Jurisdictions B, C and D Councils Combined A-Team Questions
May 2024
DME MAC Response to Councils

Enteral/Parenteral/IV Therapy

1. Would the glutamic acid decarboxylase (GAD-65) antibody test be sufficient to meet the beta cell autoantibody test requirement for an insulin pump? *(Note to councils: this question was edited based on the author's verification of the specific type of test.)*

   DME MAC Response: The External Infusion Pumps LCD (L33794) and Infusion Pumps NCD (CMS Internet Only Manual (IOM) National Coverage Determinations Manual, 100-03, Chapter 1, Part 4, Section 280.14) outlines the coverage criteria for a continuous subcutaneous insulin pump for the treatment of diabetes mellitus. The criteria include the requirement that the beneficiary is beta cell autoantibody positive. A positive GAD-65 antibody test would meet this requirement.

2. One of coverage criteria for an insulin pump is that there is documentation of frequent glucose self-testing on average of at least 4 times per day (Please refer to criterion C & D). For patients who qualify for CGM prior to the pump, they would not have number of daily self-testing as the readings are continuous. When can we expect to see an update to the LCD to reflect continuous monitoring of blood glucose level as an alternative to finger stick 4 times per day?

   DME MAC Response: The DME MACs have made an interpretive decision regarding the ability of CGM measurements to meet the CMS requirement in NCD 280.14 for testing 4x/day; however, the DME MACs are unable to change the External Infusion Pumps LCD (L33794) language until CMS changes the language in NCD 280.14.

Medical Supplies/Ostomy/Urological/Diabetic Supplies

No questions

Prosthetics/Orthotics

No questions

Rehab Equipment

3. When a K0830 or K0831 is provided is it acceptable to bill for the upgraded electronics with E2310?

   DME MAC Response: Yes, separate billing for E2310 would be acceptable. Per the Power Mobility Devices Policy Article (A52498), in pertinent part: "Control of the power seating actuators though the Control Input Device would require the use of an additional component, E2310 or E2311."

4. There are instances when a power mobility device needs an adjustment or modification that cannot be performed by the beneficiary (unlike a routine task like charging a battery). For example, a beneficiary's condition or body may change that results in the need for a different seat width and/or depth from the original chair configuration. In such a case a

supplier must send a technician to change the dimensions of the chair to accommodate the beneficiary and possibly any new seating components that also may be needed. Can you verify that in those instances code K0739 (Repair or nonroutine service for DME other than oxygen requiring the skill of a technician, labor component, per 15 minutes the supplier bill labor time) can be billed for the time to change the dimensions of the chair?

DME MAC Response: Yes, adjustments and modifications needed for the proper functioning of the equipment may be covered as non-routine maintenance. Per the Internet Only Manual (IOM) Medicare Benefit Policy Manual, 100-02, Chapter 15, Section 110.2.B, in pertinent part: "…more extensive maintenance which, based on the manufacturers' recommendations, is to be performed by authorized technicians, is covered as repairs for medically necessary equipment which a beneficiary owns." Additionally, per Chapter 15, section 110.2.B, in pertinent part: "Since renters of equipment recover from the rental charge the expenses, they incur in maintaining in working order the equipment they rent out, separately itemized charges for maintenance of rented equipment are generally not covered."

5. On Oct 26, 2023, the Wheelchair Options PA was revised to remove the requirement for the RT LT modifiers when bilateral items are billed on one line with 2 units of service. Does this change apply to the Wheelchair Seating bilateral items as well or do those bilateral items still need to be billed on separate lines with 1 unit per line including the RT and LT.

   DME MAC Response: Wheelchair Seating was not listed as one of the affected policies published on that date. The "Correct Coding Reminder – RT and LT Modifiers – Revised" was published on November 3, 2023. Under "Publication History" at the bottom of the article, it states: "Removed Wheelchair Options/Accessories Policy Article (A52504) due to revised coding guidelines for these items." The laterality modifiers (LT or RT) are not required for wheelchair options and accessories, but if they are appended, they must be on separate claim lines.

6. The MACs have stated that seat elevation as an accessory can be provided on group 2 noncomplex heavy duty, very heavy duty, and extra heavy-duty power wheelchair bases (K0824-K0829) using code K0108. In this scenario how would K0108 be billed?

   DME MAC Response: DME suppliers should bill the K0108 the same as they would for other uses of the K0108. DME suppliers should bill the K0108 as a capped rental. Provide information necessary on the claim to appropriately price the item by including manufacturer make/model, item number, description, and price.

Respiratory Care Equipment/Oxygen/PAP/Other

7. On behalf of the industry, we, as Councils, want to formally thank the DME MACs for clarifying their position on SWO for mask used with PAP and RAD devices. We do agree this clarification will promote patient adherence to PAP and RAD therapy and we are receiving overwhelming favorable responses from physicians, suppliers, and patients. That said, February 2024, Dear Physician Letter specifically mentions the PAP and RAD device masks. Does the same cadence apply to other PAP and RAD accessories such as tubing, filter, pillows, cushions, humidifiers, etc.?

DME MAC Response: Yes, more generic terminology for the accessories will be accepted by DME MACs. For example, a standard written order could have "PAP tubing" and it would encompass both the heated and non-heated tubing. Listings such as "PAP accessories" or "PAP supplies" will not suffice because every accessory separately billed to the Medicare program must be listed on the standard written order. On April 15, 2024, the following FAQ was added to CGS Jurisdiction B and Jurisdiction C websites:

> Can the Standard Written Order (SWO) list multiple types of CPAP and RAD supplies and accessories such as masks, cushions, pillows, tubing?
>
> Yes. It is acceptable to use a generic description of each type of item ordered. For example, CPAP mask to fit, CPAP mask interface, CPAP tubing. It is also acceptable to list all potential CPAP/RAD supplies on the SWO. However, it is not acceptable to only write "CPAP Supplies" on the SWO. You must list each item that will be separately billed.
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> Jurisdiction B: https://www.cgsmedicare.com/jb/help/faqs/current/index.html#sixteen
> Jurisdiction C: https://www.cgsmedicare.com/jc/help/faqs/current/index.html#sixteen

Documentation/Education/ Home Medical Equipment/CEDI

8. Please consider that during the three-plus years of the public health emergency (PHE), many in-person requirements were suspended without a loss of access to equipment or quality of care to beneficiaries. This included the wheelchair in-person home assessment, which was successfully performed through a variety of methods that were an alternative to in person. As the policy does not explicitly require the assessment to be performed in-person, and as the duration of the PHE showed successful alternatives to in-person visits, we would ask that suppliers be allowed to be considered when an alternative to an in-person visit would be appropriate for any given beneficiary. (cf. CMS-1744-IFC, U "Application of Certain National Coverage Determination and Local Coverage Determination Requirements During the PHE for the COVID-19 Pandemic", effective 3/1/2020-5/11/2023).

   DME MAC Response: No, per the CMS FAQ document titled *CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency*, "Health care providers received maximum flexibility to streamline delivery and allow access to care during the PHE. While some of these changes will be permanent or have been extended due to Congressional action, some waivers and flexibilities will expire, as they were intended to respond to the rapidly evolving pandemic, not to permanently replace standing rules." (https://www.cms.gov/files/document/frequently-asked-questions-cms-waivers-flexibilities-and-end-covid-19-public-health-emergency.pdf) Thus, almost all waivers concluded at the end of the pandemic on May 11, 2023.

   The Power Mobility Devices LCD (L33789) states: "Prior to or at the time of delivery of a POV or PWC, the supplier or practitioner must perform an on-site evaluation of the beneficiary's home to verify that the beneficiary can adequately maneuver the device that is provided considering physical layout, doorway width, doorway thresholds, and surfaces. There must be a written report of this evaluation available on request."

The Manual Wheelchair Bases Policy Article (A52497) states: “For manual wheelchairs, the home assessment may be done directly by visiting the beneficiary’s home or indirectly based upon information provided by the beneficiary or their designee. When the home assessment is based upon indirectly obtained information, the supplier must, at the time of delivery, verify that the item delivered meets the requirements specified in criterion C. Issues such as the physical layout of the home, surfaces to be traversed, and obstacles must be addressed by and documented in the home assessment. Information from the beneficiary’s medical record and the supplier’s records must be available upon request.”