Jurisdiction B Ask-the-Contractor Teleconferences (ACT)

Provider Outreach & Education
Date: February 16, 2022

Moderator: Denise Winsock
Time: 2:00 p.m. EST

Welcome & Introduction

Good afternoon and welcome to the Jurisdiction B "Ask the Contractor Teleconference." My name is Denise Winsock, and I am a member of the Provider Outreach and Education team at CGS. We conduct this teleconference every quarter to give you an opportunity to ask questions of subject matter experts at the Durable Medical Equipment Medicare Administrative Contractor (DME MAC). We have a great team here today ready to address questions, including the JB provider education team, medical review clinicians, and other specialists from operational areas. You will need to call customer service if you have issues with a specific claim, as the purpose of this call is to ask questions about Medicare billing policies and or procedures.

We are recording this teleconference so that we can provide a record of the questions asked and answered here today. The questions and answers document will be available on our website within 30 business days. We will send an email through the electronic mailing list when it is available, and we'll only be taking verbal questions, since we want to record everything to be included in the document.

The provider education team puts forth every effort to ensure the information you receive today is accurate and up to date. However, it is ultimately your responsibility as a supplier to stay informed and compliant with Medicare program guidelines. Rules and guidelines change frequently, so be sure to stay up to date by reviewing all the information shared in the electronic mailing list and in the "News" section of the website. https://www.cgsmedicare.com/jb/pubs/news/index.html.

If you would like to participate in the question-and-answer segment, you must call in on your telephone and be sure to enter your audio pin. Your audio pin is located in the GoToWebinar navigation pane, right below your access code. To give everyone a chance to ask their question, we will only be taking one question at a time. Our goal is to address as many questions as possible during our scheduled time.

Just a quick reminder – you may not record this teleconference for any reason or purpose. We will be posting a copy of the questions asked and answered, if you want to refer to anything addressed here today.

So, while we queue the questions, I'm just going to go over a few updates.

COVID-19 Public Health Emergency (PHE)

As many of you know, the COVID-19 Public Health Emergency (PHE) continues, and the waiver was renewed on January 16th, 2022, for another 90 days. We have a dedicated COVID-19 web page which includes many resources for how and when to use the CR modifier. It's easy to access from our homepage or any page on our website, from the left-hand navigation menu. We've not received any further instructions from CMS on what will happen after the PHE ends. Just be sure to include the COVID-19 narrative on your claim if you are using the CR modifier for any COVID-19 waiver or clinical non enforcement reasons. https://www.cgsmedicare.com/jb/covid-19.html

Customer Service Updates

There are new menu options available when calling customer service. This includes a direct myCGS helpline. These new updates are the result of the feedback we have received from the supplier community. In addition to the existing options of eligibility, claim information, and prior authorization, we have added three new options: myCGS, general questions with an NPI, and other inquiries. Again, these updates are a direct result of survey feedback as suppliers requested a faster way for callers to access myCGS specific customer support agents. So this, again, is why we stress that you please complete surveys whenever possible, to share your feedback.

Redetermination Request

As a reminder, a redetermination request must be submitted by someone who is considered a party to the appeal. The appeal will be dismissed if the person requesting is not a proper party. For suppliers who retain a billing agency to handle their appeals, they will need to submit a properly executed appointment of representative. Suppliers can use the form CMS-1696 Appointment of Representatives or submit a statement containing all the required elements. The form can be found on the Appeals tab of CGS website at: https://www.cgsmedicare.com/jb/claims/appeals/tools.html.

More information regarding parties to an appeal and appointment of representatives is located in Chapter 13 of the Supplier Manual, https://www.cgsmedicare.com/jb/pubs/supman/index.html.

Prior Authorization

We have some updates to Prior Authorization. There are new HCPCS codes added to the required prior authorization list. The first is the Power Mobility Devices (PMDs). There are 6 additional PMD codes: K0800, K0801, K0802, K0806, K0807, and K0808. They were selected for the required prior authorization list, for prior authorization to begin nationwide on April 13th, 2022. The next category is Orthoses. Five additional HCPCS codes—L0648, L0650, L1832, L1833, and L1851 were also added to the required prior authorization list. Implementation of this requirement will be completed in 3 phases. Phase 1 begins April 13, 2022, in New York, Illinois, Florida, and California. Phase 2 begins July 12, 2022, in Maryland, Pennsylvania, New Jersey, Michigan, Ohio, Kentucky, Texas, North Carolina, Georgia, Missouri, Arizona, and Washington. Phase 3

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is going to begin October 10, 2022 in all remaining states and territories that weren't included in Phase 1 or 2. CMS also published the updated Prior Authorization information and Required List on CMS website: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.

We will be publishing additional prior authorization resources to our website prior to implementation. https://www.cgsmedicare.com/jb/mr/condition_of_payment_prior_auth.html

Required Face-to-Face Encounter and Written Order Prior to Delivery List

Next, there are new HCPCS codes that have been added to the Required Face-to-Face (F2F) Encounter and Written Order Prior to Delivery (WOPD) List. Some items, such as PMDs have statutorily imposed requirements. This means that no matter what, there must be a F2F and WOPD for PMDs. For items that do not have statutory requirements, a F2F encounter and WOPD is required, only if the item is selected from a Master List and placed on the required F2F encounter and WOPD list. Items selected for the list will be published in the federal register with no less than a 60-day notice period. Effective April 13, 2022, there are 7 non-PMD items that require a F2F encounter and a WOPD, 6 orthoses and 1 osteogenesis stimulator. Forty-six PMDs are on the list as dictated by statute. Therefore, as of April 13, 2022, a total of 53 items requires both a F2F encounter and a WOPD. The 7 non PMD additions to this required list are:

- E0748 - Osteogenesis Stimulator
- L0648 - L0650 Lumbar Sacral Orthoses
- L1832, L1833, L1851 Knee Orthoses - and
- L3960 - Shoulder-Elbow-Wrist-Hand Orthosis

However, there are 2 items on this list, the E0748, the osteogenesis stimulator and the L3960 the shoulder-elbow-wrist-hand orthosis, that do not require prior authorization, but they do require a F2F evaluation and a WOPD. We wanted to be sure to clarify to anyone that provides these items, that this is a new requirement for these codes, starting April 13 of this year. =Please be sure there is a F2F evaluation that has been conducted within 6 months prior to the order, as well as ensuring the supplier has received a complete, standard WOPD.

More information and a complete list of items on the required F2F encounter and WOPD list is found in the Special Edition Article 20007 or on the CMS website. https://www.cms.gov/httpswwwcmsgovregulations-and-guidanceguidancetransmittals2020-transmittals/se20007

We will be adding additional F2F and WOPD resources to our website prior to implementation.

Medical Record Documentation

Next, we wanted to touch on medical record documentation. For Medicare to cover any DMEPOS item, the beneficiary's medical record must include enough documentation to justify the need for

- The type and quantity of items ordered
- Frequency of use is for replacement if it's applicable
- The medical record should include the patient's diagnosis
- In addition to:
  - Their condition, their duration
  - Clinical course, whether it's worsening or improving prognosis
  - Nature and extent of functional limits
  - Other therapeutic interventions and results
  - Experience with related items

The medical record may include records from hospitals, nursing facilities, home health agencies, and other healthcare professionals. CGS conducts the documentation requirements 3-part series twice a month to ensure suppliers are aware of these requirements. For more information on medical record documentation, you'll want to review the Medicare Program Integrity Manual, Chapter five, Section 5.9, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.

Sequestration Fee Update

The sequestration fee update has been suspended until March 31 of this year. However, the 1% payment adjustment will occur from April 1 through June 30 of this year, and the 2% payment adjustment will begin July 1, 2022.

Accreditation Edits

We also want to be sure everyone is aware of the accreditation edits CMS has put into place. Starting January 3, if you are not properly accredited, you will receive notification on your remittance advice, indicating the ANSI adjustment reason code, CO 185, which states "The rendering provider is not eligible to perform the service billed." Also, the reason/remark code N790-provider/supplier not accredited for product/service and N6369, which reads, "Alert, although this claim has been processed, it is deficient according to state legislation regulation."

Be sure to contact an approved organization to get accredited. If you believe this message is incorrect, review your enrollment to ensure your accreditation information is up to date. Contact the National Supplier Clearinghouse (NSC) for help changing your enrollment records. If your record is correct, ask your approved organization to check their records. There is more information on the accreditation edits and can be found on the DMEPOS Accreditation fact sheet at CMS.gov: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/dmepos_basics_factsheet_icn905710.pdf.

Medical Review

CGS has recently added functionality to the myCGS web portal to assist suppliers with medical review audits and tracking of targeted probe and educate (TPE) cases. These functionalities now include the ability to directly submit your additional documentation request (ADR) responses to TPE reviews. You can also now view each ADR letter that was mailed to you as part of TPE probe, along with the letter showing notification and results. Finally, myCGS also allows you to view the summary from the post probe educational call. myCGS, is the fastest and easiest way to respond to the different aspects of TPE reviews, and we hope that you will

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take advantage of all these new capabilities. https://www.cgsmedicare.com/jb/mr/tpe.html

Education Updates

I have some educational updates to review with you. As I mentioned previously, CGS continues to improve our educational resources for suppliers. In addition to adding new webinars to our robust schedule, we are now offering our popular 3-part series on "Documentation Requirements," twice a month. Additionally, we have begun scheduling one set of webinars in the morning, and the other in the afternoon and our hope is that these additional options will make it more convenient for you and your staff to attend when your schedule permits. Our "Encore Events" are recordings of our most popular webinars. You can download these at your convenience when you can't attend a regular scheduled webinar. It's also handy if you attend the webinar and would like to share it with other staff members.

We're also excited to introduce 2 new educational formats. First is our "To the Point" recordings. As the name implies, these are brief segments of 10 minutes or less with key learning takeaways on specific Medicare subjects. Our first recording is "Consolidated Billing," which explains how it relates to residents in skilled nursing facilities (SNFs), capped rental DME items, and the Home Health Prospective Payment System (HHPPS). It also looks at inpatient stays and hospice as it applies to DMEPOS items. "To the Point" recordings will rotate every few months and offer resources for further education. "To the Point" can be found under the education tab on the left-hand navigation panel. https://www.cgsmedicare.com/jb/education/point/index.html

The second is a pilot program titled "Listen and Learn," which is a prerecorded webinar that gives listeners the opportunity to submit questions, written questions, and receive responses via email shortly after the session, usually within a few business days. The first of these "Listen and Learn" events were on knee orthoses and held February 14 at 12 PM and 4 PM ET. The next was external breast prostheses on February 21 at the same time slots. Check our "Events" calendar on our website to register.

If you would like a more detailed look at a topic like "Consolidated Billing," we continue to offer our online education courses. These courses average about 30 minutes and cover both general topics, such as upgrades and ABNs, plus specific policies, such as ostomy supplies and ventilators. The online education courses include a 10-part series on "Welcome to Medicare." It takes you step by step through the Medicare process, and these are great training tools for new staff, as well as opportunities for veteran suppliers to update their knowledge or learn about a new policy. Best of all, these online education courses, they are available whenever you find it most convenient. You can also pause the course and come back at a later time. It's another way we strive to provide information that will help your company thrive.

The CGS Medicare App is newly refreshed with new features and functionality. The DME menu offers access to LCDs and Policy Articles, results from the CGS Wizard, the DMEPOS Fee Schedule, the MBI name to number converter, Dear Physician Letters, Drug Pharmacy Fees, Contact Information, Tools and Calculators, and much more. It is available in the App Store and Google Play Store. Just for CGS Medicare. https://www.cgsmedicare.com/pdf/cgs_medicare_app_guide.pdf

Tools & Calculators

You will also find many other resources in the "Tools and Calculators" section of our website at https://www.cgsmedicare.com/jb/help/tools.html. For example, you can utilize the "Claim Denial Resolution" tool, which is a great next-step resource for suppliers who have received a claim denial. Simply enter the ANSI denial code from a remittance advice, and the tool will provide the myCGS message why the claim denied and list possible causes and resolutions without you having to contact our customer support.

We also have a new Knee Orthosis Documentation Checklist, along with all our helpful checklists available on the "Forms/Checklists/Guides" section of our website under Documentation Checklists. https://www.cgsmedicare.com/jb/forms/index.html

CGS Connect™ Program

Our last update is the CGS Connect™ Program. It is a voluntary program that provides assurance that your supporting documentation meets the necessary requirements to process your claim for payment consideration. There are currently 16 policies for which this program allows you to request a review by one of our Medical Review clinicians, who will evaluate your pre-claim documentation. When necessary, the clinician will contact you directly to discuss their evaluation and recommendations. In all cases, you will be provided with documented detailed feedback regarding your submission. You will then have the opportunity to correct your errors in the documentation, if possible, and submit the claim for processing. I want to stress that this is not a prior authorization of your claim. However, it is a service that CGS offers to suppliers, so you have the opportunity to receive professional review and evaluation on pre-claim documentation prior to submitting an initial claim to Medicare. So we strongly urge you take advantage of this program. You will find more information on the CGS Medicare website located under the Medical Review tab in the left-hand navigation menu. https://www.cgsmedicare.com/jb/mr/index.html

This concludes our updates and I see that we do have some questions in queue. Now, if you have a question, please raise your hand and Kathryn Torro will unmute your phone line and call your name. Kathryn, are we ready for the first question?

Questions and Answers

Q1: Can CGS confirm that the COVID Public Health Emergency is still ongoing and that CGS is not applying the LCD criteria for Continuous Glucose Monitors to restrict coverage or deny continuous glucose monitor (CGM) claims?

Answer: Yes, you are correct that the PHE is still in place. For CGMs, we are not enforcing the clinical coverage criteria. Medical necessity has to be notated in the medical records.

Q2: When did the requirement for a WOPD and F2F exam for items such as hospital beds, CPAP, and wheelchairs stop being required?

Answer: The Affordable Care Act (ACA) requirements for those that list a F2F and WOPD ended December 31, 2019. The standard written order was implemented with the

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required list that went into effect January 1, 2020. https://www.cms.gov/files/document/required-face-face-encounter-and-written-order-prior-delivery-list.pdf

Q3: How do we know when items have been removed from the Master List? Is there a list of items, specifically, that require the F2F with the codes, or is it just in that publication?

Answer: There is a list (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Master-List), and we're going to be publishing more about that. We're going to send out an electronic email list message (https://www.cgsmedicare.com/jb/pubs/news/2022/02/cope25178.html). We'll have more information on our website prior to it being implemented. It is currently in the federal register.

Q3A: How do we find out when something is removed or added to the Required F2F encounter and WOPD?

Answer: Anything on the master list could potentially be added to the required list. We send that information out on our electronic mailing list. You can sign up at https://www.cgsmedicare.com/email.html.

Q4: If the physician has seen the patient within the last year, documented the need for a capped rental item like a wheelchair or a continuous positive airway pressure (CPAP), and written order, is there any limitation from the time the order is written to when we have to set up the equipment?

Answer: A DMEPOS item is determined to be reasonable and necessary at the time the order is written. Timely delivery of that item is dependent upon the beneficiary's medical condition and that particular DMEPOS item. Extended periods of time between order and delivery should be rare and well documented in case of an audit by a Medicare contractor

Q5: Where does the documentation for the medical necessity of a knee orthosis need to be recorded in our physician note?

Answer: The documentation for the medical necessity of a knee orthosis needs to be in the medical records.

Q5A: Why does surgery not suffice as a F2F encounter for a knee orthosis when the equipment is being dispensed during or after the surgery upon discharge?

Answer: The medical documentation of the surgery should suffice as long as the operative notes are included in the documentation.

Q6: Please clarify who's considered a qualifying medical professional for the purposes of oxygen saturation testing? Can a physical therapist do the testing?

Answer: That's a question for which you'd want to contact the A/B MAC. Your local A/B MAC makes that determination. If it's covered, they would be able to let you know.

Q7: The K0554 and the K0553 were billed in the past. The patient now wants to discontinue and go back to the E0607/A4253, the blood glucose monitor. How is that done without denial?

Answer: Medicare is not going to allow for a new monitor unless the CGM is past the 5-year reasonable useful lifetime (RUL). We published an article on May 26, 2021, titled "Billing Reminder: Blood Glucose Monitor Supplies, and Continuous Glucose Monitor Supplies – Switching" (https://www.cgsmedicare.com/jb/pubs/news/2021/05/cope22121.html). If the beneficiary wishes to return to the blood glucose monitor (BGM) testing, they can do so. Medicare will consider payment for the BGM supplies and discontinue paying for CGM supplies. The supplier should submit a claim for the BGM supplies. If the claim is denied, the supplier will need to submit a redetermination request. Once it has been confirmed that the beneficiary has switched back to the BGM, proper editing will be updated to discontinue allowance for the CGM supplies and any future claims for the BGM.

Q8: Is the LCD criteria for CGMs still waived for diabetic patients as long as the item is reasonable and necessary?

Answer: The clinical coverage criteria for CGMs is not being enforced during the pandemic. Remember to put COVID-19 in the narrative field and the CR modifier on the claim. Also include the CG modifier which indicates that a standard written order (SWO) is on file for the item and medical records support the item is reasonable and necessary.

Q9: What specific information is needed for medical necessity? What does the doctor's notes need to include?

Answer: Check the LCD of the item that you're providing. Medical records from the treating practitioner should include the beneficiary's diagnosis, duration of that condition, clinical course, prognosis, functional limitations, and past experience with related items. Records from other health care professionals may be included to paint the picture for the claim reviewer. Checklists are available for specific items. Those can be found under the "Forms/Checklists/Guides" tab (https://www.cgsmedicare.com/jb/forms/index.html) on our website.

Q10: How do you bill Medicare for a PAP loaner (K0462) that is patient-owned and has been recalled (Respironics PAP)?

Answer: For beneficiary-owned equipment, suppliers will need to bill the rental. Suppliers should bill code K0462 and enter "Philips Recall" with the brand name or brand model number impacted and the date purchased. Also enter the replacement device's manufacturer's name, brand name, and model number in Loop 2300 or 2400 segment of electronic claims, or item 19 of paper claims.

Q11: For mastectomy bras/prosthesis, do we need a new prescription or doctor notes when the initial order has expired, and the patient comes back for more?

Answer: It should be documented in the treating practitioner's record, and a new order is required. Suppliers will need to keep the initial order and new order on file.

Q12: If a patient is a transfer from a Medicare replacement plan back to Medicare and they have active equipment, (CPAP), do we still need a new F2F to justify continued need if we have notes dated within 6 months prior to the change?

Answer: Yes. When the beneficiary switches from a Medicare Advantage Plan to Medicare Fee-for-Service, and they have a CPAP, a new F2F encounter and a new order are required.

Q12A: Is a replacement plan considered Fee-for-Service?

Answer: No, the replacement plan is not considered Fee-for-Service. Fee-for-Service is traditional Medicare.

Q12B: For CPAP, if the beneficiary was in Medicare Fee-for-Service, enrolled in a health maintenance organization (HMO), and then returned to Medicare,

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would our billing just pick back up?

Answer: Yes. This would be considered a break in billing.

Q12C: A capped rental item was never submitted to traditional Medicare. The HMO paid the item as a capped rental. The beneficiary is now on traditional Medicare. Will a new capped rental period begin?

Answer: If it was never billed to Medicare, it would be a new capped rental.

Q13: If an oxygen patient is being discharged from a skilled nursing facility (SNF) or rehab place, does the testing reported on the certificate of medical necessity (CMN) have to be within 30 days, or would it be like a hospital discharge where testing may be within 2 days?

Answer: The hospital stay is the only one that has to be within 2 days. If it's an SNF or rehab, it would be within those 30 days.

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 within 30 days and send out an electronic mailing list notification when it's available. Thank you so much for attending, and we look forward to seeing you at future educational events. https://www.cgsmedicare.com/jb/education/act.html

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