Ask-the-Contractor Teleconferences (ACT)

DME MAC Jurisdictions B & C POE
Date: August 5, 2021

Moderator: David Heller
Time: 2:00 p.m. EST

## Introduction

Good afternoon and welcome to CGS Administrators DME MAC Jurisdiction B and C General "Ask the Contractor Teleconference." This ACT call is hosted by the DME MAC Provider Outreach and Education team. My name is David Heller, and on the call this afternoon are subject matter experts from CGS operational departments. For this ACT call, you are welcome to ask questions on any Medicare-related topic. **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.

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 audio 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 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 the latest updates and reminders.

## 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. Medical Review has been conducting widespread post-payment reviews for specific HCPCS in the following policies: ankle-foot orthosis, blood glucose test or reagent strips for home blood glucose monitors, immunosuppressive drugs, knee orthosis, lower limb prostheses, lumbar-sacral orthosis, manual wheelchairs, osteogenesis stimulators, ostomy supplies, surgical dressings, therapeutic shoes, and urological supplies.

A list of applicable HCPCS codes and links to the announcements can be found on the CGS Jurisdiction B or C website (https:www.cgsmedicare.com) under the Medical Review tab and then Post-Payment Reviews.

**Reminder:** You can now review pending Additional Documentation Requests (ADRs) and submit responses through the ADR screen in myCGS.

## New Prior Authorization Coversheet

CGS has issued a new Prior Authorization coversheet. Suppliers are advised to begin using the new coversheet as soon as possible. Links to the forms and additional information on Prior Authorization, are available on the Jurisdictions B & C (https://www.cgsmedicare.com) web pages, by clicking on the Prior Authorization link, located under the Medical Review tab in the left-hand navigation menu.

## 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 the **"COVID-19"** narrative to the affected claims.

One June 9, 2021 CGS published an article to remind suppliers of important information when filing appeals during the public health emergency. Specifically, please note that you must state a reason for a late appeal request. There is not an assumption that the PHE impacted all suppliers.

Additionally, CGS published an article on July 13, 2021, regarding the updated CMS Frequently Asked Questions (FAQs) about repaying COVID-19 accelerated and advance payments. Suppliers who received these payments should refer to the FAQs to learn more about how recoupment works and how it affects Medicare claims payment amounts.

These articles and much more are available in our comprehensive COVID-19 Resources page located on the Jurisdictions B & C (https://www.cgsmedicare.com) web pages, by clicking on COVID-19 under the left-hand navigation menu.

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

On June 15, 2021, CGS published an update to the Billing Reminders article published on May 5, 2021 regarding Continuous Glucose Monitors (CGM) and the Supply Allowance (K0553).

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 solution). 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, February does not have 30 days, and you must adjust your billing to accommodate. *Bill only one unit of service every 30 days.*

The recent update included additional information about claim denials and the KS modifier.

- Use modifier KX if the beneficiary is insulin treated.



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- Use modifier KS if the beneficiary is non-insulin treated.

  **Note:** If the beneficiary is non-insulin treated (KS modifier), the CGM device (code K0554) and the supply allowance (code K0553) will be denied as not reasonable and necessary.

- Use modifier CG only if all of the therapeutic CGM coverage criteria 1-6 in the Glucose Monitor Local Coverage Determination (LCD) (L33822) are met.

  **Note:** Services performed on or after July 18, 2021, use modifier CG only if all of the therapeutic CGM coverage criteria 1-5 have been met.

- When LCD requirements are met, you must add the KX modifier and the CG modifier to both the CGM device (code K0554) and the supply allowance (code K0553).
- Do not use the KX modifier if the beneficiary is not being treated with insulin.
- Do not use the CG modifier if any of the coverage criteria are not met.
- You cannot use the KS and KX modifier at the same time.

This article is available on the CGS website (https://www.cgsmedicare.com) under the News section of our left-hand navigation menu.

## Recent Policy Updates

Next, we will provide a brief summary of recent policy updates:

- **External Infusion Pumps:** Effective 07/18/21
  - **Revised:** Criteria V(H) to allow non-primary immune deficiency disorder that responds to IVIG treatment
- **Glucose Monitors:** Effective 07/18/21
  - **Removed:** Four times or more per day testing with blood glucose monitor as prerequisite for CGM coverage
  - **Revised:** "injections" to "administrations" for insulin treatment regimen criterion for CGMs
- **Negative Pressure Wound Therapy Pumps and Suction Pumps:** Effective 08/15/21
  - **Added:** A9272 coding guideline information, to clarify all-inclusive and supplies are not separately billable
  - Removed: Direction for billing miscellaneous A9900
- **Oral Appliances/PAP/RAD:** Effective 08/08/21
  - **Revised:** Sleep Tests section to point to NCD 240.4.1 and applicable A/B MAC LCDs and Billing and Coding articles

Along with the final LCDs and LCD-related Policy Articles, on June 24, 2021, the DME MACs published three Response to Comments (RTC) articles, which address written comments received during the comment periods, applicable to oral appliances for obstructive sleep apnea, positive airway pressure (PAP) devices for obstructive sleep apnea, and respiratory assist devices. This article can be found on the JB or JC News page (https://www.cgsmedicare.com).

In addition to the policy updates, on July 22, 2021, the DME MACs published the following final LCDs and LCD-related Policy Articles (PAs):

- Enteral Nutrition LCD (L38955) and LCD-related PA (A58833)
- Parenteral Nutrition LCD (L38953) and LCD-related PA (A58836)

These LCDs consist of finalized content, as a result of the new LCD request process and written comments received during the comment periods for the proposed LCDs. The posting of the final LCDs marks the beginning of the 45-day notice period. **The final LCDs go into effect for claims with dates of service on or after September 5, 2021.**

In a recent electronic mailing, CGS published a reminder that orders from chiropractors will be denied. Medicare coverage for all items and services furnished or ordered by chiropractors is statutorily excluded, meaning these services are not billable to the DME MACs, with the exception of treatment by means of manual manipulation of the spine to correct a subluxation. Refer to the Medicare Benefit Policy Manual, Chapter 15, §40.4 for more details.

**Reference added:** *Medicare Benefit Policy Manual*, Chapter 15, §40.4: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

## Orthotics & Prosthetics

CMS issued CR 12282 (https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/R10801OTN.pdf) to communicate the addition of HCPCS codes that require the use of a licensed/certified orthotist or prosthetist for furnishing custom fabricated and prefabricated (custom fitted) orthoses. In addition, Transmittal 10896 (https://www.cms.gov/files/document/r10896otn.pdf) further expanded the list of states where the new requirement apply. This change will apply to dates of service on or after October 1, 2021. On July 22, 2021 CGS published an update to an article (originally published May 25, 2021), including applicable states and specialty codes, as well as links to the CR and transmittal. Please visit our News page for either jurisdiction for additional information (https://www.cgsmedicare.com).

## Phillips Respironics Recall

On June 14, 2021 Philips Respironics announced the voluntary, global recall of an estimated 4 million Continuous Positive Airway Pressure (CPAP) devices, bilevel Respiratory Assist Devices (RADs), and ventilators. The situation is quite fluid; consequently, impacted beneficiaries and DME suppliers should check the Philips Respironics website for the most up-to-date information. On July 16, 2021 CGS published updated FAQs specific to this recall. This article is available on the CGS website (https://www.cgsmedicare.com) under the News section of our left-hand navigation entitled Frequently Asked Questions – Philips Respironics Respiratory Products Recall – Revised.

I want to briefly mention two of these FAQs:

- **Question:** How should DME suppliers address the situation with Medicare beneficiaries who are in the first 90-days adherence metric in the PAP and RAD Local Coverage Determinations (LCDs)?
  - **Answer:** During the Public Health Emergency (PHE), CMS has instructed the DME MACs to not enforce clinical indications of coverage for the types of respiratory devices involved in the voluntary recall. Services must still be reasonable and necessary. Additional information on the PHE waivers and flexibilities is available in the June 29, 2020 article on the DME MAC websites titled "CMS Issues Interim Final Rules with Comment (CMS-1744-IFC & CMS-5531-IFC) – COVID-19 Public Health Emergency – Revised."



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- **Question:** Once a beneficiary gets the new replacement equipment, do they have to restart the 90-day adherence trial? Or do they just pick it up where they left off?
  - **Answer:** The beneficiary has the option to restart the 90-day adherence trial or they may resume meeting the adherence metric where they left off. The supplier should notate in their records if the recall impacted the beneficiary's adherence timeline.

We want to emphasize that the decision to stop or to continue use of an impacted device rests with the beneficiary and their treating practitioner. If a beneficiary chooses to continue using an impacted device, the supplier may bill supplies to Medicare. If a beneficiary discontinues use of an impacted device, the supplier should ascertain that information, document their records accordingly, and stop billing Medicare for the device (if still in a capped rental) and any related supplies/accessories.

**Reference Added:** Frequently Asked Questions – Philips Electornic Respiratory Products Recall - Revised

- **Jurisdiction B:** https://www.cgsmedicare.com/jb/pubs/news/2021/07/cope22777.html
- **Jurisdiction C:** https://www.cgsmedicare.com/jc/pubs/news/2021/07/cope22777.html

## Voice Recognition Added for Entering Medicare Beneficiary Identifiers (MBIs) When Calling Customer Support

Next, I want to touch on a few CGS-specific updates.

Many suppliers have requested a voice recognition option when giving an MBI during a Customer Support call. We're excited to announce that as of Friday, June 4, this option is now available!

When prompted, simply read the 11 alphanumeric characters of the MBI in a clear volume and at a normal speed. (Alternatively, you can still key in the MBI if you prefer.)

Please refer to the Computer Telephone Integration (CTI) for detailed information and step by step instructions, and enjoy the new voice recognition feature!

**Reference Added:** Voice Recognition Added for Entering Medicare Beneficiary Identifiers (MBIs) When Calling Customer Support

- **Jurisdiction B:** https://www.cgsmedicare.com/jb/pubs/news/2021/06/cope22294.html
- **Jurisdiction C:** https://www.cgsmedicare.com/jc/pubs/news/2021/06/cope22294.html

## myCGS Web Portal

myCGS 7.1.3 has been installed and is now available. The new version includes an important change to how Multi-Factor Authentication (MFA) text and email codes work in myCGS.

MFA codes are now the same for the 12-hour period following your request. If you make an additional MFA request within 12 hours, you will receive the same code.

While you can use text and email MFA, **we highly recommend that you use Google Authenticator for INSTANT MFA codes.** No waiting! You can download Google Authenticator on your mobile phone or through a website browser. It is by far the fastest and easiest MFA choice.

In addition to the MFA change, myCGS 7.1.3 also includes the following:

- Improvements to the speed of switching from one jurisdiction to another and switching from one NPI/PTAN to another.
- Improvements to the ADR Detail screen, allowing you to view Reprocessing data directly on the ADR screen.
- Updates to the myCGS "splash" page (the page before you log in).

Did you know that you can make simple claim corrections online through myCGS? You can correct minor clerical errors or omissions using the Claim Correction function rather than sending a written reopening or calling Telephone Reopenings.

Additionally, CGS is encouraging all suppliers to submit redetermination and reopening requests through the myCGS online portal. Using myCGS is the fastest, most efficient ways 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.

To identify which submission methods you can use for different types of claim adjustments, please utilize our newly published Reopenings Chart which can be found on the JB or JC web pages, https://www.cgsmedicare.com, under the Reopenings section.

**Addendum:** The Reopenings Chart is available on the JB or JC web pages https://www.cgsmedicare.com under Tools, Checklists, and Guides

**Reference:** https://www.cgsmedicare.com/pdf/dme/dme_reopenings_chart.pdf

On a related note, our Appeals Department would like to remind the supplier community that when submitting an appeal, be sure to appeal all lines on the claim that are denied. We have noted a trend where the appellants are only appealing the base-item and not the accessories. Consequently, when the base is found favorable, appellants are escalating inquiring as to why the accessories remained denied. Remember, the Appeals Department will only address the HCPCS appealed.

## CGS Educational Resources

Before, we start taking your questions I want to briefly touch on our webinar offerings. CGS Provider Outreach and Education offers an extensive range of both policy based and general topic webinars to assist suppliers in understanding Medicare policies. Policy based webinars review the Local Coverage Determination (LCD) and related Policy Article of the medical policy, describe billing and payment rules, and detail the documentation requirements specific to the policy. General topic webinars follow the same format as policy-based sessions but focus on broader concepts such as documentation requirements and the audit process. CGS also offers LiveLine PLUS webinars. These policy-based webinars include top claim denials, CERT data, and frequently asked questions, and are dedicated to answering your questions and providing the opportunity to learn from others' experiences.

Due to popular demand, we recently instituted our Encore Webinar series. These are recordings of our popular webinars, available via direct link to view at your convenience. The Encore webinars will be updated when a new presentation on that topic



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is held, or if something changes, so you always get the most up-to-date information.

Access our Calendar of Events for live webinars, as well as direct links to LiveLine PLUS and Encore webinars, on the https://www.cgsmedicare.com web pages for either jurisdiction, in the left-hand navigation panel, under the Education tab.

Finally, I want to mention our new Medicare Customer Experience (MCE) survey. Those of you who have been attending our webinars for a while may remember that our previous survey system used to pop-up at the end of a live webinar when you close the webinar product. Now the survey is available in three formats. In the chat box, we provide a link to the survey at both the beginning and end of the webinar. At the end of the webinar, we will display a scannable QR code, if you want to take the survey on your smartphone. Lastly, we'll send the survey link in an email after the webinar ends.

I want to emphasize that these surveys are extremely important for us as a company. They help us gauge what is successful and where we can improve. We read every single comment and take everything into consideration, and we're grateful for everyone. As mentioned earlier, the Encore Webinar series is a direct result of your feedback. So, please attend our webinars, take a few minutes to complete the survey, and provide us with any and all feedback.

## 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 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. To give everyone a chance to ask their question, we will only be addressing one question when your phone is unmuted. After your 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. Judie, we are now ready to take the first question.

**Judie:** Well, hello, everyone. Our first question comes from the line of Anne. Anne, your line is on unmute, go right ahead.

**Anne:** Hi. I just had a question on myCGS, they were saying that we can do claim corrections. I was told if the denial has to do with medical necessity, denial reasons C050 or anything like that, it has to go through redeterminations. Say it got denied not medically necessary for a diagnosis or whatever the reason is, we can no longer do a claim correction. It's got to go through redetermination to correct. Say, example, primary diagnosis is what caused our denial; I was told it has to now go through Redeterminations. I think it changed in February, is that correct?

**Tracy:** Hi, this is Tracy Sessoms. To answer your myCGS question for claim correction, that is correct. There was actually an update that was sent out and the manual itself, I believe it's on page 46, will guide you through exactly what you can do through plan correction.

**Anne:** Okay, yeah, I was told to go straight through Redeterminations. And they'll do it from that area if it's based on a medical necessity denial.

**Tracy:** And that is correct.

**Anne:** Okay, or if it was a ZPIC audit, and we need to do a correction, they can't touch it either. It's got to go through redeterminations if we were trying to fix a quantity.

**Tracy:** Yes, ma'am, if it causes the CO50 denial, that would be correct.

**Anne:** Okay, thank you.

**Tracy:** You're welcome.

**Judie:** Thank you.

**David:** Thank you very much. Go ahead, Judie.

**Judie:** The next question comes from the line of Ann. Your line is off mute, go right ahead.

**Ann:** Hi, this is Ann, and my question is about capped. Sorry, I lost my thing… it is about parenteral and enteral nutrition pumps, regarding the capped rentals. So, if the patient chooses the purchase option, we can bill for rental for up to 13 months, and if they choose, I'm sorry, that was the purchase option… if they choose a rental option we can bill for up to 15 months, but do we maintain ownership of the pump, and continue to provide the pump, and only bill Medicare for maintenance and service? Is that correct? That we maintain ownership?

**Judie:** Yes, that is correct.

**Ann:** Okay, and we can bill for maintenance and servicing for how long?

**Judie:** That's for the life of the pump.

**Ann:** Okay, thank you.

**Judie:** You're welcome. Okay, just one moment while I mute your line. Alright. And the next question comes from the line of Brenda. Your line is off mute, go right ahead. Hello, Brenda?

**Brenda:** Okay, sorry, I can barely hear; you're cutting in and out. My question is in regard to…

**Judie:** I apologize.

**Brenda:** That's okay. My question is in regard to ABNs and the COVID-19 pandemic. Are ABNs allowed to be signed COVID-19? I didn't think that was part of the waiver.

**Judie:** So, there is some flexibility with providing an ABN in the delivery of the ABN itself. You can actually… there's an article on our website on our COVID-19 web page from April 2. And you can provide the ABN through telephone, through secure email. So, you do have some other options for providing the ABN during the COVID- 19 pandemic.

**Brenda:** Okay. But it cannot be signed COVID-19; it has to be signed by the patient, correct?

**Judie:** Only the proof of delivery is waived for COVID- 19.

**Brenda:** Okay. So, we still have to follow all the ABN requirements? The patient still has to sign it.

**Judie:** That is correct.

**Brenda:** I just wanted to clarify that.



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**Judie:** Except, again, there are some exceptions, such as, you know, you don't have to get signed ABN. You do have some options of obtaining a valid ABN from the beneficiary.

**Brenda:** And how would that… and those options, you said, were telephone and email, so they can get a verbal authorization over the phone?

**Judie:** Yes. And the notice should be annotated with the circumstances of delivery, including if it was an in-person notice, if it was through the telephone, if it was an email.

**Brenda:** Okay.

**Judie:** And again, on our COVID-19 page, there's an article that details exactly how to handle that ABN in light of the COVID-19.

**Brenda:** And that is dated April 2?

**Judie:** That is correct, 2020.

**Reference added:** Beneficiary Notice Delivery Guidance in Light of COVID-19

- **Jurisdiction B:** https://www.cgsmedicare.com/jb/pubs/news/2020/04/cope16641.html
- **Jurisdiction C:** https://www.cgsmedicare.com/jc/pubs/news/2020/04/cope16641.html

**Brenda:** Oh, okay, thank you so much.

**Judie:** Oh, you're welcome. Your line is off mute, Deanne.

**Deanne:** Oh, thank you. Regarding the prior question on ABNs, I did see that CMS released an update to revised ABN guidelines on July 14. And actually, I don't recall seeing that via listserv. But I did see the announcement through our National Home Infusion Association organization, and I'm just curious if you're going to do any further education on some of these changes and revised ABN guidelines. Or, if you're going to provide any kind of an article or a document that's a little bit more concise than reading the full 22242.

**Judie:** Yes, we actually did publish an article on July 28th, and it talks about some of the key changes to Chapter 30, Section 50 of the Advance Beneficiary Notice of Non-Coverage.

**Deanne:** Oh.

**Judie:** The effective date of those changes is not until October, but we will provide updated information in our webinars that pertain to the ABNs as well when we get closer to those dates or after the implementation date.

**Deanne:** Okay, so I was traveling during that timeframe. So, can I find that on the CGS website then?

**Judie:** Absolutely, it is under News, July 28th.

**Deanne:** News, July 28. Thank you so much. I appreciate it.

**Reference added:** Advance Beneficiary Notice of Non-coverage (ABN) – Revised Guidelines CMS

- **Jurisdiction B:** https://www.cgsmedicare.com/jb/pubs/news/2021/07/cope22861.html
- **Jurisdiction C:** https://www.cgsmedicare.com/jc/pubs/news/2021/07/cope22861.html

**Judie:** Oh, you are most welcome. And the next question comes from Leanne. Leanne, your line is off mute, go right ahead.

**Leanne:** Hi. My question is coming from some recent same and similar denials that we've been receiving. When the claims come in, are they basically paid by looking at the date of service, or are they just paid based on whichever claim is received first?

**Judie:** Okay, so you have two claims come in for similar dates of service, and it's another supplier, I'm assuming?

**Leanne:** Correct.

**Judie:** Okay, so whichever claim is processed first, whichever one has the most recent or the earliest date of receipt, that one would process and pay. And then any claim received after that would be denied as same and similar if it is indeed a same and similar item.

**Leanne:** Okay, so in this situation, it would be the claim was paid, and then another claim came in for an earlier date of service. So, the claim wasn't received until after the first claim was paid.

**Judie:** Right. So, it's based on the date of receipt, not the date of service.

**Leanne:** Okay, thank you.

**Judie:** Great question. Alright, I'm going to go ahead and re-mute your line. Alright, Carl. I do see your hand is raised, but you do need to enter your pin number into your telephone. I'll be sending you your pin number. But for us to be able to unmute your line, you do need to enter your pin number into your telephone. And let's go with Jennifer. Your line is off mute, go right ahead.

**Jennifer:** Yes. Thank you. We have a patient who received an off-the-shelf LSO in 2017 from a different supplier. He had subsequent surgeries required a customed TLSO, which was billed to the hospital under a Part A stay. He's had multiple additional surgeries since that time and, the custom TLSO no longer fits him, and he needs a new custom brace to be fabricated. I fully expect a same and similar denial. What would you suggest we have on file to appeal this denial?

**Judie:** We created an article with same and similar denials and we also have a documentation checklist. What you would want to include when requesting an appeal of that similar orthoses is documentation to substantiate the change in need from the previous item to the current item, why the current/the previous item is not sufficient for their conditions, or their change in condition, and documentation to substantiate the need for the current item.

**Jennifer:** Okay, thank you. And that checklist is available on CGS?

**Judie:** Absolutely. That's available actually in a few locations, but I get it from medical review.

**Jennifer:** Okay.

**Judie:** And then under resources, all the documentation checklists are available for medical review resources on the Jurisdiction B and C pages.

**Jennifer:** Perfect, thank you.

**Reference added:** Same or Similar Denials for Orthoses and the Appeals Process

- **Jurisdiction B:** https://cgsmedicare.com/jb/pubs/news/2020/08/cope18619.html
- **Jurisdiction C:** https://cgsmedicare.com/jc/pubs/news/2020/08/cope18619.html

**Reference added:** Documentation Checklists



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- **Jurisdiction B:** https://www.cgsmedicare.com/jb/mr/documentation_checklists.html
- **Jurisdiction C:** https://www.cgsmedicare.com/jc/mr/documentation_checklists.html

**Judie:** No, thank you. And you're still off mute. Okay, I re-muted your line. Rachel, your line is off mute. You go right ahead.

**Rachel:** Hi, I'm actually calling from a supplier in Michigan, and I just found out this past Monday, we no longer have a POE rep. So, we have many pending issues out there regarding appeals. So, who can I contact to get some resolution on that?

**Judie:** You can absolutely send an email to the outreach and education team.

**Rachel:** Okay.

**Judie:** We would have sent you the confirmation for today's call. You would have received an email. It actually goes to… just one moment. It is… ready? CGS.JBJC.LEARNINGONDEMAND; that's all one word. LearningOnDemand@cgsadmin.com (CGS.JBJC.LEARNINGONDEMAND@cgsadmin.com).

**Rachel:** cgsadmin.com, okay.

**Judie:** That is correct.

**Rachel:** So, not any of the emails that were going to Stacie, was ever anybody checking them, or are they just kind of a wash right now, or how is that working?

**Judie:** I am unable to answer that question. I would suggest just going to your sent emails and send them to that outreach email address that I just provided.

**Rachel:** Okay.

**Judie:** And so, we don't miss anything.

**Rachel:** All right. Great, thank you.

**Judie:** Oh, you're welcome. Thank you. I'm going to re-mute your line. Deanne, your line is off mute. Go right ahead. Hello, Deanne, your line is off mute, go right ahead.

**Deanne:** I'm sorry, I thought I'd put my… I will lower my hand; I have no further questions. Thank you.

**Judie:** Okay, I'm gonna go ahead and mute your line. Alright, Gao, your line is off mute, go right ahead.

**Gao:** I have a question regarding when a primary payer is… when Medicare is secondary and I know that they, Medicare, does not accept a purchased CPAP machine. They only do rentals. And I know the provider guideline says that they will not cover. But, how do we deal with the charges if the primary payer puts like a certain amount of deductible to Medicare, but it's a purchase claim? So, Medicare would process it as CO denial, so then patient would not be responsible for this. So… can we… I mean… that's… are we able to charge the patient if it's denied CO… I think it's like CO something. Or, if there's… how do we handle that, like, since Medicare doesn't take purchase?

**Judie:** Hello, this is Judie again. And just to be clear, to address one of your questions, if you do receive a contractual obligation or CO denial, it'll specifically state that the beneficiary cannot be billed. Does the primary accept a rental?

**Gao:** Like the certain specific primary will take, like they do three months rental and then the fourth month has to be a purchase. So, they will purchase on the fourth month.

**Judie:** Does anyone at CGS want to address this?

**Andrea:** This is Andrea Rittman with Medical Review. If I can get you to email your question, or if we can get your email address, we can do some research and let you know.

**Gao:** Okay and how… who do I send it to?

**Andrea:** We have an email address; it's JC.TPE.Inquiries@cgsadmin.com. We'll be happy to look into that a little bit further and… and then provide you back some recommendations.

**Angie:** Hi, this is Angie Cooper, I'm also part of the Provider Outreach and Education team. And I also, I want to refer you to the supplier manual because that situation is actually addressed in Chapter 11 of the Medicare Secondary Payer. That's the Chapter 11 MSP Chapter in the supplier manual, and it talks about MSP capped rentals and the different rules depending on whether it's a power wheelchair or an enteral or parental pump, but it goes into the rules there. And how to handle that situation.

**Gao:** Okay, so, I did see that, so, I guess my question is, do… so then, if since Medicare does not cover still, then does not just falls under us? As a provider, that is our responsibility then to accept that? It's just not covered, and we just contractual off?

**Angie:** Well, yeah, because the rental guidelines are not going to change if Medicare is the secondary payer, and we're not going to pay more as a secondary payer than we would have if we were primary.

**Gao:** Okay.

**Angie:** So, if the primary insurance pays the lump sum, then we're going to take that amount into consideration when we're making payments on any claims that's Medicare Secondary Payer.

**Gao:** Even though they put it towards deductible?

**Angie:** Yeah. We cannot make a secondary payment on a lump sum purchase.

**Gao:** Okay. Thank you.

**Angie:** You're welcome.

**Judie:** Oh, thank you, everyone. Karla, the next question comes from you. Your line is off mute.

**Karla:** Thank you so much. My question is concerning CGM products. We tend to ship out supplies three months at a time for the CGM, and we're getting denials for the proof of delivery not matching the date of service. But from what we understand, we're allowed to ship CGMs for a three-month supply. So, it wouldn't match at that point for the CGM dates of service.

**Judie:** Karla, who is denying your claims?

**Karla:** I believe it's Medicare, and I've even gone as far as… we have one example as far as going into the reconsideration stage where it was denied, we provided the proof that we shipped out sufficient amount of supplies in order for us to bill that supply allowance.

**Kathryn:** Good afternoon, Karla. This is Kathryn Torro, and I'm with Provider Outreach and Education as well. And you're stating that they are CGM… the supplies, correct, and not the diabetes supplies, glucose supplies?

**Karla:** Correct. For CGM supplies, we're being denied for the date of service not matching the tracking, the ship date.

**Kathryn:** Now, you are allowed to ship out up to a 90-day supply. Are they looking at your initial date of service, like the first month that you bill versus your delivery ship date? They shouldn't be



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looking at the second and third month. They should be, you know, if they were to audit something… it's just a question. Are they looking at the first month claim that you billed?

**Karla:** We've noticed them on these supply allowances, on the second or third.

**Kathryn:** Okay, I'm thinking this might be a claim that was chosen for an audit. Is this the Recovery Audit Contractor that has denied your claim?

**Karla:** The one that I'm speaking about was a… I believe it was just a denial, a first-time denial.

**Kathryn:** So, it was never chosen for review, and it just came through with a denial?

**Karla:** Correct. So, we submitted a redetermination and was denied again. And then we went through the reconsideration and it was still denied.

**Kathryn:** Okay, and this was in either Jurisdiction B or C?

**Karla:** I believe so. I can't really confirm that. I would have to go back into that account to confirm.

**Kathryn:** Okay. If it was Jurisdiction B or Jurisdiction C, you certainly can follow the instructions that Judie gave earlier in regard to contacting the email box and sending your contact information. Don't send any PHI or anything. And that inquiry will then be forwarded to your community coach, and we can look into that further. And if need be, get claims involved, or perhaps redeterminations involved, if in fact it was Jurisdiction B or Jurisdiction C, okay?

**Karla:** Okay, I'll look into that then.

**Kathryn:** And do you need that information repeated again, or do you have that email address from your invitation today for this meeting?

**Karla:** I actually wrote it down when you guys said, just in case.

**Kathryn:** Okay, perfect. Alrighty, well thank you.

**Karla:** Thank you.

**Judie:** Okay, thank you very much, I'm going to mute your line and put down your hand. Alright, and Brenda, your line is off mute. Go right ahead. Hello, Brenda?

**Brenda:** Hi.

**Judie:** Hi.

**Brenda:** I'm going back to my original question about the ABN and being signed COVID-19. I was reading through the article and it says, it pertains to beneficiaries in isolation. But I'm talking about beneficiaries because we're a DME company, and they come and they pick up supplies; they are there in their car, they're not in isolation. So, does that just pertain to people in isolation, or is that for all beneficiaries?

**Judie:** No. It is for flexibilities for… Okay. so, Chapter 30 of the Claims Processing Manual talks about times that you can… alternate methods that you can deliver an Advanced Beneficiary Notice of Non-coverage. So those flexibilities do apply even without COVID. So, I would definitely suggest referring to that Chapter 30. It's right in that article that I referred to earlier and you can go to delivery of ABN.

**Reference added:** Medicare Claims Processing Manual, Chapter 30- Financial Liability Protections https://www.cms.gov/files/document/r10862cp.pdf#page=9

**Brenda:** Okay.

**Judie:** And you can see what those exceptions are. If the beneficiary is signing for other items, though… if they're signing perhaps a beneficiary authorization or their proof of delivery documentation, then they should also be able to sign that ABN as well.

**Brenda:** Right.

**Judie:** Okay.

**Brenda:** But that's still, yeah, we're still, sometimes, we're still going ahead with the delivery tickets and signing them COVID-19; we are not interacting with the patient.

**Judie:** Okay. And in those circumstances, you do have that flexibility of, like I said, the telephone or secure email notice. And that's again, in Chapter 30 of the Medicare Claims Processing Manual.

**Brenda:** Okay, thank you for the clarification.

**Judie:** Oh, you're welcome. Go ahead and re-mute your line and put down your hand. Alright, Leif, hold on you're still off mute, one second. There we go, Leif. Your line is off mute. Go right ahead.

**Leif:** Sure enough, I have a question regarding the national and local coverage determinations, about oxygen therapy. Specifically, I'm looking where I can find additional information regarding coverage determinations of oxygen therapy, where beneficiaries who were diagnosed with conditions of cognitive impairment. The cases that I'm looking at, such as cerebral palsy or down syndrome.

Now these patients, these beneficiaries, rather, are experiencing symptoms of hypoxemia. However, there is no underlying chronic severe conditions, such as a lung disease or heart disease. The coverage determinations are a little ambiguous regarding the coverage criteria. I know that the testing conditions are outlined, but as far as the group one, second section, where it says, "or," and then it brings in the example, given an impairment of cognitive processes for group one criteria, I guess. Does that, where can I find, I guess what specific cognitive impairments would be covered or considered or coverage of oxygen therapy?

**Judie:** Okay, so in the coverage criteria, as you stated for the local coverage determination for home oxygen therapy, it is reasonable and necessary if the coverage criteria in the policy are met and there are five criterion. And the first is that the beneficiary has a severe lung disease or the hypoxia-related symptoms that should be expected to improve. It does have to be a chronic underlying lung disease. So, if you're looking for additional information beyond that, you can definitely send it to that email address that we provided earlier, and we could do some research for you.

**Leif:** Okay, sounds good.

**Judie:** Unless anyone else at CGS has any additional Information? Okay, yep, definitely send us an email, and we'll follow up with you, and we will include information in the minutes as well.

**Leif:** Alrighty.

**DMD Clarification:** Current coverage criteria require a severe underlying lung condition; therefore, coverage for a cognitive impairment without hypoxemia would not be reasonable and necessary.



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The overarching criterion is the severe underlying lung disease. Once you meet that, you further qualify with the blood gas studies. The Group I criteria, Number 3 (see below) is one of the ways you can use a blood gas study to qualify.

Per the Local Coverage Determination (LCD): Oxygen and Oxygen Equipment (L33797) (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33797&ContrID=140):

> Group I criteria include any of the following . . . 3. A decrease in arterial PO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent from baseline saturation, for at least 5 minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and [nocturnal restlessness or insomnia]) or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributable to hypoxemia.

**Judie:** Alright, thank you, Leif. Alright, and the next question comes from the line of Tad. Tad, your line is off mute. Go right ahead.

**Tad:** Hi there. I just had a kind of an additional question on the fact that we have to go through Redeterminations for many of the things that Reopenings could have fixed in the past. If we have something simple like, you know, we just billed with the wrong diagnosis code. So, I don't disagree with the denial. It just needs to be reprocessed with a correct diagnosis code. Is that something we could just fill out, you know, the redeterminations form? I'm kind of struggling as far as clinical documentation because I'm not really fighting the denial at all. I'm just saying that, you know, we made an error, and we need to have that reprocessed. Is that something where we could just send in that form, or are they going to always be looking for documentation as well?

**Judie:** Well, at a minimum, in that redetermination, we would be looking for documentation to substantiate that change in diagnoses.

**Tad:** So, this wasn't a change in diagnosis. It was the first claim on ASV rental, and they just accidentally put the OSA diagnosis instead of the treatment emerging central that they have.

**Judie:** Okay, well, we would, again, be looking for the documentation to substantiate that central sleep apnea.

**Tad:** Okay,

**Judie:** If it was just a typo…

**Tad:** Just document the diagnosis that we're changing.

**Judie:** You would also want to include any other applicable documentation. I mean, you… you should be having a have an order. You should have… all of your documentation requirements ideally should be submitted to redetermination as well.

**Tad:** Alright.

**Judie:** Okay?

**Tad:** Yep.

**Judie:** Alright, I'm going to re-mute your line. Thank you. Great question. Alright, Jennifer, your line's off mute. Go right ahead.

**Jennifer:** Yes. Is there any guidance on coverage criteria or medical necessity for custom spinal bracing? I don't really see anything in the LCD or the policy article.

**Judie:** Is there a specific code you're referring to?

**Jennifer:** For, I'm looking for, like, a custom bivalve, TLSO, for L0486, I think it is. Is the…

**Judie:** So, if you are billing for the L0486, there is information in the local coverage determination about the requirements, including it's covered when it's ordered for one or more of the following indications. Did you review that?

**Jennifer:** I felt like that was just more of general regards to spinal bracing, but I'll… I haven't looked at it in a minute, so…

**Judie:** Okay, you may want to review that local coverage determinations, and in addition, if it is a custom fabric, if you're actually providing a custom fabricated item, you do want to include all of the information regarding custom fabricated item being ordered, as well as all of the details of fabrication.

**Jennifer:** Okay, so what you said that was, I'm sorry, in the LCD or policy article?

**Judie:** In the LCD.

**Jennifer:** Okay. Thank you.

**Judie:** And a trick, a nice trick for everyone on the line: if you are in a particular policy and you're having difficulty finding the code that you will be billing for, you can do a "Ctrl F," and that will take you right to all incidences of that specific HCPCS code. Much easier.

**Jennifer:** That's my favorite trick.

**Judie:** Not everyone knows it. So, it's good to share with everyone.

**Jennifer:** Awesome. Thank you.

**Judie:** You're welcome, Jennifer. Alright, Kara, your line's off mute. Go right ahead.

**Kara:** Thank you. So, my question is, regarding proof of delivery, method two, delivery via shipping. If the beneficiary signs and dates a delivery ticket prior to shipment, can the hand date be used as a data service on the claim?

**Judie:** Can you please repeat that question?

**Kara:** Sure, this question is regarding proof of delivery, the method two, delivery via shipping. If the patient signs and dates the proof of delivery or delivery ticket prior to shipment, can the hand date that the patient enters, can that date be used as a date of service on the claim?

**Judie:** Actually, the standard documentation requirements is very specific on the dates of service to use for the claim. There is no signature required for method two; there just must be evidence of delivery.

So, you can use that ship date as the date of service, which could be the date the label is created, the date the item is retrieved for shipping. However, there should not be a significant variation, or you can use the date of delivery. So, if the date that you create the label is the same date that the beneficiary signed and dated their proof of delivery documentation, then you could use that date. However, you would want to have documentation from the shipping service and something to tie your proof of delivery documentation to the shipping services, proof of delivery.

**Kara:** Okay.

**Judie:** So if the beneficiary signed the proof of delivery and they didn't receive that item, you cannot use that date as your date of



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service unless they're picking that item up at your retail location or if you're shipping the item directly to the beneficiary utilizing your company vehicle.

**Kara:** Okay.

**Judie:** Because then it would fall under method one.

**Kara:** Okay, got it, thank you.

**Judie:** Oh, you're welcome. Great question. Re-muting your line and putting your hand down. Diana, your line is off mute. Go right ahead.

**Diana:** Hi, thanks. My question is kind of simple. I was just wondering if there's an educational webinar or something on your site, and I did look, but I don't see anything for billing Part B chemotherapy drugs regarding DME and the PDAC. Is there something else out there to help us with that? I know there's the LCD and the article. But I didn't know if there's like a webinar or something recorded that we can refer to.

**Judie:** Currently, we do not have an online educational course. Or, I don't believe we currently have any webinars scheduled for oral anti-cancer drugs. If you are having some challenges, you can absolutely contact your community coach, and we'd be able to assist with that particular policy, any questions that you may have.

**Diana:** Okay, thank you.

**Judie:** Oh, you're welcome. Re-mute your line, put your hand down. Heather, your line's off mute. Go right ahead. Hello, Heather? Okay, I'm not sure if you're on mute or if you can't hear me, but I'm going to go ahead and re-mute your line and put your hand down. If you do have a question, Heather, go ahead and raise your hand again and, I'll be more than happy to unmute your line. Shannon, your line's off mute, go right ahead.

**Shannon:** Hi, thank you. I've got a patient who three years ago was on a commercial insurance policies and got a CPAP. They are now Medicare primary and requesting a new CPAP. Would they be eligible for a new one as Medicare has never paid for a CPAP for them?

**Denise:** Yeah, this is Denise with CGS Outreach and Education. Yes, they would be eligible because Medicare never paid for it, so they are entitled to a new piece of equipment. Your testing, as long as it meets the requirements as the date, they became Medicare eligible, that can be used for qualification.

**Shannon:** Okay, alright, thank you.

**Denise:** You're welcome.

**Judie:** Great. Thank you, Denise and Shannon. I'm going to re-mute your line. Nancy, your line's off mute. Go right ahead.

**Nancy:** Hi, I just want to expand upon—I think it was Karla that spoke earlier. We've also received denials for CGM Supplies and they were through Region C. For the subsequent billings, they were taken through Redetermination, denied at Redetermination, and I even spoke to a level two rep who said that she agreed with the information that I was providing as far as there was no proof of delivery requirements. But she said there was nothing that they could do about it, and I've had to take those claims to Reconsideration. I'm waiting for their response now.

**Judie:** If you could send it, of course, as Kathryn stated earlier, please be sure to send that email, but don't include any PHI. So, if either a DCN, your appeal number, or a claim control number; no Medicare numbers or anything to that outreach education email address. And the POE team can research that for you.

**Nancy:** Okay, I just wanted to, I can send it. Can you repeat the email address?

**Judie:** Sure, one moment.

**David:** It is CGS.JBJC.LEARNINGONDEMAND@cgsadmin.com.

**Nancy:** At cgsadmin.com? Okay, yeah.

**David:** That's right.

**Nancy:** I just wanted to kind of give a little bit more information since I heard Karla mention it. Because we experienced that same scenario.

**Judie:** And did you receive the… how did was the claim initially denied? Through claims processing or from a review, a documentation review, from perhaps the recovery auditor or CERT?

**Nancy:** The initial denial was straight through the EOB, saying that the product was not delivered to the patient's home. And then in submitting it through Reconsideration, I mean, Redetermination, the verbiage was provided that it was subsequent billings of a 90-day shipment. I provided the initial proof of delivery documents. But obviously that wasn't the date of service that they were auditing, and they denied it, stating that I still did not prove proof of delivery in of the three acceptable methods.

**Judie:** Okay, who did you receive the audit request from? Because you said it was denied through an EOB, but where did the initial audit request come from?

**Nancy:** It was a denial through Jurisdiction C.

**Judie:** A claim denial on your EOB?

**Nancy:** Correct.

**Judie:** You never received a request for additional documentation or any notification from the audit contractor?

**Nancy:** No.

**Judie:** Okay.

**Nancy:** No.

**Judie:** It may be…

**Nancy:** So, I sent it through level one, I'm sorry. Go ahead.

**Judie:** It may be a date of service issue. I know that we've sent out numerous reminders. If you're not, if your dates of service are not 30 days apart, that could be causing an initial denial.

**Judie:** But again, we'd have to take a look at what exactly is occurring and see if there's some internal education that needs to occur or some supplier education to see what's going on.

**Nancy:** Okay, yeah, right now they're in Reconsideration. I'll go ahead and send over the information to that email address so that you guys will have it.

**Judie:** Terrific, and we can do some research. Of course, if they are currently at the QIC, we would not be able to adjust those claims, but we can definitely take a look at what's occurring and see what we can do to address it.

**Nancy:** Sure, totally understand, thank you.

**Judie:** Great, thank you very much, Nancy. Your line's re-muted, and your hand is down. Danielle, your line is off mute, go right ahead.



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**Danielle:** Hi, I just wanted to clarify that additional payment edits for custom fit orthotics. So my question is, if a patient gets a custom fit orthotic in the doctor's office, from a consignment closet, that us, the supplier has in their office, and it's still fitted by a licensed, certified orthotist, can the supplier bill?

**Judie:** Are you actually asking about the additional payment edit or competitive bidding?

**Danielle:** I am not sure. like, I'm trying to read this edit and I don't understand, like are suppliers not allowed to bill for those things that need custom fitted, then?

**Judie:** No. They just have to be licensed in those specific states.

**Danielle:** Okay, so, we're like, in Pennsylvania. So, just ours, the supplier has to have these.

**Judie:** The supplier that's providing the item does need to be licensed and that's all handled by the National Supplier Clearinghouse.

**Danielle:** Okay, alright, thank you.

**Judie:** Okay, you're welcome. I'm going to re-mute your line and put your hand down. Alright, Vinita, your line's off mute. Go right ahead. Hello, Vinita?

**Vinita:** Hi, can you hear me?

**Judie:** Hi, we sure can.

**Vinita:** Awesome. So, we are physicians and suppliers and we usually provide orthotics to our patients. We just got a question recently that if we want to supply oxygen… is there a restriction on managing oxygen and enrollment as physicians/suppliers with the National Supplier Clearinghouse?

**Judie:** You would actually want to contact the National Supplier Clearinghouse, what you can provide based on what your company does, your licensure, and all of all of those items.

**Vinita:** Okay. Great. Thank you.

**Judie:** Oh, you're welcome. And I think I accidentally put someone's hand down. If you were waiting for a question to be answered, please raise your hand again. Carol, your line's off mute, go right ahead.

**Carol:** Hi. I have a quick question about purchasing a part or piece for something that a patient owns. If they purchase, say, a walker, and they were on Medicare, but they purchased it somewhere, on their own. And now they need a platform attachment. That is a billable item to Medicare? Am I correct? Even if they were… they were Medicare at the time that they bought it, but they didn't buy it from any specific provider, but they own one. So, they could have gone to a Wal-Mart or a Walgreens and actually bought themselves a walker. Now they need a platform. Will it be covered for that? Hello?

**Judie:** Hi, we're here.

**Carol:** Can you hear? Oh, okay.

**Judie:** Yes. Sorry. I think that feedback is on your end. Can you pick your phone, maybe?

**Carol:** Yeah, hold on…There we go. Well I've been hearing all kinds…

**Judie:** Oh, that's so much better.

**Carol:** I've been hearing all kinds of crazy noise. So…

**Judie:** Oh, I'm sorry. I hope that's not on our end. But just so you know, if there is beneficiary owned equipment and they do qualify for coverage of that item, Medicare will consider replacement accessories. Medicare will also cover repairs or any additional accessories they need as long as they're medically necessary.

**Carol:** Okay, that's what I wanted to be sure of. Okay.

**Judie:** Yep, and you just follow the beneficiary owned guidance in the supplier manual about how to bill it.

**Carol:** Okay, that's perfect. Great, that's what I needed. Thank you so much.

**Judie:** Oh, you're welcome.

**Carol:** Have a great day.

**Judie:** You do the same thing, Carol. And Anne, your line is off mute. Go right ahead.

**Anne:** Hi there. This is Anne. I do have a couple of questions. What if the patient changes from the HMO plan to Medicare, say for an example, oxygen, and we do have notes within six months, we do have a valid O2 test when they were on the HMO plan. Can I still use those notes while they was under the HMO plan, or do I need to say, okay, I can only use the O2 test? I need to have the patient qualified within 30 days.

**Judie:** That's correct.

**Anne:** With a new order and a new delivery from Medicare.

**Teresa:** Yes. This is Teresa Camfield with POE. And she would need a new face-to-face exam after her Medicare eligibility date. The testing while she was enrolled in the HMO would be acceptable, if it is qualifying, and then she would need new orders and of course, the required CMN.

**Anne:** Okay, and one more question. The only difference with a CPAP is the notes must be within six months, new delivery, new order, etc. If they go from HMO to Medicare, it's just like a Fee-for-Service to Medicare, no change.

**Teresa:** If they go to Fee-for-Service for a CPAP, they will still need a face-to-face after their Medicare eligibility date that shows continued need. And the sleep study is what could be used previously, and they would require new orders. And that's all.

**Anne:** And the same if they're coming from HMO to Medicare, as long as my notes are valid within six months, I'm okay, because that is our Medicare replacement, correct? I don't need it on or after Part B, if they was already HMO, then they went Medicare as long as I had my continued need notes within six months. I'm okay on that part. Is that correct?

**Teresa:** They are required to have a new face-to-face. Even if they were on an HMO, they would need a face-to-face after their traditional Medicare enrollment date, showing continued need for the CPAP and a new order.

**Anne:** Okay.

**Teresa:** And as long as they have a qualifying sleep study, they would qualify.

**Anne:** Okay, so it doesn't matter if there was an HMO plan or not? It still…

**Teresa:** No, ma'am.

**Anne:** Okay, I gotcha. And let me ask you one more question on the… what is the grace period for CPAP supplies? Is that only five days? Some stuff, I read five or seven; I was just trying to clarify that. I think it's only five, but I want to make sure.



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**Teresa:** I'm sorry. Could you repeat that question?

**Anne:** What is the grace period for CPAP supplies for billing?

**Teresa:** Oh, you mean the overlap?

**Anne:** From one shipment? Yeah, from one shipment to another. I'm thinking it's only five days, but I just want to make sure.

**Teresa:** There is the allowance that you have to have request for refill if you or they are contacting for refills and they are not picking them up, that can take place within 14 days prior to your shipping date or delivery date. And you'd have up to 10 days that you could ship prior to the end of their current usage period, 10 days.

**Anne:** Okay, so, 14 days on the contact, and then 10 days on the… from the last shipment to the new date.

**Teresa:** That will be prior to the end of the current usage period, correct.

**Anne:** Okay, thank you so much.

**Teresa:** You're welcome.

**Judie:** Just a quick follow up on that because these are considered non-consumable supplies. You would also want to have documentation of why those items are no longer functioning.

**Anne:** Exactly, we do have that. I was just wondering what the grace period was.

**Judie:** Just wanted to provide that for everyone's benefit.

**Anne:** Thank you.

**Judie:** Oh, you're welcome. I'm going to mute your line. Alright, let's see. Who do we have who hasn't asked a question yet? Grace, go right ahead, your line is off mute. Hello, Grace?

**Grace:** Yes, can you hear me okay?

**Judie:** Sure can, go right ahead.

**Grace:** Oh, great, thank you. I have a question regarding the Competitive Bidding Program. So, we're a provider's office that supplies some of those braces that are on that competitive bidding program this year. And we're getting some denials that if we don't fill an office visit on the same day as giving out one of those braces, that it gets denied. So, it's my understanding when reading that, is that they consider, it has to be part of the treatment plan, of the, the physician, that's why they want the offices as part of that day's treatment plan. But what if the patient is in post-operative period? So, they're in a global and so we can't bill an office visit and, but the doctor wants them to have this item for post-operative care.

**Judie:** So, if the item is not provided as a part of the office visit, my understanding—you may want to contact the competitive bidding implementation contractor on this—but my understanding is that it must be provided by a contract supplier if it is one of the competitive bid items in a competitive bid area.

**Grace:** Okay, and how would I get this, the competitive bidding program contractor information, to call?

**Judie:** Well, you stated that you were reading the article regarding the KT modifier on our competitive bid. We have a competitive bid page, on this CGS website; it's under education.

**Grace:** Yes.

**Judie:** And then competitive bidding.

**Grace:** So that information will be there and who to contact, okay?

**Judie:** Absolutely, it's a very top of the form… the page.

**Grace:** Okay, thank you.

**Judie:** Oh, you're welcome. Let me mute your line and put your hand down. Oh, you put your hand up. Alright, Heather, your line is off mute. Go right ahead.

**Heather:** Hi, thank you. I actually have a question regarding the Philips Respironics recall. And the frequently asked question that's related to question number nine, we get asked a lot of questions and there's a lot of confusion about supplier liability for a Medicare beneficiary who owns the recalled device but is not yet to the end of the RUL. Patients call us, quite upset, telling us that we need to give them a new machine for free. Where our understanding… well, first of all, we, we can't always provide a new machine for free, because we don't have inventory, because there's a worldwide inventory crunch right now, because Respironics is out of the picture. But our understanding is that the machine with Respironics is a voluntary recall, and it's between the physician and the patient to determine the risk of continuing to use the device. But it's not necessarily the device is not usable. So, I mean, how is Medicare advising those beneficiaries, and what is our responsibility in that situation?

**Judie:** So, for item, question number nine, in the Respironics recall questions, you're asking if the equipment is beneficiary owned, and it was provided… paid for by Medicare. You've transferred the ownership to the beneficiary, correct?

**Heather:** Yes.

**Judie:** So, you're curious what your obligations are regarding providing the replacement equipment as addressed in that frequently asked question, just to confirm?

**Heather:** Correct.

**Judie:** Okay, we have not received additional information on that. I would actually suggest contacting the National Supplier Clearinghouse and let them know that there is a nationwide shortage, so you were unable to provide a replacement and find out with them what your obligations are.

**Heather:** Okay.

**Judie:** We do have some additional questions out to CMS regarding this recall, and we will post those as soon as we get additional information as well.

**Heather:** Okay, my concern is, like, the patients are calling us, telling us, well, Medicare said you have to give us a free machine. So, I just am wondering how beneficiaries are being advised when they're calling Medicare customer service.

**Judie:** Well, Medicare Customer… 1.800.MEDICARE has been informed of the recall information, and they have been provided—from what I understand—they have them provided the information that we currently have. So, I don't know what 1.800.MEDICARE is telling specific beneficiaries, but I do know that they have been advised of the recall and the issues.

**Heather:** Okay, so right now there's what I'm hearing is there's really no good answer, and I can reach out to the NSC. But there's probably not even going to be a really good answer from them either.

**Judie:** I'm not sure if there would be a good answer from the NSC because this obligation does fall under the supplier standards. So, that's where I would strongly suggest that



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you would contact them. You know, based on our standard guidelines, it is the supplier's responsibility to provide equipment that will last five years.

**Heather:** Except the equipment is still lasting five years, it's still usable, so…

**Judie:** And it's under recall so their items actually is perhaps being returned. But that's where, because you don't have a replacement item available, that's where I would suggest contacting the National Supplier Clearinghouse.

**Heather:** Okay.

**Judie:** To see what your obligations are.

**Heather:** Alright, so on that same question then, it talks about rental equipment, in question number 12 of the FAQ. So, in that instance… so, we know most of our suppliers are being allocated a certain number of machines from the competitors, right? We get X amount of machines per month. So, if we have machines and we are getting these new machines, and because we don't have any on hand rental devices right now, if we take some of those new machines, turn them into rentals, we can bill this K0462 temporary replacement code for however many months it takes Respironics to correct the issue?

**Judie:** That is what, the question… the question and answer state… yes, ma'am, that K0462 can be billed if you are providing a temporary replacement item to an item that is being repaired.

**Heather:** Okay. So even if it takes up to 12 months, we could do that.

**Judie:** There is currently no specified timeframe in that frequently asked question. Stay tuned. Just like for all of these questions, stay tuned. Things are changing on a rather rapid basis.

**Heather:** Okay. Alright. Thank you.

**Judie:** Okay. Thank you, Heather, your lines off… re-muted, and your hand is down. And let's try Kevin. Kevin, your line's off mute. Go right ahead.

**Kevin:** Hi, just a quick follow-up clarification on the question about the patient that was not Medicare, with oxygen, then switching to Medicare, is there a timeline for what that testing needs to be as long as it meets Medicare criteria?

**Teresa:** This is Teresa again, and that applies specifically to Medicare replacement plans. If the beneficiary is enrolled in a Medicare replacement… Medicare Advantage Plan… and using oxygen, then the testing, while they're enrolled in that Medicare Advantage Plan, as long as it is qualifying, can be used when they move from an advantage plan to traditional Medicare.

**Kevin:** Yep. Okay, just wanted to make sure. I'm sorry…

**Teresa:** Yeah, that's the only payer.

**Kevin:** Yep.

**Teresa:** That's the only payer that is allowed for.

**Kevin:** Okay that was my only question. I'm like, did I hear that right? But I was doing five different things, so thank you very much.

**Teresa:** You're welcome.

**Judie:** Thank you, Teresa. Alright, Kevin, your hand is down. Anne, go right ahead. Anne, your line is off mute. Go right ahead.

**Anne:** I already answered the… I already answered the question, thank you.

**Judie:** Okay, great, re-mute your line and make sure your hands down. Marty, your line is off mute. Go right ahead.

**Marty:** Hi there. I have a question about CPAP and custom fabricated oral appliances for obstructive sleep apnea. I'm looking at a report that we generated off of myCGS. It's a CMN detailed information report, and there's a line there that says rental months paid. Can you give me a number of months paid that would show in those reports that would make the patient eligible or ineligible for a custom fabricated oral appliance replacement for a delivered CPAP?

**Denise:** Marty, this is Denise. I'm not sure what report you're talking about. Are you in myCGS, is that where you're at?

**Marty:** Yes. Yes.

**Denise:** Okay.

**Marty:** Even if we answer it generally before the report, I mean, we can, I'm just… we've used the report because, know that gives us some months, it gives us a numerical value. But, you know, we're just… we're trying to understand if a patient can't or won't continue to use the CPAP, you know. What is the actual number of months paid where they're allowed to change and the custom fabricated oral appliance would still be paid for?

**Denise:** I didn't hear the last part and where the custom fabricated oral appliance will be considered. Is that what you said?

**Marty:** Will be paid for. Will still be allowed.

**Denise:** There is… there's no certain, certain amount. The CPAP device, that's a five-year reasonable useful lifetime. So, that should be five years. If the beneficiary wants a replacement at that time, just for preference, you need to make them aware that Medicare is not going to pay for additional equipment unless their medical need changes. For whatever reason they cannot tolerate the CPAP, whatever the medical need, the doctor needs to document what that is. And try the oral appliance; that would be considered. But there, again, everything has a five-year reasonable used for lifetime, most items do. If it is any less or more, it would indicate it in the LCD if there's what they're reasonable useful lifetime is. Did that your question, Marty?

**Marty:** Not really. And I don't know if it's you breaking-up or me breaking-up. So, if you can't hear me, let me know, but we've been told, and maybe this is incorrect. But, we've been told that during an initial period, like the first month, if the patient decides that they can't use the CPAP and it doesn't go past that first month, that they would still be eligible for a custom fabricated oral appliance. And, if you're telling me that that's not true, I mean, I'm just trying to get clarification on that.

**Denise:** That's true, if they're only getting one month payment and they can't use the device, then documentation in the records there, that you know, if they need the oral appliance, medical records would have to meet coverage criteria, and they only got one month. Normally it only goes up to 13 payment for the CPAP device, and ownership transfers to the beneficiary for the next five years.

**Marty:** And I understand about the 13 months, but we're just trying to get clarification on, initially, if the patient, you know, we're talking about the same and similar. If there's, like, some initial period that wouldn't kick in this permanent, same and similar for five years. So that if the patient said, you know, in less



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than or one month was billed on the rental that Medicare would still cover the custom fabricated oral appliance. You follow me?

**Denise:** I do. And… if everybody… I'm calling right back in.

**Marty:** I can't hear you.

**Judie:** I believe she said she's calling right back in.

**Marty:** Yeah, it was really… I mean, again, can you hear me okay?

**Judie:** Yes, we can.

**Marty:** Okay, because then the break-up was on her end, because I could barely hear her on and off.

**Judie:** I understand.

**Denise:** Okay, I'm sorry, is this any better?

**Marty:** Sounds to be better right now, let's keep going, please.

**Judie:** Okay, so your question is they, and I apologize to everyone, I just want to re-iterate. So, the question was they get one month of rental for the CPAP device, and at that point, Marty, what happens? They don't want it, or they can't use it?

**Marty:** They can't use it; they don't want it. I mean, I don't know if that matters, you can tell me, but they've decided, you know, they can't or won't use it. And that they want to have custom fabricated oral appliance therapy for the diagnosis of obstructive sleep apnea. You know, we're trying to see if that one month, if they'd still be allowed coverage for the oral appliance?

**Denise:** And you're right, it does matter. If they can't use it, that would be considered for coverage of the oral appliance based on the medical records, why can't they use it? If they don't want to use it, that's where you need to make them aware that Medicare made payment for this CPAP device. There's no documentation stating, you know, that it's not working for you. It's just that their choice; they don't want to use it. So, you got to make them aware that Medicare is not going to pay for the oral appliance. That's where you want to get an ABN in that situation.

**Marty:** Okay, understood, but let's say they can't use it and there is documented medical necessity in the medical records. If they are unable to use it, they can't use it, then how do we look at the number of months paid as the factor here? In other words, once it gets the two-months paid, even if they can't use it, does that mean the oral appliance is going to not be covered?

**Denise:** I'm thinking… there is no specific limit for that. That's… I mean, it's same and similar to the CPAP, but it depends on the documentation.

**Marty:** Yeah, I mean, and we've been told similar things before and it's very complicated to really get a definitive answer for this. I mean, I understand about the same and similar, I understand that there's a five-year life of this or use predicted on this. But, you know, we've also been led to believe that during an initial period, because if a patient has never used it before, and then, with their physician, they find out that they cannot use it. It would seem, to me, it would be logical that there would be some initial period based on the medical necessity where they could make a change. That's what we're trying to define more. You know, is there a period where, even with a change in medical condition, they're not going to be able to go from CPAP to oral appliance, because it's considered same and similar?

**Denise:** Yeah, and, again, you just need to document that, Marty. That's something that would need to be documented by the physician. Why can't they use the CPAP device, and that an oral appliance is considered. So, you can do that. There's no specific timeframe when that needs to be done. It doesn't have to be done one month, right after the CPAP, one rental; it can be done at any point.

**Marty:** Alright, okay, well, thank you for your… thank you for the answer.

**Denise:** You're welcome.

**Judie:** Thank you very much. Sorry, Denise, I muted him. Okay, Brett, I do see that you have your line off mute, or that you have your hand raised, but you do have to enter your pin number into your telephone, so please do so. Same with Morgan. I've sent you your pin number. We are unable to unmute your line if you have not entered your pin number into your telephone. So, Gao, your line is off mute. Go right ahead.

**Gao:** My question is regarding if patients in a nursing home or hospital, and patients is to receive, like, like an arm brace or a leg brace, and the date of service is during the time that they were in, like, a nursing home. And I remember reading somewhere that, if it's… if the data sources within 48 hours of the discharge date, we can change the answers to the discharge date. Or… but then I'm also reading somewhere that says, um, we can change it to the discharge date, but can it be greater than 48 hours?

**Judie:** So, if the item is provided for training or fitting purposes, and not rehab, it can be provided within two days prior to discharge, but it must be within two days prior to discharge. And that's when you can change the date of service from the date provided to the date of discharge.

**Gao:** Okay, alright. Thank you.

**Judie:** You may also want to refer to our Consolidated Billing Tool on our Tools page to confirm because some items can be billed separately if the beneficiary is under some orthotic items, as well as prosthetics, can be billed if the beneficiary is under a Part B covered stay.

**Gao:** Okay.

**Judie:** So, I would definitely suggest referring to the consolidated billing tool with the appropriate HCPCS code.

**Gao:** Thank you.

**Judie:** You're welcome. Venita, go right ahead.

**Vinita:** Hi, can you hear me?

**Judie:** Yes.

**Vinita:** Hi. So, my question is, if an item is statutorily excluded by Medicare, can we just bill the patient and not bill Medicare at all? Or do we have to bill Medicare with GA modifier? For example, orthopedic shoes that are not part of the orthotic braces, are statutorily excluded by Medicare. Do we have to bill Medicare for them if patient says please at the time of service?

**Judie:** If the item is never covered by Medicare, then only if the patient demands that you submit the claim, then you must submit the claim under the Mandatory Claims Submission Act. You may choose to get a voluntary ABN as well. Just in case the beneficiary comes back and says, "Oh, I want you to submit the claim now." At least you'll have that ABN in your files if the beneficiary comes back and demands that the claim is submitted.

**Vinita:** Okay. Sounds good. Thank you so much.

**Judie:** You're welcome. Heather? Heather, your line should be off mute. No, it's not, just one moment.



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**Heather:** There we go. I have a question. Hopefully, it was pretty simple about the Medicare Secondary Payer questionnaire. Is this a required document that DME suppliers have to have on hand, or is it just a recommendation to make sure that we're ordering our payers correctly?

**Judie:** No, sorry, hold on, hold on one second. We do have another line off mute and my webinar has frozen, and I can't re-mute their line. There we go. Okay, wait, hold on.

**Heather:** I thought maybe you were having a party behind you.

**Judie:** No, that was not me. Alright. So, you're asking if the Medicare Secondary Payer Questionnaire is a mandatory form?

**Heather:** Correct. For DME suppliers. Or is it a recommend form to use to determine of Medicare is primary or secondary payer?

**Judie:** Would anyone CGS like to address that question?

**Sarah:** Hi Judie, this is Sarah Barbian. I'm with POE too. You're talking about the MSP questionnaire. Correct?

**Heather:** Correct.

**Sarah:** That's not mandatory. We won't be asking for that in an audit. That's just a suggested form to help with intake to make sure Medicare is primary or if they aren't… that sort of thing.

**Heather:** Okay.

**Sarah:** No, it's not mandatory, it can be customized too, you know, if you'd like to.

**Heather:** Okay. Alright. Thank you.

**Sarah:** Thank you.

**Judie:** Great. Thank you both very much. Anne, your line is off mute, go right ahead.

**Anne:** Hi, this is Anne. I do have one more question. If the patient is receiving, say, for example, a CPAP before the five years, and it during this COVID, his other machine's not working. Can we continue to provide that with that CR modifier, or would we still get denied same or similar?

**Judie:** I'm so sorry, I missed the beginning of your question. Can you please repeat it again?

**Anne:** Sure, if, say for an example, I'm just going to throw an example out there. Say before the five-year RUL is up on DME. Say, CPAP… say, he three years ago because it drops so many times. We have the patient write a letter, and now it's during this COVID epidemic. He hadn't been able to go back to the doctors, to get the notes, but we got a new order, etc. Can we still do that replacement CPAP with the CR, and would we get denied for same or similar? Or too many because he already had one? Would that COVID CR override that for that replacement?

**Judie:** So, we would expect replacement equipment to be extraordinarily rare due to COVID. It's unlike any other natural disaster where the item is lost, destroyed, irreparably damaged by a fire, flood, hurricane. But according to CMS, we do have a special edition article that states that replacement equipment would be considered in that waiver process with the CR modifier.

**Anne:** Okay, thank you so much.

**Judie:** And that should be rare. And you would want to have documentation as to why the beneficiary needs a replacement item and how it's affected by COVID.

**Anne:** Right. We just couldn't get them to go back to the doctor. Say, for an example, because of this COVID, but we have everything else, we have this letter of why it needed to be replaced. We have the new order. We just couldn't get them to go back. We have all the other medical necessity paperwork, except for face-to-face to go forward. He had dropped it so many times, and actually the motor blew, and he did dispose of it. So, because we didn't have the face-to-face, I was thinking if we did it with the CR modifier, and I didn't know what the sequence was if that would still be covered.

**Judie:** My concern would be on that if item is broken beyond repair because of beneficiary negligence. I don't think that that would fit under that waiver requirement. I would suggest you send that email to our outreach and education team so we can research that.

**Anne:** Okay.

**Judie:** I'm apprehensive to say that's correct because it's beneficiary negligence that they need a replacement, and it's not after the reasonable useful lifetime. So that concerns me a bit. If they just couldn't go back to the doctor or just wouldn't go back to the doctor, or you know, then that would be acceptable for the CR modifier usage. But because of the equipment being broken due to beneficiary and negligence, I would have some concerns about utilizing that CR modifier.

**Anne:** Yes. Sometimes they're not sure why the motor blew, or was making that loud winding noise, so you know, and then it's passed the warranty. And then therefore they may need a new piece. Sometimes they don't last five years.

**Judie:** Right. Well, we will consider repairs during the reasonable useful lifetime, but again, I'm very apprehensive based on all those other scenarios. So please be sure when you send your email to be very clear about all of the scenarios, and we can address that individually.

**Anne:** Okay, and where do I need to send it to?

**Judie:** That's actually in the chat. You should see that email address in the chat feature.

**Anne:** Okay, thank you so much.

**Judie:** Okay? Oh, you're welcome, Anne. Thank you. Gao your line is off mute. Go right ahead. Gao?

**Gao:** Oh, I'm sorry, I didn't. I didn't realize my hand was up. Sorry.

**Judie:** No worries, I'll go ahead and re-mute you. Hold on, you're not off mute. Let me get you re-muted. I saw you lowered your hand. Brett, your line's off mute. Go right ahead.

**Brett:** You said, Brett?

**Judie:** I did, I said you.

**Brett:** Yeah. Sorry about that. So, to piggyback off to the previous question related to rentals due to COVID, didn't we say that…. so, if, due to the recall, we could bill under a certain code, due to a patient not being able to use the recalled unit?

**Judie:** Yes, and that is for the loaner equipment. If you are providing a loaner item until their recalled item is repaired and/or replaced, then you can bill that loaner code.

**Brett:** Yes, what was that called?

**Judie:** K0462.

**Brett:** Okay, thank you. And then I also have an additional question related to same/similar. If a patient is new to Medicare, previously they say they got their unit from or through Anthem,



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commercial payer, and now with Medicare. Are we able to bill with an RA modifier as a replacement unit, or is it considered initial? And, they would have to follow…

**Judie:** It would be considered a new item with traditional Fee-for-Service Medicare if they received the previous item through a Medicare Advantage Plan or private insurer. So, it would be the first item billed to Medicare.

**Brett:** Okay, so, even if they have a Medicare replacement plan, too, and they're new to traditional Medicare, they will consider that an initial, and they would have to follow the, like, the guidelines.

**Judie:** The guidelines.

**Brett:** Okay, perfect.

**Judie:** Yeah. Yep. Thank you and you did state an orthotic, right? It was an orthosis you were asking about?

**Brett:** Actually, no, it's as it relates to CPAP equipment.

**Judie:** Okay, there is specific guidelines if it is a Medicare HMO or Medicare replacement plan, Medicare Advantage Plan. There are specific guidelines that do apply right in the, I believe it's in the policy article, and Teresa had covered that earlier. Teresa, do you want to provide that information again regarding CPAP if the beneficiary is coming from a —

**Teresa:** Oh, from a Medicare Advantage; it's the same for Medicare Advantage or private insurance, once they become Medicare eligible, their sleep study can be used from the previous timeframe.

**Brett:** Yeah. No, I get that.

**Teresa:** As long as it's qualifying. But it would be a new initial with Medicare, yes.

**Brett:** Okay, that's my question. It's related to whether or not they have to follow the compliance requirements again if they had a Medicare Advantage Plan.

**Teresa:** Yes, they do. (Addendum - clarifying responses below, in bold)

**Brett:** Okay, great.

**Teresa:** Oh wait, **no, they do not have to have compliance** if they were continuously using the CPAP prior to their Medicare enrollment, they do not have to go through the compliance again. You just have to have the face-to-face and documentation of continued need, and a new order.

**Brett:** Okay, and that's only for Medicare Advantage to Medicare. But if it was commercial to Medicare, they would still need to follow those compliancy requirements.

**Teresa:** No, the rules are the same for private insurance or HMO for Medicare, when they have been on a CPAP, continuously using it prior to their Medicare eligibility date. You have to have a qualifying sleep study, a new face-to-face exam after their Medicare eligibility date and a new detailed written order. The documentation and face-to-face has to document continued need. And then, it is a new initial with Medicare. But they do not have to meet compliance in that scenario, as long as they've had continuous need prior to their Medicare enrollment.

**Brett:** Okay, thank you.

**Teresa:** You're welcome.

**Judie:** I'm glad we got that clarification, Brett. Okay, put your hand down. Oh, somebody's lines off mute. Morgan, your line's off mute. Go right ahead.

**Morgan:** Morgan, did you say Morgan?

**Judie:** Yes, you.

**Morgan:** Okay, hi, sorry. My question is regarding the requirement for the repeat sleep study due to noncompliance for PAP devices. Are we, as suppliers, still allowed to request that the patient go into the lab and have the repeat sleep study done, to be restarted, even though it's technically, it's currently, like, under the waivers due to COVID?

**Denise:** Morgan, this is Denise, is… are they affected by that? Do they, can they not go into a facility to get a sleep study?

**Morgan:** See, that's kind of why I'm asking the question because we have certain doctors' offices that are… they're questioning why we're requesting to have the patients come in when they're like, "Medicare does not require this right now, it's under the waiver, you can just go to CR modifier." But we are coming from it more like as standpoint from, like, where you're coming from. So, if the patient has had COVID or they've had like certain, you know, they're compromised or whatever and they can't go into the lab, then that was one thing we would consider doing. But if the patient is fine, able-bodied, you know, sleep lab is open, the doctor's office is open, I mean, are we still able to require that, that patient go through the normal process to restart?

**Denise:** It's still the pandemic… during the health emergency, and the CR modifier could be applied. I know what you're saying if they could… you could put the CR modifier because it is still affected by public health emergency.

**Morgan:** Right? But would it be wrong if we want the patient to go ahead and do what they should be doing to restart as going back, having the face-to-face, whether it be a telehealth, and going in the lab, to have the repeat sleep study.

**Denise:** If they're okay with doing it, then, yes, that's fine. The beneficiary can refuse to, if they refuse to, that's where you can just continue putting the CR modifier on your claim.

**Morgan:** Okay, and as far as doctors' offices, they're not going to be under any type of, like, they won't get dinged or anything like that if they're billing for the sleep studies during the public health emergency. Correct?

**Denise:** That, I don't know. I mean if it's a process… I don't know that… the answer to that one.

**Judie:** That would actually have to be referred to the part of Medicare that is processing the claims for the testing. The DME MACS would not be able to answer that question. There's nothing stating that if they provide any service that they're going to, I have not seen anything that says just like a supplier providing DMEPOS items. There's nothing published, to my knowledge, that states you're going to be in trouble for providing a DMEPOS item. But you would have to contact the A/B MAC to confirm that.

**Morgan:** Gotcha, gotcha, okay, great. Thank you so much.

**Judie:** Well, you're welcome. Great questions from everyone. Alright, I'm going to put your hand down. And Kassie, go right ahead, your line's off mute.

**Kassie:** So, I have a question about competitive bid as well. And just for the previous caller, I had had those things ask questions about the global visits very, very early this year, and then when



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I did ask the competitive program, they redirected me back to CGS. And then my contacts and CGS said that they asked several people and need to escalate it to Medicare. And I never got another answer. So, piggybacking off of that the reason I was asking a question was, is there a posted set of professional service codes that the competitive bid items data service can be tied to so that we… our providers can understand what, like, what their professional visits will qualify for providing those competitive bid items.

**Judie:** Kassie, I would actually suggest going back to the competitive bidding implementation contractor, as they deal with that particular branch of CMS that provides the guidelines and direction. The DME MACs will have that information, you know, what we have posted to our website states, "an office visit." So again, I would suggest going back to the CBIC; if you don't get a response from the CBIC, feel free to send us an email and we can see if we can work with them to get a response.

**Kassie:** Okay, I have; I've done it a couple of times and I've gotten automated responses saying that you just said… just for a subset of information that's easily found. So, I've been bounced around about four or five times at this point. Is there any way that we can just go ahead and log and ask that?

**Judie:** Sorry, Kassie, I lost you. Are you there?

**Kassie:** Yeah, I just got muted and unmuted through. Yes, so is there any way that we can just go ahead and ask that CGS, CBIC, and Medicare go ahead and define those parameters for us? Because there are providers… are trying to provide items to our patients? And then we're having problems when they are allowed to, when they're not allowed to. And there's not really clear information. And, like I said, I keep getting bounced, "please refer to this entity" and then that entity tells me to refer to someone else. And back to the first person.

**Judie:** Kassie, I sent you my email address. So, send me an email with exactly your request, and I will see what I can do to get this resolved.

**Kassie:** Okay, I appreciate that. Thank you.

**Judie:** Yeah, you're most welcome. Thank you. And that is the last hand we have raised, so thank you all so much for such great questions. David, I'll turn it back to you.

**David:** Thank you, Judie, and thank you to everyone for attending today's Jurisdiction B & C Ask the Contractor Teleconference and for participating in the live question and answer session. We will post the transcript to our website and send out an electronic mailing notification when it is available. I'd like to thank you all so much for attending today and we look forward to seeing you at future educational events. Have a great day.



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