Jurisdictions B, C and D Councils Combined A-Team Questions
January 2024

Enteral/Parenteral/IV Therapy

1. Updates to MLN 3191598 *Intravenous Immune Globulin Demonstration* restrict the place of service (POS) for the coverage of the new IVIg services benefit, Q2052, to POS 12, 13, 14, 32, or 33.
   12 – Home
   13 – Assisted living facility
   14 – Group home
   32 – Nursing Facility
   33 – Custodial care facility

   We are disappointed/concerned that this restriction will unnecessarily create a barrier for beneficiaries seeking to access the benefit, especially those that have been accessing the IVIg Demo in places of service (POS) that will be rejected under the permanent benefit.

   I. Could the DME MAC provide any changes/updates to their response to IV/PEN POS question #3 posed in Q4 2023?

      In Quarter 2 (May 2023), the council posed the following question and received the following answer:
      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?”
      d*isclaimer: This Q&A document is not an official publication of the DME MACs. The official guidance documents from the DME MACs are CMS manual instructions, national coverage determinations, local coverage determinations, bulletin articles and supplier manuals.*

      i. "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."

      1. Would it be appropriate to bill with POS 01 and have DMEPOS covered in any of the following examples?

         a. A beneficiary asks to receive an infusion in an infusion suite attached to a pharmacy because the beneficiary is temporarily displaced from his/her home.

         b. A beneficiary asks to receive an infusion in an infusion suite attached to a pharmacy because the beneficiary has privacy concerns about having infusion drugs and supplies delivered to his/her home.

c. A beneficiary asks to receive an infusion in an infusion suite attached to a pharmacy because a nurse cannot be scheduled to perform the infusion in the beneficiary's home on the date the beneficiary requests the infusion.

d. A beneficiary prefers to have his/her infusions performed in an infusion suite attached to a pharmacy.

Response – Any of the following examples are acceptable for use of POS 01.

a. A beneficiary asks to receive an infusion in an infusion suite attached to a pharmacy because the beneficiary is temporarily displaced from his/her home.

b. A beneficiary asks to receive an infusion in an infusion suite attached to a pharmacy because the beneficiary has privacy concerns about having infusion drugs and supplies delivered to his/her home.

c. A beneficiary asks to receive an infusion in an infusion suite attached to a pharmacy because a nurse cannot be scheduled to perform the infusion in the beneficiary's home on the date the beneficiary requests the infusion.

d. A beneficiary prefers to have his/her infusions performed in an infusion suite attached to a pharmacy.

II) Will coverage of immune globulin (J-code) for PIDD also be restricted to POS 12, 13, 14, 32, or 33?

III) For beneficiaries in a homeless shelter or residential substance abuse treatment facility, for example, can the immune globulin (J-code) be billed and considered for payment, even if the administration code, Q2052, cannot?

IV) What is the best means/venue to advocate for an expansion of the place of service options for Q2052?

DME MAC Response: CMS has updated the IVIG POS in CR13217 (https://www.cms.gov/files/document/r12437cp.pdf) to include 04, 12, 13, 14, 32, 33, 54, 55 or 56. CMS determines POS codes for billing DMEPOS and has elected to NOT include POS 01 since a pharmacy is not considered “home” for the purposes of the DMEPOS benefit. CMS will allow the DME MACs to process claims with POS 27 (Outreach Site/Street) as comparable to POS 12.

Medical Supplies/Ostomy/Urological/Diabetic Supplies

2 In a recent Noridian publication, the DME MACs added to the “High-level spinal cord injury patients (T3 and higher)” to the list of not all-inclusive conditions that may meet the criteria # 2 (beneficiary who is immunosuppressed).

Will the LCD be updated to reflect the change and if yes, when can suppliers expect to see the update in the LCD?

DME MAC Response: At this time, the DME MAC Medical Directors have no plans to add the “T3 and higher” statement to the Urological Supplies LCD. Note the language in the Urologicals LCD that the list of examples is not all-inclusive.

Prosthetics/Orthotics

No Questions Submitted

Rehab Equipment

3 When replacing a power wheelchair within the 5-year RUL due to a one-time incident (theft, natural disaster, etc.) would a prior authorization be required? The RA modifier would be used (and possibly CR if natural disaster) plus all other required modifiers. Please advise on proper procedure for replacement due to loss (theft, natural disaster).

DME MAC Response: The DME MACs are discussing the response and will provide feedback after the Council meetings.

4. If the beneficiary qualifies for a group 2 multiple power K0841, however, there are no products listed on the PDAC site under that product classification code nor available on the market, would Medicare approve the group 3 since that would be the least costly available alternative. In this situation the beneficiary does NOT have a group 3 condition. Please advise how to address this situation.

DME MAC Response: All applicable LCD requirements and prior authorization processes must be met in order for the DME MACs to consider coverage. The absence of a product does not change these rules. DMEPOS suppliers may follow appropriate upgrade guidelines as applicable or utilize the Appeals process if they file a prior authorization, receive a non-affirmation, and subsequently file a claim.

Respiratory Care Equipment/Oxygen/PAP/Other

5. If a patient is on the Inspire device for treatment of their Sleep Apnea and needs supplemental oxygen at night would an in-lab titration on the Inspire be allowed for testing for supplemental oxygen coverage (providing the remaining criteria is met?)"

DME MAC Response: Yes, as long as the results of the titration must meet all Oxygen LCD guidelines for a valid test result and the need for nocturnal oxygen therapy.

6. For NIV, would the need for battery and/or alarms be enough to support medical necessity? Reasoning for alarms could be something like a quadriplegic would not be able to reconnect the tubing if it became disconnected or the patient had the full-face mask on and vomited. Either situation would require advanced alarms. Reasoning for batteries could be the same beneficiary needs to use the device continuously and needs to be able to move around in a wheelchair. A BiPAP does not have battery backup according to our clients.

DME MAC response: The DME supplier community is reminded of the coverage criteria for ventilators:

The Centers for Medicare & Medicaid Services (CMS) National Coverage Determination Manual (CMS Pub. 100-03) Chapter 1, Part 4, Section 280.1 stipulates that ventilators are covered for the following conditions:

[N]euromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease.

These ventilator-related disease groups overlap conditions described in the Respiratory Assist Devices Local Coverage Determination (LCD) used to determine coverage for bi-level PAP devices. Each of these disease categories are conditions where the specific presentation of the disease can vary from patient to patient. For conditions such as these, the specific treatment plan for any individual patient will vary as well. Choice of an appropriate treatment plan, including the determination to use a ventilator versus a bi-level PAP device, is made based upon the specifics of each individual beneficiary's medical condition. In the event of a claim review, there must be sufficiently detailed information in the medical record to support the treatment selected.

Per the coverage statements above, medical need is based on the individual beneficiary and their medical condition(s). Thus, the possible need for batteries and/or alarms alone is not enough to prove medical necessity for the use of a ventilator.

Documentation/Education/ Home Medical Equipment/CEDI

No questions submitted.