Ask-the-Contractor Teleconferences (ACT)

DME MAC Jurisdictions C POE
Date: November 30, 2021

Moderator: Angie Cooper
Time: 2:00 p.m. EST

Introduction

Hello and welcome to the Jurisdiction C "Ask the Contractor Teleconference". My name is Angie Cooper and I'm a member of the Provider Outreach and Education team at CGS Administrators. Our department conducts this teleconference every quarter to give you an opportunity to ask questions of subject matter experts at the DME MAC. We have a great team here today ready to address questions, including the JC provider education team, Medical Review clinicians, and other specialists from operational areas. You will need to call Customer Support if you have issues with a specific claim or beneficiary, since the purpose of this call is to ask questions about Medicare billing, policies and/or procedures.

We are recording this teleconference so that we can provide a transcript of everything that is asked and answered here today. The transcript will be available on our website within 30 business days. We will send an email through the electronic mailing list when it is available. Because of the transcript, we are not allowing written questions since we want to record everything to include in the transcript.

The Provider Education team puts forth every effort to ensure the information you receive today is accurate and up to date. However, it is ultimately your responsibility as a supplier to stay informed and compliant with Medicare program guidelines. Rules and guidelines change frequently, so be sure to stay up to date by reviewing all the information shared in the electronic mailing list and in the News section of the website.

Before we open it up for questions, I just need to go over a few housekeeping rules. Even though we are conducting the call using our webinar platform, and you may be accustomed to some of the features available during a webinar, this teleconference does not include a presentation and we cannot accept written questions. All questions must be asked verbally.

You can use either your computer or your telephone for audio. If you are on the phone, then you must enter the PIN using your telephone keypad so that we can unmute your phone line in case you have a question. You can find your PIN in the Audio section in your GoToWebinar control panel.

Now, if you have a question, please raise your hand and I will unmute your phone line and call your name. To raise your hand, just click on the hand icon located in the control panel. If you see a red arrow on your hand, that means your hand is raised, and I will unmute your phone line when it is your turn to speak. The green arrow means your hand is not raised.

To give everyone a chance to ask their question, we will only take one question at a time. Our goal is to address as many questions as possible during our scheduled time.

Just a quick reminder, you may not record this teleconference for any reason or purpose. Just watch for the transcript if you want to refer back to anything.

While we queue the questions, I'll go over a few updates very quickly. We encourage you to ask follow-up questions about any of these items.

COVID-19 Public Health Emergency (PHE)

First of all, the COVID-19 public health emergency continues, and the waiver was renewed on October 15 for another 90 days. We have a dedicated COVID-19 web page that includes many resources for how and when to use the CR modifier. It's easy to access from the home page or any page on our website from the left navigation menu. We have not received any further instructions from CMS on what will happen after the PHE ends. Just be sure to include the "covid19" narrative on your claim if you are using the CR modifier for any of the covid-19 waiver or clinical non-enforcement reasons.

Targeted Probe and Educate (TPE)

TPE has resumed and claims during the PHE will be selected for review. If you are selected for TPE, you will receive a letter with details that includes an email address where you can communicate directly with medical review. We have provided many resources including videos and a dedicated web page in the Medical Review section of the website.

myCGS

myCGS 7.2 was released this month and included a lot of new and exciting changes to the registration process to make it easier and faster to register as a new user and for Designated Approvers to manage their users. There is a news article dated 11.15.21 to gives an overview of the new features. Some highlights of the new version include:

- Streamlined registration process for both Designated Approvers and End Users,
- We made it simple and easy for Designated Approvers to recertify a large number of users at once,
- Recertification every 365 days instead of every 90 days
- We also fixed a couple of known issues. You can search ADR letters by Case ID and the new TPE letter types have been added to the ADR education summary.

K0553

Also, a reminder the K0553 therapeutic continuous glucose monitors supply allowance code should not be billed with a span date. This HCPCS code is set up to pay for 30 days of supplies, and claims billed with a span date will be denied. These claims should have denied all along, but we started rejecting them as unprocessable on November 15. We have created a calculator to help you determine subsequent billing dates if you need help. The calculator is located under Tools & Calculators on the website.

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Questions & Answers

When you registered for today's call, we did include a space in the registration for questions and comments. So, if you submitted a question during registration, you can go ahead and raise your hand, as well.

I'm just going to give everyone the opportunity to find your find out how to raise your hand, and we'll go in and look and unmute your phone line.

Leslie: I just wanted to verify in a previous webinar, you discuss the incident to signatures with the nurse practitioner, PA, or MD. And we've been doing that process, where the doctor is signing incident to the nurse practitioner or PA. I had a medical review denial because of this. So, I just wanted to see if this has been adjusted. Right now, it's going to redetermination. But we did everything, the signatures exactly like it was laid out.

Angie: OK, so I can't speak to your specific claim, but I can refer to the guidelines for the certifying physician that is found in the therapeutic shoes for persons with diabetes policy. In November of 2020, they did update the guidelines to allow the use of a certifying physician to be an incident to practitioner. That incident to practitioner can be a nurse practitioner or physician's assistant and can perform the function of a certifying physician if they meet the incident to guidelines. That means they have a supervising physician who is signing off on everything. So that supervising physician would need to be an MD, or a DO, and they would have to sign off and agree to that medical record. They would sign off on the examination, the diabetic exam. They would need to sign off on concurring with any foot examination that was conducted by another practitioner. They would need to sign off on the statement of Certifying Physician as well. They do have to sign off on everything as that supervising physician.

With your medical review case, you probably had the ability to contact and communicate with your medical review clinician. You do have appeal rights on those denials as well. It sounds like you've exercised those. Just make sure that you've provided all the information with your appeal.

Leslie: Where is the medical review clinician information?

Angie: It would have been in your letter that you received on that specific case.

Leslie: OK, Thank you.

Angie: OK, Anthony, your phone is unmuted. Go right ahead.

Anthony: Good afternoon. And thank you for your time. My question is regarding the knee orthoses LCD specifically the section regarding objective description of joint laxity. There are only two tests that are listed in the LCD. Or is there a master list that includes other objective descriptions that are acceptable?

Angie: OK, the tests listed in the LCD are just examples. There's not a list of all the acceptable tests. It does depend on the medical records, so the treating practitioner must examine the beneficiary and document knee instability with an objective description of joint laxity. Knee instability is related to the chronic or the acute injury of the knee ligaments, therefore an objective description of the instability can be notated through the documentation as an objective test of the ligaments; such as the examples in the LCD of the varus/valgus instability and the anterior/posterior Drawer test. These are just examples of that. But there is not a full list of every possible way to document that.

Anthony: Right? My concern is everything that you just said and everything that is in the LCD relating to ligament laxity. And since most of the Medicare beneficiaries are, I would say the majority of them, are receiving knee orthoses for osteoarthritis, which more times than not would not include ligament laxity, what would be considered an objective description that would suffice for osteoarthritis?

Sienna: This is Sienna with medical review, our orthotist/prosthetist, and I'm going to just kind of address that a little bit and remembering that for knee orthoses in Medicare it is a defined benefit policy. So, what is defined in the LCD is the only thing that Medicare covers for any orthoses. If there are other areas that you know, you think should be addressed in that policy, I would suggest that you take that in and address, you know, changing that LCD and submitting that LCD request.

Anthony: If the only thing that they're covering would be related to joint laxity, you also have the corresponding diagnosis in section 2 or 4. So if osteoarthritis is in the diagnosis, which is acceptable diagnosis, doesn't make sense that it wouldn't be also covered.

Sienna: Based on the coverage criteria, it also requires that it has the instability, as well as one of the diagnoses in the applicable policy article. If there are additional areas, I would suggest an LCD reconsideration.

> **Note:** This question only addresses coverage requirements in the LCD - Knee Orthoses (L33318) (cms.gov) for Knee orthoses L1832, L1833, L1843, L1845, L1851 and L1852 for a beneficiary who is ambulatory and has knee instability due to a condition specified in the Group 4 ICD-10 Codes in the LCD-related Policy Article - Knee Orthoses - Policy Article (A52465) (https://www.cms.gov). These codes are also covered if the beneficiary has had recent injury to or a surgical procedure on the knee(s). Refer to the diagnoses listed in the Groups 2 or 4 ICD-10 Codes in the LCD-related Policy Article.

Anthony: Then, who would that be submitted to?

Sienna: We can get you that information.

Anthony: OK, awesome, thank you.

Angie: Thank you, Sienna. And yes, Anthony, the information about submitting the LCD reconsideration is in the Local Coverage Determinations section of the website. There are links in the top portion of the page right above where we list all the LCDs. There are quite a few documents out there that go with that and explain the process.

Anthony: Awesome. Great. Thank you for the information.

Angie: The next question comes from Dr. Kesselman.

Dr. Kesselman: So, I'm just a little frustrated. I know, I was one of the people that advised the portal folks to make an annual certification. And now I'm kind of regretting it because it appears, and you please correct me, if I'm wrong, that we have to put in a check number or a statement number or something like that. And my problem is, and many other people are going to have the same exact problem, that I don't bill Region B or C. And the only reason I need to use the portal is to make sure the patient has a clean same or similar history from a supplier in region B or C. That's not something that we thought of before.

Angie: OK, I will go ahead and let Jonathan Bergey speak to that since he's here to represent myCGS. He may have some more information that he can share.

Jon: I'm not sure that we necessarily considered your specific scenario. Mainly because the portal is intended for suppliers who actively bill in Jurisdictions B and C. So, unfortunately, the

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way that it is right now, in your scenario, that you do have to be an active Jurisdiction B or C supplier to use myCGS. That's simply the intended user base of myCGS. So, yes, you do have to enter a check number from Jurisdiction B or C to maintain your annual access. As far as, if there's a way around that, that's something we'll have to discuss internally. And I'm not sure of the answer. But I can tell you right now, from what I've been told by management before, that we really are looking at the intended audience as active jurisdiction B and C suppliers. So, I'm not sure that there's going to be a way around that.

Dr. Kesselman: I think what we need to escalate, just have a further discussion. I don't want to do it here and I don't think you do either. But this is something that I think needs to be very heavily considered because you're going to have a lot of suppliers in region A and D who are going to be really upset about this. People who are in B and C need to look at the A and D portal. This is exactly the scenario I think you didn't want to create. I'm sure it was unintentional. So, let's just see if we can keep the lines of communication open. I, myself, have a 30-day window to get this resolved because I just got an e-mail the yesterday. I need to recertify.

Jon: Sure. Well, let me also ask you a question. I believe that Noridian has a similar requirement for their annual certification.

Dr. Kesselman: Well, I don't know that they actually have one. They've just been, all I've gotten from them is advice on resetting my password every 90 days, that's about it. They have not followed that requirement as far as I know. I don't ever remember getting a recertification request. I know it's on the books, but Noridian hasn't done it. So, I would add, if I didn't bill region A and D, I would have the same problem if I was in region B and C that I'm going to have in region B and C. You follow what I'm saying? I look forward to 1 or 2 if you're getting back to me. Thank you very much.

Angie: The next question comes from Sharon.

Sharon: Hi, I have a question on how we would be getting some denials for M-U-E edits for syringes. I'm wanting to know when I read the LCD it states that irrigation solutions or routine irrigation solutions are denied. What kind of documentation do I need from the physician to support a routine irrigation?

Angie: Are you talking about the irrigation for catheters?

Sharon: Yes, I'm sorry, that's where I went with my urological Supply LCD is where I went to look, to see about the syringes. And I called customer service to check on my denial and they said it was an M-U-E edit medically unlikely. But yet, when you go in the LCD with this HCPCs code, there's not a determined amount you know, that you can get 10 per month or so. It just says syringes trays, sterile saline and water when used for routine irrigation, they will be denied as not reasonably reasonable and necessary. Yeah, trying to figure out, how do we get the best way? Or maybe I just need to tell our beneficiary, you can't have these syringes. Or Medicare won't pay for them, I guess I shouldn't say she can't have them.

Angie: OK, one of my team members may be a little bit more up to date on this particular policy than I am.

Judie: This is Judie with CGS. A routine irrigation of a catheter will be denied is not reasonable and necessary. So, per the policy LCD of urological supplies that would not be covered through Medicare because it will be denied is not reasonable and necessary.

Sharon: Ok, because I, I just wanted to make sure I knew because when I call the beneficiary's mother, she's not going to be very happy and I want to make sure that I am telling her correctly that that's not something that is in the coverage.

Judie: Does the beneficiary have a secondary insurance? Or Medicaid?

Sharon: Yes, she has Medicaid, Oklahoma Healthcare.

Judie: Well, what you can do is submit the claim. Obtain an ABN prior to providing those items going forward and provide an Advance Beneficiary Notice of Noncoverage. Which, depending on how many you are providing, because you're getting, I believe you said you were not getting a CO 50, you're getting an over utilization from an MUE edit, correct?

Sharon: Yes, and we're putting out 30, which I'm sure, I'm sure that's too many. Just trying to determine how many she could have and what I needed to have the doctor document to why he thinks she needs to do this more often.

Judie: OK, because that would be the first step to take, would be to obtain documentation to substantiate the need for that irrigation because that, that's quite high for irrigation. Then I would suggest obtaining an ABN for the correct number of units that the physician is actually ordering and documenting as reasonable and necessary for that patient. And depending on the way the claim is processed in the system, if you received a CO 50 denial, your ABN, if it's a complete and accurate and valid ABN, would give you a PR 50 that you should be able to take to the beneficiary's secondary insurance, or Medicaid.

Sharon: All right, OK, well, thank you very much.

Judie: You're welcome.

Angie: While we wait for another question, I do want to just give a reminder that myCGS does allow you to submit your responses to TPE ADR letters and the entire registration process is now built into myCGS directly, so that you don't have to submit a physical registration form.

Angie: I see that Susan's hand is raised. Go ahead, Susan.

Susan: Hello, I'm a new biller for enteral supplies and tracheostomies and I have a question about December to January span dates. I've been told by one person in my organization that with spanned supplies that you can put, let's say for enteral, that you can put all the supplies on one invoice, but you have to put December date separately from January date. I've been told by another individual in the organization that, no, you have to have two separate invoices: one for all the December supplies, and one for all the January supplies. Which one is correct?

Angie: I did check on that prior to the call, and you would not need to split your claims for your enteral nutrition. I believe you gave an example of enteral nutrition and tracheostomy supplies. Enteral nutrition does require a date span, but you would just follow normal date of service guidelines. You don't have to split bill the claim. If you provide the nutrition on December 13th, just bill your claim line December 13th, 2021, through your January date if It was a one-month supply. Now your tracheostomy supplies, those do not require a span date. You would just bill your date of service as the date of delivery or the date of shipment. Don't span your dates on those.

Susan: OK, so I was told that the reason for supplies having to have different line items for the different, for the December January months, was because the pricing changes on January first. So, that's why we had to, we were supposed to bill half of them in December under old pricing, and the other half in January, under new pricing.

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Angie: You don't have to split those out. The system can recognize the date and process accordingly.

Susan: And you did say that tracheostomy supplies no longer have to be spanned?

Angie: Those do not require a span-date.

Susan: OK, is there Is there something in the LCD because I tried looking for LCDs and I tried reading through CMS?

Angie: The LCD doesn't tell you that you have to bill spanned dates. The Policy Articles of the LCDs provide billing guidance and there is nothing in the tracheostomy supplies policy telling you that you must span the date. We have also published information on when to use date spans. There is a Claim Narrative and Date Span Chart that lists the codes that require a date span.

Susan: Where is that located?

Angie: It's currently located under forms. If you go to the Forms, Checklists and Guides page, look under the Claims section in the Guides column.

Susan: We'll do that. Thank you so much.

Angie: You are welcome. Stacy, I have unmuted your line.

Stacy: I was wondering if there is any billing guidance for oral anti-cancer? Most of what I've learned is, you know, trial and error. I know we do have to bill the generic S code and then put in a narrative, the NDC. But none of that information is actually in the LCD, or the policy article. And there's not ever any webinars available for it either. I just wonder if there's any resources out there on billing oral anti-cancer?

Angie: What we can do, is I can turn this in as a suggestion for either maybe an online education course or to do a webinar, but we currently don't have any webinars scheduled for oral anti-cancer drugs. And we can take that feedback back, to provide more information on the website about it.

Stacy: Yeah, because everything I found out is trial and error, like you know, you can't bill by the J HCPC code. You have to go with an S code, which I found out thankfully through, you know, our clearinghouse. Like, everything I've found out has been trial and error, and now we have a large population that we do that for. Anyways, I was just wondering if there was any kind of published guidance because you knew it's an odd billing.

Angie: I understand. You also have the ability to provide feedback and suggestions for things like that on our website. That would be something very helpful to tell us. We pay a lot of attention to those surveys and the feedback option that's on our education page. That's another avenue for you to let us know when you're looking for something and you can't find it, or there's not any information available. We can use that information and add it to our enhancements.

Belinda: Hi, this Belinda. I am currently working on an OEC for oral anti-cancer. So that should be available within the next month or so.

Stacy: Thank you.

Angie: And when that course is available, we will announce it. So be sure to look for our electronic mailing list. We'll, we'll let you know when it's out there.

Stacy: OK, yeah, I'm subscribed. I get all the updates. Thank you, I appreciate it.

Angie: Thank you. Thank you for the update, Belinda. The next question is from Carol. Go ahead, Carol. I've unmuted your line.

Carol: My question is, when we are getting patients that are coming out of the hospital, that have been with a previous provider and we're setting them up at this point and we're taking it over. When I go through the process, even if they've had a CMN, do I need a CMN? Or do I just do a CR, COVID and then put a narrative in addition to that stating it's a change in provider?

Angie: What are you billing? What are you providing?

Carol: I'm sorry oxygen

Angie: OK, so the beneficiary was already on oxygen and you're taking over billing the rental. During the COVID PHE, the oxygen, those guidelines, the clinical indications for coverage, are not being enforced. If you're using the CR modifier, a CMN is not required. You can apply those flexibilities and waivers during the PHE for oxygen or any of the respiratory policies.

Carol: OK, so I don't have to worry about putting a narrative that there's a change in provider, just do the CR and COVID19 narrative.

Angie: You would do to CR and the COVID 19 narrative. I'm trying to think if there are any other billing implications. Since you're changing providers it will not start a new rental period or anything like that.

Carol: Correct

Angie: Yes, that should work as long as you have your order, where the treating practitioner ordered the oxygen, and you've got medical records supporting the need for it.

Carol: Yeah, OK so as long as my records are intact that's all I need to do.

Angie: Anyone else from CGS on the line, please feel free to speak up if there's anything I missed on that oxygen question.

Carol: Thank you very much.

Angie: Janice, I have unmuted your line. Do you have a question?

Janice: Yes, my question is, I might have misunderstood. If I wanted to check in myCGS to see if a patient had a brace or items, and the patient is from another region, would I not be able to see that?

Angie: Right, the myCGS Portal can only display information on claims that have processed in either Jurisdiction B or Jurisdiction C. CGS is the DME MAC for those jurisdictions, so that's the claim history that we're able to display.

Janice: Ok, as we see patients in region A and region C, I'm actually on both web pages, so, I have the access to do. But occasionally, especially in the summer, we have patients come from other regions, and you're saying that we can't connect to that region, because we don't routine bill the region. How was that protecting the providers?

Angie: So, what you need to do is have that very strong intake process, where you're getting this information from the beneficiary. Where you find out if they have traveled, if they have other addresses, and their permanent address. Do they obtain these items from another supplier in another location? Where you ask them specific questions about their previous equipment. If you have access into Noridian's portal, then you can check their claims history with Noridian. But we don't have the ability

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to share across jurisdictions, as far as different contractors go, claims and information.

Janice: OK, I was double checking that. So, basically, being in the rural area that I'm in, I'm in the DC, Maryland and Virginia area. Technically, now, what I'm hearing, even though you not saying, I'm hearing, I should bounce in both portals, because if a patient comes from another region, I wouldn't know they had a break somewhere else.

Angie: Yes, it's a business decision for you on how you handle your intake and how you verify information with the beneficiary.

Janice: OK, yeah, I know you said not two questions, but I have a follow up to that question. Is region C ever going to consider posting the patient address? Because region A does, and it's very helpful, when the patient don't tell us that they've moved, not to mention that you would be surprised how many patients come into my office and tell me they've never had a brace before. And it's not until I check myCGS that I see that they have.

Angie: I believe that the beneficiary address is something that is on the list of things to consider for a future enhancement. It has been submitted as a request and we are aware of that.

Janice: Alright, thank you.

Angie: OK, Anthony, I see that your hand is raised again. Go ahead.

Anthony: Thank you for taking my second question. This is regarding a physician assistant writing orders, but they are not treating the patient, but they would be knowledgeable of a qualifying event like a surgery or something like that and writing an order. Is that acceptable or do they have to have a face-to-face with the patient?

Angie: Well they need to be treating the patient. The treating practitioner must order the item. Have they not ever seen the patient?

Anthony: No, so it would be like a hospital setting where you know the surgeon has certain protocols following surgery for patients. The physician assistant is writing the orders for post-operative care, but they haven't had contact with the patient. And I'd found conflicting information on CGS and Noridian as to whether or not a physician's assistant can write an order if they know of a qualifying event that took place. They don't have to be the one seeing the patient and the person that is the physician that is treating the patient doesn't have to be the one to write the order. So, I can't get a good, clear sense on either website, whether that is acceptable or not?

Judie: If you would like, I can address this if you'd like, Angie.

Angie: Yes, you can go ahead.

Judie: OK, so this information is actually in the Program Integrity Manual, regarding physician assistant rules concerning orders and certificates of medical necessity. So, they can provide the dispensing order, and, of course, this is a little older, sign a detailed written order if they satisfy all of the following: they meet the definition of a physician assistant, they're treating the beneficiary for the condition for which the item is needed, they're practicing under the supervision of an MD or a DO, they have their own NPI, and they are permitted to perform the services in accordance with their state laws. And it sounds like they are not meeting those Program Integrity manual criteria.

Anthony: Right, I've read that section, and then if you go farther down, there's a section regarding the items listed on the face-to-face master list. And in that paragraph, it says something about—

Judie: OK, so there's no current, face-to-face master list. That was retired a while ago. There is no current master list that requires a face to face except for power mobility devices. Are you providing power mobility devices?

Anthony: No, No. But that's just the paragraph, is that was the confusing part. I read the first section that says they must be seeing the patient, further down it says that it doesn't require face-to-face, so you're saying go with the first section and not the second paragraph,

Judie: 5.8, in the program Integrity Manual, that's the current guidance for physician assistants concerning orders, to be treating. It doesn't say face-to-face. They have to be treating the beneficiary for the condition for which the item is needed.

Anthony: Right. So, they would have to have the clinical documentation that they are seeing the patient clinical notes, or something of that sort.

Judie: They would have to meet all of those five criteria in the program integrity manual, Yes.

Anthony: Great, thank you.

Angie: The next question comes from Cindy. Go ahead, Cindy.

Cindy: Hi, I had a follow up question to the question about the span every year. Does that apply also to parenteral and also it looks like code A4222? If it spans over a year, we no longer have to split that claim, is that what you're saying, for anything?

Angie: Right. There are only certain items that require a date span. Only if it's one of the items that require a date span would you have to even worry about that. But there's no requirement to have to split that claim now. What code did you say?

Cindy: A4222 is another one that is spanned. Um, so I just wanted to confirm that that was across all codes. And then also wanted to make sure that that it's, you know, if a secondary payer requires split, then we would go ahead and split it and just make a note of it. Is that accurate? OK, Thank you very much.

Angie: You're welcome.

> **Note:** A4222 does not require a date span. Refer to the DMEPOS Requiring Claim Span Dates & Claim Narratives chart.

Angie: OK, Pamela, I have unmuted your line.

Pamela: Good afternoon. I have a question regarding PAP resupply. If a patient is receiving supplies and they're not eligible for an item at the time due to the frequency limitation, is it still a requirement that we have to have an ABN to sell it to the patient out of pocket?

Angie: Yes, those do deny with a medical necessity denial, so that would be an ABN situation.

Pamela: OK, thank you.

Angie: You're welcome. Sharon, I've unmuted your line.

Sharon: I just, I didn't have, well, I my question is regarding the telephone discussion for reconsiderations that's ending, and I wondered if there was going to be something else in place, because I have found that very helpful.

Angie: We'll take that suggestion back for consideration, I know that we don't have anything announced right now. So, thank you.

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Sharon: Yes, and then I had another question on workshops and seminars. Have you guys decided when you thought you might start back having a in person workshops?

Angie: As soon as we are able to schedule in person events, again, we will definitely announce that. That will be a huge announcement when we're able to do that, but we do not have any dates at this time.

Sharon: OK, All right! Well, I appreciate your help. Thank you.

Angie: You're welcome. Thank you. OK, Janice, I've unmuted your line. Go ahead.

Janice: My question is prosthetic liners. How many can a patient get within a year? Like if we, we deliver two, and the patient is back within three months because they say they're not working anymore, will Medicare pay for another one?

Angie: Liners fall under the same guidelines as replacements. If they need a replacement, there must be documentation of the reason for the replacement. There's not a reasonable, useful lifetime on those.

Janice: OK, that's wonderful to know. Thank you.

Angie: You will need documentation of the reason for the replacement.

Janice: OK, Thank you.

Angie: You're welcome. Do we have any other questions?

Angie: I just want to remind you that the revised ABN guidelines went into effect October 14th. It's the same ABN but there were some revisions made to the guidelines. There were revisions to some general notice preparation requirements, and also, the period of effectiveness of the ABN for repetitive or continued non covered care. Your ABNs can be effective for the entire 13 months of rental, as long as there's no change in the beneficiary's condition or treatment, or a change in coverage. There were also some changes or revisions made to how the financial liability protection provisions apply to dually eligible individuals. So that would be your QMB or your qualified Medicare beneficiaries. So be sure and read Medlearn Matters Article 12242 for those changes.

Angie: All right, Andy, your phone line is unmuted.

Andy: Fabulous! I wanted to see if I could get some clarification on diabetic shoes, especially at this time of year, where it's end of year, beginning of year. I understand the foot exam from the physician is good for six months, and the shoes need to be delivered within, I believe, it's 45 days of the statement of the Certified Physician. How does that all work out at the end of the year, in the beginning of the year? If we have documentation that's still valid, but the patient, the beneficiary received diabetic shoes with inserts in November or December. Is all that documentation as long as it's within those parameters still valid for a January pair of shoes? Or what's the recommendation there?

Angie: Yes, so the statute is one pair of shoes per calendar year. So, if they obtain shoes at the end of the year, and they want to go ahead and get another pair at the beginning of the year, as long as all of your documentation is within the timeframe, then those evaluations can be used.

Note: A new order is required for the replacement of any shoe. A new order is also required for the replacement of an insert or modification more than one year from the most recent order on file. Refer to Article - Therapeutic Shoes for Persons with Diabetes - Policy Article (A52501) (cms.gov)

Andy: I just wanted to make sure that double dipping was allowed as long as the time parameters within the requirement side were met.

Angie: As long as you meet the requirements of the policy.

Angie: You're welcome.

Angie: Andie, I have unmuted your line.

Andie: Great. I was calling asking about CGMs and BGMs, and I have a patient who received a CGM in 2020 and has been using blood glucose monitor supplies and got a denial on that. I was wondering if can they go backwards basically, from a CGM to a BGM and what kind of documentation is required for that?

Angie: OK, good question. They can, and I will ask someone from CGS to help address this question.

Sheila: This is Sheila Pearson, I'm one of the RN reviewers. You just need to have documentation from their practitioner that the CGM didn't meet their needs or that it didn't work for them. And just paint the picture kind of thing, as to what the problem was, that they need to go back to the BGM and how many times a day they need to be testing. And you would have to go back, if they're going to be tested more than three times a day for an insulin dependent, you'd need to document all of that. As long as you've got documentation from the physician that says that the CGM is not working for the beneficiary anymore and they need to go back.

Note: Changing back to standard BGM testing and supplies is allowed without additional documentation of medical necessity, other than documentation of a diabetes diagnosis. Refer to Billing Reminder: Blood Glucose Monitor Supplies and Continuous Glucose Monitor Supplies - Switching (https://www.cgsmedicare.com)

Andie: Can I tag another one? About the sensor and history through myCGS. And, showing a history for those, I was able to pull up, same or similar for the reader, but not anything on the sensor history, on how often they've been receiving, lifetime, et cetera.

Angie: You should be able to pull claims history in myCGS.

Andie: Would it be under the diabetic supplies?

Angie: You can look for claims history, for all claims that have been filed under Claims History. You can either search by specific HCPCS or you can also do a wildcard search and just use the first letter with an asterisk.

Andie: OK, thank you so much.

Angie: You're welcome, also there is an article that you can refer to that was published in May about the CGMs.

Andie: Thank you.

Angie: All right, Carol, I'm going to try to unmute your phone line again

Carol: OK, I'm on the phone this time around. So, on the oxygen when we are billing either a break in need or break in service, I'm back to the CR and the COVID because I know they're gonna ask me these questions as well. So, with the CR code and COVID, and then at that point, put any narrative in that? Or if it's the five-year replacement and they want oxygen at this point, a new concentrator and portable.

Angie: If you're using the CR modifier because of the COVID-19 PHE, the narrative needs to include COVID-19.

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Carol: So, even if I use the CR modifier and just the COVID narrative or do I still need to put in for the break in need or break in service? Showing that it's not, that it's just sort of a new capped rental.

Angie: Now, if it's a replacement, you would follow your normal guidelines to show whatever information for the replacement as well.

Carol: But if it's a break in, if there was a break in need, and break in service, and they are starting a new capped rental, can I do the CR modifier?

Angie: Now, you'll use the CR Modifier and the narrative if you are following the PHE waiver requirements because you don't have the CMN and you don't have everything that meets the requirements in the policy. Other guidelines would still, you would still need to look at what other information you're needing on the claim, as far as telling us, so that we can start the new capped rental period if it's a replacement situation, or if we need to extend the rental period.

Carol: OK, that answers my questions, thank you.

Angie: Anne, your line is unmuted.

Anne: I had a denial on CPAP supplies for over usage, and I had went through myCGS, I looked at the history, didn't see any other supplier, and I looked through my history. Then, when I called the Customer Service Line, this is what they had told me: She says, I'm sorry, because I said, can you tell me what it's conflicting against? Because maybe I'm missing something. She says, I'm sorry you should have known what it's being denied against. We're not allowed to tell you that. So, I said, Well, I would like to talk to a level two. She said, I am a level two. So, I said, well, I would like for your supervisor to call me, and I haven't received a call back, but I just want to verify, is that correct information? I mean, to me, you would think they would say, OK, you're A7035 is conflicting against supplier A, or it's conflicting against what you had billed. From everything I was looking at, to me, it looked like it was being denied an error. Because she couldn't even give me an answer.

Angie: The call center, they should be able to help you with explaining the reason for the denial.

Anne: What she said was, overutilization, and that was it. I couldn't tell you. The way she said it to me. I cannot tell you when it's conflicting again, you should know that yourself.

Angie: Yes, they should provide the information for your specific claim denial reason and information to help you understand the denial. I apologize, I don't know what may have been involved in that conversation, but they should be able to help you with that.

Anne: OK, alright, thank you so much, I just wanted to re verify that.

Angie: You're welcome.

Angie: I don't see any other questions in the queue, and we are at the end of the hour, so I do thank everyone for your attendance today. Thank you to all our panelists that helped answer questions and we will publish the transcript in the next 30 days.

Thank you.

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