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

Enteral/Parenteral/IV Therapy

1. DME Suppliers of External Infusion Pumps and Supplies (EIP) are getting many questions about how to locate a Medicare enrolled Home Infusion Therapy (HIT) Services supplier to meet the in-home nursing needs of patients using DME Infused drugs. Can the DME MACs provide direction regarding how to locate HIT Services suppliers? DME suppliers may very well need to discontinue servicing beneficiaries if the nursing component of care cannot be met for safety concerns.

   DME MAC Response: The Centers for Medicare & Medicaid Services maintains a searchable directory of home infusion therapy suppliers on their website. Per the CMS website, this list will be updated bi-weekly. You may view this directory at: Home Infusion Therapy Providers | Data.CMS.gov

2. In situations when a supplier has made a minor error or omission in filing a claim which causes a denial or short payment, a reopening to correct the error should be the course of correction; however, recently as of February, claims denied for CO-151 due to billing errors with incorrect units of service and/or service dates are no longer allowed and are now required to go through the appeals/redetermination process. Why has CGS implemented this change when it creates additional administrative steps to both the supplier and the medical review teams, and will this be a permanent change?
   a. https://cgsmedicare.com/jc/pubs/news/2012/0712/cope19367.html
   b. https://cgsmedicare.com/jc/claims/reopenings.html#written

   DME MAC Response: Claims denied as not reasonable and necessary (not medically necessary) must be appealed through redeterminations. Due to the complexity of these types of denials, additional research or consulting with medical staff may be required. Both CGS and Noridian require all claims denied for medical necessity to be appealed to correct a minor error or omission.

Home Medical Equipment

No questions received.

Medical Supplies/Ostomy/Urological/Diabetic Supplies

3. We are requesting additional review and coverage clarification for criteria # 2 for A4353 under LCD 33803. The LCD criteria lists four bullet point examples but goes on to say that these four examples are not an all-inclusive list of immunosuppressed conditions.

   The coverage criteria states that A4353 is covered when:

   2. The beneficiary is immunosuppressed, for example (not all-inclusive):
   • on a regimen of immunosuppressive drugs post-transplant,
   • on cancer chemotherapy,
   • has AIDS,
   • has a drug-induced state such as chronic oral corticosteroid use.

   Research indicates that high-level lesion spinal cord injuries (greater than thoracic level 3) result in the loss of CNS control over the peripheral immune system leading to spinal cord injury-induced

immune deficiency syndrome putting the patient in a state of immunosuppression. There is an abundance of clinical research to support these findings. Attached is a list that includes some of the related research.

The clinical scenario in question – complete high-level spinal cord injury –meets the definition of immunosuppressed, however auditors tend to look only at the four bullet point examples to determine if the 2nd criteria is met. The criteria specifically note that the examples are not an all-inclusive list, which indicates that other clinical scenarios meet the definition of immunosuppression. High level (> T3), complete, spinal cord injury is one of these conditions.

What documentation would need to be in the medical record to support medical necessity under this criterion (i.e. immunosuppressed)?

DME MAC Response: The DME MACs have received the reference list and will review it, and afterwards will respond to your request.

Updated MAC Response (October 28, 2021): The DME MACs have received and reviewed the reference list and literature demonstrates that high-level spinal cord injury patients experience increased infections, such as pneumonia, at a higher rate relative to mid (T4-T8), and lower level thoracic injury (T9-T12). The list of examples in the Urological Supplies LCD (L33803) describe scenarios that could result in immunosuppression and is not all-inclusive but rather represents common conditions likely to result in immunosuppression. The example of high-level spinal cord injury patients (higher than T3) will be considered for coverage when conducting medical reviews of Intermittent catheterization using a sterile intermittent catheter kit (A4353).

Prosthetics/Orthotics

4. Does the definition of "individual who has specialized Training" for the custom fitted orthotics outlined in the March 11, 2021, "Custom Fitted Orthotic HCPCS Codes Without a Corresponding Off-the-Shelf Code – Correct Coding" article parallel/correspond with the definition for "Specialized Training" as stated in the Appendix C Glossary section of the DMEPOS Quality Standards booklet (MLN 905709)? While this training is not further defined by CMS, to obtain certification and licensing an individual would need to work with BOC, ABC, or some other organization that provides this recognized training. If the NSC licensure database does not have an O & P license requirement we would suggest referring to the state requirements, as they often have an O & P board that could better define these parameters.

   DMD MAC Response: The DME MACs recommend that you consult CMS for further direction on this topic as they are the authors of the booklet referenced above.

Rehab Equipment

5. If we are submitting a claim expecting a medical necessity denial for a wheelchair - we are not adding KX, we do have a valid ABN and are adding 'GA" to the claim; do we also still need to add KE/KU/KY? Do we need to include a detailed narrative for any K0108s?

   DME MAC Response: To ensure claims are adjudicated correctly, suppliers must append the appropriate KE/KU/KY modifier to their wheelchair accessory claim lines along with the GA modifier. Items billed with the not otherwise classified (NOC) code K0108, require a

narrative description to be entered on the claim. Failure to include a narrative description for the NOC item will result in the claim being rejected as unprocessable.

6. Can we get some clarification on medical necessity denials (where we would need an ABN and bill with the GA modifier and expect to receive a PR denial) vs statutorily non-covered denials (bill with GY, no ABN required, should deny PR) for these common situations:
    a. Beneficiary is getting a Group 4 PWC
    b. Beneficiary is getting a back-up chair (example - has a PWC paid for by Medicare as a primary chair, but wants to get a back-up manual chair)
    c. Beneficiary needs repairs to a non-covered back-up chair
    d. Beneficiary is getting a wheelchair, but the documentation is clear that a wheelchair is needed for community use only
    e. Beneficiary who resides in a SNF needs a wheelchair (even if their stay is not covered by Medicare)

DME MAC Response:

a. **Beneficiary is getting a Group 4 PWC -** Per the LCD for Power Mobility Devices, Group 4 PWCs have added capabilities that are not needed for use in the home. Therefore, if these wheelchairs are provided for use in the home, they will be denied as not reasonable and necessary. Suppliers are required to properly execute an ABN and append the GA modifier to these claims in order to receive a patient responsibility denial PR-50.
b. **Beneficiary is getting a back-up chair (example - has a PWC paid for by Medicare as a primary chair but wants to get a back-up manual chair) -** Medicare does not cover spare or back-up equipment. Claims for backup equipment will be denied as not reasonable and necessary - same/similar equipment. Suppliers are required to properly execute an ABN and append the GA modifier to these claims in order to receive a patient responsibility denial PR-151.
c. **Beneficiary needs repairs to a non-covered back-up chair -** All Medicare requirements (i.e., National Coverage Determination criteria, Local Coverage Determination criteria, documentation requirements, statutory requirements) must be met for the base equipment before billing for any repairs. Medicare does not reimburse for the repair of equipment previously denied or does not meet Medicare's requirements. Suppliers are required to properly execute an ABN and append the GA modifier to these claims in order to receive a patient responsibility denial PR-50.
d. **Beneficiary is getting a wheelchair, but the documentation is clear that a wheelchair is needed for community use only. –** Per the Policy Article for PMDs, if any POV or PWC is only for use outside the home, it will be denied as noncovered. Supplier must append the GY modifier to the base code and all accessories in order to receive a patient responsibility denial PR-96.
e. **Beneficiary who resides in a SNF needs a wheelchair (even if their stay is not covered by Medicare) –** ABNs are not applicable to services provided during a SNF stay. If a wheelchair is provided while the beneficiary is covered under a Part A SNF stay, the claim will deny as not separately payable, as the SNF is required to provide DME to beneficiary during their Part A stay. If the wheelchair is provided to the beneficiary in a SNF outside of a Part A stay, the wheelchair will be denied as not covered. Review the Medicare DMEPOS Improper Inpatient Payments (PDF) fact sheet to help you bill correctly. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedDMEPOSInpatient-MLN1541573.pdf

Respiratory Care Equipment/Oxygen/PAP/Other

No questions to submit.

Documentation/Education/Regulatory/Miscellaneous/Other

7. If an SWO is provided to the supplier prior to delivery, and a WOPD isn't required, but the item(s) is not immediately provided, how long is the SWO valid before the supplier would need to request a new one? (reworded original question)

   DME MAC Response: The length of time an order is valid can vary, based upon the clinical condition for which the item(s) is prescribed. For some clinical conditions for which there is little change over time, an order may be valid for longer than something like surgical dressings or support surfaces, where clinical conditions may change daily or weekly. Suppliers must also be aware that there may be state laws or regulations governing the length of time an order may be valid. Additional information on orders and documentation requirements may be found in the Standard Documentation Requirements (SDR) Policy Article (A55426).

8. With all of the documentation waivers in place during the PHE, has CMS provided any guidance for what will happen after the PHE ends? Specifically, with Oxygen CMNs and Pap Compliance.

   DME MAC Response: No. The most current and up to date information related to the public health emergency can be reviewed on the DME MACs COVID-19 web pages or on the CMS Current Emergencies web page at: Current emergencies | CMS

CEDI

No questions received.