Jurisdictions B, C and D Councils Combined A-Team Questions
February 2022
Final to Council Chairs 01/27/2022

Enteral/Parenteral/IV Therapy

1. Suppliers report when seeing B HCPCs denials related issues for date span/quantity (units) billed, they are being forced to go through redeterminations to get resolution for a technical/clerical error vs simply allowing the date span or units to be corrected via reopening. Claims with these clerical errors could be corrected and reopened. CGS is now denying those claims CO151 and is requesting suppliers to send to redetermination when these are not related to medical necessity. This causes huge administrative burdens for both suppliers and CGS. ***Noridian is doing re-openings on the respective claims for clerical errors***. Why is CGS forcing suppliers to go to redetermination?
    a. If there is no alternative other than to take those respective claims to redetermination, would CGS be able to give a different denial than CO151,that would instead allow doing clerical fixes instead of taking to redetermination?
        i. Note: Examples are available if needed.

    Answer: CO151 is the correct denial message for the claim examples provided. These were MUE related denied and paid claims.
    Reference: Medically Unlikely Edits (MUEs)
    https://cgsmedicare.com/jb/pubs/news/2021/12/cope24468.html
    The Centers for Medicare and Medicaid Services (CMS) created MUEs to reduce the paid claim error rate for Part B claims. An MUE for a HCPCS code is the maximum units of service that a supplier/provider would bill under most circumstances for a single beneficiary on a single date of service. These edits are set to deny claim lines exceeding the acceptable maximums. **MUE denials are identified by ANSI Reason Code CO151 with Remark Code MA01 on the remittance advice.** MUE denials cannot be corrected via reopenings, they must be submitted to redetermination appeals.

Medical Supplies/Ostomy/Urological/Diabetic Supplies

2. How can we request that the HCPCS K0553 for monthly allowance of CGM supplies be updated to a unit of 3 every 3 months? This would allow a DME supplier to bill a one-time quantity of 3 instead of the monthly allowable of 1. Suppliers could then indicate a 3 month supply was sent in the NTE segment.

    Answer: A supplier does not have to deliver supplies used with a therapeutic CGM every month in order to bill code K0553 every 30 days. Suppliers may deliver enough supplies to last for 90 days if they choose; however, only a 30 day supply at a time may be billed to Medicare. This is a CMS decision and not under discretion of the DME MACs to change.

Prosthetics/Orthotics

No questions submitted

Rehab Equipment

No questions submitted

Respiratory Care Equipment/Oxygen/PAP/Other

No questions submitted

Documentation/Education/ Home Medical Equipment/CEDI

3. When a patient's doctor has prescribed over the usual quantity limitations for a product like urological catheters, and there are chart notes to support the extra quantities, we are faced with a dilemma. If we bill the full quantity with an ABN, the claim will deny as patient responsibility. If we don't bill with an ABN, the claim will deny as provider responsibility. Either way, the claim is denied. Is there any way to establish medical necessity for the overage amounts with Medicare so that we don't have to go through the burdensome appeal process every month for the same patient?

   Answer: Initial claims may need to go through the Appeals process to establish the medical need for the ongoing quantity billed; however, once medical necessity has been established for the quantity billed, contractors have the ability to add processing instructions on a case-by-case basis. Those processing instructions should prevent future claim denials for the HCPCS code utilization for that beneficiary.

4. Regarding documentation for CGM - criteria 3 from the LCD, states the beneficiary's insulin treatment regimen requires frequent adjustment by the beneficiary on the basis of BGM or CGM testing results.
   a. Can you provide any insight or guidance on this specific criteria and what clinicians might be looking for to show this criteria has been met? There is a lot of confusion around this. Is simply a statement indicating this acceptable or are there other types of documentation you are seeking?

      Answer: As noted in the Glucose Monitor LCD-related Policy Article (A52464):

      For the in-person treating practitioner visit that is required as part of the initial provision of a therapeutic CGM, there must be sufficient information in the beneficiary's medical record to determine that the beneficiary has diabetes mellitus (criterion 1), requires frequent dosing of their insulin (criterion 2) and frequent adjustment of their diabetes treatment regimen (criterion 3). For criterion 3, it is not a mandate that insulin dose adjustments must be made if glucose levels are within the target range as established collaboratively with their treating practitioner and documented in the beneficiary's medical record.

   b. Similarly, if a medication list in a progress note indicates CGM usage and the list indicates "using or taking as directed" or "reviewed and reconciled" or similar language...if this is the manner in which CGM adherence is documented, is it sufficient to substantiate coverage for ongoing therapy?
      Answer: The DME MACs do not pre-approve specific verbiage in the medical record. Medical Review clinicians look at the totality of the medical record to discern affirmative adherence to CGM usage documentation.

5. If a patient has equipment that Medicare paid for and it is patient owned, can the supplier charge a service fee to go an assess the equipment in the patient's home? It could be a manual wheelchair, power wheelchair, hospital bed, seat lift mechanism or other equipment that the patient owns and that was dispensed by another supplier or the current supplier. There might not be any repairs needed. A similar question/answer was in a Jur D DAC Q & A, Feb 2009, question #4, and this is even more of an issue today.

   Answer: As noted in the Medicare *Benefit Policy Manual* (CMS Pub. 100-02), Chapter 15, Section 110.2.B: *Routine periodic servicing, such as testing, cleaning, regulating, and checking of the beneficiary's equipment, is not covered.*

6. When a CPAP beneficiary is new to Medicare:
   a. Do the MACs allow suppliers to utilize any documentation that originated prior to the Medicare eligibility date?
      i. Prescriptions?
      ii. FTF visits?
      iii. Sleep tests?
      iv. Proof of Delivery?

   Answer: Refer to PAP LCD L33718. For beneficiaries who received a PAP device prior to enrollment in fee for service (FFS) Medicare and are seeking Medicare coverage of either rental of the device, a replacement PAP device and/or accessories, both of the following coverage requirements must be met:

   1. Sleep test – There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare enrollment, that meets the Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks Medicare coverage of a replacement PAP device and/or accessories; and,

   2. Clinical Evaluation – Following enrollment in FFS Medicare, the beneficiary must have an in-person evaluation by their treating practitioner who documents in the beneficiary's medical record that:
      a. The beneficiary has a diagnosis of obstructive sleep apnea; and,
      b. The beneficiary continues to use the PAP device.

   PROOF OF DELIVERY REQUIREMENTS FOR RECENTLY ELIGIBLE MEDICARE FFS

   The supplier record must document:

   - A statement, signed and dated by the beneficiary (or beneficiary's designee), that the supplier has examined the item, meets the POD requirements; and
   - A supplier attestation that the item meets Medicare requirements.

7. When a CPAP beneficiary replaces equipment due to a reasonable useful lifetime:
   a. Do the MACs allow suppliers to rely on any documentation from the original delivery?
      i. Prescriptions?
      ii. FTF visits?

iii. Sleep tests?
iv. Proof of Delivery?

b. If the originating documentation is over 7 years old and is no longer available, what documentation will the MACs require? Is a statement about the past existence and age of the prior documentation sufficient?

Answer: Refer to the PAP LCD L33718. If a PAP device is replaced following the 5 year RUL, there must be an in-person evaluation by their treating practitioner that documents that the beneficiary continues to use and benefit from the PAP device. There is no requirement for a new sleep test or trial period. A new SWO is required for replacement. Proof of delivery is required for the replacement equipment, please refer to Article - Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426) (cms.gov)

If the original device was not paid for Medicare, then refer to the answer to question # 6.

8. When an oxygen patient is new to Medicare:
   a. Do the MACs allow suppliers to utilize any documentation that originated prior to the Medicare eligibility date?
      i. Prescriptions?
      ii. FTF visits?
      iii. ABG and SAT tests?
      iv. Proof of Delivery?

Answer: Refer to the Oxygen LCD L33797. All requirements in the Oxygen policy for an initial oxygen certification must be followed. There is only one exception to the 30-day test requirement; beneficiaries who were started on oxygen while enrolled in a Medicare HMO (Medicare Advantage Plan) and transition to fee-for-service Medicare. For those beneficiaries, the blood gas study does not have to be obtained 30 days prior to the Initial Date but must be the most recent qualifying test obtained while in the HMO.

If a beneficiary enters Medicare FFS with beneficiary-owned equipment, accessories, maintenance, and repairs are statutorily non-covered by Medicare. Contents are separately payable for beneficiary-owned gaseous or liquid systems.

9. When an oxygen patient replaces equipment after five years of service:
   a. Do the MACs allow suppliers to rely on any documentation from the original delivery??
      i. Prescriptions?
      ii. FTF visits?
      iii. ABG and SAT tests?
      iv. Proof of Delivery?

Answer: Refer to the Oxygen LCD L33797. Repeat blood gas testing is not required. Enter the most recent qualifying value and test date in the CMN. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN.

There is no requirement for a treating practitioner visit that is specifically related to the completion of the CMN for replacement equipment. Proof of delivery is required for replacement equipment. A new order and CMN is required for replacement.

10. We are seeing beneficiaries using PO Boxes in rural areas that do not offer home delivery and increasingly in cases where beneficiaries are opting for PO Boxes for personal security purposes. As long as the supplier utilizes proper tracking protocols with each shipment, will shipping to a PO Box cause an issue with audit when the delivery service tracking document contains a PO Box address?

    Answer: Proof of delivery via shipping or delivery requires documentation of evidence of delivery. Medicare does not specify how evidence of delivery is documented. A PO Box would not be appropriate for any item that requires direct, in-person delivery.