Jurisdictions D, B, and C Councils Final Combined A-Team Questions
2nd Quarter May 2023

Enteral/Parenteral/IV Therapy

1. The place of service for DMEPOS claims is considered the location where a beneficiary will primarily use the DMEPOS item. The list of acceptable POS codes includes, among others, 04 – Homeless Shelter, 12 – Home, 13 – Assisted Living Facility, and 56 – Psychiatric Residential Treatment Center.

   01 – Pharmacy is also listed as place of service where DMEPOS claims would be considered for coverage. Under what circumstances would DMEPOS items be covered when the place of service is 01 – Pharmacy?

   DME MAC response: Any covered DMEPOS item will be considered in place of service 01 Pharmacy. Chapter 6 of the Supplier Manual provides a list of place of service codes that may be considered. DME MACs would expect that this would be an unusual occurrence. Please provide examples in which POS 01 place code has been used.

Medical Supplies/Ostomy/Urological/Diabetic Supplies

No questions submitted.

Prosthetics/Orthotics

No questions submitted.

Rehab Equipment

2. Is it possible to disclose the exact formula used to determine the allowable on miscellaneous codes (K0108, E2609, E2617)? There have been varying amounts from 20%-70% of MSRP and in the current environment with significant cost increases, it is essential for suppliers to know the allowable for misc. codes in order to decide if they can provide the item.

   DME MAC response: Reimbursement for miscellaneous codes is determined individually. The allowed amount for these codes are calculated under individual consideration using the gap-filling methodology described in Publication 100-04, Medicare Claims Processing Manual, Chapter 23, Section 60.3.

3. Revisited Question from February 2023 - There have been PA and ADMC approvals for skin protection and or positioning cushions and solid seat PWC bases without a qualifying diagnosis as required per policy. In addition, there has been a captain's seat PWC denied in PA as a result of the reviewer indicating that the beneficiary qualifies for a skin protection and or positioning cushion. We've been informed that the reviewers are not approving / denying these in error but are making a clinical judgement. When the supplier submits for PA / ADMC without a qualifying ICD10 and it is approved or a captain's seat PWC is denied for this reason,

could the MAC override the claim edit for the ICD10 to ensure it will not deny for lack of a qualifying ICD10 based on the individual consideration / clinical judgement? Otherwise, this will continue to lead to a denial and a subsequent appeal which uses unnecessary resources for both the supplier and the MAC.

DME MAC response: The ICD-10 code itself is not required for a prior authorization review, however, a diagnosis description is required as a part of the medical record. Medical review will take into consideration that documentation in the medical record for a covered diagnosis or condition when issuing a prior authorization or advance determination of Medicare coverage (ADMC) decision.

4. To accommodate the requirements at 42 CFR 410.38, when the treating practitioner sees the beneficiary, regardless of whether a referral to an LCMP is made, that visit date begins the six (6) month timeline for completion of the SWO for the wheelchair base. If the treating practitioner chooses to refer the beneficiary to an LCMP for a mobility evaluation, the treating practitioner's co-signature, dating and indicating agreement or disagreement with the LCMP evaluation must occur within this six (6) month timeframe. In cases where the LCMP evaluation is being adopted into the practitioner's documentation to substantiate the need for the base item, the SWO may not be written until the LCMP report is signed, dated and agreement/disagreement indicated.

   As written, this states if there is a referral by the treating practitioner to an LCMP for a mobility evaluation, that treating practitioner must co-sign, date, and note agreement or disagreement with the LCMP evaluation within the six (6) month timeframe between the treating practitioner's face-to-face encounter and the writing of the SWO for the base equipment.

   If the prescribing clinician refers the beneficiary to the LCMP prior to conducting their face-to-face encounter, and if the prescribing clinician co-signs, dates, and notes agreement/disagreement on the LCMP evaluation before seeing the beneficiary for the face-to-face encounter, is this acceptable, or must the prescribing clinician wait until after they conduct their face-to-face to sign/date annotate the LCMP mobility evaluation, so the date of signature, etc. falls within the 6-month window? (i.e., does the treating practitioner need to wait until after they conduct their face-to-face to sign the LCMP eval if the LCMP eval was conducted and sent to them prior to their face-to-face encounter)?

   DME MAC response: The visit with the treating practitioner starts the 6-month timeline for completion of the SWO for the base. If the treating practitioner chooses to refer the beneficiary to an LCMP for a mobility evaluation, and the LCMP evaluation is being adopted into the practitioner's documentation to substantiate the need for the base item, **the treating practitioner's co-signature, dating and indicating agreement or disagreement with the LCMP evaluation must occur within this six (6) month timeframe.** *Therefore, a specialty evaluation performed prior to the treating practitioner's visit should be reviewed and agreed/disagreed upon at the time of or after the date of the treating practitioner's visit.*

Respiratory Care Equipment/Oxygen/PAP/Other

5. For oxygen patients that were initially set up while the patient was in fee for service, then switched to a Medicare Advantage plan, but switch back to fee-for-service. Is it required to obtain new proof of delivery for the oxygen equipment, or are we able to use the initial set up proof of delivery?
   DME MAC response: The DME MACs would allow the original proof of delivery documentation if the beneficiary was initially prescribed and delivered oxygen under fee-for-service (FFS) Medicare and then transitioned to a Medicare Advantage plan and back to FFS without a break in need.

6. A physician orders a pulse oximetry study, reviews the results, and orders oxygen. To meet the oxygen LCD requirement of "order and evaluate" will the following documents be required to meet the new LCD?

   a. Does the physician need to sign the pulse oximetry test? (This may not be likely in some offices because the physician may or may not have the ability to print, sign and upload back into the records?)
      DME MAC response: No, however, co-signature or initialing by the treating practitioner may be used as evidence of testing evaluation.
   b. Does the physician need to clearly document in the medical record "I personally **r**eviewed the pulse oximetry record"?
      DME MAC response: No, however the DME MACs will look for documentation of a qualifying test result in the beneficiary's medical record along with a discussion about the need for oxygen to improve the beneficiary's medical condition or hypoxemia (Groups I and II). Alternatively, as noted above, the DME MACs will accept co-signature or initialing by the treating practitioner as evidence of testing evaluation.
   c. Can it be assumed that for patients who are ordered oxygen tests the completion of a standard written order will fulfill the requirement of "order and evaluate"?
      DME MAC response: No, the requirement in the LCD is for the blood gas study to be ordered and the results evaluated by the treating practitioner. The medical record would need to reflect the evaluation and subsequent order of oxygen. The SWO for the oxygen equipment is a separate requirement.

7. With confirmation from CGS that the CMS 484 certificate of medical necessity (CMN) can't be used as the SWO for the oxygen, when a recertification is needed for a patient that is due, if we had an CMS 484 prior, are we required to get a SWO to continue billing?
   DME MAC response: No
   From January 1, 2023, forward, suppliers must follow the continued need requirements. The following are acceptable documentation of continued need per the standard documentation article A55426:

   - A recent order/prescription by the treating practitioner for refills of supplies;
   - A recent order/prescription by the treating practitioner for repairs;
   - A recent change in an order/prescription;
   - A properly completed CMN or DIF completed prior to DOS 01/01/2023, with the appropriate length of need specified;
   - Timely documentation in the beneficiary's medical record showing usage of the item.

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

a. If notes or new order can show continued medical need but if the CMS 484 had 99 months, does it have to be updated going forward?
DME MAC response: No, CMNs are no longer acceptable after January 1, 2023. Any CMNs prior to January 1, 2023, are considered valid to support continued need for 12 months (or LON listed on CMN) from the date of issuance.

b. What if our original CMS 484 had the refills listed on it and we are now billing for refills of capped patient, if we have notes showing continued need, do we need a new SWO to replace the CMS 484 we had from the original setup?
DME MAC response: If the CMN provided prior to January 1, 2023, was acting as the order, and indicated oxygen contents, that order will remain valid assuming state law does not mandate a time limit on orders. Suppliers will need to continue to monitor continued need and produce documentation of need upon request.

c. Does the CMS 484 expire if it is part of the medical record prior to 1/1/2023?
DME MAC response: The CMN has never been considered part of the medical record. CMNs issued prior to January 1, 2023, will expire at 12 months (or less, depending on LON listed)

8. Can you confirm on oxygen 36 months rental the requirement is specific to 36 rental payments and not just the customer having oxygen for 36 months?
DME MAC response: Yes, the oxygen is capped after a total of 36 months of rental have been paid.

Documentation/Education/ Home Medical Equipment/CEDI

9. We are seeing TPE denials for sections of the medical record where a portion is being denied as not part of the medical records. The notes are authenticated by the author or clinician prior to hospital discharge. Per the information below, we believe these records should be substantiated as part of the patient's medical record. We are seeing inconsistency in the interpretation of what is considered part of the medical records during the TPE audit.

   Resources below and also the Q&A from CGS. Examples are available if needed.

   CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, §5.9; Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15; Pub. 100-04, Medicare Claims Processing Manual, Chapter 12; Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426) and Chapter 3 section of the Supplier Manual states "The beneficiary's medical record is not limited to the treating practitioner's office records. It may include hospital, nursing home, or home health agency records, records from other 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 the purpose of determining that an item is reasonable and necessary."

   Are the notes from the nursing home acceptable as part of the medical record?

- Yes. The Standard Documentation Requirements for All Claims Submitted to DME MACs states: In the event of a claim review, information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. 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).

  https://cgsmedicare.com/jc/education/qa/principles.html

DME MAC response: Please contact the appropriate jurisdictions and provide examples.