Jurisdictions B, C and D Councils Combined A-Team Questions
1st Quarter 2023

Enteral/Parenteral/IV Therapy

1. MLN Matters Article MM8853 states "a denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an Advance Beneficiary Notice (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE." The MACs have told the supplier community that MUE denials are medical necessity denials. Since CMS states in this article that they are coding denials, will the MACs allow suppliers to correct clerical errors on CO-151 denials through reopening, instead of having to correct them through appeals?

   Answer: MLN Matters MM8853 provides an explanation of the MUE program. It is true that claims denied due to MUEs are not considered medical necessity denials and ABNs cannot be used to shift liability to the beneficiary.

   The MACs have not issued information that MUE denials are medical necessity denials. MM8853 includes information about when a denial may be changed during the appeals process for certain edits with an MUE Adjudication Indicator (MAI) of "3" or "1". If the units were actually provided but one of the other conditions is not met, a change in denial reason may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under section §1862(a)(1)(A).

   MUE denials cannot be corrected via Reopenings; they must be submitted to redetermination appeals. This question was addressed in the February 2022 Council questions.

Medical Supplies/Ostomy/Urological/Diabetic Supplies

No questions submitted

Prosthetics/Orthotics

2. In May 2021 the DME MACs announced that additional payment edits would be implemented that would prohibit Medicare payment for custom fitted and custom fabricated orthoses for non-licensed/certified O&P providers in the 21 states with licensure requirements. Can the DME MACs provide data on the claim edits that have been put in place to prevent payment to non-licensed/certified providers in the 21 states and data on the number of claims that have been denied as a result of these claim edits?

   Answer: No. The DME MACs cannot provide or publish this information.

Rehab Equipment

3. ADMC has approved skin protection and or positioning cushions (and Prior Authorization has approved solid seat pan bases) when a qualifying ICD-10 for the cushion (or a corresponding narrative) was not present. There may be something in the documentation that would show the medical need for such a cushion that would lead a reviewer to approve a cushion and or base through the ADMC or Prior Authorization process. At the claim processing level however, a required ICD-10 may not be present on the claim line even though an approval was granted through ADMC or PA. Will the affirmative ADMC/PA override a missing ICD-10? If denied, what recourse would a provider have in a case like this? Examples are available.

Answer: A claim for an item that received a provisional affirmative PA decision must meet all Medicare coverage, coding, and payment requirements in order to be paid. The ICD-10-CM Codes that Support Medical Necessity for these items are listed in the Coding Information section of Article - Wheelchair Seating - Policy Article (A52505) (cms.gov) and LCD - Wheelchair Seating (L33312) (cms.gov) lists covered ICD-10 code groups in the Coverage Indications, Limitations, and/or Medical Necessity section. If one the criteria is not met, the cushion will be denied as not reasonable and necessary. Medical necessity denials retain appeal rights.

4. A major manufacturer of PMDs - Pacesaver - has gone out of business and manufacturer specific parts are no longer available. If a bene is using one of their PMDs, bene-owned but within the 5-year RUL, and repairs are needed but unavailable - what are the options? Can the PMD be replaced as irreparably damaged or lost? A similar precedence has been established for oxygen patients when their oxygen suppliers exit the oxygen business. CMS considers the oxygen equipment "lost" under the Medicare regulations at 42 CFR §414.210(f), which provides that a patient may elect to obtain a new piece of equipment if the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or has been lost, stolen, or irreparably damaged. See Chapter 5 section 6 of the Supplier Manual. https://www.cgsmedicare.com/jc/pubs/pdf/chpt5.pdf.
    a. While this question is specific for Pacesaver and PMDs, the same situation will come up for other products and manufacturers as vendor challenges continue. Please provide guidance that would apply to any similar situation.

Answer: The current guidelines for replacement prior to 5-year RUL due to supplier exit only applies to oxygen. Repairs can be done by any supplier.

Respiratory Care Equipment/Oxygen/PAP/Other

5. We appreciate the education with the recent oxygen webinars discussing when beneficiaries are transitioning into Medicare FFS from any payer where the oxygen testing is acceptable as long as it meets current Medicare policy. Does the beneficiary transitioning into Medicare FFS require an in-person office visit with their treating practitioner during this time? If yes, is it acceptable to use a visit that occurred within the preceding 12 months that documents the medical need for oxygen therapy?

   Answer: There is a long-standing policy in Medicare that to get an item under Medicare, you must meet Medicare's requirements at the time of initial Medicare eligibility. While we have allowed an exception to utilize a previously qualifying test, we would expect the treating practitioner to evaluate the results of the qualifying test and write a new SWO upon enrollment in FFS Medicare. The DME MACs are seeking clarification from CMS regarding the need for an in-person or Medicare-approved telehealth visit once enrolled in Medicare.

6. Previously we had 90 days from the qualifying CMN to set the patient up, now that it's based on time of need will there be a time limit?

   Answer: While there are no timelines in the LCD, the DME MACS expect that the delivery of oxygen and oxygen equipment would occur shortly after the testing / visit. The NCD defines R&N based on time of need and testing. Any delay between time of need and set up would need an explanation in the supplier's records.

Documentation/Education/ Home Medical Equipment/CEDI

7. We would like clarification of the level of detail needed in the medical record to support **frequency of use** and **refill frequency** as it specifically relates to PAP supplies. As an example, our SWO

states, “full face mask (1 per 3 months)”. We understand this satisfies the SWO requirement to establish “Quantity to be dispensed, if applicable”. We were on the Jurisdiction B ACT call on 11-17-22 and in referencing the SWO resources, they said that **frequency** and **quantity** did not have to be on the SWO, but if it were missing, it must be in the medical record. They also stated that even if these elements were on the SWO, they **also** had to be part of the medical record **because** an SWO is not part of the medical record. This raised a concern about the level of detail the MACs expect from the medical record. We have always understood the medical record would need to support the need for a base item, and that would justify related medical supplies. Barring any excess utilization for any particular item, this would be sufficient to support all related supplies. Does the medical record specifically need to address **each** individual supply item along with quantity and frequency before a supplier can dispense any supplies?

a. From the Supplier Manual, chapter 3: “Note also that while the SWO has a limited number of required order elements, additional elements may be included to provide clarity for issues such as length of need (LON), frequency of use, dosage form/strength, refills frequency, etc. This additional information shall be corroborated by information in the medical record.”
b. From the new SDR effective 1/1/2023: “In those limited instances in which the treating practitioner is also the supplier and is permitted to furnish specific items of DMEPOS and fulfill the role of the supplier in accordance with any applicable laws and policies, a SWO is not required. However, **the medical record must still contain all of the required SWO elements.**”

Answer: For any DMEPOS item to be covered by Medicare, the patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable).

There is no requirement that each supply item must be listed in the medical record.

Please refer to the section “Refill Documentation Requirements” section of the Standard Documentation Requirements Policy Article A55426.

This response is consistent with the information provided during the teleconference.