

Receivable Number (the Adjusted Claim Number preceded by "1"), and the Patient Account Number as submitted on the claim and displayed on overpayment letters. Offsets for receivables created prior to transition to HIGLAS will either show the original Accounts Receivable Number along with the associated Adjusted Claim Number or a new HIGLAS Accounts Receivable tracking number. If available, the Patient Account Number as submitted on the claim, HICN, or MBI will also be included to identify the beneficiary. When only the new HIGLAS Accounts Receivable tracking number is displayed, a CGS Customer Service representative can assist in providing more information about the receivable and offset.

4) What is an acceptable time frame for physicians to make an addendum to a beneficiary's medical record (i.e., face to face, reference to PAP compliance in the record, and quantity/frequency information of testing, or receiving recurring supplies etc.)?

   Response: There is not a specified time frame for amendments to medical records. Please refer to the Medicare *Program Integrity Manual*, Publication 100-08, Chapter 3, section 3.3.2.5 – Amendments, Corrections and Delayed Entries in Medical Documentation. Physician notes should generally be contemporaneous with the actual visit. Entries that are made later could be given individual consideration but would carry less weight than contemporaneous notes, particularly the more remote the date of the amendment/addendum relative to the original note.

Prosthetics/Orthotics

No questions submitted

Rehab Equipment

No questions submitted.

Respiratory Care Equipment/Oxygen/PAP/Other

5) The MAC's have indicated that sleep studies scored at 3% can be re-scored.
   a. Does the test need to be rescored at the 4% or can the results at 4% be added to the existing interpretation utilizing properly amending the document?

      Response: Raw data from the original polysomnogram may be used to rescore hypopneas using the 4% desaturation metric. The rescoring and interpretation may be made by either the original interpreting practitioner or a new interpreting practitioner. The report may take the form of a new report (preferred) or a detailed addendum that includes the data and an interpretation indicating that the 4% hypopnea desaturation metric was utilized.

   b. Can a different Physician rescore the test?

      Response: Yes, see 5a.

Documentation/Education/Regulatory/Miscellaneous/Other

6) Is there an update from CMS when the revised ABN form will be issued. The link via CMS with the most recent versions of the form(s) English and Spanish versions is below, but the ABN form CMS-R-131 (Exp. 03/2020) - attached as well.

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN

Response: The ABN form CMS-R-131 is currently waiting update approval from the Office of Management and Budget (OMB). Suppliers are instructed to utilize the existing form until a new form is issued. You will find that information at the link referenced above. The DME MACs have no update on timeframe.

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No questions submitted.