Jurisdictions B, C and D Councils Combined A-Team Questions
August 2024 – POE Proposed Responses to the DMDs
Final to Councils from the DME MACs - July 27, 2024

Enteral/Parenteral/IV Therapy

1. The Kangaroo Joey Enteral Pump feeding bags have been on backorder or unavailable for most of 2024. This is due to the Kangaroo Pump which will no longer be manufactured, being replaced with a newer enteral pump from this manufacturer and new feeding bags which do not fit the Joey pump. There are no universal alternatives to use with the Kangaroo Joey pumps that many enteral patients have in their home, so providers have had to purchase new pumps for these patients.

   Is there clinical justification for coverage of a new pump within the 8yr RUL since the lack of a feeding bag renders the pump useless and these beneficiaries are reliant on this life sustaining nutrition support therapy on a daily basis. (This may have some similarity to other situations where manufacturers go out of business, stop making products that are necessary for a given device etc.)

   See the following URL for background information:
   Kangaroo-ePump-Kangaroo-Joey-End-of-Life-Communication-6-17-2024.pdf (nutritioncare.org)

   DME MAC Response: Based on Medicare DMEPOS Supplier Standards 42 CFR 424.57(c)(14), "Must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries. The item must function as required and intended after being repaired or replaced;" during the rental period, if a pump is non-functional, in this case, due to a lack of access to certain parts, the supplier would need to replace the pump with one that is operable.

   Similarly, if the pump is purchased, based on the Medicare DMEPOS Supplier Standards 42 CFR 424.57(c)(15), "Must accept returns from beneficiaries of substandard (less than full quality for the particular item or unsuitable items, inappropriate for the beneficiary at the time it was fitted and rented or sold);" a parenteral/ enteral pump that is considered inoperable during the reasonable useful lifetime (RUL) of 8 years, would be regarded as substandard and it is the supplier's responsibility to provide the beneficiary with a new pump.

Medical Supplies/Ostomy/Urological/Diabetic Supplies

2. The recent FAQ published for Lymphedema was extremely helpful in clarifying that no RT/LT modifiers were required for the compression pantyhose items; however, there is still some confusion around whether you would bill with a QTY of 1 or 2 for these HCPCS code since the HCPCS description is "each".

   DME MAC Response: As the HCPCS description is "each," DME suppliers should bill one pair of pantyhose compression item as one unit of service.

Prosthetics/Orthotics

3. Related to the updates to the master list released in May and effective August 12. The policy article for knee orthoses (A52465) states that the difference between a prefabricated, OTS product and a prefabricated, custom fit product is "only differentiated by the nature of the final fitting performed at the time of delivery". When both items require prior authorization, but which item is necessary for that patient is determined at the time of fitting, how are suppliers supposed to know which code to get authorized for the patient when authorization must occur prior to fitting?

   DME MAC Response: The DMEPOS supplier should initially submit both HCPCS codes for prior authorization to help assure the conditional affirmation is in place prior to submitting a claim to the DME MAC.

4. When both custom fit and OTS codes require authorization, but authorization isn't determined until fitting, can suppliers request authorization for both codes? How would that work?

   DME MAC Response: The DMEPOS supplier should initially submit both HCPCS codes for prior authorization to help assure the conditional affirmation is in place prior to submitting a claim. Submission will follow standard prior authorization avenues (use of the DME MAC web portals).

5. When a custom fit code is sent for prior authorization, how is it reviewed differently than the same products OTS code? In other words, are there different requirements for prior auth for a custom fit code than a OTS code when the product is the same?

   DME MAC Response: The documentation packet will be reviewed in accordance with the applicable LCD coverage criteria and standard documentation requirements. The documentation of fitting of delivery and proof of delivery could be reviewed in a post-pay audit.

6. If a supplier requests authorization for the custom fit code and then determines at the time of fitting that custom fitting is not required, can they bill the prefab/OTS code or would they have to stop the fitting, get a new authorization for the prefab/OTS code and then re-schedule the patient to deliver the OTS orthosis?

   DME MAC Response: If both HCPCS codes require prior authorization, the supplier will need start the process for the OTS HCPCS code. The DMEPOS supplier can initially submit both HCPCS codes for prior authorization to help assure the conditional affirmation is in place prior to submitting a claim. Be aware of written order prior to delivery (WOPD) and face-to-face encounter guidelines for HCPCS on the Master List as well as prior authorization requirements.

7. If a standard written order lists the custom fit code (instead of a narrative or a product name), but the supplier determines at the time of fitting that custom fitting is not necessary, must a new prescription be obtained with the OTS HCPCS on it prior to delivery?

   DME MAC Response: If the order is specific to a HCPCS code and that item is not provided, a new order should be obtained. The DMEPOS supplier should be aware of written order

prior to delivery (WOPD) and face-to-face encounter guidelines for HCPCS on the Master List and prior authorization.

Rehab Equipment

8. When an accessory such as seat elevation is added to an existing power wheelchair due to the beneficiary meeting the coverage criteria would it be appropriate to bill labor time K0739 since this addition requires the skill of a technician?

   DME MAC Response: The DME supplier should not bill K0739 because no repairs were made to the beneficiary's wheelchair. The allowance for the seat elevation accessory covers any associated labor costs of adding the accessory to the wheelchair base.

9. If a beneficiary weighing 428 – 600 lbs. qualifies for a power wheelchair with power tilt and power recline per policy but the mobility limitation is not due to a neurological condition, skeletal deformity, or myopathy; will Medicare allow - during the prior authorization process - a group 3 VHD multiple power base code (K0863) since there is no group 2 VHD multiple power option base code equivalent?

   DME MAC Response: Similar questions have been asked and answered multiple times over the past few years. DME MACs are unable to authorize an upgraded/different DMEPOS item when the coverage criteria are not met for that item. The DMEPOS supplier can provide the upgraded base (in this scenario) to the Medicare beneficiary or they can get a valid, signed ABN and charge the Medicare beneficiary for the upgraded item.

Respiratory Care Equipment/Oxygen/PAP/Other

10. In situations where Medicare is the secondary payer to a commercial insurance, there are statutory obligations to submit the claim to Medicare. Increasingly commercial insurers are requiring the PAP to be rented for the first 3 months, then converted to a purchase after compliance is achieved. The insurer denies claims for month 4 and beyond if submitted as a rental. When attempting to bill Medicare for the cost share on the 4th month purchase, the claim front end rejects because it is a purchase. The patient meets medical necessity guidelines for compliance. How can we meet the statutory requirement for claims submission while still accepting reimbursement from the primary insurance as a purchase?

    DME MAC Response: When Fee-For-Service Medicare is secondary and the beneficiary's primary health insurance company purchases the PAP device at month four, there is no avenue for reimbursement from Medicare due to its capped rental requirements.

Documentation/Education/ Home Medical Equipment/CEDI

11. For any rental equipment patient that was set up while the patient was in fee for service, then switched to a Medicare Advantage plan, but switched back to fee for service, is it required to obtain new proof of delivery (or re-inspect the equipment and secure an attestation statement about the equipment's condition), or can we rely on the initial set up and proof of delivery?

DME MAC Response: In the scenario presented a new proof of delivery is not required. Since the equipment has been in continuous use by the Medicare beneficiary, the supplier should, if at all possible, inspect the DMEPOS item to assure it is fully functional/operational.

12. Does Medicare require pricing details to satisfy proof of deliver requirements? For example, drop ship orders rely on a packing slip to support the contents of a package and it includes item descriptions and quantities, but no pricing details for the item in the box. Would we need to submit another document that contains these pricing details (such as a sales order printed from our billing software) to meet Medicare's proof of delivery requirements?

    DME MAC Response: There is no requirement for pricing details in proof of delivery requirements as outlined in the Standard Documentation Requirements for All Claims Submitted to the DME MACs (A55426).