Jurisdictions B, C and D Councils Combined A-Team Questions
August 2023

Enteral/Parenteral/IV Therapy

No questions submitted.

Medical Supplies/Ostomy/Urological/Diabetic Supplies

1. According to the Urological Supplies policy article, "for all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered, therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. Once initial medical need is established, unless continued coverage requirements are specified in the LCD, ongoing need for urological supplies is assumed to drain or collect urine for a beneficiary who has permanent urinary incontinence or permanent urinary retention. There is no requirement for further documentation of continued medical need as long as the beneficiary continues to meet the Prosthetic Devices benefit." If a patient's urological supplies are audited by the MAC and the MAC determines medical necessity has been established for the urological supplies, is there a mechanism in place to exclude that patient from future similar audits conducted by the MAC? For example, a patient was audited for the A4351 during the TPE and the claim was allowed, is there any mechanism in place that would prevent a subsequent order for the same patient to be audited again in the same TPE case?

   DME MAC response: If the DME MAC Medical Review staff determine a supply item is medically necessary, that beneficiary MBI should not receive another TPE letter for that specific HCPCS code later in the same TPE case (i.e., the following month's claim).

2. CO273 Denials:
   a. A6196 and A6197 Denials. Began 05/2023 to 06/2023: These occur where a traditional alginate primary is used with a super absorbent alginate secondary of the same size (A6196 or A6197) are being provided for the same wound(s). Based on the LCA update in 2020, use of the two types of alginates is allowed for the same wound. Denials are in all regions. We believe this to be a recent MUE change or auto denial edit. Please advise if an MUE shift has occurred here. If so, we would like to request the MUE be reverted back to 60 per A1 and the claims globally reprocessed. Or we would request a mechanism to alert the MACs that this situation is occurring, since we must combine like codes to avoid a duplicate HCPC denial.
      i. CCN Examples:
         1. JC – 23157701850000
         2. JC – 23157701873000
         3. JC – 23158716608000
         4. JC – 23163727652000
         5. JA – 23153713559000
         6. JA – 23153737922000
         7. JD – 23150892663000

      DME MAC response: These particular codes are not listed on the July 1, 2023, MUE list at https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-

initiative-ncci/ncci-medicare/medicare-ncci-medically-unlikely-edits. As such, the DME MACs are unable to provide any guidance on any MUE denials. Suppliers are encouraged to utilize the Appeals process for claim denials.

b. A6011 Denials – Began 09/2022: This product is billed by the gram. A6011 claims are being denied due to billing for 42 or 84 units. Because of the conversion from ounces to grams, all sizes of the gel tubes exceed the allowable units/mo, triggering all units to deny. A 1.5 ounce tube converts to 42 grams. It seems an MUE/automatic denial edit has been created if the units exceed 30 units for A1 or 60 units for A2, etc. The LCD does not specify a limit for collagen gel. The edits have been/should be max 84 units per wound, or 3 ounces, per month. Will you please advise if a systemic change occurred for this code? If so, we ask that the adjustment be reversed and claims reprocessed.

   DME MAC response: This particular code is not listed on the July 1, 2023, MUE list at https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare/medicare-ncci-medically-unlikely-edits. As such, the DME MACs are unable to provide any guidance on any MUE denials. Suppliers are encouraged to utilize the Appeals process for claim denials.
   Additionally, the following is from the Surgical Dressings related Policy Article (A54563): "For some wound fillers, the units on the package do not correspond to the units of the code. For example, some pastes or gels are labeled as grams (instead of fluid ounces), some wound fillers are labeled as cc. or ml. (instead of fluid ounces or grams), and some are described by linear dimensions (instead of grams). In these situations, the supplier must contact the manufacturer to determine the appropriate conversion factor or unit of service, which corresponds to that used by the code narrative."

3. Surgical Dressing Modifier Protocol Issues/max limits: When a patient has 1 wound (A1) receiving 30 units of a certain product per month, then with in that month, the patient develops a 2nd wound that also receives the same dressing using the same HCPCS code, the current modifier protocol is unable to differentiate that the beneficiary has a 2nd wound, and lumps those units toward the "30 per month" maximum amount allowed "per wound". Providers are seeing denials for products when the combined total of supplies for two wounds exceeds the quantity max for one wound. The request is for a mechanism to identify multiple wounds when the modifier alone does not provide clarity.

   DME MAC response: Suppliers should append the A2 modifier which signifies dressings for two wounds and add a claim narrative indicating the dressing is for two wounds.

Prosthetics/Orthotics

No questions submitted

Rehab Equipment

4. Since group 4 power wheelchairs, group 2 scooter and total electric hospital beds are never covered could the requirement of an ABN be removed and the system be updated to auto deny with a PR.

DME MAC response: The use of the ABN is to assure the Medicare beneficiary is aware of the approximate amount they will be responsible for if/when the claim is found not reasonable and necessary and denied.

5. Suppliers are having claims split, then all the accessories will deny CO16 since they process before the base code. Suppliers have to wait until the base posts to pay then resubmit the accessories. The MACs have indicated in the past that with more than 9 lines this will occur due to system limitations but recently it's happening on claims with less than 9 lines. This example is for a manual wheelchair K0005 with 7 accessory codes (total 8 lines). The base was separated by itself, and ALL accessories denied CO16. Please advise the best practice to address this other than having the accessories deny and resubmit as that uses internal resources. Example available for Jur C.

   DME MAC response: The CCN was requested from the council administrator. (Per a member of the CGS Technical Team and the CGS Claim Denial Resolution Tool, a CO-16 generally indicates the HCPCS code(s) in question were not billed correctly. They must be corrected and resubmitted.)

6. Jurisdiction B has recently issued a non-affirmed decision in a prior authorization case for a power articulation foot platform (E1012) stating that the coverage criteria were not met, but listed the coverage criteria for tilt/recline. Jurisdiction D has recently denied the same item on a K0823 stating that the base cannot accommodate power elevating legs.
   a. While the PDAC indicates that power elevating legrests/platforms are considered a power function, the actual LCDs do not.

      DME MAC response: Reach out to the appropriate DME MAC for specifics. (DME suppliers must adhere to the coverage criteria outlined in the LCDs. Please be aware that any non-affirmation prior authorization decisions may be resubmitted with updated documentation assuming LCD timelines allow for it.)

   b. Would a beneficiary be able to qualify for a power wheelchair with power elevating legs as the only power function? And if so, what would be the appropriate base for that beneficiary given that all other PWC coverage criteria were met?

      DME MAC response: Again, reach out to the appropriate DME MAC for specifics. (Please note the Power Mobility Devices LCD (L33789) indicates a not reasonable and necessary denial if power elevating leg rests is the only power function.)

Respiratory Care Equipment/Oxygen/PAP/Other

7. Patients set up before the PHE, who were not able to obtain a retest, re-evaluation or sleep study during the PHE and are still on service after the PHE, can the CR modifier and COVID-19 narrative be used on claims for these patients?

   DME MAC response: If the DME supplier has previously billed claims with the CR modifier and “COVID-19” narrative, they can continue to bill using the CR modifier and narrative.

8. If a patient was set up during the PHE under non-enforcement of certain LCDs, and did not have a break in service, do PHE waivers continue to apply when the patient is eligible for an RUL replacement? Can we continue to use the CR modifier as long as we have an order for the equipment and supplies?

   DME MAC response: Please refer to Question 16 of the Post COVID-19 Public Health Emergency (PHE) Questions & Answers. The question reads: "How long can the CR modifier be used after May 12th, 2023, for items initially dispensed during the PHE?" The answer reads: "For dates of service on or after May 12, 2023, the CR modifier can be used for as long as the item continues to be reasonable and necessary."

9. Would like clarification on the nebulizer policy. Prior to 6-2022 we had to follow Group 8 diagnosis codes from the policy article to bill E0570 when used with the drug albuterol. The policy was updated in June of 2022 and now it reads differently. It says to refer to the Group 3 Codes in the policy article for a small volume nebulizer (A7003, A7004, A7005), and related compressor (E0570) to administer the listed FDA-approved inhalation solutions. Albuterol is a listed drug. The questions are:
   a. If albuterol is being prescribed and they are coming to us for a nebulizer compressor and supplies, do we use the Group 3 codes or the Group 8 codes?

      DME MAC response: Use the Group 3 Paragraph ICD-10 codes for HCPCS A7003, A7004, A7005, and E0570.

   b. Neither Group includes Covid as a diagnosis. Will there be consideration to update the Group codes to include Covid? As of right now, if the patient has Covid, would we need to use an ABN and bill the patient?

      DME MAC response: If additional diagnoses are requested for addition to the Nebulizers LCD or related Policy Article, please send the proposed changes to the DME MACs as part of an LCD Reconsideration. Proposed changes could require a notice and comment period. Alternatively, the specific reason or diagnosis for the use of the nebulizer should be appended in lieu of, or in addition to, the Covid-19 diagnosis.

Documentation/Education/ Home Medical Equipment/CEDI/Other

No questions are being submitted.