Ask-the-Contractor Teleconferences (ACT)

Provider Outreach & Education
Date: May 27, 2021

Moderator: Judie Roan
Time: 12:00 p.m. CST

Introduction

Good afternoon and welcome to the 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 Judie Roan, and on the call this afternoon are Jurisdiction C subject matter experts from various CGS 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.** The call is being recorded, and a complete transcript will be posted to our website within 30 business days.

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 in the GoToWebinar navigation pane, right below your access code. Note that each PIN is unique and may not be shared with other attendees. In order for us to unmute your line, your PIN must be entered.

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

Now, before I openg the call to your questions, we're going to go over some latest updates and reminders.

Competitive Bidding Program (CBP)

First, we'll start with competitive bidding. This is regarding Round 2021 of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP). Beginning in January of 2021, off-the-shelf (OTS) back braces and knee braces are the only items subject to Competitive Bidding.

These items must be provided by a contract supplier in a Competitive Bid Area (CBA) unless an exception applies. The exceptions include Medicare Secondary Payer (MSP) claims, repairs to the affected codes, traveling beneficiaries, and physicians and other treating practitioners that provide these items. When off-the-shelf back and knee braces are provided by physicians and other treating practitioners, the item must be furnished by the physician (or other treating practitioner) **to his or her own patient as part a of his or her professional service**. On the claim billed to the DME MAC, the off-the-shelf (OTS) back brace or knee brace line item must have the same date of service as the professional service office visit, or physical or occupational therapy service billed to the Part A/Part B MAC. The KV modifier should be appended to the claim. If a non-contract supplier provides a competitive bid item to a beneficiary that resides in a Competitive Bid Area (CBA), they must obtain an Advanced Beneficiary Notice of Non-coverage (ABN).

CGS has created a web page providing all of the competitive bid information, which 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 under Education in the left-hand navigation section of the CGS website, which is https://www.cgsmedicare.com.

Post-Payment Reviews

Moving into post-payment reviews: to protect the Medicare Trust Fund against inappropriate payments, the MACs are continuing post-payment reviews. The Targeted Probe and Educate (TPE) program will resume at a later date. Currently, specific HCPCs in the following policies are being reviewed: ankle-foot orthosis, blood glucose test or reagent strips for home blood glucose monitors, immunosuppressive drugs, knee orthoses, lower limb prostheses, lumbar-sacral orthoses, manual wheelchairs, osteogenesis stimulators, ostomy supplies, surgical dressings, therapeutic shoes, and urological supplies. A list of the 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.

A major enhancement with myCGS 7.1 is the addition of post-pay to the Additional Documentation Request (ADR) screen. So you can now review your pending ADRs and submit responses to the requests.

COVID-19 Public Health Emergency (PHE)

To provide status of the ongoing COVID-19 Public Health Emergency (PHE): There have been no recent updates as to when the non-enforcement will end and no additional information regarding continued coverage after the end of the PHE. If the claims are affected by the PHE, continue to append the CR modifier, and add "COVID-19" narrative to the affected claims.

Sequestration Suspended

The Coronavirus Aid, Relief, and Economic Security (CARES) Act suspended the sequestration payment adjustment percentage of 2% applied to all Medicare Fee-for-Service (FFS) claims, and the suspension period has recently been extended to December 31, 2021.

Medicare Administrative Contractors have released any previously held claims with dates of service on or after April 1 and reprocessed any claims paid with the reduction applied. No action is needed by suppliers.

Repayment of COVID-19 Advance Payments

Suppliers that received advance payments due to the COVID-19 Public Health Emergency (PHE): CMS has begun recovering those payments starting on March 30, 2021, depending upon the 1-year anniversary of when you received your first payment. Please be sure your billing staff are aware that the recovery has begun or will begin soon, but no sooner than 1 year from the date we issued the advanced payment to you. Advance payments were issued to suppliers

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in Jurisdiction C between March 31, 2020 and June 11, 2020. Letters describing the repayment process were sent to the applicable suppliers in October of 2020.

Comprehensive information regarding the PHE, including sequestration and advance payments, is located on the CGS website in the left-hand navigation under COVID-19.

Custom Fitted Orthoses without a Corresponding Off-the-Shelf (OTS) Code

The next update is regarding the coding and billing of custom fitted orthotics that do not have a corresponding off-the-shelf equivalent code. A helpful article was posted on March 11, 2021 and is available in the news section of the CGS website. This information provides a list of custom-fitted codes that do not have a corresponding off-the-shelf (OTS) HCPCS code (that's minimal self-adjustment) and provides guidance to utilize the applicable miscellaneous code. When submitting a claim for a miscellaneous code, be sure to include a narrative on the claim which includes a description of the item or service, manufacturer name, product name and number, Supplier Price List (PL) amount, and the HCPCS code of related items (if applicable). If you ever have questions on the correct coding, or billing, or clarification of coding, contact the PDAC, or Pricing Data Analysis and Coding contractor. Their website is https://www.dmepdac.com.

Same or Similar Orthoses and Change in Condition

Items that are identical or similar to items previously paid for by Medicare may be provided when the item is lost, stolen, irreparably damaged, or if there's been a change in the beneficiary's medical or physiological condition. When an orthosis is denied as same or similar it may be submitted for Redetermination. The DME MACs will review documentation to determine if the previous item was lost, stolen, irreparably damaged by a specific incident, or if there was a change in the beneficiary's condition. In the circumstance of a change in condition, the supplier should submit the following with their Redetermination request: a standard written order, proof of delivery, and the medical record documentation to substantiate a change of medical/physiological condition, which includes information such as the diagnosis, prognosis, duration of condition, functional limitations, clinical course, and past experience with related items and the reason why the previous orthotic devices are not functional or not appropriate for the current condition. CGS has a helpful documentation checklist for replacement orthoses on the jurisdiction website. The checklist is located under Medical Review Resources, then select Documentation Checklists, and select the document titled Replacement Orthotics for Change in Condition During the Reasonable Useful Lifetime (RUL).

Billing Reminder for the K0553 Supply Allowance for Continuous Glucose Monitors (CGMs)

Our next update is a billing reminder for the K0553, which is the supply allowance for continuous glucose monitors (CGMs). The code K0553 is for an "allowance," which means it includes every supply item necessary for the Medicare beneficiary to use the CGM receiver. Items may include transmitters, sensors, batteries, and blood glucose monitor supplies (such as strips, lancets, and control solutions). None of these supply items should be billed separately to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC). Suppliers should bill one unit of service of the K0553 at a time. Suppliers should bill only once every 30 days. Please be aware that if you have recurring billing set up in your system, billing on the last day of the month may cause future denials. For example, as you know, February does not have 30 days, and you must adjust your billing to accommodate billing only one unit of service for K0553 every 30 days. This article is available on the CGS website under the News section of our left-hand navigation.

A DME MAC Program Manager Update: Collaborative DME MAC and A/B MAC Practitioner Education

Next is a DME MAC Program Manager update: Collaborative DME MAC and A/B MAC Practitioner Education. In this article, the Program Managers want to share the activities of the A/B and DME MAC Collaboration Workgroup. This workgroup evaluates high Comprehensive Error Rate Testing (CERT) error categories and develops educational opportunities for physicians and non-physician practitioners. The DME MAC Provider Outreach and Education teams collaborate with the A/B MACs to enlist the support of prescribing practitioners in reducing the error rates related to orders and medical records. This national collaboration includes quarterly educational webinars and helpful "Physicians/Practitioners are you ordering…" articles, which are distributed by the A/B MACs to the practitioners that order DMEPOS items.

Redeterminations/Reopenings Through myCGS

Next, Redeterminations/Reopenings through myCGS: CGS is encouraging all suppliers to submit redetermination and reopening requests through the myCGS online portal. Utilizing myCGS is the fastest, most efficient way to submit these requests, and suppliers save time, money, and resources. If you currently have access to myCGS, information is available in the reprocessing section of the user manual; if you are not registered for myCGS, refer to the Registration Guide to learn how to register and start using this valuable resource.

Some important information: if the claim was denied as not reasonable and necessary, or it was denied as a result of an audit, such as CERT or the Recovery Audit Contractor (RAC), the claim must be submitted to Redeterminations and must follow the appeals process. Include supporting documentation for minor omissions and clerical errors with your request.

The following claims cannot be sent to Reopenings: not reasonable and necessary claim denials, claims denied by a review contractor, requests to extend the date for the end of a 13-month rental period due to a break in service/break in need, or to start a new capped rental period, or to change, add, or remove the KX, GA, GZ, and GY modifiers.

Online Education Courses (OECs)

And finally, I would like to review the the educational resources we have available.

CGS offers over 30 online educational courses, and they are located on our website on the left-hand navigation panel under Education. The Online Education Portal is available to you 24 hours a day, seven days a week, at no charge. A few of the new courses include: Continuous Passive Motion (CPM) devices and Pneumatic Compression Devices. You can take advantage of these courses whenever it is convenient for you. You can even pause the presentation.

Encore Webinars

Provider Outreach and Education also has a newer program called Encore Webinars. In response to requests from suppliers, our most popular webinars are available on-demand. This

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includes the Documentation Requirements 3-part series, Oxygen, Positive Airway Pressure (or PAP), Urological Supplies, and Orthotics and Prosthetics, and more. Keep an eye on our electronic mailing list for the announcement of new webinars as they become available. You can find the Encore series on the CGS website, under the left-hand navigation tab for Education.

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 and recovery auditor (RAC) issues.

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 into your telephone. Your audio PIN is located on the right-hand side of the navigation pane, right below that access code. To raise your hand, simply click on the icon of the hand. Then, my teammate Angie Cooper will announce 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. To give everyone a chance to ask their question, we will only be taking one question when your phone is unmuted. After your one question is addressed, please raise your hand again for each additional question. Our goal is to address as many questions as possible during our scheduled time. I will now give you just a moment to prepare your questions and raise your hands.

Questions & Answers

Judie: Angie, we are now prepared to take the first question. Do we have any hands raised?

Angie: Yes, we have a couple of people with questions, and the first one on deck is Anthony. Go ahead, Anthony, your phone is unmuted.

Anthony: Yes, my question is regarding the March 11th guidance on the off-the-shelf products and the use of the miscellaneous codes. Can you provide any guidance on why the miscellaneous codes would be denied for CO-181 with remark code 20 for invalid code for that date service?

Judie: Are you including a narrative on the claim?

Anthony: Yes. Would it... well, I guess the question would be, if the narrative is not in there, or in there correctly, would it deny for those two reasons?

Judie: Yes. If it's missing a narrative, we are unable to identify what exactly that item is, so we're unable to process or identify reimbursement because miscellaneous codes are individually reimbursed. So, that very well may be the issue. I would suggest contacting Customer Service or Provider Outreach and Education team, so we can look at your specific claims and identify what the issues are.

Anthony: Awesome. Great. Thank you.

Judie: You're welcome. Great question. Thank you.

Angie: OK, the next question comes from Carol.

Carol: Hi.

Judie: Hello.

Carol: It's Carol.

Judie: Hi, Carol.

Carol: How ya doing?

Judie: Good, how are you?

Carol: I'm doing well, thanks. My question is regarding CPAP mask and the replacements with cushions. My question really is if... since we can bill three months of supplies... we've always been under the impression that if you're billing the mask, we would have to also bill the cushion... say... the next day, for the replacement cushion. Is that correct? Or can we bill the mask and one replacement cushion for... say... whatever month they may have called in?

Judie: My understanding...

Carol: Does that make sense?

Judie: It is... it absolutely does...

Carol: Okay.

Judie: And my understanding of replacement items is they should not be provided at the same time as the initial issue of the "base."

Carol: Correct.

Judie: Right. So, I don't believe they should be on the same date, but does any CGS staff want to weigh in on this topic?

Carol: No, huh?

Judie: I guess not. Carol...

Ed: Hi Judie, this is Ed Knapp. So, are these both replacement items that you're providing?

Carol: Right. So, a patient is due for a mask... they need a mask. Generally, it's just one cushion obviously, with that mask. So, we need to provide them, most of the time, with an additional cushion, so that they have…. because they're out of cushions as well, they need to replace everything. So, at that point, can we ship both pieces at the same time?

Ed: Yeah, if they are individually billed items and they are replacement items, as long as you're providing the replacement within a specified timeframe, and you check with the beneficiary prior to, that they need a... that they actually need a replacement; I do not see an issue with billing these on the same day.

Carol: Okay, I just wanted to make sure because we had billed a few. We were always told that could not be done... and then we had a few that billed out... and now the question is arisen... and I wasn't sure if I needed to refund Medicare, because it was a mistake on the billing on their end... you know... through processing, because I know a lot of things have been relaxed. So, I wasn't quite sure, and I thought it best to ask the question. So, we can?

Ed: As long as it's within the timeframe and you're allowed to give out so many units per a certain timeframe, as long as it falls within that timeframe, and you checked with the beneficiary, prior to, and that they need a replacement and you have documentation of that; then I do not see an issue with billing on the same day.

Carol: Okay, alright, that's what I needed to know. Thank you very much.

Judie: Thank you, Ed and Carol.

Ed: Thank you.

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Carol: Have a great day.

Judie: You too, thank you.

Addendum (clarifying reference added):

Refill Requirements for Non-consumable Supplies FAQs (https://www.cgsmedicare.com/jc/help/faqs/current/refill_requirements.html)

Angie: Okay, the next question comes from Gretchen. Gretchen, your phone line is unmuted.

Gretchen: Hi, my question is regarding oxygen. We have a patient who... or several patients... if they are ordered oxygen with a restrictive lung disease as a qualifying diagnosis... that's in their notes... saying that they have pneumonia or COVID at the same time. Are the qualifying stats? Can we go with those? Or do we have to get new ones? And if so, when?

Judie: Okay, there's two separate issues, Gretchen. So, first is that the oxygen policy criteria... clinical coverage criteria are not being enforced during the Public Health Emergency (PHE). So, in that scenario, we would consider coverage for the beneficiary with COVID, or if they don't meet the coverage criteria in the LCD. So, during the duration of the PHE, it would be considered for coverage due to the "waiver," but the claim would need to be submitted with the CR modifier and COVID-19 in the narrative. Prior to the PHE, the underlying condition... I'm sorry... the temporary condition, such as pneumonia or a virus, would have had to been treated. It would have had to have been a chronic lung condition for Medicare to consider coverage. But again, because we are in the Public Health Emergency and the clinical criteria are not being enforced at this time, it would be considered for coverage. Again, with that CR modifier, there must be documentation from the physician to identify that there is a medical need for that item.

Gretchen: So, if we have patients who were set up five years ago and it stated... that in the notes... that they had pneumonia at the time, would we... say they recovered three months later... were we supposed to get new stats three months later?

Judie: So that beneficiary...

Gretchen: COPD and pneumonia.

Judie: Again, the underlying condition should have been treated and resolved prior to Medicare considering coverage. Again, this is prior to the Public Health Emergency. I don't believe a new test is necessary. Does anyone from CGS want to jump in on that? I don't believe new testing would be required in that particular scenario, but your question for the current beneficiaries who may have COVID or another condition that has not been treated due to the fact that the policy is not currently being enforced... that the coverage criteria are not being enforced, it would be considered for coverage now.

Gretchen: Okay, thank you.

Judie: You're welcome. Great question.

Angie: Okay, the next person is Randy. Randy, your hand... I mean your phone line is unmuted.

Randy: Hello.

Judie: Hi, Randy.

Randy: Hi, just making sure you can hear me. My question is basically having to do with billing the salvage claim. In the Medicare Supplier Manual, in chapter five... specific for me... so orthotics/prosthetics... in section four, it actually says, that if a beneficiary, for any reason, canceled the order, payment can be made to the supplier in such cases... you know... in this case, the patient died and passed away. So, we were going to file a savage claim and it says, in such cases, the expenses considered... considered incurred on either the date the beneficiary died or the date that you learned of the cancelation of the item. So, we found out that the patient died when we spoke to one of the family members.

Judie: Okay...

Randy: So, we put that date down, as we went through our salvage, and everything we billed. It was denied through Redetermination, Reconsideration, and then at the ALJ level. Obviously, because they were saying that the services were provided after the date of death. We knew that was the case. However, through the second level of appeal, we ended up contacting the family back (felt like total idiots calling the patient's family back to say, "hey, can you tell us when they died?"), but we got that date of death... and even though we went all the way through to the ALJ; they still denied it because we've provided, prior... after the patient's date of death. So, can you help me understand why that second bullet point is on there, to say that we can bill using the date that we learned of the cancelation of the item? What... what does that mean, and why can't I use it in this case?

Judie: So... because of the beneficiary... had passed away... I'm assuming that we were looking for the date of death... no later than the date of death... that cancelation would apply to... say the beneficiary calls and says, "I don't want it, I changed my mind, I don't want the item." So, you've started to build a custom-made item for the beneficiary, and they call and cancel. That's why that date would be there, or the date that the supplier learned of the cancelation, because it's already gone through... you've already gone through the ALJ. Are you going to go to the next level of appeal with it?

Randy: Yeah... I mean... it feels like it's only right... that we... we didn't feel like we did anything wrong, based on exactly what it says: the date you learned of the cancelation of the item. If it... if it doesn't apply to death, then it should probably say that.

Judie: I'm sorry, I absolutely understand. Did you include a copy of the article and any documentation to substantiate that you did not find out that the beneficiary had passed away until a week, or two weeks later? Whatever the scenario was.... did you include all of that in your appeal?

Randy: We did, and we actually had a copy of the Supplier Manual, and everything... and, while we're on the phone with the Administrative Law Judge, he was reading it from another section of the Supplier Manual... and we were reading the same exact bullet points. So, I actually thought that he understood where we were coming from, when we had proved our point, and then he went ahead and denied it anyway... and I'm like... I just don't understand... like I hear what you're saying... but that is not what this says, and so…

Judie: I understand.

Randy: Am I seeing it weird? Am I not reading something? Is there another place that...

Judie: Nope.

Randy: Says can't do this? So that's my question.

Judie: You are absolutely correct, and the information is also available in the CMS IOM Publication 100-2 of the Benefit Policy Manual, Chapter 15. That information is also in an IOM, not just in a CMS—CGS—manual. The only thing I can suggest... we can definitely take back the clarification of this article... but the only thing I can suggest is, absolutely, taking it to the

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fourth level of appeal and including as much information as you can. Perhaps, in your intro to the appeal request, include that information, exactly what happened. So, we can definitely take that back to address that.

Randy: Thank you for your time.

Judie: Oh, you're most welcome. I apologize.

Addendum (clarifying reference added):

Artificial Limbs, Braces, and Other Custom-Made Items and Incurred Expenses (https://www.cgsmedicare.com/jc/mr/limbsbraces.html)

Judie: Angie?

Angie: Okay, the next question comes from Luis, and your phone is unmuted.

Luis: Good afternoon. My question's related to orthotics. I just wanted to verify how they worked. We got this week… that for Medicare billing of orthotics, effective October 1 of 2021, that you must have a licensed individual on staff.

Judie: If you're in one of those 17 states, yes, that is correct.

Luis: Okay. Thank you very much.

Judie: If you are providing custom-fitted or custom-fabricated orthoses, and that information...

Luis: What about off-the-shelf?

Judie: That does not apply to off-the-shelf. Let me double check it. No, it's custom-fitted and custom-fab.

Luis: Okay, that I understand. Okay.

Judie: Okay… so if you do… if you are providing those items and you do have an orthotist, definitely contact the National Supplier Clearinghouse (NSC) to provide that update. But it does not apply to off-the-shelf items.

Luis: Thank you very much. Have a great day.

Judie: You're welcome, you too.

Angie: Okay, the next question is from Jeff. Jeff, your phone line is unmuted.

Jeff: Hello, good afternoon. My question is elaborating on the custom fit criteria. I know you guys do state that you want more than minimal self-adjustment for custom fitting and an individualized fit. When we're dictating those codes, and we're using them versus expertise, how much is more than minimal self-adjustment? So, what we're getting is... you know... we're getting codes like that... if you just use like a heat gun on the frame, then now you're individualizing that brace to the patient. Is there going to be any elaboration on that definition to clear that kind of gray area?

Judie: There hasn't been any clarification on that definition since it was published. I believe it's been probably about 10 years now. But what I'll do is I'll turn it over to our orthotist, Sienna, to address that for you. Sienna...

Sienna: Thank you, Judie, this is Sienna. There is no additional information or any documentation on what you would need to provide. All I can say is make sure that your notes are very thorough and give us a picture of what you are doing to that brace to fit that beneficiary, so that our nurse reviewers can see the entire picture of what's being done for that item.

Jeff: So, if we were to just use like a heat gun on like just the frame… if it's an existing prefab brace that was always billed OTS... and now it's being sold as a custom fit with a heat gun... I mean... is that gonna pass dictation? You can't really allow...

Sienna: I cannot give you an exact answer, unfortunately, on what exactly you would want to write. You would want to make sure that you're very thorough in why the beneficiary needed the item to be customized, and what you did to that device to customize it.

Jeff: So, there is a criteria that the patient needs it to be customized? Like... there has to be a criteria that...

Sienna: We would want to see the documentation that you provided those services and what all that entailed, for a complete picture of that. There is nothing written in the policy of exactly what needs to be written, or exactly what that would be defined as. It's just beyond minimal self-adjustment.

Jeff: Okay, awesome, thank you for your time.

Judie: Thank you for your question, and thank you, Sienna. Angie?

Angie: Okay, the next question is from Barbara.

Barbara: Hello.

Judie: Hi.

Barbara: My question has to do with surgical dressings. I've been receiving denials... well actually... not denials... reduced quantity, and they're basing it on the MUE limit, stating that these are the set limits for a particular patient for a particular date of service. The patients that I have have severe wounds on their body and require large quantities. Does the MUE follow the LCD, because we are dispensing based upon the allowed amounts in the LCD, but yet, that's... we're getting reduced number of units.

Judie: We would actually need to look into that in a little more detail. However, if… so you're providing the number of units as limited in the policy, correct? But you're still getting...

Barbara: Correct.

Judie: A denial.

Barbara: Does the MUE limits follow the LCD?

Judie: I'm gonna have to look at...

Barbara: Because obviously, it didn't in this case.

Judie: We would have to look into that specific MUE, and we could only release information if it is a published MUE, so that's why we would need to take this inquiry offline and be able to look at your specific beneficiary and circumstances. You can contact your Community Coach, and that information is under Education on the CGS website. Or you can send it to the Outreach and Education Team, which you received the confirmation for this webinar from, or from this ACT call from.

Barbara: Okay, thank you.

Judie: Yep. You're absolutely welcome, and I apologize we couldn't answer that today, but it's a little more detailed than what we have access to during the ACT call.

Barbara: Okay, thank you.

Judie: No, thank you.

Angie: Okay. The next question is from Lynn.

Judie: Hi Lynn.

Lynn: Good afternoon. I have a question... you know I have a couple... but I want to ask my first one, based upon the ADR

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request, what is Medicare Signature Requirement or expectation for Medical Record Amendment? Both paper and EHR? Does the physician have to specifically sign at that spot where they made the amendment and date it?

Judie: Okay, it's going to depend on if it is a paper record, or if it is an electronic record. We do have a very helpful article available on our website regarding Electronic Healthcare Records (EHR), but mostly... what we see most frequently, is there will be a hand-written amendment to previously created information. Now, the amendments do have to follow Standard Recordkeeping Principles, and they are that we need to be able to see what was there initially, so no scribbling it out, of course Medical records should never be whited out (if anybody uses white out anymore).

Lynn: Oh yes.

Judie: We would need to see what was originally there, the amendment in itself, then an initial and a date to that change. Usually what we see with Electronic Healthcare Records (EHR) is that it is much clearer to identify an amendment in the medical record. It's usually at the bottom—the actual change—and it has the physician's electronic signature and date.

Lynn: We have some physicians who say that their system will not allow them to do that, that additional signature and anything to differentiate that it is an amendment.

Judie: Okay, we do have an article available on our website, now it's an old article. And what you can do is type in addenda on the search engine of the CGS website. And that'll bring up a July 17, 2014, article that talks about electronic health care and addenda, and you are more than welcome to look at this. There's also a Dear Physician Letter that talks about addenda. So, you can definitely send that to the physician. You can request that they do a wet signature, and or wet initials and dates, but, yes, there's a Dear Physician article that you may want to send to the physicians, because it does state that it must clearly and permanently identify the amendment correction or delayed entry, the author of the amendment, and all original content must be there without deletion.

Lynn: And you see that is where we… we have sent in that we have sent them the Dear Physician letters... and maybe in a revenue cycle I send things back down to our office administrators and they get... they get the flack from our physicians. And I'm the one sitting here going, "No, no, no. Medicare, Medicare, Medicare."

Judie: Right.

Lynn: And the physicians are giving them a pretty hard pushback, saying, "It's right there, and I don't need to electronically sign it again." But you cannot tell where the addendum was.

Judie: Right. And that would definitely cause an issue with your claim in a review. So, it's important that...

Lynn: Exactly.

Judie: It's important that addenda. And you sent them the actual Dear Physician Letter that was revised in April on Electronic Healthcare Records and addenda?

Lynn: Yes.

Judie: Do you know if that one specifically was sent to them?

Lynn: Yes. And it's just…. we get the pushback, because if we don't get paid, it doesn't affect them.

Judie: I know, I understand.

Lynn: And, we are going to try to go out and do a little bit more of an educational presentation, based on all of these webinars that I've been attending here lately, and showing them, this is not my rule or guidelines, this is per Medicare.

Judie: Absolutely.

Lynn: This is Medicare's answer.

Ed: Judie.

Judie: Go ahead, Ed.

Ed: Hi, this is Ed from Medical Review. I… just a couple of points I just want to stress. With addendums, I just want to make sure that, that it is the original author that is doing the addendum, and not somebody else. And the second point is, a lot of times with Electronic Health Medical Records, while it doesn't necessarily say addendum, physicians or clinicians have the ability (when they're adding to records) to put in that actual note, addition to prior visit, et cetera. You know, we can tell that… as long as we can tell that... where the additional information is put and that it was done by the original author and... you know... there might not always be a signature... electronic signature... next to an addendum. It could be someplace else in that medical record. As long as we can see that, and we can correspond the date and time to that, then we can put that together. So, I think when you're educating the physicians, and they're coming back to you and saying "it's there," I just want to remind folks that it doesn't have to be the exact words "addendum," or something along those lines. What we need to see is that this information is being added into the Electronic Health Record at that point, what's being added in, and then that... you know... at what point that was being added in too. So, if that's contained in the medical record, and we can see that, and you can see that, then that's an acceptable addendum.

Lynn: Okay.

Ed: Does that make sense to you?

Lynn: Oh, it makes huge sense to me, it's just… you know getting them….

Ed: I'll be honest with you... I mean... there is... there are all kinds of Electronic Health Records applications out there, all kinds. Some of them are homegrown, some of them they pay some money for, some of them they paid a lot of money for. So, there's all kinds of different variations in that. So... you know... when we're reviewing these records, we're looking for that, and we know that. So as long as we can see it there...

Lynn: Okay.

Ed: Then we can tie it. So, I just want to be careful about when you're looking at these, and when you're providing that education, that, a lot of times, we focus in on exact words, et cetera, not necessarily concepts. So, the concept of an addendum is, it's additional information that was put in the medical record at a certain point in time to clarify condition, that is not... doesn't necessarily mean it's an additional exam (or something like that). It was something that was done during that time that wasn't pointed out in the notes previously, basically.

Lynn: Correct, correct.

Ed: So, then we need to see when that was done and who it was done by.

Lynn: Okay.

Ed: As long as we can see all that, then you're okay.

Lynn: Okay.

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Ed: Does that make sense to you?

Lynn: Alright, makes a lot of sense, Ed. That definitely helps a lot. I really appreciate it.

Ed: OK, thank you.

Lynn: Thank you so much.

Judie: Thank you, Ed.

Addendum (clarifying reference added):

Entries in Medical Records: Amendments, Corrections, and Delayed Entries (https://www.cgsmedicare.com/articles/cope31711.html)

Angie: Okay, thank you... and the next question comes from Evelyn. Evelyn, your line is unmuted.

Evelyn: Hello.

Judie: Hi.

Evelyn: My question is about the CPM machines. So, we're relatively new, trying to get into doing those CPM machines and we're just wondering, is there somewhere that we can go to look up what the storage/sanitation guidelines are for those devices?

Judie: Well, I believe that that question would have to go to either a healthcare attorney or the Pricing Data Analysis and Coding (PDAC) contractor. The DME MACs... usually that's your state laws that identify sanitation guidelines because there's different sanitation guidelines for each state dependent upon the item as well. Such as a hospital bed mattress may have a different sanitation guideline than a CPM device. So, I would definitely suggest you check with your statutory or state laws, or perhaps... and don't quote me... that the PDAC would be able to provide that information (or the Pricing Data Analysis and Coding contractor); but I would probably start... if your company has an attorney... a healthcare attorney... I would probably start there.

Evelyn: Okay. Alright. Well thank you very much for your help.

Judie: Oh, you're welcome.

Angie: Okay. The next question comes from Nancy.

Judie: Hey, Nancy.

Nancy: Hi. How are you?

Judie: Fabulous.

Nancy: We're struggling with…

Judie: How are you?

Nancy: Good. We're struggling with the best way to document knee instability and joint laxity, as required by the LCD. Can you… what... in some instances, our physicians are saying... they'll say that the patient has valgus in-step instability. They're not actually saying that they're doing a test... or are providing the test results... and we're seeming to having some issues with that... where we're having claims deny on review. My question is... I understand that they're doing these tests... should they be saying that they did an anterior drawer test, and saying that it was positive or negative?

Judie: Sienna, you can correct me if I'm wrong, but to my knowledge, yes, you would want to have as much information regarding... the information regarding any testing or drawer tests that were done.

Nancy: Okay.

Judie: You would definitely want to have that information from the physician in the medical record. Sienna?

Sienna: Yes, that's correct, Judie. Is... what the LCD says is that you need an objective test and the results... you know... and that showed that it is unstable. So, we would be looking for... you know... the type of test, what they did, what that objective analysis was to determine that instability and what that result was from that test.

Nancy: Okay, thank you, that answers my question.

Judie: Okay, great, thank you so much.

Angie: Okay, and it looks like Julie has had her hand up, but I have sent her her PIN. So, you'll need to enter that in your telephone, Julie, and that way you'll be able to... I'll be able to unmute your phone line so you can ask a question. The next question comes from Katrina, and Katrina I've unmuted your phone line.

Katrina: Hi, I'm gonna go back to the lady with the oxygen who asked about the pneumonia.

Judie: Okay.

Katrina: So, my question is, is that, for oxygen, all the documentation has to be within 30 days. So, if it takes three months for the patient to recover from pneumonia, wouldn't the testing be outdated?

Judie: Since the test must be within 30 days of the initial date?

Katrina: Right.

Judie: Yes, that is correct. So, if the beneficiary... say you have not identified a chronic lung condition as of yet, the beneficiary just has pneumonia. Just to give an example.

Katrina: Well, but the patient has a chronic lung condition and pneumonia. See, in my experience dealing with these situations, we've been told that that test is not valid because the patient was not stable...

Judie: They weren't in a chronic stable state?

Katrina: That they had to be retested once they were stable. Right.

Judie: Okay. Well, that depends on if it's discharged from a hospital, or an inpatient facility as well. Ed, do you want to address this one?

Ed: Hi, this is Ed. It's really hard to talk about individual situations unless I can see in the entire documentation, to be honest with you. I mean... chronic stable state needs to be established at that point. I mean... there's usually... there's oftentimes... there are acute conditions that can be... that can be causing the person to qualify for oxygen at the time, or may not, but we don't know that at that point, until that acute condition is resolved, we cannot determine if they qualify for the oxygen benefit. I mean... I can say that... I mean... kind of beyond that... you know... really these are individual circumstances, and... you know... chronic underlying lung disease is not necessarily cause... is defined in the LCD. But we need to see some... some... that the beneficiary has been having a chronic lung disease for a period of time, that is causing them to require chronic... to be in chronic stable state requiring oxygen.

Katrina: That part I know. What I'm trying to figure out is the patient... say... has had COPD for the last 10 years but hasn't needed oxygen.

Ed: Right.

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Katrina: They now have a pneumonia and the hospital's trying to put them on oxygen...

Ed: And... you know... when they... when the beneficiary is getting ready for discharge an inpatient setting, like was mentioned earlier, it can be dependent upon where they are actually too. So... you know... if it's at discharge... and you know... the hospital saying they're in a chronic stable state and they continue to use oxygen once they leave. Then, that's a little bit different, but it really depends on what's being treated at the time. You know, they could potentially still be on antibiotics, et cetera. So, it's... it's really hard, unless... you know... you can see the individual cases.

Katrina: Okay. Okay, but to answer the question about the testing, if it takes three months for them to recover, they need new testing.

Ed: If they're in acute condition...

Katrina: Okay.

Ed: And that acute condition is... if they have a chronic underlying disease, like you mentioned COPD earlier, and they've had it for 10 years. Right? And then, all of a sudden, they develop an acute condition that qualifies them for oxygen. That acute condition needs to be resolved before you can... qualify as chronic stable state. So, at that point, yes, if they had been an acute condition, and that condition is resolved, then you would need to have another oxygen test to establish chronic stable state.

Katrina: Okay, you answered my question. Thank you very much.

Ed: Thank you.

Judie: Just to follow that up, currently, again, the coverage criteria for... I'm sorry... the clinical criteria for oxygen is not being enforced during the Public Health Emergency (PHE). So, we would still consider coverage, as long as, there is a medical need and the claim is submitted with the CR modifier, as well as, the COVID-19 narrative. We're not quite sure what's going to happen after the PHE has ended yet. We have not received that direction. So, please keep that in mind as well.

Katrina: Okay.

Judie: Great question. Thank you.

Angie: The next question is from Gretchen.

Gretchen: Hi, I have another question about oxygen stats. Patients who are given an exercise test to qualify. If they complete the first two steps... so, they've had a room air reading, an exertion reading on room air, but then the third step they're unable to continue exertion. Does that reading qualify or is that considered recovery testing?

Judie: In that particular scenario, I believe we would need all three tests. So, is that your question? Or...

Gretchen: If the documents say that they're unable to tolerate further exertion due to shortness of breath, but they've been placed on oxygen and shown improvement. Does that qualify or not?

Judie: So, are they qualifying on room air?

Gretchen: No, they were qualifying…. they're… they dropped below 88 with exertion on room air.

Judie: Only with exertion though?

Gretchen: Yes.

Judie: Okay, so they don't qualify if they're just sitting?

Gretchen: No.

Judie: Just one moment... unless someone at CGS has additional questions or information on this... I would prefer if you send us an email. Under most circumstances, we would need all three tests, but with documentation to substantiate the need, we can consider that in the appeals process. But I would prefer if you sent your Community Coach an email, and we can definitely look into your specific issue a little better.

Addendum (exercise testing):

When oxygen is covered based on an oximetry study obtained during exercise, there must be documentation of three (3) oximetry studies in the beneficiary's medical record: (1) Testing at rest without oxygen, (2) testing during exercise without oxygen, and (3) testing during exercise with oxygen applied (to demonstrate the improvement of the hypoxemia) are required.

- All 3 tests must be performed within the same testing session. Exercise testing must be performed in-person by a treating practitioner or other medical professional qualified to conduct exercise oximetry testing.
- Only the testing during exercise without oxygen is used for qualification and reported on the CMN. The other two results do not have to be routinely submitted but must be available on request.
- Oximetry obtained after exercise while resting, sometimes referred to as "recovery" testing, is not part of the three required test elements and is not valid for determining eligibility for oxygen coverage.

Gretchen: Okay, thank you.

Judie: You're welcome.

Angie: OK, the next question is from Lynn.

Lynn: Hi, thank you for my second one. Are the date... can you tell me... as far as the practitioner, physician notes, and clinician notes, are the date of birth, reason, and date of amputation, height and weight, required by Medicare guidelines to be included in those notes?

Judie: In the medical record?

Lynn: Correct. Like in the physician's… when the physician sends the record over to us... shouldn't they have the patient's date of birth, the reason of amputation, the height and weight listed within those records?

Judie: I am going to have to defer to Medical Review. I don't believe that any of those docs… those specific documents... or documentation is required in the medical record. Of course, we would need to be able to identify the specific patient.

Lynn: Right.

Judie: So, their name or Medicare numbers should absolutely be listed. But, to my knowledge, we would not audit for that. Ed, to you.

Ed: No, I would agree. I mean… I think… I think we need to be able to tell in the medical record that… you know… that it's actually that beneficiary. So, usually its name or something along those lines. In terms of height and weight, that is really kinda dependent upon the that particular item that you're dispensing or you're giving... that you're providing…

Judie: It's a lower limb prosthetic.

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Ed: Oh, a lower limb prosthetic. Oh, I'm sorry, I missed that part. You know... that... weight can sometimes be used if you're… if you're saying that you're providing this particular product because the beneficiary's weight, et cetera. So that would need to be in the medical record, or… yeah, that would need to be in the medical record so we can kind of justify that… but along those... besides that… you know… I can't really see requirements for every single time.

Lynn: Okay, so the physician…. so, say if we're doing a socket replacement...

Ed: Yeah.

Lynn: The physician notes do not need to state the date of the amputation and what the patient's weight was at the last time they were at the physician's office… and if there was… if the reason they're needing it is the change in… they're… you know… as far as like if lose… they've lost volume… a volume has changed. So, at that point, if that's the reason that we're doing the replacement, does the physician need to have a pre and… you know… what his weight was, say, eight months ago?

Ed: No…. I mean… I see what you're saying… because the limits off actually kind of got bigger or smaller, and maybe any weight can kind of determine that.

Lynn: Okay.

Ed: No, I think… as long as we can… you know… we can see that in your records, in... or… that's being replaced, then you should be fine.

Lynn: Okay. If the…

Ed: And in terms of… oh, I am sorry, just one second… in terms of the date of the amputation, we just need to see that there was an amputation done. We don't necessarily… and a lot of times there is dates associated with that, but that's not necessarily required, I would say.

Lynn: You just need to know that they have… they just need to state that that they have the amputation?

Ed: Correct. Yeah... and you know... right or left... you know... sometimes that can cause issues.

Lynn: Yeah, yeah, okay.

Judie: The only time I would see... Ed, and please let me know if I'm wrong... but the only time that I would see that they would actually need the patient weight is if the socket or prosthetic replacement is due to significant weight loss or weight gain, then we would expect to see it in the medical record. Correct?

Ed: Well, not necessarily weight. I think we need to see documentation that there was a... you know... that there was a change of weight or something like that. Usually, there's associated weight there, but I wouldn't necessarily say it's a requirement. You know... I think what we need to be able to tell in a replacement situation... for a socket replacement situation... is basically kind of why it was replaced. That can be a description. Can also... you know... can be a weight... I mean that's... that's always helpful... but you know... I wouldn't necessarily say it's a requirement. I think it's painting a picture of that beneficiary that's the most important part... and I think that's with any claim that you submit to Medicare. Because in that record we don't have the ability to see that patient. You guys do. So, everything that we're going by is in that paperwork. So, unless we see that in that paperwork, then we don't necessarily know. So, where things may not be requirements, if they help to give us a little bit of a better picture, then... you know... I wouldn't say it's required, but... you know... it's going to help. So... you know... I think those are some things to think about.

Lynn: So, if they say there's been a volumetric change, the patient has… the limb has increased or decreased inside... size... that would be sufficient?

Ed: Yeah... I mean... I think... again, these are conditions that happen on a recurring basis, sometimes.

Lynn: Correct.

Ed: You know... beneficiaries go through these things, and so I'm not going to say you have to go out and weigh every beneficiary, when this... you know... this happens on a regular... daily basis for you. So, where it would help, yes. As long as we have a good description of kind of what's going on... I'm not going to say... you know... use this, because then people will... you know... as long as we have a good description of kind of what's going on, why you did it, and why it's being replaced, then you should be good.

Lynn: Okay. Thank you, Ed. I appreciate you all.

Ed: You're welcome.

Judie: Great. Thank you both very much.

Addendum (clarifying reference and excerpt added):

Standard Documentation Requirements Local Coverage Article: https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleid=55426

> Claims involving the replacement of a prosthesis or major component (foot, ankle, knee, socket etc.) must be supported by a new treating practitioner's order and documentation supporting the reason for the replacement. The reason for replacement must be documented by the treating practitioner, either on the order or in the medical record, and must fall under one of the following:
>
> - A change in the physiological condition of the patient resulting in the need for a replacement. Examples include but are not limited to, changes in beneficiary weight, changes in the residual limb, beneficiary functional need changes; or,
> - An irreparable change in the condition of the device, or in a part of the device resulting in the need for a replacement; or,
> - The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

Closing

We have come to the end of our time. So, I would like to thank you all so much for attending our Ask-the-Contractor Teleconference today. I would like to remind you that there are numerous questions that we have received. We do have webinars where you can ask many more questions than you have the ability to do so on the ACT call. Our minutes will be posted within 30 business days; there will be a transcript of today's call. So, thank you all so much for attending, and we look forward to seeing you at future events. Have a great day.

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