Ask-the-Contractor Teleconferences (ACT)

Provider Outreach & Education
Date: February 25, 2021

Moderator: Belinda Yandell
Time: 1:00 p.m. CST

Introduction

Good afternoon, thank you for joining us here. It is at the top of the hour so we will begin.

Good afternoon and welcome to CGS Administrators, LLC (CGS) DME MAC Jurisdiction C General "Ask the Contractor Teleconference." These ACT calls are hosted by the DME MAC Provider Outreach and Education team for Jurisdiction C. My name is Belinda Yandell, and on the call this afternoon are Jurisdiction C subject matter experts from CGS Medical Review and various operational departments. For this ACT call, you are welcome to ask questions related to recent changes and updates from CGS and Medicare. Remember, the latest DME MAC Jurisdiction C news is located under the "News" section of the website. Please note that there is not a presentation for this call. This call is being recorded and a complete transcript will be posted to our website within 30 business days. Hyperlinks for more information on our topics today will be provided in the transcript.

If you would like to participate in the question and answer segment, please be sure to enter your audio PIN. Your audio PIN is located on the left-hand side of the navigation pane, right below your access code. Note that each audio PIN is unique and may not be shared with other attendees. In order for us to unmute your line, your PIN must be selected.

Please note that while the Provider Outreach & Education team has put forth every effort to ensure that the information you received today is up to date and accurate, it is your responsibility as a DMEPOS supplier to stay abreast and compliant with any changes within the Medicare program.

Before opening the call to your questions, let's go over a few of the latest updates and reminders.

Competitive Bidding Program (CBP)

Effective January 1, 2021 Off-the-Shelf (OTS) Back Braces and Knee Braces are included in Round 2021 of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP). The affected items must be provided by a contract supplier in a Competitive Bidding Area (CBA). CGS has created a webpage providing all of the competitive bid information located in the "Education" section of the website. It includes information on the affected codes, how to identify if the beneficiary is in a CBA, information for non-contract suppliers, and much more. This information is available at https://www.cgsmedicare.com/jc/education/cbp.html.

Intravenous Immune Globulin (IVIG) Demonstration Extended

The Intravenous Immune Globulin (IVIG) Demonstration, which was scheduled to end on December 31, 2020, has been extended until December 31, 2023. Beneficiaries previously enrolled in the demonstration as of November 15, 2020 will be able to continue and do not need to take any action. No re-enrollment in the program is required. Suppliers can continue to provide and will be paid for demonstration services to eligible and enrolled beneficiaries beginning on January 1, 2021. You will find more information in the News section of the CGS website at https://www.cgsmedicare.com/jc/pubs/news/2020/10/cope19256.html.

Nurse Practitioners (NP) and Physician Assistants (PA) as Certifying Practitioner

A joint DME MAC article, published on November 5, 2020, clarified that MDs and DOs [Doctor of Medicine and Doctor of Osteopathic Medicine] may delegate duties of a certifying physician to nurse practitioners (NP) and physician assistants (PA) ONLY if the nurse practitioner or physician assistant is practicing "incident to" the MD's/DO's authority (under the MD's/DO's supervision and billing under the MD's/DO's NPI [National Provider Identifier]), when the following criteria are met:

- The supervising physician has documented in the medical record that patient is diabetic and has been providing, and continues to provide, the patient follow-up under a comprehensive management program of that condition.
- The NP or PA certifies that the provision of the therapeutic shoes is part of the comprehensive treatment plan being provided to the patient.
- The supervising physician must review and verify (sign and date) all of the NP's or PA's notes in the medical record pertaining to the provision of the therapeutic shoes and inserts, acknowledging their agreement with the actions of the NP or PA.

For more information on this subject, please see the article in the November 2020 "News" section of the CGS website at https://www.cgsmedicare.com/jc/pubs/news/2020/11/cope19409.html.

Primary Care First (PCF) Model – NPs as Certifying Physicians for Therapeutic Shoes

As announced in a joint DME MAC article, published November 5, 2020, the Primary Care First (PCF) model – NPs as Certifying Physicians for Therapeutic Shoes, is effective January 1, 2021 and extending through December 31, 2025. It allows nurse practitioners who are practicing independently to certify that an order for diabetic shoes is required when enrolled in the PCF model. CMS launched the model in 26 regions in total. The states in Jurisdiction C are Arkansas, Colorado, Florida, Louisiana, Oklahoma, Tennessee, and Virginia. You will find full information in the "News" section of our website at https://www.cgsmedicare.com/jc/pubs/news/2020/11/cope19408.html.

Advance Beneficiary Notice of Noncoverage (ABN) Form CMS-R-131 – Renewed

The renewed Advance Beneficiary Notice of Noncoverage (ABN) Form CMS-R-131 with the expiration date of June 30, 2023 became mandatory on January 1, 2021. Confirm that

Originated March 17, 2021.

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you are using the correct version of the ABN, as the expired version will not protect you from liability. The revised Certificate of Medical Necessity (CMN) and DME Information Forms (DIF) now have an expiration date of February 2024. All of these forms and instructions may be found in the "Forms" section of the CGS website at https://www.cgsmedicare.com/jc/forms/index.html.

Resumption of Post-Payment Reviews

To protect the Medicare Trust Fund against inappropriate payments, the MACs have resumed post-payment reviews of items/services provided before March 1, 2020. The Targeted Probe and Educate program will resume at a later date. Currently, the following policies are being reviewed: ankle-foot orthosis, ostomy supplies, urological supplies, knee orthosis, surgical dressings, blood glucose test or reagent strips for home blood glucose monitors, and lumbar-sacral orthosis. A list of applicable HCPCS codes and links to the announcements can be found on the CGS Jurisdiction C website, under the "Medical Review" tab and then "Post-Payment Reviews," at https://www.cgsmedicare.com/jc/mr/post_payment_reviews.html.

GW Modifier – Items Provided in Hospice for Conditions Not Related to Terminal Condition

Effective for claims submitted on or after December 1, 2020, with dates of service on or after September 7, 2020, the GW modifier must be appended to all HCPCS codes when the beneficiary is in hospice but are provided for conditions not related to a hospice patient's terminal condition. Claims submitted without the appropriate hospice exclusion modifier will be denied. These claims may be corrected through myCGS or resubmitted with the GW modifier. Please refer to the article in the "News" section of our website at https://www.cgsmedicare.com/jc/pubs/news/2020/11/cope19459.html.

Online Education Courses (OECs)

I want to talk a little about the online education courses we have available. The online education courses are located on our website, on the left-hand navigation panel, under the "Education" link: https:// www.cgsmedicare.com/jc/education/online_education.html.

The online education portal is available to use 24 hours a day, seven days a week, at no charge. You can take advantage of these courses whenever it is convenient for you. You can even pause if you need to.

We offer over 30 course titles. This a great resource both for new employees and for ongoing education for your seasoned staff. We will be adding additional policy-specific courses in the near future. If you have not taken the opportunity to view the online course titles, I encourage you to do so.

Encore Webinars

In 2020, CGS Provider Outreach and Education launched a new program called Encore Webinars. In response to requests from suppliers, we are now making recordings of some of our most popular webinars available on demand. We began with the Documentation Requirements 3-Part series: Principles, Orders and CMNs, and finally Refills and Delivery, as well as our Lower Limb Prostheses Prior Authorization. In the coming months, we plan to add recordings of our oxygen, PAP [Positive Airway Pressure device], ventilators, auditing entities, urological supplies, surgical dressings, and orthotics and prosthetics webinars. Keep an eye on our ListServ for the announcement of new webinars as they become available. You can find the Encore series on the website, under the left-hand navigation tab for Education: https://www.cgsmedicare.com/jc/education/encore.html.

LiveLine PLUS

Our LiveLine PLUS webinars are an interactive format devoted to questions-and-answers on various topics and policies. They also include top claim denials, documentation examples, and CERT [Comprehensive Error Rate Testing] and RAC [Recovery Audit Contractor] issues. In the coming months, we will be offering LiveLine PLUS webinars for oxygen, PAP, nebulizers, CGMs [Continuous Glucose Monitors], surgical dressings, lower limb [orthotics and prosthetics], therapeutic shoes for persons with diabetes, and urological supplies. For more information, please visit https://www.cgsmedicare.com/jc/education/liveline_plus.html.

Online Tools & Calculators

CGS takes prides in our Online Tools & Calculators. We currently offer 38 online tools to make your work day easier.

- The Same/Similar Tool displays the HCPCS codes that may cause a denial if billed with a particular base item.
- The Therapeutic Shoes for Persons with Diabetes Activity Timeline provides documentation and activity timeline regarding diabetic shoes.
- The Advanced Modifier Engine (AME) helps you bill the proper HCPCS codes and modifier combinations for DMEPOS in specific billing scenarios.
- The Overpayment Interest Calculator allows you to simply enter the date on the demand letter, the overpayment amount, the interest rate, and the date your check is being mailed to find the total amount due.
- We've just added a new Remittance Advice Tutorial to help suppliers understand the standard paper remittance, much of which also applies to the electronic version.

All CGS Online Tools & Calculators can be found on the CGS website left-hand navigation panel at https://www.cgsmedicare.com/jc/help/tools.html.

myCGS Web Portal

The myCGS Web Portal continues to be our most versatile and complete tool. You may reach the portal at https://mycgsportal.com/mycgs/.

For a complete look at all the many options and capabilities of myCGS, consult our interactive user manual at https://www.cgsmedicare.com/jc/mycgs/pdf/mycgs_user_manual.pdf.

If you need to make a simple claim correction to a completed claim, you can do so using the Claim Correction function in myCGS web portal. This is similar to a telephone reopening, but done in the web portal instead of over the telephone. Only minor corrections can be completed through the claim correction process. Minor clerical errors include adding modifiers to your claim (excluding those that assign liability), correcting a HCPCS code, or correcting the units of service.

The Reopenings Request Form in the myCGS Web Portal allows you to submit Reopening requests for claims, just like requests submitted via fax or mail. You would use the Reopenings Request Form in the web portal for any MSP [Medicare Secondary Payer] related issues and entitlement-based denials (to add a primary EOB [Explanation of Benefits]), adding a claim narrative, correcting a CMN or DIF with an associated claim, and change assignment on the claim. The reopening features also allows you to upload documentation to your request.

Originated March 17, 2021

If a claim is eligible for a simple claim correction, then using the "Claim Correction" screen in myCGS is the fastest and easiest way to reopen and correct your claim. You should use the Reopenings Form Submission only when a simple claim correction is not an option. Reopenings must be filed within one year from the date of initial claim decision.

Please keep in mind that any medical necessity denials must be appealed.

Redeterminations can now be submitted via the myCGS web portal. They must be requested within 120 days from the date of the initial determination, communicated to you via a remittance advice or overpayment demand letter. Redeterminations requests are required to revise modifiers assigning liability (such as KX, GA, GY, and/or GZ modifiers), or if you wish to dispute a not reasonable and necessary denial. You can attach supporting documentation with your redetermination submission in myCGS.

You can search beneficiary claim history for same or similar items, as well as check CMN status and check diabetic shoes inserts and supplies for same/similar.

For ADMC [Advanced Determination of Medicare Coverage] and Prior Authorization status and submission, you can submit ADMC and Prior Authorization requests, and check their status directly through myCGS.

For complete details and step-by-step instructions about what myCGS can do for you, visit https://www.cgsmedicare.com/jc/mycgs/index.html.

myCGS 7.0 – Live March 1, 2021

Lastly, I want to mention that myCGS 7.0 will go live on March 1, 2021. The new version will include some major improvements that we are very excited about. A ListServ was released on February 18, and, additionally, individual user emails were sent out with this information and detailed instructions for any actions required on your part. Please be aware of the following:

1. The portal will be down from 4 pm ET on Friday, February 26 through 7 am ET on Monday, March 1.
2. The first time you log in after 7 am ET on March 1, you will be required to change your password, regardless of when you last changed it.

There are several upgrades in myCGS 7.0, but here are the highlights:

1. In previous versions of myCGS, resetting your password required using a temporary password, as instructed in the password reset email. In myCGS 7.0, you will receive a link that takes you directly to the "Change Password" screen in myCGS. You will no longer need that temporary password.
2. The portal will now offer a suggested password. You may either use it or make your own choice. It's your decision.
3. The password rule has been relaxed so that you can reuse characters from your previous password, as long as they are in a different position. For example, if your previous password started with the letter P, your new password should start with a different character, but you can still use the letter P in a different position of the password.
4. There is a new Multifactor Authentication (MFA) option called the Google Authenticator. Users who download the free Google Authenticator app can save time when logging in. Rather than waiting for an MFA text or email, simply enter the 6-digit code displayed in your Google Authenticator.

We think you'll be very pleased with these new features.

Wrap Up

As we prepare to queue your questions, please note that we will only take questions over the telephone, as this call is being recorded for transcription purposes. If you would like to participate in the question and answer segment, please be sure to enter your audio PIN. Your audio PIN is located on the right-hand side of the navigation pane, right below your access code. To raise your hand, simply click on the icon of the hand. Then my teammate, Judie Roan, will announce you and unmute your individual line, so that you can ask your question. Also, remember that no specific claim information or Medicare beneficiary's private health information should be verbalized. I will now give you just a moment to prepare your questions.

Q&A

Belinda: Judie, we are now ready to take the first question.

Judie: Great. Thank you very much, Belinda. Hello, everyone. Our first question comes from the line of Kim. Kim, your line is off mute, go right ahead.

Kim: Okay, it may not apply to this seminar. But we did a refund on an overpayment in December, and I have now received a recoupment notice. So how do I contact someone about this? If we've already refunded it, but you guys have sent us recoupment on the outstanding balance?

Judie: Is it possible that they crossed in the mail? I know there are some delays in the mail.

Kim: Maybe, and that's what I was thinking too… but will they send me another notice if that's not the case?

Judie: Well, I would strongly suggest contacting Customer Service to confirm that we have received that payment.

Kim: Okay, I will do that. Alright.

Judie: Any other questions while you're off mute?

Kim: That's it. That's it.

Judie: Alright, great. I'll re-mute your line and put your hand down. Thank you, Kim.

Belinda: Thanks, Kim. Who do we have next Judie?

Judie: It looks like Calandra. Calandra's line is off mute. Go right ahead.

Calandra: Hi, can you hear me?

Belinda: Yes, we can.

Calandra: Hi, I have several questions. My first was... in the nurse practitioner PA... in MD DO rule change. If a nurse practitioner... the patient... I have one now... January 26, 2021... and the MD or DO can sign the note saying that he agrees with it. She electronically signs the note. In this particular office... that they don't have a way for the MD or the DO to go in electric… electronically sign it, but he can hand sign it. Is that okay?

Belinda: That should be fine.

Calandra: Okay, my next question, is with the Statement of Certification for the physician. If the nurse practitioner saw the patient and the MD/DO counter-signs her note... and he is the

Originated March 17, 2021

one... that signs the Statement of Certification... and it's not jointly signed by both of them. Is that okay?

Belinda: So, let me make sure I'm understanding. So, the certifying physician, the MD, signs the certifying statement. But the PA or the NP did the exam?

Calandra: Yes, ma'am, and he co-signed it. Is that okay?

Belinda: That should be okay. I can't see a problem with that.

Calandra: Okay.

Belinda: Judie, do you have any problem with that?

Judie: No, I don't have any additional feedback at this time.

Belinda: Okay.

Calandra: I've got two more and I'm done. My next question is, if Dr. Jones did the physical examination... we have a teaching hospital here, where residents come in, and they interchanged every six months to a year... if Dr. Jones did the medical examination and Dr. Brown is also in the physicians' office, did Dr. Jones have to sign the Statement of Certification, since he was the examining doctor? Or can his partner sign it?

Belinda: Are we talking about where the hospitalist has rotated out, and it's no longer available?

Calandra: Yes, ma'am?

Belinda: I believe... correct me if I'm wrong, somebody... but I believe that's fine for the other partner to take over and sign those statements, for a hospitalist that's in rotation.

Calandra: Okay. Okay. And then what if it's a private practice with two MDs practicing. One MD did the examination... and I'm using real live examples... if one MD went on vacation, and the Statement of Certification needed to be signed. Can that doctor sign it, or do we need to wait until that doctor comes back from vacation, since he was the examining doctor?

Belinda: I'm not sure about that one. Not sure how vacations fall into it.

Judie: This is Judie, and ideally, it would be the same physician, that actually did the assessment, would also sign that statement of Certifying Physician, because they treated the beneficiary for that specific condition. I would attempt to make that occur, if possible, if the physician retired, or something else that happened, it... we could, absolutely, individually consider that. But, again, I would personally suggest attempting it to be the same physician.

Calandra: Okay. And then my last question is, a patient went in... was in the emergency room... and went through a PCP for hospital follow-up. So, they're saying that's the reason for the visit. But during that visit, they are sent to a diabetes benefit as well. I guess my question is can you use that note as part of the exam... that's being seen by a PCP MD or DO, within six months? Even though it was as a hospital follow-up? Or do they need to come back in for their annual diabetic's examination?

Belinda: Honestly, I'm not sure on that one. Anyone else like to chime in here?

Judie: This is Judie again, keep in mind that the documentation doesn't always have to come from the actual PCP. Documentation is considered if it comes from the hospital... it comes from a nursing home... all of that documentation is considered for coverage. So, as a part of the documentation, that would be considered, as long as it met the policy requirements.

Calandra: I see. Okay. Thank y'all so much for answering my questions.

Judie: Oh, you're welcome. I'm going to go ahead and re-mute your line. Thank you. And let me put her hand down.

Okay, it looks like Rebecca is up next. Rebecca, your line is off mute. Go right ahead.

Rebecca: Hi, we are non-participating DME provider, and we don't accept assignment to Medicare. However, whenever the claims are being crossed over to supplemental plan G or F, which is supposed to cover excess charges, they are showing that we are accepting assignment, and they're not covering those excess charges. What can I do? Do I need to file a complaint with Maximus? Because, whenever I send them the remit from Medicare showing that we do not accept assignment, they are still refusing to pay those excess charges for the patient. So how do I handle that?

Judie: I'm sorry, what item are you billing?

Rebecca: It's an oral device to treat obstructive sleep apnea.

Judie: And for some reason... is it your claim is also being changed from non-assigned to assigned? Or is it just in the appeal?

Rebecca: I haven't done an appeal. I'm not able to on the supplement. I've asked that they re-process the claim, stating that we do not accept assignments, and they continue to tell me that they don't cover excess charges.

Judie: Okay, who is processing the claim? Is it Medicare? Or is the secondary?

Rebecca: It's auto crossed over to Blue Cross Blue Shield Supplemental Plan G or Plan F, incorrectly.

Judie: Okay. What we would have to do is take a look at those individual claims to see exactly what's going on. So, you can absolutely send us an email with this claim control number, and we can take a look at the claims to see if we can identify a specific issue; maybe the way the file is setup.

Rebecca: Well, I did send that to you and was told that you're showing us as non-assigned assignments, that the problem is on the supplemental plan. And so, I need to file a complaint against the supplemental plan, because they are refusing, even when we provide them with an EOB showing that we don't accept assignment, they are still refusing to process for those excess charges, and I can't get anywhere with the company. And we're having this happen with all of our Blue Cross Blue Shield Plan G and F.

Judie: Okay. The only thing, that I could suggest, is contacting that plan. They're private pay plans, correct? Because if we're crossing over correctly, there's not much else we can do.

Rebecca: Okay. We have tried that, and they continue. So, where do I file a complaint against Blue Cross Blue Shield?

Judie: I would have to look into that. I don't have that contact information in front of me. So, definitely, send us a follow-up, and we can try... but I would definitely try to escalate it within Blue Cross and Blue Shield.

Rebecca: Okay. Well, what I did... what I'm saying is I tried to do a DOI with the Department of Insurance… with Blue Cross Blue Shield, and whenever I go through it, it tells me that I have to go through Maximus, because it's a Medicare product.

Judie: The only thing I could suggest is, perhaps, the Insurance Commissioner for your state.

Originated March 17, 2021

Rebecca: That's who the DOI is.

Judie: Again, you can send a follow-up email, and we can look into it. This is a little bit outside of our normal issues. So, if you could send an email to us, we can definitely look into it and see if there's any assistance we can provide.

Rebecca: Okay, Judith. Yeah. That's great. You are our contact. So... so, we'll, send you... send you another email, and see what you can do for us.

Judie: Okay great. Thank you very much, Rebecca. Any other questions?

Rebecca: Alright, thank you. No, that's it right now. Thank you.

Judie: Okay. I'm going to re-mute your line... and go ahead and put your hand down...

And... Anne your line is off mute. Go right ahead.

Anne: Hi there, this is Anne. I have a couple of questions as well. If a patient starts off on an HMO plan... a Medicare advantage plan... and then during the capped rental, they switch to a Medicare plan. I was told the month carry over as long as the Medicare guidelines are met. And a new delivery ticket is not needed. It's just like a continuation of the billing. Is that correct?

Judie: This is Judie again. We do have information in the standard documentation requirements. If an item is transferring from a private payer, we would not have any record of any previous claims from another payer. What is the item you're providing?

Anne: Okay. Here is an example, say if it's a CPAP... if there was a private insurance fee-for-service... then going into Medicare... then... I was told... yes, you have to have a new order, yes, you have to have a new delivery ticket. But I was told if it's a HMO plan... a replacement plan... a Medicare advantage plan... going back to Medicare, it doesn't follow those guidelines as fee-for-service to Medicare. I was told it just continues, carries over, because it was always Medicare from the beginning. But they were in a replacement plan. I was trying to figure out, is that a difference?

Judie: No, it shouldn't be... and please, anyone who feels differently, feel free to provide additional information... but we would be looking for proof of delivery information for any claim that was initially being billed to Medicare.

Anne: And are there are specific requirements? It's not a full proof of delivery?

Judie: If the beneficiary is coming to us from another insurer, we would be looking for documentation to substantiate the need. Did the beneficiary initially have fee-for-service Medicare?

Anne: No. Okay. I've got two different examples... initially, the patient started off with a Humana replacement plan and then, during the capped rental, they went back to straight Medicare. So, when we set them up on the base equipment, they were in an advantage plan, which replaces the traditional Medicare. So, I was told, in that situation, the rentals would carry over? And we would need...

Judie: That's incorrect.

Anne: That's incorrect. Okay.

Judie: Yeah.

Anne: Okay. So, whenever they go from one plan, whether it's an advantage plan or fee-for-service to Medicare, we still need a new order and we still need a new delivery, to bill Medicare with the documentation of the continued use.

Judie: That's correct. We'd be looking for all the documentation to substantiate the need for the coverage of the item. It would be a new capped rental item for Medicare, and we would be looking for that proof of delivery documentation, confirming that the beneficiary had the item and that it was in good working condition.

Anne: Would we also need that new order as well. Correct?

Judie: You would need current documentation to substantiate the need for the item.

Anne: Okay. So, that includes the face-to-face notes?

Judie: If that's required for that particular policy, yes. You want to make sure that whatever policy criteria are in effect for that date of service are being met.

Anne: Okay. Let me ask you this, because I just want to make sure I understand this. So, say they was in a Medicare advantage plan, and the notes are required, and it was within the six months. Can we use those notes, because they were in a Medicare advantage plan? Or do we do it based off of when they went Medicare going forward?

Judie: I'm sorry, can you re-ask that question? I lost you somewhere.

Anne: Sure. That's okay, because I get confused myself. Okay. Say they're in a Humana advantage replacement plan, and now they're going to Medicare. But they were seen, under that advantage plan, within six months, which meets the guidelines. Can we use those face-to-face, because they were in an HMO plan? Or is it gonna go back to that fee-for-service Medicare, where... say 5/1 they're going back to Medicare. So, we have to have notes going... 5/1 going forward, when they went back to Medicare.

Judie: Well, the documentation from the previous private insurer, from the HMO, would still be considered within Medicare's guidelines, as long as the beneficiary meets the coverage criteria in effect on that date of service. Now, PAP does have specific rules, if you're referring specifically to a replacement PAP. And that information is in the policy, about the documentation that the beneficiary has had a sleep test prior to fee-for-service Medicare enrollment, that meets our AHI/RDI coverage criteria...

Anne: Yes.

Judie: Okay, so you have that, and also, we will be looking for that clinical evaluation as well. So, it depends on the item that you are providing. If PAP, you would want to refer to the policy.

Anne: So, wheelchair for an example. Say we do have valid notes during the HMO and now they're going Medicare, which is going to start in month one. So, as long as those notes criteria meets the guidelines, while they were in that HMO, we could use those notes.

Judie: That's correct. As long as it meets the policy guidelines, and you would want to confirm that the item is still reasonable and necessary for that beneficiary. Say, they're not now bedbound. So, you would want to obtain some pertinent recent documentation to substantiate the beneficiary still needs the item.

Anne: Okay. And then we would still need a new order? Or we would not? Only if it was fee-for-service to Medicare?

Judie: It would depend on how old your previous order was, and if the order met the Medicare requirements. So, if the order met the Standard Written Order requirements (which it may not, due

Originated March 17, 2021

to the fact that they weren't Medicare primary at the time) and it was relatively recent, then you should be fine.

Anne: Okay. But if it was the opposite, Fee-for-Service to Medicare, then yes, we would need a new order to meet Medicare's guidelines.

Judie: Fee-for-service Medicare to HMO?

Anne: Yeah, private insurance.

Judie: You would need to check with the private insurer on that. From us to them?

Anne: No. From private... from non-HMO to Medicare.

Judie: No. For the majority of items, the same rules apply.

Anne: Same rules apply. Okay. Got it.

Judie: That is correct.

Anne: And I do have a couple more questions. Okay. My phone disconnected when you guys were talking about the GW modifier... about the diagnosis unrelated. Here's my question, if we provided, a patient with COPD, and the hospice is billing for muscle weakness. We're still able to get paid while they're under the Hospice Program because it's not related. Correct?

Judie: As long as their condition is not related to the reason why they are in hospice, then traditional Medicare would consider coverage for the item.

Anne: And then we would also have to bill with that GW Modifier, at that time.

Judie: That is correct.

Anne: Okay. I have one more question, for a patient to qualify for oxygen... and then... say they have the OSA and they have the COPD, and they've only had a sleep study done; that's not sufficient. They also have to have a titration done, at or below 88%, to qualify. Correct?

Judie: That is correct. They have to meet the coverage criteria for oxygen, in addition to…

Anne: Right. And a sleep study alone doesn't qualify. And here was my second...

Judie: Right.

Anne: Part of that question. During that titration, if they're at 89%, they wouldn't qualify, correct? For Group II? They... because it's during the OSA?

Belinda: I don't carry those percentages in my head. I'd have to look back at the actual LCD. Judie, do you?

Anne: The 89% is the Group II, but I didn't know if it was during a titration. If 89% would actually be covered.

Judie: So, yes, they could get Group II coverage. And they would need another titration, to confirm that their OSA is controlled.

Anne: OK. I gotcha. So, they would, if at 89%... desat for more than the five minutes?

Judie: That is correct.

Addendum – For beneficiaries with OSA, a qualifying oxygen saturation test may only occur during a titration polysomnographic study (either split night or stand-alone). The titration PSG is one in which all of the following criteria are met:

1. The titration is conducted over a minimum of two hours
2. During titration, one of the following occurs:
   a. The AHI/RDI is reduced to less than or equal to an average of ten (10) events per hour
   b. If the initial AHI/RDI was less than an average of ten (10) events per hour, the titration demonstrates further reduction in the AHI/RDI
3. Nocturnal oximetry conducted for the purpose for oxygen reimbursement qualification may only be performed after optimal PAP settings have been determined and the beneficiary is using the PAP device at those settings
4. The nocturnal oximetry conducted during the PSG demonstrates an oxygen saturation ≤ 88% for 5 minutes total (which need not be continuous)

Anne: Thank you so much for answering all my questions.

Judie: Oh, you're welcome. I'm gonna go ahead and re-mute your line and put your hand down. And just a brief reminder that I cannot unmute your line if you have not entered your pin number into your telephone; and your pin number is under the audio portion of the webinar panel.

So, with that, I'm going to go ahead and unmute Gretchen's line. Gretchen, go right ahead.

Gretchen: Hi, I have questions regarding oxygen. The patient was set up with oxygen with a COVID diagnosis. How long are we able to bill with that diagnosis?

Judie: Medicare is currently under... I'm sorry, if anyone else wants to answer, go right ahead… But Medicare is currently under a Public Health Emergency for COVID-19. So, that diagnosis would be considered for coverage as long as you are following the COVID guidelines available on our website. Utilizing that CR Modifier and the narrative. Beyond that, we do not have additional information at this time.

Gretchen: Okay. So, if a patient switches from a Medicare advantage to Medicare. Would they just need new notes in order to keep the oxygen?

Judie: Yes. What's required, right now during the Public Health Emergency, is an order and documentation to substantiate the need for the item being ordered, for oxygen.

Gretchen: Okay, one more question... she had already asked about capped DME. Specific to oxygen, if the patient is on maintenance with Medicare, and they switch to a Medicare advantage plan, are we allowed to restart them with the Medicare advantage plan? Or does it count towards their CMN status with you?

Judie: You would need to contact the Medicare advantage plan. We do not have access to their claim information. So, if you're curious if our rental months will apply to the Medicare advantage plan, you would need to contact them to confirm that.

Gretchen: Okay, thank you.

Judie: You're welcome, great questions. Thank you. I'm gonna go ahead and re-mute your line.

Originated March 17, 2021

And it looks like our next question is from Nancy. Nancy, go right ahead.

Nancy: Good afternoon everyone. I have a question related to the continuous glucose monitor. There was documentation out in the Federal Register, that there's a proposal to adjust the fee schedules for how the CGMs are reimbursed, and it said that they would go into effect, either in April or the end of the public emergency, whichever is the latter. Do you know roughly how much notice they would actually provide, when they truly know a date that it's going to go into effect?

Judie: This is Judie again, and usually for Federal Register Notices, there is a 30- or 60-day notice. I cannot tell you for sure that that's what the notice would be. There's usually at least a 30- or 60-day notice.

Nancy: At least.

Judie: Usually.

Nancy: Okay. Alright. Thank you.

Judie: Oh, you're welcome.

Nancy: Thank you for that. That was my only question.

Judie: Okay, I'm gonna go ahead and re-mute your line.

Alright, Edna, you're up. Go right ahead Edna.

Edna: Okay, my question is a COVID-related question: we supply wheelchairs, bedside commodes, hospital beds, Medicare items, and when we go on to deliver these items, there are items that we have to set up, or there's items that we can just drop off. Do we need a signature from the member? Or due to the COVID pandemic do we need a signature from the member or do we…

Judie: No.

Edna: Oh, we don't?

Judie: Well, it depends on which signature you're referring to.

Edna: The signature proof of delivery.

Judie: For your proof of delivery, we do have an article about that under our COVID page, that you do not need a signature for proof of delivery. You can annotate COVID-19, and the beneficiary wouldn't sign. However, for your assignment of benefits, to be able to submit claims to Medicare, a signature is required.

Edna: Okay, and how do we work with that? If we don't know if the patient might have COVID or not?

Judie: The only thing I can suggest, you can always mail them the information and ask that they respond, and then you would not have to worry. You could handle it, quarantine your mail the same way that you do now. But you would definitely need a signature for your assignment of benefits.

Edna: For what? The assignment of benefits, right? The AOB?

Judie: Yes.

Edna: Okay.

Judie: But for proof of delivery, you do not. But I would definitely refer to that article if you have any questions.

Edna: What article would that be?

Judie: It is... have you looked at our COVID page?

Edna: No, I haven't, well...

Judie: Okay.

Edna: I probably have. There's so much on that page that I can't find anything.

Judie: Yeah, if you'd go to that page... I'm trying to find it. It was very early on we provided that information regarding the proof of delivery. Let me see if I can find it. I believe it's under the use of the CR modifier code, as well, because you would append the applicable modifier, as well. I am just looking to see if I can find that particular signature reference. What I'll do is I'll send a chat out to everyone when I locate that particular link, or it'll be in the minutes in the transcript.

Addendum – Provided in GoToWebinar Chat Box to all attendees:

- Signature Requirements on Proof of Delivery During the COVID-19 Pandemic: https://www.cgsmedicare.com/jc/pubs/news/2020/04/cope16792.html

Edna: Okay, that was my only question.

Judie: Okay, great, thank you.

Edna: Thank you so much!

Judie: Have a good day. Alright, it looks like we're getting closer to the top of the hour. So, I'm going to go ahead and lower Edna's hand.

Nancy, it looks like you may have a question. I'm gonna go ahead and unmute your line. Nancy, your line is open.

Nancy: Yes, ma'am. Thank you for taking my question. Back in... I think around October of 2020, there was a CO-151 denial, that was coming through. Mainly I saw it on enteral nutrition items. And we got emails saying that it was an error in the system, and that Medicare was reprocessing the claim. So, we did not need to send in for a Redetermination. I am still seeing a lot of denials that are still out there on my AR that had the CO-151. I haven't done anything with them because we were told not to. So, is there a timeframe that we should wait to send in a Redetermination on the CO-151? And how long a time was it an error that was happening? Was it just for a month? Or was it several months? Or do you have any idea?

Judie: This is Judie, and there were two phases of adjustments. This occurred, I believe, back in October of last year, and this should be resolved. There were two phases of adjustments that occurred. These were for files that were in our system on September 23 and 24, and we were adjusting those claims back in October. So, was that one of these claims? Or is it a true CO-151 denial... rejection? Was it for those dates (in process from 9/23 or 9/24)? Or is it where it may be a true CO-151?

Nancy: I have several dates that go from October/November is what I'm seeing as I look at our report.

Judie: Is it different dates of service?

Nancy: Yeah.

Judie: Okay. That should not be that specific issue. So, what I would suggest is contacting the contact center, to identify why those are denying as CO-151. It's possible, that they are a true CO-151 denial... or rejection.

Nancy: Yeah. I, mean, I definitely have seen the CO-151 denials in past. Usually, it's maybe $20 or $50, that is not paid, because of that. But, these, I'm seeing more like $200... $250, so it just seems to have been an issue for the last quarter of 2020. Not just those two dates.

Judie: OK. Well, we would need to take a look at those specific claims, and we can't, unfortunately, do so on our ACT call today.

Originated March 17, 2021

But, definitely either contact Customer Service or reach out to your Community Coach, and we can look into those and see exactly what's going on for you.

Nancy: Okay. Thank you very much.

Judie: Alright, you're welcome. Thank you.

Okay... it looks like we have about three minutes left. Belinda, shall we take one more or shall I turn it back over to you?

Belinda: Yeah let's swing back to Melissa. She finally put in her audio pin.

Judie: Okay, there we go Melissa, your line is off mute. Go right ahead.

Melissa: Thank you. I appreciate it. I just would like to know what the expectations are for the Public Health Emergency documentation requirements. Specifically, is there going to be a base set of documents, that both the MACs and other agencies are going to be looking for, should they eventually start auditing claims billed during the Public Health Emergency?

Belinda: Unfortunately, Melissa, we do not have any guidance on that from CMS. We don't know how long this will go on, and we don't have any information about what may happen when it's over. I will say one thing, that not all claims are... depending on the beneficiary, where they're located and what their health condition is... not all of them are unable to meet the standard requirements because of COVID. So, if there's any possible way... again, it goes to what the patient's condition is... what the equipment is... if you can get the documentation, really do make an effort to do that. That way, you don't have to worry about this question. But we don't have any information other than that.

Addendum – Provided in GoToWebinar Chat Box to all attendees:

- Here is a link to the CGS COVID-19 web page. This page will be updated with information as soon as it is available: https://www.cgsmedicare.com/jc/covid-19.html

Melissa: Okay. Thank you.

Belinda: Alright. You're welcome.

Closing

I want to thank you all for attending today's Ask-the-Contractor-Teleconference and participating in our live Q&A session. We will post the transcript to our website and send out a listserv notification when it's available. Thank you so much for attending, and we look forward to seeing you at future educational events. Have a great day.

End

Originated March 17, 2021