

## Jurisdictions B, C and D Councils Combined A-Team Questions January 2016

### Enteral/Parenteral/IV Therapy

1. We would like clarification on how to complete a TPN or ENT DIF when initially the beneficiary did not qualify under the LCD criteria, then later meets the coverage criteria  
Scenario:
  - We Completed the DIF with the answer “No” to question No. 1 (ENT) or question No. 7 (TPN) regarding “Is there documentation in the medical record that supports the patient having a permanent non-function /disease”
  - We understand this puts the DIF in a non-payable status and claims will deny as “not medically necessary”
  - Later the documentation to support the coverage criteria is obtained and the patient now qualifies
  - We understood we would complete a NEW INITIAL DIF for the date the patient meets coverage criteria and answer “YES” to either q. No. 1 or Q. No. 7 to now have a payable DIF on file to start the payable monthly pump cycles and payment for TPN/ENT therapy.
  - The explanation given was a Non-Payable DIF cannot be revised for a Payable Status.
  - Recently however, we were advised to complete the DIF as REVISED vs an INITIAL and change the answer to the question No. 1 and/or 7.

Can you provide direction on what is appropriate in this situation?

**Response: If the answer to Question 1 or Question 7 on the DIF is “No”, then this will generate a statutory denial, not a medical necessity denial (i.e., does not meet the prosthetic benefit). If the beneficiary’s condition changes and the coverage requirements are met you should submit an Initial DIF.**

2. We would like clarification on how to complete a TPN/ENT DIF in the situation where a patient initially meets coverage criteria & length of need, DIF is completed appropriately, and is on file in a payable status; however, later the patient’s condition changes where they no longer meet coverage criteria per the LCD.

For example, in a situation where the patient is non-compliant and not adhering to the prescriber’s orders or has improved and nutritional support is only supplemental. The provider has a valid ABN on-file and will bill Medicare for denial on a go forward basis.

AT this point, should the DIF be completed as a (1) Revised DIF with the answer to Q. 1 or 7 indicating “NO” (does not meet), or (2) as a New Initial DIF with the answer to Q. 1 or 7 as “No” for a non-payable status with the DMEMAC?

Can you provide direction on what is appropriate in this situation?

**Response: The answer assumes that the statement “...later the patient’s condition changes where they no longer meet coverage criteria per the LCD” means that the**

patient no longer meets the requirements for the prosthetic benefit. In the scenario provided it would be appropriate to submit a Revised DIF and if the answers to Question 1 or Question 7 on the DIF are “No”., based upon the beneficiary’s medical records, this will generate a statutory denial.

3. We are seeking clarification regarding conflicting information on pump coverage for subcutaneous immune globulin.

Section V.H. of the current EIP LCD states, "Only an E0779 infusion pump is covered for the administration of subcutaneous immune globulin. If a different pump is used, it will be denied as not reasonable and necessary."

The Joint Publication detailing the coverage criteria for subcutaneous HyQvia states:

- The criteria for Subcutaneous Immune Globulin as specified in the External Infusion Pump LCD are met, and
- HYQVIA is administered subcutaneously through an E0781 pump that is pre-programmed, and
- The E0781 pump is delivered to the Medicare beneficiary in a "locked mode" i.e., the patient is unable to self-adjust the infusion rate.

We request the HyQvia coverage criteria detailed in the July 30, 2015 DME MAC Joint Publication <http://www.medicarenhic.com/viewdoc.aspx?id=2872> be added to External Infusion Pump (EIP) LCD and the language regarding pump coverage to be modified so as to not conflict.

**Response: The External Infusion Pump LCD is currently in the process of being revised to clarify the pump coverage for HyQvia.**

#### **Education**

No questions submitted

#### **Home Medical Equipment**

No questions submitted

#### **Oxygen**

No questions submitted

#### **PAP/Other Respiratory Care Equipment**

No questions submitted

#### **Prosthetics/Orthotics**

4. Recently there have been some issues as to how the LCD for Knee Orthotics (including code L1833) has been interpreted. It appears that there are 2 sets of criteria;
  1. Patient qualifies by having surgery and being ambulatory

2. Patient qualifies by having instability in the knee joint

Can you please affirm that there are 2 clearly separate criterion in which a patient can qualify for a covered knee orthotic?

**Response: Yes, you are correct. For L1833 the LCD describes two separate criteria.**

5. We have seen a recent increase in claim denials as a result of invalid proof of delivery documentation. While we understand that for pre-fabricated items or pre-manufactured components of a device that the best practice is to include a model number, brand name, or serial number on the proof of delivery, there is tremendous confusion regarding how to provide a compliant narrative description of custom fabricated items. We have asked for specific guidance on this issue and have repeatedly been told that, "We cannot tell you what to write as a narrative." When, if ever, will the DME MAC be able to provide additional guidance on what specific criteria is needed in order for a narrative description to be considered compliant as part of the proof of delivery documentation.

**Response: The DMDs are currently discussing this question and it remains under review.**

6. The current knee orthosis LCD states the following:

"A knee immobilizer without joints (L1830), or a knee orthosis with adjustable knee joints (L1832, L1833), or a knee orthosis, with an adjustable flexion and extension joint that provides both medial-lateral and rotation control (K0901, K0902, L1843, L1845), are covered if the beneficiary has had recent injury to or a surgical procedure on the knee(s). Refer to the diagnoses listed in the ICD-9 Diagnosis Codes That Support Medical Necessity Groups 2 or 4 section as applicable."

The LCD continues with the following statement:

"Knee orthoses K0901, K0902, L1832, L1833, L1843 and L1845 are also covered for a beneficiary who is ambulatory and has knee instability due to a condition specified in the ICD-9 Diagnosis Codes That Support Medical Necessity Group 4 Codes section."

Finally, The LCD discusses ways to document the presence of joint laxity with the following statement:

"For codes K0901, K0902, L1832, L1833, L1843, L1845 and L1850, knee instability must be documented by examination of the beneficiary and objective description of joint laxity (e.g., varus/valgus instability, anterior/posterior Drawer test).

Is it a correct assumption that if a knee orthosis is covered as a result of the first statement in the LCD (recent injury to or surgical procedure on the knee) that there is no requirement to document joint laxity?

**Response: Yes, see response to #4.**

Also, in situations involving a diagnosis of osteoarthritis, there may be established medical need to use an “unloader” brace described by codes K0901, K0902, L1843, L1844, L1845, or L1846 to open the medial or lateral compartment of the knee to provide pain relief. This may or may not manifest with inherent knee instability or joint laxity. Is the objective documentation of joint laxity a requirement of coverage in these circumstances?

**Response: Yes.**

7. While HCPCS codes and descriptors are no longer acceptable by themselves on proof of delivery documentation, they have always been acceptable on detailed written orders. The policy language in the question below was pointed out to one of our team members and reads very close to what is required for proof of delivery. We would like the DME MACs to confirm that HCPCS and descriptors remain valid for DWO purposes

**Response: The *Medicare Program Integrity Manual*, Chapter 5, Section 5.2.3 states: “The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number.” A HCPCS code or HCPCS narrative description is acceptable as the narrative description on the order for the item. If the item falls under a NOC code, the HCPCS code or narrative description is not acceptable; information to identify the specific product is required.**

### **Rehab Equipment**

8. Some beneficiaries do not have a qualifying diagnosis per the LCD, but may still have a well-documented medical necessity for a skin protection and/or positioning wheelchair cushion. Please explain what the options are for applying individual consideration to qualify for an item that is outside the guidelines of an LCD. Can the MACs provide individual consideration at the 1<sup>st</sup> level of appeal? Can the QIC?

**Response: The appeals process is the correct avenue to request individual consideration where an item does not meet the diagnosis requirement as listed in the LCD. In addition, suppliers may request an LCD reconsideration to have a diagnosis code added.**

9. There is a new code, E1012 for power center mount elevating legrest/platform. When can we expect to see this added to the WC Options LCD?

**Response: HCPCS code E1012 became valid on January 1, 2016. CMS requires that the Medicare contractors update any new HCPCS code-impacted policies within 120 days of the code effective date.**

10. There is still a lot of confusion regarding counting power functions when determining what Base wheelchair code is valid. Do power legrests (E1010 or E1012) count as power functions when coding a base? What about non-covered power functions – power seat elevator and power standing? These did not ‘count’ when the PMD policy was

issued in 2006, but there seems to be conflicting decisions being made at times in the PMD PA demo and with ADMC.

**Response:** If a power wheelchair has an electrical connection device described by code E2310 (electronic connection between wheelchair controller and one power seating system motor) or E2311 (electronic connection between wheelchair controller and two or more power seating system motors) and if the sole function of the connection is for a power seat elevation or power standing feature, it will be denied as non-covered. The power legrest/power center mount foot platform can be used to determine the need for E2311 versus the E2310.

**Non-expandable controllers can control up to two power seating actuators through the drive control. To meet the coverage criteria for the expandable controller, including all related electronics and mounting hardware (E2377) and the harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware (E2313) the initial issue must include three or more covered power seating systems (which includes power legrests) or an alternative drive control interface. You may refer to the joint DME MAC publication article “Power Wheelchair Electronics Clarification,” published in 2010.**

11. What changes, if any, affect the use of the KE, KY and KEKY modifiers for 2016, with the new fee schedule that incorporates expanded bid pricing?

**Response:** The 2016 adjusted fee schedule for non-competitive bidding areas and rural areas does not change how claims should be billed and the modifiers required.

#### **Ostomy/Urological/Medical Supplies/Diabetic Monitoring and Supplies**

No questions

#### **Documentation/Regulatory/Miscellaneous/Other**

No questions