Jurisdictions B, C and D Councils Combined A-Team Questions
May 2022

Enteral/Parenteral/IV Therapy

1. For PEN therapies can you confirm that the qualifying medical coverage criteria is based on the policy(s) that was effective on the date that the patient initiated PEN therapy?

   DME MAC response: For beneficiaries already enrolled in Medicare when therapy began, coverage is based on the criteria in effect at the time therapy began. For beneficiaries who began PEN therapy prior to Medicare enrollment, the criteria in the LCD in effect at the time of Medicare enrollment must be met.

Medical Supplies/Ostomy/Urological/Diabetic Supplies

2. Effective with dates of service on or after April 1, 2022, there is a new code for Adjunctive Continuous Glucose Monitor (E2102) and the Supplies and Accessories (A4238). Has there been discussion about what the potential coverage guidelines and allowable will be?

   DME MAC Response: The Glucose Monitor LCD (L33822) and related Policy Article (A52464) and the External Infusion Pumps LCD (L33794) and related Policy Article (A52507) were revised to include the coverage criteria for adjunctive glucose monitors effective 02/28/2022. The related policy articles include the coding guidelines. The LCDs and related Policy Articles were published on March 24, 2022.

   Pricing for HCPCS codes E2102 and A4238 is based on local fee schedule amounts set by DME MACs. In accordance with the final rule (CMS-1738-F) provisions, fee schedule amounts for the adjunctive CGM monitor or receiver, the monthly supplies and accessories for an adjunctive CGM monitor or receiver, are set using existing fee schedule amounts for comparable items in accordance with regulations for gap-filling under 42 CFR 414.238(b).

Prosthetics/Orthotics

3. The following questions are related to the Required Prior Authorization List where orthoses have been added and phase 1 implementation becomes effective April 13, 2022:
   a. If a company is currently under audit (TPE, UPIC, RAC, etc.) for HCPCS codes that are on the list that will now be subject to prior authorization, how will that audit be affected with the addition of the prior auth

requirement? Education related to this notes that audits are not routinely done on HCPCS subject to prior auth, but there is no mention of how current audits will be handled in light of the change.

DME MAC response: Orthosis PA will be implemented in phases. Beneficiaries in the affected states will not be included in new prepay TPE medical reviews. For TPE cases already in progress, an individual assessment of Prior Authorization requests will be conducted on a case-by-case basis to determine how this will impact the TPE probe review.

b. Other parts of DME have been using the prior auth process for their items for a long time, but O & P has only recently had codes added on the list. Is there an educational plan for O & P providers, not DME providers, so that we can be in compliance and have the highest chance of success under what is, to us, a new system of operations with Medicare?

DME MAC response: Both CGS and Noridian have comprehensive web pages devoted to Prior Authorization. In addition, Provider Outreach and Education has scheduled webinars and other education specific to prior authorization requirements for orthoses. O&P providers/suppliers should refer to their respective DME MAC websites for upcoming events and webinar schedules.

c. CMS has acknowledged the need to create a pathway that will allow for coverage of orthoses that require provision in an emergent situation (e.g. outpatient post-op, treatment of acute injury, etc.) In a FAQ updated March 29, 2022, under Orthoses, 5.Q on the time frames to receive the decision, the answer indicates on the timeframe "…make reasonable efforts to communicate a decision within 2 business days of receipt of the prior authorization request." There are certain acute scenarios where even 2 business days wait for prior authorization may not be in the best interest of patient care/access. What are suppliers supposed to do, tell the healthcare professional to wait 2 business days (or more if ordered on the weekend) until they get the response from Medicare?

DME MAC Response: CMS updated the FAQs on April 12, 2022 and addresses acute need for orthoses in Q5 under Orthoses. In addition, acute scenarios are addressed in the Operational Guide in Section 6.7.3.

Rehab Equipment

4. Is it compliant for a wheelchair supplier's employee to fill in the demographic information (patient name, address, phone, etc.) on the LCMP wheelchair

evaluation document provided by the wheelchair supplier (whether it is paper or electronic)?

DME MAC Response: The supplier's employee may provide information about the patient's name, address, and phone number to the LCMP providing the specialty evaluation.

5. Are 3rd party electronic wheelchair evaluations that have template drop down justification along with the ability to include free form narrative compliant?

   DME MAC Response: CMS has published guidelines regarding templates and which documents may be considered during a medical review in Medicare Program Integrity Manual, Chapter 3, section 3.3.2.1.1. Templates are not prohibited and a physician/LCMP may choose any template to assist in documenting medical information. If a physician/LCMP chooses to use a template during the patient visit, CMS encourages them to select one that allows for a full and complete collection of information to demonstrate that the applicable coverage and coding criteria are met.

6. It is in policy that the equipment supplier may not have a financial relationship with the LCMP performing the wheelchair specialty evaluation. Is it considered a financial relationship if the equipment supplier provides access to an electronic wheelchair evaluation in which the equipment supplier is paying for the program subscription.

   DME MAC Response: The supplier should consult with an attorney knowledgeable in healthcare matters for questions about financial relationship.

7. E2620 POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
   E2621 POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE

   From the WC Seating Policy Article:
   '…for planar cushions with lateral supports (E2620, E2621),there is at least 75 mm of lateral contour in the pre-loaded state. A lateral contour is a backward curve measured from a horizontal line connecting the lateral extensions of the cushion; '

   There are some beneficiaries with complex positioning needs who qualify for the E2620/E2621 due to significant postural asymmetries, but the minimal amount of

lateral contour built into the back cushion is not sufficient to meet all their positioning needs. Will you confirm that - with appropriate individual medical necessity documentation - there may be situations where adding additional external lateral supports and hardware (E0956/E0953/E1028) may be billed and paid in addition to the back cushion itself? (All Councils, Paula Koenig, paula.koenig@numotion.com)

DME MAC response: Coding Guideline Criterion 2 from the Wheelchair Seating Policy Article (A52505) for E2620 and E2621 states:

*2. For posterior-lateral cushions (E2615, E2616) and for planar cushions with lateral supports (E2620, E2621), there is **at least 75 mm of lateral contour** in the pre-loaded state. A lateral contour is a backward curve measured from a horizontal line connecting the lateral extensions of the cushion*; [Emphasis Added]

The minimum lateral contour is at least 75mm with no maximum indicated in the coding definition. For the scenario described where the beneficiary requires more than 75mm of lateral contour, the supplier should seek out products that have the required depth of contour to meet the beneficiary's need.

Alternatively, in order to address the lack of contour depth, it is more economical to provide a custom fabricated cushion (E2617). The addition of more external lateral supports and hardware (E0956/E0953/E1028), as suggested in the question, will not increase the contour depth.

Respiratory Care Equipment/Oxygen/PAP/Other

8. When will the DME MACs start following the Oxygen NCD changes that were effective on 9/27/2021 which will eliminate the CMN requirement & chronic stable state allowing for acute coverage? Can provider education be made to help clarify questions on the topic of the NCD changes and the impact for the DME provider community?

   DME MAC response: Following the issuance of the policy changes, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) are in the process of revising the Oxygen and Oxygen Equipment Local Coverage Determination (L33797) and the related Policy Article (A52514) to reflect the national CMS policy changes to NCD 240.2 and the removal of NCD 240.2.2 (see Appendix B and C of CMS Decision Memo EXT).

Note that the Oxygen NCD change simply removed the language around CMN documentation. The revised NCD did not eliminate the requirement to submit a CMN with oxygen claims.

A CGS/Noridian collaborative Oxygen Changes webinar is planned on May 19. Refer to your DME MAC websites for upcoming events and webinar schedules.

Documentation/Education/Home Medical Equipment/CEDI

9. Suppliers would like clear guidance on what telehealth benefits will remain to support DME items in medical review after the Public Health Emergency (PHE) ends and the CR modifier is no longer applicable. Specifically, which practitioner and patient interactions can continue outside of traditional in-person office encounters once the current waivers expire? Suppliers are seeing many more patients using telehealth visits, and we are confused about which provisions are unique to the pandemic and which have been made permanent. In order for suppliers to screen records appropriately, it would be helpful to have a table that compares the protocols/requirements (eligible to support DME claims) during the three phases of telehealth evolution including:
    a. pre-pandemic telehealth requirements
    b. pandemic telehealth requirements
    c. post-pandemic telehealth requirements

    DME MAC response: CMS has not provided any instructions to the DME MACs regarding the end of the PHE. The most current and up to date information related to the PHE can be reviewed on the DME MACs COVID-19 web pages or on the CMS Current Emergencies web page at: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.

10. After the pandemic ends, can suppliers continue to rely on a telehealth visit, conducted from the patient's home instead of a rural health clinic, to establish continued medical need for all products or for compliance where Medicare policy mandates a follow-up visit with the practitioner (CPAP, Oxygen, Respiratory Assist Devices, etc.)?

    DME MAC response: Refer to the answer provided for question 9.

11. The **Consolidated Appropriations Act, 2022** (the Act), was passed by the U.S. House and Senate on March 9th and 10th, 2022, and signed into law by the President on March 15, 2022. The Act extends certain telehealth flexibilities for Medicare patients for 151 days after the official end of the federal public health emergency (PHE). For example, the Act extends the flexibility to continue

allowing beneficiaries' homes as an "originating site." Will the DME MACs continue to accept these telehealth visits, performed within 151 days following the end of the PHE, to meet the face-to-face requirement for certain DMEPOS?

DME MAC response: Refer to the answer provided for question 9.

12. We occasionally have the situation where we provided equipment to a customer and billed and been paid by their commercial insurer. At a later date, they are enrolled in Medicare with retroactive coverage. The primary payer then recoups their payment, stating that Medicare is responsible. But this is often a year or more after the date of service, so we have several issues:
    a. We may not have all the Medicare required documents on file.
    b. The customer may not meet Medicare coverage criteria.
    c. We do not have a Medicare ABN since the customer was not showing as enrolled on the date of service.
    d. We will not have prior authorization from Medicare before the original delivery.
        i. Can we use evidence of timely filing to the primary along with the current overpayment notification advising of the retroactive entitlement change to support late filing if the claim is more than a year old?

            DME MAC Response: Medicare regulations at 42 C.F.R. §424.44(b) allow for exceptions to the 1-year limit for filing fee-for-service claims, including retroactive Medicare entitlement. The Medicare contractor and/or CMS will determine if the requirements for a particular exception are met.

        ii. If authorization is required, can we get a retro authorization with the above evidence?

            DME MAC Response: The Prior Authorization Process for DMEPOS – Operational Guide PDF includes instructions for beneficiaries with retroactive Medicare eligibility status. When submitting a PAR, the supplier should indicate that the item has already been delivered, that Medicare coverage is retroactive and submit all necessary PAR documentation to support the medical necessity of the item.

        iii. If the medical records are inadequate to support Medicare coverage, can we execute a retroactive ABN to disclose details where the medical record does not meet Medicare coverage criteria?

DME MAC Response: For the purposes of financial liability protections, the Medicare contractor may determine, on a case-by-case basis, whether or not the supplier did not have knowledge the denial could have been expected.

iv. What modifier(s) can and should be used - to get a valid PR denial?

DME MAC Response: There is not a modifier for retroactive entitlement situations. The claim should be submitted with all appropriate modifiers that are applicable to the claim for the date of service.