Ask-the-Contractor Teleconferences (ACT)

Provider Outreach & Education
Date: February 12, 2020

Moderator: Michael Hanna
Time: 1:00 p.m. CST

Introduction

Good afternoon everyone. This is Michael Hanna with CGS Administrators. Thank you so much for attending this afternoon's ACT call. We appreciate you taking time from your schedule to attend this particular event. Just a quick reminder, all of these ACT calls are hosted by your DME Provider Outreach and Education team. On the call this afternoon are Jurisdiction C subject matter experts regarding the topic in question which is Standard Written Orders as outlined in Final Rule 1713.

Two significant changes came about based on Final Rule 1713, which came effective for all dates of service beginning January 1, 2020. First, standard written orders were implemented for all DMEPOS items. Standard written orders replace the detailed written order, the 5-element order, the 7-element order, as well as the detailed product description. Here are the elements for standard written orders: the beneficiary's name or Medicare Beneficiary Identifier, the order date, the general description of an item - this description can be a very simple description such as wheelchair or hospital bed, it can be the HCPCS code, the HCPCS code narrative, or a brand name, make, and model number. In addition to description for that base equipment item, the standard written order may include all concurrently ordered options and accessories, or additional features that are going to be separately billed to the Medicare program. For supplies, in addition to the description of that base item, or main piece of equipment, the DMEPOS order description may include all concurrently ordered supplies that are separately billed to the Medicare program. We need the quantity to be dispensed, if applicable. If you are providing one hospital bed or one oxygen concentrator, quantity is not necessary. But, if you are providing accessory or supply items such as surgical dressings, urological supplies, or ostomies supplies, then we would definitely need a quantity to be dispensed. Another element is the treating practitioner's name or their National Provider Identifier (NPI). The final element is the treating practitioner's signature must be on the standard written order. The information that I just reviewed can be accessed via Policy Article A55426, Standard Documentation Requirements for all Claims Submitted to the DME MAC.

Final Rule 1713 also created the Master List and the Required List, which is forthcoming. The Master List contains approximately 350 HCPCS codes, which could potentially be chosen as written order prior to delivery. When the Required List is published, it will include all HCPCS codes that require a face to face encounter and the standard written order prior to providing that DMEPOS item to the beneficiary. We will alert you as soon as we get the Required List from CMS. There will also be a Required List for HCPCS codes that require prior authorization per Medicare guidelines.

Now one nuance I want to verbalize concerns Power Mobility Devices HCPCS codes - you must have a complete, valid standard written order prior to delivery. This standard written order must be completed in its entirety by the treating practitioner who conducted the face to face encounter. This is a statutory requirement. You are welcome to create a standard order template, but the treating practitioner must complete every aspect of it and sign it. If the accessories for the power wheelchair are not on the treating practitioner's completed standard written orders, you are welcome to create one and have the treating practitioner sign it. Once the required list is published by CMS, every HCPCS code on that list will be written order prior to delivery. Thus, you must have a valid standard written order in your possession before providing that DMEPOS item to the beneficiary. We will alert you when that list is published, so watch the Jurisdiction C ListServ and the CGS website homepage (https://www.cgsmedicare.com/jc).

Just a couple more items I want you to pay close attention to before we open the telephone lines. First, the order date is one of the required elements for a standard written order. That should be the date that you, the DMEPOS supplier, first became aware of the need for a DMEPOS item for a particular Medicare beneficiary. This should support the date of service on the claim from written order prior to delivery items. This date will likely be the date the treating practitioner wrote the order.

Second, frequency of use, dosage calculations for medication, and similar items, are no longer required elements for a standard written order per Medicare guidelines, but we strongly encourage suppliers to add that information to the standard written order for clarification purposes. It never hurts to have more information than the barest minimum on these standard written orders. Be mindful that some states may require this information on orders, so be sure to follow the strictest requirements.

Third, recall the rules for blanket orders. If more than one accessory or supply item on the order and the contractor is not able to ascertain what has been provided, you could see some claim denials. An example of this would be just writing the words "tubing" and "heated tubing" on a standard written order for PAP accessories. Both items provide the same function so any claim lines for tubing would be denied. And one final cautionary thought. Even though that standard written order replaces the detailed written order, the 5-element order, and the 7-element order; all national coverage determination, local coverage determination, and statutory requirements remain in place. You're expected to meet the coverage criteria as well as any specific instruction in any LCD before you dispense an item to a beneficiary. For example, the Oxygen LCD requires an encounter and qualifying test within 30 days prior to the initial date on the CMN. Please don't let these slight changes to orders cause claim denials for you in the future.

Now as I prepare to key your questions, please note that we can only take questions over the telephone and this call is being recorded for transcription purposes. To raise your hand, simply click on the icon of that hand, we will announce you and unmute that individual line so you can ask your question. Also, please remember that no specific claim information or Medicare beneficiary's private health information should be verbalized on this call.

Originated March 11, 2020.

CGS® A CELERIAN GROUP COMPANY

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

I will give everyone just a moment to prepare your questions.

I see some hands raised but I am unable to unmute the line because the individual has not input their audio PIN. When I see that occur, I will send you the audio pin, so make sure that you input the audio pin into your telephone keypad. Until that happens, I will be unable to unmute your line. The first question this afternoon comes from Wayne. Go ahead Wayne, that line is open.

Wayne: Yes.

Michael: How are you doing today?

Wayne: Doing good thank you. I've got a question regarding the SWO. If we receive an initial order from a physician, and because of the CPAP accessories and all that, we later need to send our version of a SWO out to the physician for signature, in order to bill all of the accessories, and when we receive it back, it is signed by a different practitioner in the same practice then it was originally sent to. It also has an image of an electronically signed and then below that it has electronically signed by, you know, 'Dr. Jones', but Dr. Smith is the one listed at top. Since we have a signature and the practitioner's name, is that a valid SWO or is there some other requirement that the signature has to match what we originally listed at the top?

Michael: Just out of curiosity, which physician did the encounter prior to ordering the PAP device?

Wayne: I don't have that information, but they are in the same practice, the same address, that type of thing. I know there's the rules that the person who does the encounter does not have to be same one who signs the order.

Michael: Correct. Are you aware for sure that the physician that electronically signed the order is in the same practice as the physician on that particular order?

Wayne: Yes, that has been verified.

Michael: I've got to be honest with you, Wayne. I haven't had that question come up, and I'm not sure how it would be reviewed in case in our situation with a TPE audit from CGS Medical Review.

Wayne: That's where we are at. We believe that it would be valid because it makes the elements of an SWO, however we are not sure how it would be taken during an audit either.

Michael: The reason I ask if the physician is the one that is conducted the encounter, is because our clinicians can review the medical records to help ascertain if it is all the same physicians we are talking about. I will make a note and make sure that I get verification from medical review before we publish the transcript.

Wayne: Thank you.

Note Added after the teleconference: Since the practitioner who signed the order is different than the name of the physician listed on the order, a new order would be required or the signing physician should cross out the printed name, write in theirs, and initial/sign and date the change. The supplier also has the option of providing a new standard written order with the signing practitioner's name printed on it and allow them to sign the new order.

Michael: Thank you, Wayne. The next kept question comes from Jackie. Jackie, go ahead, please.

Jackie: Hi. Good afternoon. We have a general question. We normally get the initial order from the treating physician. So, I guess Question #1 is, is this replacing the initial order and then we normally generate a detailed written order. So, if we don't get a SWO from the treating physician, can we generate it and send it back for their signature?

Michael: Yes, that is acceptable, except for power mobility devices, where the physician who did the encounter must complete that standard written order in its entirety. You mentioned the initial order. It is probably commonly referred to as a dispensing order, and that has technically gone away with standard written orders, but you will have to have some avenue, of course, to find out when to provide DMEPOS items to your clients. As such, if you get that dispensing order, or initial order, and it doesn't meet all the requirements for a standard written order, you can definitely create one and send it back to that physician for him or her to sign it after they review it.

Jackie: So, if they send us that initial order not in the standard written order format, we would have to generate one and send it back to them.

Michael: Correct, and what I mean by dispensing or initial order, it doesn't meet all the elements for an SWO.

Jackie: Ok.

Michael: For example, they sent you an order that just said diabetes.

Jackie: Ok.

Michael: Diabetes is a condition, not the supply items required for the beneficiary to use - a glucose monitor and related supplies. So, you would probably refer to that any think, 'Oh, okay this is a dispensing order. I need to create a standard written order," or you may need to reach back out to the physician to verify what all they needed – is it their normal testing supplies - test strips, lancets, control solution, that kind of thing. But you can definitely create an SWO and send to the physician so they can review and sign it.

Jackie: Ok, which is what we have been doing with the DWO.

Michael: Yes Jackie, you are absolutely correct.

Jackie: Yes, ok. Alright. Thank you. Have a good afternoon.

Michael: You too. Thank you so much Jackie. The next question comes from Kristy. Go ahead Kristy.

Kristy: Hi. I just had a general question. Is the length of need required on the SWO before we can bill to Medicare?

Michael: It is not a required element for a standard written order.

Kristy: Okay. That is what I was wondering.

Michael: If it is something that you already have and are getting from the physician – as I mentioned in the initial statements at the beginning of the call – if you have the length of need on there, it shouldn't create any problems if you have more information than what's required for a valid standard written order.

Kristy: Alright. Thank you so much.

Michael: Thank you, Kristy. Before I take the next question, Kristy brought up a valid point about the length of need. You know, there are some states, or even municipalities, whose order requirements are more strict than Medicare's. Remember, that when we are talking about standard written orders, the article is coming from a Fee-For-Serv Medicare perspective only. If you

Originated March 11, 2020

are in a state that requires annual orders or maybe orders every six months, for inhalation medication or other medication/drugs, make sure that you are following the most strict guidelines – and those could differ a little bit for Medicare. I just wanted to mention that. It is a little reminder to everyone that our information provided today is based on Medicare's guidelines, while requirements in your particular state might be a little bit tighter.

The next question comes from Cindy. Go ahead Cindy. That line is open.

Cindy: Thanks. I just wanted to verify that when you get a provider's signature, they do not have to date their signature?

Michael: That is correct. The physician's signature date is not one of the required elements.

Cindy: Okay, and then just to verify – if a patient has gone in for a face to face for power mobility, does that same provider that did the face to face have to write the SWO?

Michael: Yes, that is a statutory requirement.

Cindy: Okay.

Michael: The power mobility standard written order – that is a written order prior to delivery. You must have that in your possession before you can provide the items.

Cindy: An earlier question asked about a different provider but in the same practice.

Michael: Correct. I guess we can put an asterisk there that it's okay for everything except power mobility devices.

Cindy: Okay – got it.

Michael: There are statutory restrictions on those so really, the only thing to remember is for power mobility devices the physician who conducted the encounter, must complete, not simply just sign, but complete every aspect of the standard written order, as well as get it back to you before you provide the items. If all the accessories are going to be separately billed or are not on there, you can create one – kind of like you used to do with the detailed product description, and send that in, so they can review and sign that as well. Then, you can provide the power mobility device. So, the power mobility devices are still written prior to delivery.

Cindy: Okay – thank you.

Michael: Thank you, Cindy. Brittney, that line is open. Go ahead please.

Brittney: Hello. You limitedly touched base on - I was going to ask about the DPD – especially for customer mobility, so I guess that the standard written order form is eliminating that DPD form, but if you have, you know, the complex wheelchair that we have here that has up to 15 different codes, are they wanting us to list all of the accessories on the standard written order or can we still use the DPD for the physician to sign off on that? How should we go about that?

Michael: Effectively, it is a DPD, Brittney. You can still utilize that template if you would like, as long as all elements for a standard written order are on it.

Brittney: Okay – Perfect. So, then that doesn't mean that the physician has to complete everything of the standard written order, or should we have a standard written order plus the DPD that meets the standard written order elements?

Michael: You might need two. For power mobility, the physician has to complete the standard written order for the base, just like they used to for the 7-element order, and then if they don't know every individual accessory - which is probably very likely especially in your complex rehab situation, that would be something you guys could complete, send it to them, and they could sign and get the back to you before you provide it.

Brittney: Okay – Perfect.

Michael: Thank you, Brittney.

Brittney: Thank you.

Michael: Donna, that line is open. Donna?

Donna: Hello, hello. Good afternoon. Specific to power mobility devices, if a specialty evaluation is performed, after the physician's face to face encounter, is the physician allowed to complete the SWO after their face to face, and before they sign and concur with that examination from the specialties, you know, PT or OT, or can they do that at the same time?

Michael: So, I kind of lost you there. Can you repeat the scenario for me please?

Donna: Absolutely. So, if we have for power mobility, a physical therapist involved, for the specialty evaluation…

Michael: Okay.

Donna: …can the physician complete the SWO before they review and concur with that piece of the examination, can they complete it at the same time, or do they have to complete their SWO after they have reviewed and concurred with the PT's eval?

Michael: They would have to concur, because they are requiring it as part of the basic encounter – the face to face process, if you will. Is that what you are asking? Am I understanding the question?

Donna: Yea, I think so, right? Because the client will have… for complex rehab, they have their face to face encounter with the physician, and then the specialty evaluation which quote completes the face to face encounter, so there is still a stipulation then or timing requirements that they have to first review and concur with that specialty eval before they can complete this SWO – is that right, or can they do it the same day, at the same time?

Michael: If they can do it the same day and time, which sometimes happens in big research hospitals.

Donna: Right.

Michael: Yes, it is possible. If that happens, it is okay. You know, all that information about all those nuances on who sees the beneficiary when, is outlined in the policy article for power mobility devices, and that is not changing. The end result is once the face to face process is complete, that's when the physician who does the face to face encounter completes the standard written order.

Donna: Very good. Very helpful. Thank you. And can the physician then in these rehab hospitals complete the SWO for the base and the supplier generated SWO for the accessories at the same time as well?

Michael: If you are aware of what specific accessories are going to be required, that would be acceptable. The important thing is, and for the most part these rehabs, you've got your ATP working in very close proximity or in conjunction with the physician as

Originated March 11, 2020

well as that LCMP, so you probably have a pretty good idea of what is going to be required throughout that entire process. And, I have seen that happen before, where it is almost like a team approach, where the treating physician, the therapist or LCMP, and the ATP all gather together and basically go through all of the encounters or visits or whatever you want to call them as a team to make sure that they have answered all of the mobility issues and the accessories that the beneficiary is going to require.

Donna: Yes sir, yes, that has happened a lot. We just want to make sure we were good. Thank you.

Michael: Thank you, Donna. I appreciate that. The next question comes from Patrick. Go ahead, Patrick.

Patrick: Good afternoon. I just to make sure this is clear to me. When we get the chart notes and we go to send the doctor the standard written order for a power mobility, and there is the base, and batteries, and arm rest, on the SWO, we can list the arm rest and batteries, and have the doctor fill in the rest of it. Is that correct?

Michael: The standard order for the base must come directly from the physician, so you cannot send him anything pre-populated and just add the base to it. It is just like the "old school" 7-element order. It is highly possible that you might have two standard written orders – one on a template that is completed by the physician for the base, and then one that you complete for the necessary accessories and then they can sign that one – but they must complete the first one for the base in its entirety.

Patrick: Alright. The second part of the question is – for the completion dated face to face, we've had 45 days to get the 7-element order in and date stamped. Is there a time restriction on this new standard written order?

Michael: Yes, six months.

Patrick: Six months.

Michael: Yes. So, from the time the encounter process completes, six months.

Patrick: Alright. That answers my questions.

Michael: Thank you, sir.

Patrick: Thank you.

Michael: Luis, I've unmuted your line. Go ahead please.

Luis: Yes, how are you doing? I have a few questions. You mentioned NPI or doctor name, not AND doctor name?

Michael: That is correct.

Luis: Okay. The other is with respect to something like a hospital bed narrative. Would I be able to bill a manual or a semi-electric with just a narrative hospital bed?

Michael: You would be able to. It's a general description. However, if you want to provide more clarifying or identifying information on the standard written order, that is perfectly acceptable.

Luis: And the same would hold true with the, and again for an order for a wheelchair, and it could be a manual standard, or a transport, or an extra-wide, it would probably be better to have the doctor illicit exactly what kind of wheelchair he wants?

Michael: Or you could add that information on the standard written order.

Luis: Okay, and my last question would be the dispensing order. If it happens to have all the elements of a SWO, and it is signed, doesn't that dispensing order become my SWO?

Michael: Yes.

Luis: Okay, I appreciate your help.

Michael: Thank you. Adam, that line is open. Go ahead, Adam.

Adam: Yes. So, my question is, so what I am hearing is that a lot of DME suppliers on here, does this apply to orthotics and prosthetics?

Michael: It does. This is across the entire DMEPOS spectrum. So, orthotics or prosthetics are definitely included in this standard written order arena, if you will.

Adam: Okay, and then so when we send the SWO to the doctor, and let's say we just have "AFO" on there, like he was talking about the hospital bed, do we have to put specifically on there, 'custom' and we want to do custom, or do we do 'off the shelf', or do we have to specify on there?

Michael: The element from Policy Article A55426, says the description can be either a general description, like "wheelchair" or "hospital bed," the HCPCS code, the HCPCS code narrative, or a brand name/make/model number. In your situation, I think it can only help you to provide a HCPCS code and/or a HCPCS code narrative, simply to help differentiate the different types of AFO.

Adam: Okay, okay. Alright. Thank you.

Michael: You're welcome. Sue, that line is open. Go ahead, Sue.

Sue: Thank you so much. My question is going to pertain to the POD's, with in regard to the DPD's. Can you hear me okay?

Michael: Yes Sue, I can.

Sue: Okay, thank you. I would love the DPD's because it allows us to provide the doctor the information for the exact equipment that we were going to provide, along with batteries and accessories and any other issues. If we are going to provide another standard written order, that used to be our DPD, do we need to either retire that DPD or is it still okay to be called a DPD – a detailed private description – or do we need to change that terminology for the template that we already use?

Michael: If you already have a template that is applicable and meets all the elements for a standard written order, I don't know if it is absolutely necessary to retitle it, but if you can, it won't hurt anything. The standard written order for power mobility accessories and options is effectively a detailed private description.

Sue: Okay. When it comes to the doctors sending in the initial standard written order, and we are allowed to send one back with the specifics of the accessories and batteries that are needed, are we also able to still list the base code unit, like if it is a K0822 or a K0823, because when the doctor sends the standard written order, he may just say power wheelchair, but he may not realize, based on the medical necessity, that maybe that patient needs a solid seat with a cushion. So generally, whenever I was going to be the DPD, I would send them with the information with the correct coding for the unit at the same time with any accessories and any seat cushions, and anything at that time. Are we able to not list the base on there at all?

Michael: It's not a requirement – no.

Originated March 11, 2020

Sue: But is it okay for us to, if we already have a standard written order saying power wheelchair, is it okay to still list it as part of the DPD, per se, when we send it to the doctor for a final approval?

Judie: This is Judie Roan with CGS, and if you chose to do that, if you had an audit situation or if the item was being prior authorized, you would definitely want to send that initial written order prior to delivery that was completed in its entirety by the physician, along with that old DPD, or the standard written order that has all the accessories if you choose to list the base, because that base must have that written order prior to delivery completed in its entirety by the practitioner. So, if you had an audit or if you had a prior authorization you want to be sure to submit both.

Sue: Okay, yes. That would not even be a question in my mind in it being submitted that way. Okay, I think that is all of my questions. I really appreciate it.

Michael: Thank you, Sue. Laura, that line is open. Go ahead Laura.

Laura: Hey there. So, I understand that the length of need is not required on the SWO, but when we do send for that CMN, is the length of need required on that documentation or is it supply specific?

Michael: When you say CMN, are you talking about a required CMN for example, oxygen?

Laura: Yes.

Michael: Yes, it is required there because that's an element on that CMN.

Laura: Okay. So, are we talking then it is just specific to oxygen?

Michael: Well, CMN is applicable for, what - about five or six equipment categories? If you must have a CMN required by CMS, then it does need to be complete. For any items that don't require CMN, such as prosthetic limbs, PAP devices, hospital beds, whatever, then you don't have to have it on there.

Laura: Okay, and so how long is that order good for then, the initial? Twelve months?

Michael: The CMN?

Laura: No, the items that do not require the CMN? If there is a need on there, is it only good for twelve months?

Michael: Well, for our purposes, from a Medicare standpoint, it is good until it is not. What I mean is this… There is no requirement on how long an order is good for, unless there's information on that order signifying something different. So, if a physician wants to, or you want to add in 'length of need ninety-nine months to lifetime' that is perfectly fine. It will not take away from that standard written order in case of an audit review, but for our purposes, it is not a required element. You would need a new order, of course, if something changes. Remember also that I mentioned some states may have more strict guidelines than there be for Medicare, so you need to make sure you are following the strictest guidelines.

Laura: Okay, thank you.

Michael: You're welcome. Crystal, that line is open.

Crystal: Hi, Michael. Good evening. I have a question first off about the standard written orders. When it has a requirement for 'order date,' can that be the physician's signature date, or does it have to be classified as an 'order date' or 'start of care date,' something along that line?

Michael: If we had the physician's signature date, we would consider that valid, Krystal.

Crystal: Okay. My other question is concerning verbal orders. So, is it still acceptable to dispense on a verbal order for those items that that applied to originally, and then follow it up with say 484, the CMN for oxygen?

Michael: Yes, that is perfectly fine. And, this is not just for you, Crystal, but for everyone. If you have avenues in place in how you know you are going to get equipment, or items to beneficiaries, it is probably going to be some type of dispensing order. There is no need to stop that simply because the rules for standard written orders have changed a little bit from detailed written orders as in 2019. You still have an avenue for you to know when and how to provide something to the beneficiary, and that is perfectly fine. In your situation, of course, you would have to have the standard written order. It could be a CMN, that is valid, signed and completed before you bill the claim to the Medicare program – which effectively is no different than what you've done before.

Crystal: Okay. Alright, thank you.

Michael: Thank you. William, that line is open. Go ahead William.

William: Hello, can you hear me?

Michael: I can.

William: Perfect, alright. So, it is a similar question you have already received but, so earlier you called out I could not have just 'mask' for a PAP mask, right - obviously, because there are multiple HCPCS codes for masks. But, then you reference the hospital beds, where there are multiple HCPCS codes for hospital beds, and you just said it could be just as simple as hospital bed, which I could quote the policy, but I guess my question is, how do I know as a supplier, when I need to be more in-depth than not, right?

Michael: Well, it is up to you. I mean, you are the one that can create that standard written order and put that information on it. As I have stated to different callers, you can put as much clarifying information on that order as you want – not only to help you, but to help the physician understand what the beneficiary is getting. Remember the issues of blanket orders. If you have multiple types of masks and tubing listed, those would be denied in case of a review, because they are blanket orders for those items.

William: Yea, I totally get that. I guess this is where I am struggling with it in my head, is because there are multiple hospital beds as well, right? So, there are multiple HCPCS codes in that regard. So, that is just where I am struggling. I get I can put whatever I want. What I really want to know is when I have to have it more specified out versus when I don't – because in the hospital bed, I don't have to have to have it specified out. I can do a manual or semi-electric, or whatever the case might be there, but in the masks, obviously I can't just use masks – I need to use full-face or nasal, or whatever the case might be, or obviously the call I referenced yesterday that you were on – it was heated tube versus non-heated tube, so I guess I am just curious when it is absolutely required for the more detailed versus when it is not – because in my mind, hospital bed semi versus manual, is the same concept as a mask - full-face versus nasal.

Michael: Where applicable, you have the opportunity to send written order to CGS Connect or for certain HCPCS codes and get feedback from them. The end result is it is going to be a

Originated March 11, 2020

business decision on how you want to do it. If you want to put the very barest minimum information, that might be detrimental down the road in case of reviews. The entire Provider Outreach and Education team at CGS are educating that it can only help to provide clarifying information. For most folks, they have systems that will input that information already on there, so there is no a lot of time and effort involved.

William: Yea, it is just like so just a concept that goes back to the blanket order concept. If I have an order for a mask, and they start with a nasal mask, and then I switch them to a full-face, I have to go and get a new order – but the first order said 'mask', so how do you…I think I got the information. Thank you.

Michael: Thank you. Stephen, that line is open.

Stephen: Yea, hi, how are you doing? When it comes to glucose supplies, I know that you stated earlier that the signature date is no longer needed. But let's just say they do put a signature date, but it is incorrect. Would that still be acceptable?

Michael: They put an incorrect signature date versus …?

Stephen: Yes. Yes, let's just say they put 2/12/2028?

Michael: Well then, you should probably send that back to them, and make them sign a new order.

Stephen: Okay. Now you also have a spot for, you did say, the signature or the NPI number. Let's say that we have Dr. Smith sign, but our original doctor was Dr. Brown, and his NPI number is still on there. Would we need to get a new order when it comes to something like that?

Michael: I stated it is their name OR their NPI plus the signature – it is not an "either or" situation. The order must be signed.

Stephen: No, right, right, right. But what I am saying is on the order, we originally had Dr. Brown with his NPI number because on our form we had the NPI number as well. But let's say Dr. Smith had signed it and crossed out Dr. Brown's name but left the NPI number. Would that be acceptable, or would that not be acceptable – even though we need one or the other?

Michael: I could perceive that causing issues since it is not the signing physician's NPI. In your scenario, Dr. Smith could cross out NPI printed on the order, write his own, and then initial and date the change to the order.

Stephen: Okay – I get it. I think that is it for my questions.

Michael: Okay, thank you sir.

Stephen: Thank you.

Michael: Shirley, that line is open. Go ahead, Shirley.

Shirley: Hi Michael. Everybody has been talking around DME's as far as hospital beds, oxygen, CPAPs. What has changed throughout for home infusion, for external enteral, GPN's, any of those? What has changed on the SWO? Is there a date, a physician date required? Is the length of need required? What we have done, Michael, is we have created or modified our SMN, that was also represented as our DWO. Now, everything that we have on that – still most of it is still required on the SWO – so I'm thinking of not of even making any kind of change. Is that correct? I mean, what has changed for the DIF?

Michael: Nothing. For those items that require a DIF, you will still submit that with your claim.

Shirley: For the SWO, are we still going to require the length of need?

Michael: No.

Shirley: Okay – so whatever you are saying and what you're talking within this call, most of what I am hearing, like I said, is regarding DME, but everything you are saying relates and is also for the home infusion side.

Michael: That is correct, yes. All DMEPOS items.

Shirley: Okay. Alright. I just wanted to make sure. Thank you.

Michael: It doesn't matter if it is nutrition, whether it is an oxygen concentrator, whether it is a lower limb prosthesis, whether there is a shoulder orthotic – anything and everything now requires a standard written order.

Shirley: Okay. That is what I need. I appreciate it. Thank you.

Michael: Rebecca, that line is open. Go ahead, please.

Rebecca: Yes, good afternoon. My question is regarding prosthetics. If a prosthetic is delivered with consumable supplies, base liners, suspension sleeves or socks, if this supply needs to be replaced within 4 to 6 months after that initial fitting, is a new order needed for these or do they fall under the original prosthetic order?

Michael: It is going to depend on how the order is written.

Rebecca: If the original order that has the liners and suspension sleeves – initially they get 6 socks, 2 liners, 2 suspension sleeves with the prosthetic and then 6 months down the line, they need to replace those consumable supplies, would they be under the same order, or will we need a new order?

Michael: Well again, it is going to be how the information is on the order. If it is items provided on a reoccurring basis, remember you must have the quantity, and you are more than welcome to indicate the frequency on there. That is the clarifying information that I've stated can only help you in review from any auditing entity.

Rebecca: Okay. That frequency – could that be surpassing a year, or would it be within a timeframe? In other words, should the frequency say replace every 3 months, or replace as needed? Would that cover that consumable supply for a period of time?

Michael: We don't accept "as needed," but "every three months" would be acceptable. There doesn't have to be an end date on that order, of course.

Rebecca: Okay. That answers the question. Thank you.

Michael: For example, if you had "3 liners every three months," that frequency would be okay, unless something changed and they needed a different type of liner or sock or something, you know, due changes in that residual limb. You would need to get new orders for those, or for whatever the case might be. But you should be okay.

Rebecca: Okay. Thank you.

Michael: Thank you, Rebecca. Lori, that line is open.

Lori: Hey, how are you today?

Michael: I'm good.

Lori: Quick question, well two actually. Were there different slides that was with the presentation you did today, because mine only stayed on the first page?

Michael: No, there were no slides associated with this. I just put a title slide up there simply so you wouldn't have to see a blank

Originated March 11, 2020

screen. All the information we have discussed today is found in Policy Article A55426.

Lori: Okay. Alright. I do have another question. On the quantity, so for the catheters, would that need to be a monthly amount, because that can be written for a year – is that correct?

Michael: The order?

Lori: Yes.

Michael: I think you should put what you are going to provide for billing. So, let's use intermittent catheters, for example, and you are providing 150 per month. I think you can put "150 per month" on that order. That way we would know what the quantity is going to be provided per month.

Lori: To match up with your billing.

Michael: Right, so it would correspond with what you are filing claims to the Medicare program for. Correct.

Lori: Okay. And then I did notice that 'no diagnosis' is required now on the standard written order.

Michael: That is correct.

Lori: Okay. Alright. Well, thank you. I appreciate that.

Michael: You're welcome Lori. The next line open is Abdalla. Go ahead please.

Abdalla: Hi there. My question is related to home infusion – kind of a follow-up to the previous question. Specifically, about HCPCS code B4224. This relates to supplies associated with external infusion devices. This was (illegible…) environment on the death, however we never in the past put it on a detailed work order, and we have had some audit periodical on it, and now they are kind of penalizing us for it for not having the B4224 on the standard written order, even though from my understanding it took effect January of this year. So, are the auditing company Performant – apparently either I am missing something or are they missing something. Can you elaborate on that, please?

Michael: I can't speak to what another auditing entity is looking for. I would actually have to do some research on that particular HCPCS code.

Abdalla: It says supplies related to external infusion device, which according to the new standard, this is considered a supply, but it was never required to be on the written orders. It was required to be on the DIF form.

Judie: Michael, this is Judie again. And just to be clear, for your previous detailed written order, all of your separately billable items should have been listed on your detailed written order, and you also want to include all of your separately billable items on your standard written order. Don't confuse your standard written order with your DIF form, because the standard written order is very specific with what it requires as well as your DIF. They are two different documents, and because your DIF form is not signed by a physician or a practitioner, that cannot be used as an order. You want to make sure that every item you are billing is included is on your standard written order.

Abdalla: Okay – Well, I think this is where the confusion came from, because the DIF in the old days used to be required to be signed by a physician and we have always included these codes on it. I think since the detailed written order became separated and I think we are missing the specific codes on our detailed work orders, so I am not very sure on how to remedy that, because you know, we are still periodically being audited for services prior to January – so any recommendation?

Judie: Yes. Start adding all the codes that you were separately billing for to your standard written order. That would be the solution.

Abdalla: Alright, thank you.

Michael: Thank you so much. Judie, I sure appreciate that input. Abdalla, one other thing to add, you mentioned that there are some audits from Performant. They are the Recovery Audit Contractor. You do have appeal rights, so you can file Redeterminations to CGS if they find some information lacking on your claims – remember you do have the appeal options as well.

Abdalla: Alright, I will do that. Thank you.

Michael: Lori, that line is open. Go ahead, please. Lori?

Lori: Alright. My question real quick is with the CPAP area. Can you tell me the quantity and frequency of use - I know you talked about what needs to go in there and in terms of cushions and filters where you can give a one month or a three month, or what do you want to see in there?

Michael: On the standard written order?

Lori: Yea.

Michael: I don't think it is absolutely necessary to provide a quantity for a mask or tubing because we know that's going to be on a quarterly basis. For the cushions, since you are going to bill more than one per month, especially for your nasal ones, you can put a quantity in there. It is not a bad thing for all your accessories for PAP if you want to go ahead and put the quantity in, even if it is "one per three months," or "one per six months," whatever the case might be, that is acceptable – even if it may not be absolutely required, since you are only providing one, you can definitely put that on that standard written order for clarification purposes.

Lori: Okay. Alright, and then going back to the masks themselves. Like we will get a handwritten order from the doctor that says "mask, tubing, headgear, filters." If it doesn't say full-face or nasal, we have to get a clarification on that?

Michael: Are you going to be the one setting up the beneficiary with the CPAP device, or is the physician doing that?

Lori: We will be sending the package out.

Michael: I think it can only help you, in case of an audit by any auditing entity, not just CGS Medical Review, but post-pay audit entities as well. If you have that clarification, then that clarification will simply match up with the delivery ticket of items provided to the beneficiary, as well as the claim submitted to the Medicare contractor.

Lori: Okay. Alright, and then can a 484 take the place of a SWO for oxygen?

Michael: For oxygen? Yes, a valid CMN was considered a detailed written order. Similarly, in 2020, if you have a valid, complete CMN signed and dated by the physician it would be considered a standard written order. All the elements for the standard written order are present on a CMN.

Lori: Thank you. Alright, bye bye.

Michael: Bye now. Melissa, that line is open. Go ahead, please.

Melissa: I have a couple of questions concerning the DPD and the standard written order.

Michael: Okay.

Melissa: Can the DPD be generated prior to the standard written order being completed by the practitioner?

Michael: When you say DPD, you mean the standard written order for the accessories?

Melissa: The WOPD, yes.

Michael: To make sure I understand your question… You provide the standard written order – I am just going to go with a Group 2 power wheelchair here – for batteries and elevated leg rest possibly, and they sign it today, but you don't have a standard written order for the base until February 18, are you asking if that is okay?

Melissa: Yes.

Michael: I don't think so, because they must complete the standard written order for the base first.

We still follow that chronological protocol. And Judie or Angie, if you ladies are on the call and disagree, please go ahead and chime in.

Angie: Yea, I agree. This is Angie. The power mobility device statutory requirements are still there.

Judie: I think Michael we should probably follow-up with this one in the minutes too just to confirm because the accessories don't have the same requirements as the base. So, I think we should at least follow-up and at least add this to the minutes.

Michael: Okay. Judie you brought up a good point that we need to make sure we are all consistent here at CGS, so we will make sure that we reach out to Medical Review, and I will follow-up with our management team that covers prior authorization items, as well as we will verify that it is in the transcript when it is published in our website – okay?

Note Added after the teleconference: The standard written order for options/accessories may not be provided before the standard written order from the treating practitioner for the wheelchair base.

Melissa: Okay. Two more questions. The first one is - can the practitioners stamp their printed name and/or NPI onto the standard written order, or does that have to be completed entirely handwritten, or electronically – however the practitioner normally does their orders?

Michael: They would have to complete it how they normally do their orders.

Judie: The only time signature or date stamps are acceptable is if the physician meets the Americans With Disabilities Act. That is the only time we accept signature or date stamps.

Melissa: Well, no, not their actual signature stamp. Just like their printed name. You know, the requirements state they have to have either their printed name or NPI and then their signature?

Michael: We should take that one back as well, but I foresee issues with that, to be honest with you, Melissa.

Note Added after the teleconference: The treating practitioner may not use a stamp to "print" his/her name on a standard written order. The only exception is if the physician has a disability or is unable to print their name. Per the CMS Internet Only Manual (IOM 100-8), Chapter 3, "CMS would permit use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that they have reviewed the document." Additionally, for power mobility devices, the treating practitioner must complete the standard written order for the wheelchair base. A blank template may be used, but the treating practitioner must complete all elements of the standard written order.

Melissa: Okay, and then the last question that I have for today is this - is there a delivery timeline for POV's or any other claims that do not go through the condition of payment process? I know that there is like a six-month delivery requirement on a condition of payment submittal, you know, once you get the approval area for six months to deliver. What is ..

Michael: There is not a specific timeline associated for other DMEPOS items. Of course, it needs to be timely. If it is many months, especially on any mobility equipment, I would question the need. If they bring you an order for a POV or a manual wheelchair that is nine or ten months old, I would question the need on that, specifically. But there is not a timeline in Policy Article A55426 for time limitations.

Melissa: Okay, because you know, it used to be when we had to make the completion date in 45 days and 120 days delivery, if it would go to, you know, the prior authorization of A and C, or conditional payment, that it had to delivered within 120 days of the face-to-face completion date. But now that the face-to-face completion date and the 45 days, and that is now not a thing, we just kind of want to make sure that, you know that (illegible) hospitals or a SNF, and then they you know, get don't get discharged for four or five more months, I just want to make sure there is not a specific timeline on the (illegible).

Judie: Yes, that was removed from the policy on January 1, 2020. The information regarding the indication of delivery of the PMD must be completed within 120 days has been removed from the policy. That would no longer be a requirement if it has been removed from the policy. And, again, that is if it is not prior authorized under one of the programs.

Melissa: Alright. That is all that I have.

Michael: Thank you, Melissa. I appreciate those questions today. Thank you so much. Brenda, that line is open. Go ahead please.

Brenda: Hi. Good afternoon. My question is just a general regarding the SWO and this might have already been answered. We already have some templates for the detailed orders for DME. But, the standard wheelchairs, not the electric wheelchair, things of that nature. Can we just reuse those templates for the SWO and just rename them a bit, since all the information on the detailed written order probably goes above and beyond what the SWO requires, but our physicians are used to using, and then basically gives them more information for billing purposes. Would that be okay?

Michael: Yes, that would be perfectly acceptable. You are going to have more information than the required elements for a standard written order. Having more information is never a bad thing.

Originated March 11, 2020

Brenda: Awesome. Thank you so much.

Michael: Your welcome. A couple of folks have their hands raised. I am seeing them but unable to unmute the line because they are not signed in with their audio PIN. You need to make sure you input your audio PIN in the keypad before I can unmute your line. The next question comes from Melissa. Go ahead, Melissa.

Melissa: My question is – I came in late for this call, so I am not sure if this was already answered, but can we use a verbal order as the SWO?

Michael: You cannot, because one of the requirements is a physician's signature.

Melissa: Okay. Alright. Well I guess that answers my question. Thanks.

Michael: Thank you. Tara, that line is open. Go ahead please.

Tara: Thank you. I just have one quick question regarding electronic signatures and iPad signatures? Are those accepted if they do not state they were electronically signed?

Michael: You may want to get an attestation statement or something similar, because sometimes the digitalized signatures, you mentioned an iPad, on tablets can look like signature stamps when they are faxed through, so take a look at that - how it is going to come out? Print it out or something and see how it looks. You may need to reach out to get the attestation statement if necessary, from that physician just to keep on file.

Judie: Digital signatures are not acceptable if they are not formal electronic signatures, but you can request the signature protocols from the physician. They are required to have them on file. So, if they do meet the requirements of an electronic signature, that is completely acceptable. But, if they do not, it is not acceptable.

Tara: Okay. Perfect.

Judie: An iPad would probably not meet the requirements.

Tara: Okay. Perfect, and I actually have one more question. Now, we use a CMN for our order. Our CMN is very detailed. Does everything that is on the CMN have to be filled out? We are sending home care supplies, dressings, surgical supplies. For wound numbers or frequency of change, if that is on there and not filled out, will that still be considered a valid order?

Michael: It should be a valid order if you have met the elements for a standard written order. Keep in mind, that anything on an order must be corroborated in the medical record.

Note Added after the teleconference: The supplier references "CMN" but that is an internal term they use for an order. There is no CMS required CMN for any of the supply item she referenced. The Jurisdiction C Supplier Manual, Chapter 4, lists the specific DMEPOS equipment categories that require CMNs and DIFs.

Tara: Okay.

Michael: If a physician only puts wound measurements or similar information like that on the order, it is not found in the medical record, it is not going to be valid. And, you could reference the Surgical Dressing's related Policy Article for that information.

Tara: Ok. Perfect. That all makes sense. Thank you. That is all my questions. Thank you for your help.

Michael: Thank you, Tara. Thank you, Judie. Next question comes from Satari? That line is open. Go ahead, please.

Satari: Yes, thank you. My question is in regard to rental equipment. In the past, we have had to put the length of need for rental equipment. Are you saying with the new guidelines for the SWO, the length of need for rental equipment is no longer needed?

Michael: That is correct. It is not required.

Satari: Thank you.

Michael: You're welcome. Shannon, that line is open. Go ahead, Shannon.

Shannon: Hi. This is about CPAP. So, say I get and order from a doctor, and it says, "CPAP and humidifier," and "provide all CPAP supplies for twelve months." Is that going to be sufficient enough now or am I going to need a detailed SWO stating what supplies and the code?

Michael: You will still need a detailed standard written order because you must separately list every item that is going to be billed to the Medicare program.

Shannon: Okay. That is all we had. Thank you.

Michael: Thank you. Tammy, go ahead please.

Tammy: Yes. My question is on the new SWO. Are the refills required for supplies on that?

Michael: The number of refills is not a requirement, per se, for the standard written order. As I have noted before with other callers, if you want to have that information on there, you are more than welcome to do so for clarification purposes. And, also your state laws or statutes might require the number of refills, so make sure you are following the most strict regulations. If your state requires it, and Medicare does not, of course it needs to be on that document.

Tammy: Okay. Alright. Thank you.

Michael: You're welcome. Jason, that line is open. Go ahead, please.

Jason: Hi. Thank you, and I actually think you might have just answered this question a couple of questions ago – but I am going to go ahead and ask anyway. This is concerning catheters, and I just want to make sure that I understand how the medical records work with the SWO. So, let's just say we have medical records for a patient, and it says "4 times a day," so we are sending out 120 per month. We then receive an updated SWO for 6 times a day, which means we get back 180 per month. We would need updated medical records from the doctor outlining 6 times a day, before we could send the 180 – is that correct?

Michael: You would need to have a standard written order for 180 in your possession. The medical records, if you are ever asked for them by an auditing entity, you will need to show the medical need for why the beneficiary is cathing six times per day. That is correct.

Jason: Okay. Thank you very much.

Michael: You are welcome. Lisa, that line is open. Go ahead, please.

Lisa: Yes. I have a question about - We have some TPE ADR requests and they were January date of services. And, the first item they are asking for is the preliminary dispensing order – if the items were dispensed before the detailed written order. So, what are you looking for in that preliminary? Can it be the just "CPAP supplies?" Can it be that generic?

Originated March 11, 2020

Michael: Yea, it could be. It's whatever type of information you get from the physician. And, it is probably a situation that the medical review has not had time yet to update all the necessary documents and information surrounding standard written orders. We actually published these items on our website saying this is new as of January 1, 2020, so please give us time because there are a lot of things to update. It's much, much more than simply updating Policy Article A55426. If you want to be doubly sure, however, you are more than welcome to send an email to jc.tpe.inquiries@cgsadmin.com, and ask them if they would verify that information, since the date of service is after January 1, 2020.

Lisa: Okay, so basically, we just have to have the standard written order prior to sending the claim, and, we wouldn't even have to have any type of assisting order for CPAP supplies – is that correct?

Michael: That is correct.

Lisa: (Illegible)…the supplies with no order, we can give them the supplies, and then send the standard written order to the doctor, and you are saying we are fine – correct?

Michael: Technically, that is accurate. But you would also want to do your due diligence to make sure, did the beneficiary have a CPAP device through you. If not, then you must follow requirements Chapter 5, Section 8, of the Supplier Manual to make sure that the lead item, or the main piece of equipment is medically necessary, and meets Medicare requirements. So, there is more to it than simply a beneficiary walking in and saying, "give me these." All LCD, NCD, statutory, and Supplier Manual requirements remain in place. So, while the elements for an order have been relaxed somewhat, with Final Rule 1713, you as a supplier, should still do your due diligence and make sure you are providing items that are medically necessary to the Medicare beneficiary, through your clients. If not, get a valid ABN, explaining why that you don't think Medicare will pay for them.

Lisa: Okay.

Judie: And, just to briefly follow that up, if you have a state requirement that you have to have a dispensing order for a particular item, you want to be sure to have that dispensing order as well.

Lisa: Okay. The dispensing order, is there a …like let's say someone carries around in their wallet for 10 months and then finally walks in. There's no timeframe on that with a face to face or anything – right? It can be that old?

Judie: For the majority of items not listed in the policy, that you have to have an order within a specific timeframe, there is nothing formally published about that requirement, but the order should be relatively recent – just in case there is a change in the beneficiary's condition, maybe they haven't been compliant with their CPAP, there is no documentation of compliance in our files. So, you want to always make sure that those orders are relatively recent. You can always, at that point, if the beneficiary comes in and pulls it out of their wallet, you can contact the physician and obtain a new order and verify if he feels that's medically necessary for the beneficiary has been met.

Lisa: Okay. Alright. Thanks.

Michael: Thank you. Donna, that line is open. Go ahead Donna.

Donna: Hi. My question is, I just want to verify, when you say check the local state rules, we are a national DME company. Are we checking the state the patient lives in, or where we are based out of?

Michael: It would be the state where the patient resides - are they contacting you via a toll-free number or something?

Donna: I was just asking so we would know, because if we are shipping to different states, I want to make sure we checked the state rules to follow everything if it is more stringent, because you said it falls back to the LCD when it comes to being compliant. So, I just want to make sure we are checking the right things.

Judie: And, it is important to remember, that some items cannot be dispensed in a particular state without an order – such as opioids as a perfectly good example - or any medications. You can't just walk into a particular pharmacy and obtain actual prescription medications without a dispensing order. Medicare is no longer requiring that dispensing order, however, the states may still require it, your accrediting association may still require it, so these are things to definitely look at.

Donna: Thank you.

Michael: Thank you, Donna. Garrett, that line is open. Go ahead, please.

Garrett: Yea, hi. I just want to clarify (illegible)…

Michael: Correct. The guidelines for timely documentation are still outlined in Policy Article A55426, unless specified otherwise in policy, timely documentation is within 12 months of the date of service in question. That is correct.

Garrett: And let's say, it is a continuous situation, or a blanket, (illegible…) they are not able to back-date (illegible…) are they?

Michael: To make them retro-active for an error?

Garrett: Exactly.

Michael: No, that would not be applicable.

Garrett: Alright. Perfect. That is what I thought. I just wanted to make sure. Thanks.

Michael: You're welcome, Garrett. Not a problem at all. Stephanie, that line is open. Go ahead, Stephanie.

Stephanie: Hi, can you hear me okay?

Michael: Yes, I can. How are you this afternoon?

Stephanie: Well, thank you. So, I was wondering if you could clarify, someone mentioned earlier about the electronic signatures, and one of the other ladies - I'm sorry I don't remember all of the names – chimed in and said something in regards to the electronic signature is only valid if the physician was set up for that? Could you go over that again, please?

Judie: Sure. This is Judie Roan, and for electronic signatures, those signatures do have to meet electronic signature protocol. And, the physician will have access to those protocols to utilize their signatures. So, if you ever question the validity of a physician's signature, you can absolutely contact that physician or practitioner, and ask them for a copy of their protocol.

Stephanie: Okay – you're asking the physician directly for a protocol.

Judie: Or their office, yes.

Stephanie: Okay.

Judie: If it is obvious that it is an electronic signature - some examples are "electronically signed by" or "finalized by" - those types of options are acceptable. However, if you are looking at it, and you are questioning it, or it doesn't seem right, in

that circumstance, you can absolutely request their signature protocols from the physician's office.

Stephanie: Okay. Alright, and my second question is when it comes to the CPAP supplies, when you're talking about how they can't be blanketed, could you possibly expand on that as well? And, I guess to be more specific, we have a form that does say patient preference, but we also have on that same form, have every code available, so they have the option to say patient preference – that way they switch from one to another, is that covered or do we have to have one that has all the codes specific to what they are currently using?

Michael: You would need one that has the codes that they are specifically using. Patient preference is not valid, because that doesn't describe the individual accessories that are going to be billed separately to the Medicare program. Another example you mentioned, you had one sheet that had all the codes on it. If the physician just circled that entire section and signed it and sent it in, that would be considered a blanket order because there is not any one type of mask or one type of tubing to use for the PAP device provided. Similarly, if you had an order that was signed by a physician that had nasal mask as well as full-face mask checked and also had heated tubing and regular tubing checked, those HCPCS codes would not be payable if that claim was chosen for review because there is more than one type of item that does the same thing on there. That's what we mean by a blanket order.

Stephanie: Okay. Great. Thank you for that.

Michael: You are welcome.

Stephanie: And that is all. I appreciate it.

Michael: Have a good afternoon Stephanie. Thank you. Hailey, that line is open. Go ahead, Hailey.

Hailey: Hi Michael. I have a question. I'm sorry I got delayed getting in so you may have already addressed this. Is that face to face examination completion date on the 7-element DME's – is it gone?

Michael: It is gone. The 7-element order has been replaced by the standard written order. The face to face date is not one of those elements. However, the physician must still complete that standard written order for the base in its entirety before you can provide the item.

Hailey: Okay – so for the item ordered can that be as it used to be – power mobility device – and then we go to the detailed product description following the receipt of that standard written order for the clarification of all those accessories?

Michael: That is correct. In essence, you are going to have two standard written orders – one completed in its entirety by the practitioner who conducted the face to face encounter, and then another one, that possibly you guys complete and then the physician signs that lists all of the different options or accessories that are going to be required for that beneficiary.

Hailey: Excellent. Okay. That just helps greatly. Thank you so much. I appreciate it.

Michael: You are welcome Hailey. Have a good afternoon.

Hailey: Thank you. You too. Bye bye.

Michael: Jackie, that line is open. Go ahead, Jackie.

Jackie: Hi again. I had called in earlier and asked a question, but someone had asked how long is the standard written order good through – is it a year or is there no timeframe on that?

Michael: For Medicare purposes, it doesn't expire. If the physician adds an expiration date on it, of course, then it would expire at a certain time, and we have mentioned it throughout this call some states require restrictions on how long an order is valid for, so make sure you are following the most stringent guidelines where applicable.

Jackie: Will that be in the Medicare LCD?

Michael: It will not. Medicare is a federal program, so you will need to reach out your individual state level. Your accrediting body might have some information about that. A lot of times the state boards are where you can verify that information.

Jackie: Okay. Alright. Thank you so much.

Michael: Thank you, Jackie. Asama, that line is open.

Asama: Hello Mike. My question is if my SWO is blanket for a HCPCS other than the target of the DBE, is it still valid? So, if it is a blanket for tubing, for example, and the DBE is for mask, is it still good to go?

Michael: I'm not sure I understood your question.

Asama: If my SWO is listed as heated and non-heated tubing, but my DBE is for the full faced mask, does it qualify?

Michael: You should not have an order that has both heated and non-heated tubing on it, because that is a blanket order for that HCPCS code.

Asama: Yes, but is it a blanket for all the codes on the SWO, or not for these two codes?

Michael: If would be just for those codes. If the rest of the order is valid, and there's not other aspects like multiple masks on there, then I would anticipate that Medical Review clinicians would pay all but the blanket codes as long as it is a valid order and everything else meets the requirements, based on that particular TPE review.

Asama: I see. Thank you.

Michael: You are welcome. Dixie and Linda, I see that you guys have your hands raised, but I don't show that you've input your audio PIN, so at the present time I am unable to unmute your lines. We have a couple of more hands raised. I think they are from folks who have asked questions before, so we will reopen those lines. Stephanie? Go ahead, Stephanie.

Stephanie: Hi. I'm sorry. I didn't realize I had my hand raised, but I will go ahead and ask again. When it comes to that whole blanketed part, I understand if all of the codes are on there, and a doctor just circled them all, I can see that as being blanketed. Now, if we are trying to cut down on, let's just say, paper, per se, and they circle just the full-faced codes, with a heated tubing, but the non-heated code is on there, and the nasal pillow is on there, but they are not circled, is that still considered to be blanketed?

Michael: No. As long as we can ascertain that the physician has chosen just the items, they would want the beneficiary to use, that is just fine. Keep in mind too that you guys can fill in or complete that portion of the order and then just send it to them to sign.

Stephanie: Ah, great. Thank you for adding that. I appreciate it.

Michael: You're welcome, Stephanie. Let me make sure I got your hand down. I think I did. Dixie, that line is open. I've got your audio PIN input. Go ahead Dixie.

Dixie: Okay, you might have already answered this, but I just want to clarify. If we get a call from, say, a home health or a

doctor's office, can we dispense like a bed or a wheelchair off of a verbal order, and then use the SWO? Do we have to have that before we fill or do we have to have the standard written order first signed by the doctor before we put out the equipment?

Michael: Right now, it is acceptable for you to provide the DMEPOS item. In the very early portion of the call, I talked about the Required List that CMS is going to publish. When HCPCS codes are added to that Required List and CMS releases it, all of the HCPCS codes on there will be written order prior to delivery. So, at the present time, yes, you can provide a hospital bed based on information you receive from the physician, and make sure you have a valid standard written order in your possession before you file the claim. If the hospital beds codes end up being on that required list, it would be face-to-face encounter as well as written order prior to delivery before you could dispense. So, keep your eyes on our ListServ and on our website for that Required List. As soon as we get it, we are going to turn around and make it public for our supplier community.

Dixie: Okay, so we were just trying to make sure we were not doing anything wrong.

Michael: Not right now.

Dixie: Okay. Alright, thank you.

Michael: You are welcome. Dixie. Not a problem at all. Debbie, that line is open, and I am show we are at the hour and a half point, so this will be our last question this afternoon. Go ahead, Debbie.

Debbie: I just want to clarify the required list that is not published yet will have a future effective date.

Michael: Yes, it will probably be the date of publication, but we won't know that until we get it from CMS, and they provide instructions to the DME MAC on how they want us to proceed.

Debbie: Okay, because the last caller was talking about the bed. If they already sent it, and they did not have a written order prior to delivery, they could get in trouble if they were audited. So, I don't know what is going to be our future date?

Judie: No, you will receive some notification. From what I understand, the list will be published to the Federal Registry with the HCPCS codes, and then it will be finalized after that publication date. So, you will have some notification prior to us changing to a written order prior to delivery.

Debbie: Okay, great, and I have one other question. On the company generated forms that our physician community has, in the past, because it was our generated form, you had to have the form order date on the top and the physician's signature date. So, we only need one of those at this point. Correct?

Michael: That is correct Debbie.

Debbie: Okay. Alright, thank you.

Michael: You're welcome. And, before you leave Debbie, I have talked to a lot of suppliers, and they are still going to leave that physician's signature date on their template simply so they will know when the physician did sign it. Just for their reference standpoint. That is something to think about as well. It might be a business decision for your company, of course. But I did want to mention that while I was thinking about it.

Debbie: Alright. Thank you.

Michael: Well folks, thank you so much for hanging out with us this afternoon. We sure appreciate it. Watch that ListServ as we will get the published transcript out there in a few weeks. We will notify you via a ListServ announcement when that happens. Be sure to join us for webinars coming up in the next few weeks, and we also have the Nashville Mega Workshop scheduled for March 25-26, so if you would like to attend a live education event, go out to our website, take a look at the Nashville Mega Workshop. Thank you so much. We appreciate your attendance and we will talk to you soon. We wish everyone a great afternoon. Goodbye.

Originated March 11, 2020