Ask-the-Contractor Teleconferences (ACT)

Provider Outreach & Education
Date: August 25, 2020

Moderator: Judie Roan
Time: 1:00 p.m. CST

Introduction

Good afternoon and welcome to CGS Administrators DME MAC Jurisdiction C General "Ask the Contractor Teleconference." These ACT calls are hosted by the DME MAC Provider Outreach and Education team for Jurisdiction C. My name is Judie Roan, and on the call this afternoon are Jurisdiction C subject matter experts from CGS Medical Review and various operational departments. For this ACT call, you are welcome to ask questions related to recent Medicare updates.

The latest DME MAC Jurisdiction C News is located under the News section of the CGS Web site. Please note this call is being recorded and we will post a transcript to our website within 30 business days. We will send a listserv to notify you when it is posted.

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

Revised Advance Beneficiary Notice of Noncoverage (ABN) and Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFs)

The Advance Beneficiary Notice (ABN) and form instructions, Certificates of Medical Necessity (CMNs) and DME Information Forms have been renewed, and you will need to use the updated forms. The updated forms can be identified by the new expiration dates.

The renewed ABN Form CMS-R-131 with the expiration date of 06/30/2023 will be mandatory on 01/01/2021. The ABN form and instructions may be found on the Forms section of the CGS website.

The revised CMN and DIF forms have an expiration date of February 2024 and are also located on the Forms section of the CGS website.

COVID-19 DME MAC Contractor Guidance

On the CGS JC home page we have a link dedicated specifically to the COVID-19 Public Health Emergency (PHE). This section includes guidance for DMEPOS suppliers on the proper use of the CR modifier and the COVID-19 narrative and proper use of the KX modifier during the COVID-19 PHE.

Suppliers are reminded to append a CR modifier and include a narrative of "COVID-19" to all claims that are affected by the COVID-19 PHE. The narrative should be entered in to the NTE 2400 (line note) or NTE 2300 (claim note) segments of the American National Standard Institute (ANSI X12) format, field 390-BM of the National Council for Prescription Drug Program (NCPDP) format, or Item 19 of paper claims. You can access the COVID-19 information and claim submission instructions through COVID-19 at the top of the left navigation panel on the CGS website.

MACs Resume Medical Review on a Post-Payment Basis

To protect the Medicare Trust Fund against inappropriate payments, Medicare Administrative Contractors (MACs) are resuming fee-for-service medical review activities. Beginning August 17, the MACs are resuming post-payment reviews of items/services provided before March 1, 2020. The Targeted Probe and Educate program will restart at a later date. The MACs will continue to offer detailed review decisions and education as appropriate.

Notification was issued on August 12 that Jurisdiction C will conduct post-pay service-specific medical reviews of HCPCS Code A4253 (BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOM`E BLOOD GLUCOSE MONITOR, PER 50 STRIPS) and HCPCS Code L0650 (Lumbar-sacral orthosis).

These reviews will be conducted because data analysis revealed that Jurisdiction C's allowed dollars for these HCPCS Codes were significantly above expected amounts. Additionally, the Glucose Monitor policy group ranked #9 in total CERT errors, and the Spinal Orthosis policy group ranked #3 in total CERT errors.

Suppliers will be allowed 45 days to respond to the request for additional documentation.

Condition of Payment Prior Authorization

CMS is resuming condition of payment prior authorization requirements for Power Mobility Devices (PMD) and Pressure Reducing Support Surfaces (PRSS). Prior authorization for these items is required for claims with an initial date of service on or after August 3, 2020.

Lower Limb Prosthetics (LLP) Prior Authorization

Prior authorization will be required for certain LLPs (HCPCS codes L5856, L5857, L5858, L5973, L5980, and L5987), with dates of service on or after September 1, 2020, in California, Michigan, Pennsylvania, and Texas. CGS began accepting requests for Michigan and Texas on August 18, 2020

On December 1, 2020, prior authorization for these codes will be required for all the remaining states and territories.

There are many helpful resources on the prior authorization pages under the Medical Review section of the CGS website.

Insulin Infusion Pumps with Integrated Continuous Glucose Sensing Capabilities and Related Accessories/Supplies

Effective for claims with Dates of Service (DOS) on or after September 15, 2020, the following codes are invalid for submission to Medicare:

Originated September 10, 2020.

CGS® A CELERIAN GROUP COMPANY

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

E0787	EXTERNAL AMBULATORY INFUSION PUMP, INSULIN, DOSAGE RATE ADJUSTMENT USING THERAPEUTIC CONTINUOUS GLUCOSE SENSING
A4226	SUPPLIES FOR MAINTENANCE OF INSULIN INFUSION PUMP WITH DOSAGE RATE ADJUSTMENT USING THERAPEUTIC CONTINUOUS GLUCOSE SENSING, PER WEEK

Suppliers must bill codes E0784 and K0554 with the RR (rental) modifier when these codes are used to describe the product previously coded as E0787. A news article was published on July 20th about this.

KU Modifier Claim Reopening Requests

The Further Consolidated Appropriations Act mandates the non-application of fee schedule adjustments based on information from competitive bidding programs for wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with complex rehabilitative manual wheelchairs (HCPCS codes E1161, E1231, E1232, E1233, E1234 and K0005) and certain manual wheelchairs described by HCPCS codes E1235, E1236, E1237, E1238, and K0008 during the period beginning on January 1, 2020 and ending June 30, 2021.

DME suppliers may begin submitting reopening requests to add the KU modifier to certain accessories furnished in connection with certain manual wheelchairs (E1161, E1231-E1238, K0005, and K0008).

For a complete list of the accessory codes eligible for reopening refer to CR 11635 Claims for these accessories submitted prior to July 1, 2020, with dates of service January 1, 2020 through June 30, 2020, without the KU modifier **must be** submitted as claims reopenings to receive the unadjusted fee schedule amounts. Refer to the article published on July 17.

Coronavirus Aid, Relief, and Economic Security Act (CARES Act) Adjustments and Modifier Usage

MLN Matters article MM11784 informs suppliers that Section 3712(b) of the CARES Act increases the non-rural fee schedule amounts for HCPCS codes for DMEPOS items that are adjusted based on payments determined under the DMEPOS Competitive Bidding Program. Medicare will use these schedules to pay for these items provided on or after March 6, 2020 through the end of the COVID-19 Public Health Emergency (PHE).

The KE modifier (non-rural fee schedules for items bid in the initial Round 1 CBP) has been added back to the fee schedule file for the length of the PHE. See Attachments A and B of CR 11784 for a list of HCPCS codes and modifiers impacted by these changes. This information can be found in the July 27 article found on the CGS website under news & publications.

No immediate action is needed for suppliers to receive the increased fee schedule amounts. For dates of service from March 6, 2020 through April 22, 2020, the DME MACs will automatically reprocess affected claims to pay the higher blended 75/25 non-rural fees if the following is true:

- The date of service is between March 6, 2020, through April 22, 2020
- The HCPCS/Modifier combination is on the list in **Attachment A** of CR 11784 and
- The claim line was previously paid

After the DME MACs have completed the **automated adjustments**, the DME MACs will adjust claims for the KE modifier with dates of service beginning March 6, 2020 when brought to the attention of the DME MACs by suppliers for HCPCS/Modifier combinations in **Attachment B** of CR 11784.

The DME MACs will notify suppliers via listserv once the automated adjustments are completed and provide further instructions for requesting the KE modifier reopening/adjustment. Additional information can be found in the July 27 article found on the CGS website under news & publications.

Correct Coding and Coverage of Ventilators

Ventilator technology has evolved to the point where it is possible to have a single device capable of operating in numerous modes, from basic continuous positive pressure (CPAP and bi-level PAP) to traditional pressure and volume ventilator modes. Similarly, the product coded E0467 adds capabilities beyond these ventilator modes to incorporate the functionality of suction, oxygen concentration, nebulization, and cough stimulation. This creates the possibility that one piece of equipment may be able to replace numerous and different pieces of equipment. Equipment with multifunction capability creates the possibility of errors in claims submitted for these items.

For E0467 claims with dates of service before April 3, 2020:

Claims for any of the included HCPCS codes that are submitted on the same claim or that overlap any date(s) of service for E0467 is considered to be unbundling.

In addition, any claim for repair (HCPCS code K0739 for labor and any HCPCS code for replacement items) of beneficiary-owned equipment identified by HCPCS codes listed above is considered as unbundling if the date(s) of service for the repair overlaps any date(s) of service for code E0467.

Claims for code E0467 with a date(s) of service that overlaps date(s) of service for any of the following scenarios are considered as a claim for same or similar equipment when the beneficiary:

- Is currently in a rental month for any of the items included in the function of the E0467
- Owns any of the equipment included in the function of the E0467 that has not reached the end of its reasonable useful lifetime.

For E0467 claims with dates of service on or after April 3, 2020:

Any claim for repair (HCPCS code K0739 for labor and any HCPCS code for replacement items) of beneficiary-owned equipment identified by the related codes is considered as unbundling if the date(s) of service for the repair overlaps any date(s) of service for code E0467.

Claims for code E0467 with a date(s) of service that overlaps date(s) of service in a rental month for any of the listed codes is considered as a claim for same or similar equipment.

Suppliers are encouraged to be sure that the correct category of product is provided and billed to avoid errors in HCPCS coding.

Educational Opportunities

I would like to take this opportunity to speak about our online education courses we have available for you at CGS.

Originated September 10, 2020

The online education courses are easy to find on our website at cgsmedicare.com on the left hand navigation panel under the Education link. You can simply select the Online Education Portal link or select the Online Education icon under the education tab.

The online education portal is available to you 24 hours a day seven days a week at no charge.

We offer over 30 course titles; this a great resource for new employees and ongoing education for your seasoned staff. Also we are continuing to add additional policy specific courses in the near future.

If you have not taken the opportunity to view the online course titles I encourage you to do so.

Online Tools & Calculators

CGS takes pride in our Online Tools & Calculators available to our supplier community. We currently offer 38 online tools; of those four are new tools.

The Same/Similar Tool displays the HCPCS codes that may cause a denial if billed with a particular base item. The Therapeutic Shoes for Persons with Diabetes Activity Timeline – Provides documentation and activity timeline regarding diabetic shoes. The Advanced Modifier Engine (AME) helps you bill the proper HCPCS codes and modifier combinations for DMEPOS in specific billing scenarios, and the Overpayment Interest Calculator – Simply enter the date on the Demand Letter, the overpayment amount; the interest rate and the date your check is being mailed to find the total amount due.

All CGS Online Tools & Calculators can be found on the CGS website left hand navigation panel.

myCGS Web Portal

myCGS Web Portal Claim Correction

If you need to make a simple claim correction to a completed claim, you can do so using the Claim Correction function in myCGS Web portal. This is similar to a telephone reopening but done in the Web portal instead of over the telephone. Only minor corrections can be completed through the claim correction process.

myCGS Web Portal – Reopenings

You would use the reopenings process if you are looking to resolve minor clerical errors such as:

Add modifiers to your claim (excluding those that assign liability). Correct a HCPCS code, correct an invalid diagnosis or diagnosis reference, such as the pointer on the claim, or correct the units of service.

Be sure your request specifies what change or changes you would like to make. Please pay particular attention to the 2nd bullet: I cannot emphasize enough that all reopenings must be completed within one year of the remittance advice date.

myCGS Web Portal – Redeterminations

Now we come to appeals, specifically the first level of appeals, Redeterminations. Redeterminations can now be submitted via the myCGS Web portal. They must be requested within 120 days from the date of the initial determination communicated to you via a remittance advice or overpayment demand letter

If you need to revise a liability indicating modifier such as (KX, GA, GY, and/or GZ modifiers), or you wish to dispute a not reasonable and necessary denial; you would submit a redetermination request.

You can attach supporting documentation with your redetermination submission in myCGS.

myCGS Web Portal Additional Features & Functions

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

For ADMC and Prior Authorization Status and Submission, you can submit ADMC and Prior Authorization request and check their status directly through myCGS

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. To raise your hand, simply click on the icon of the hand. Then, I will announce you and unmute your individual line so that you can ask a question. Also, remember that no specific claim information or Medicare beneficiary's private health information should be verbalized. I will now give you just a moment to prepare your questions.

Judie: Okay, we have received some questions. The first question comes from the line of Dominick. Dominick you line is off mute, go right ahead.

Dominick: Yes, my question is, we're a new supplier, when we submitted a claim when it has RR, for months two through thirteen do I use new dates, or dates of service?

Judie: I'm so sorry, you broke up a little bit there at the end. What exactly is your question?

Dominick: Ok, when submitting claims for months two through thirteen, do I use new dates of service for the new months on a claim that had RR on it.

Judie: Yes, you would add the anniversary date for every month of rental. So, if you initially provided the item on January 1st of 2020 and it's a capped rental item, you would then bill for February 1st of the following month, and then March. You would also want to confirm that you're billing the correct modifiers.

Dominick: Yes, and just do that on a monthly basis?

Judie: That is correct, for a rental item or capped rental item, yes. It would need to be submitted on a monthly basis.

Dominick: Then another question is which fee schedule do we use? Like the fee schedule that's on the CMS website or the CGS website, or the competitive bidding CMS round 2021.

Judie: It would depend on the item you were providing, but the competitive bidding round 2021 has not started yet and it will not start until, I believe, January. So, you would use the DMEPOS current Fee Schedule from the Fee Schedule section of the Jurisdiction C or the CGS website.

Dominick: Got it, thank you so much.

Judie: Okay, you're welcome. I'm going to go ahead and mute your line and put your hand down. Okay, now is your opportunity to ask any questions about any of the material we've covered or any additional questions you may have. Okay, Gabriella, your line is off mute, go right ahead.

Originated September 10, 2020

Gabriella: Hi, good afternoon, my question is regarding the E0277, powered pressure reducing air mattress. We submitted a prior authorization or review request, and we received a denial, basically because the patient has a stage three. However, the reason for the denial states the measurements given do not reflect the size of a large pressure ulcer. So, my question is the LCD does not indicate measurements, so how do we consider what's large in regard to an ulcer in regard to the measurements?

Judie: That information is going to be based on what's documented in the medical record. Did the beneficiary have any additional conditions or additional wounds, or was it just the one wound that you provided, or did you provide measurements?

Gabriella: We did provide the measurements, and the patient does have a stage three in the right buttocks, and it does have the measurements and basically the description of the wound. However, it, the reviewer denied it because the measurements do not reflect the size of a large pressure ulcer. But how do we know what 's the size of a large pressure ulcer? The LCD doesn't indicate, you know, what are the measurements that they're referring to. You know, there's not starting point.

Judie: Okay, I understand what you're stating. Give me one moment, or does anyone on the line, since we have quite a bit of CGS staff, anyone on the line want to add anything?

Dr. Hoover: This is Dr. Hoover. We generally consider, we don't have a size in there because we take into account other factors like tunneling and undermining the location of the wound, and so forth. Generally, when you ask wound care nurses what they consider large, in general terms we would say 2 cm by 2 cm. But again, that can be modified by tunneling, undermining, some of these other factors that impact wound healing.

Clarification provided after the teleconference: While one stage III or IV pressure ulcer on the trunk or pelvis may qualify a beneficiary for group 2 support surface coverage, the policy states that this single ulcer must be a "large ulcer." The Jurisdiction C DME MAC Medical Review staff, when reviewing medical records, generally considers any wound of 8 square centimeters (length X width) or more as meeting the definition of "large." Other wounds are considered individually. We take into account, for example, whether undermining and/or tunneling are present, the anatomic location on the body and the size of the patient. This information is available at: https://www.cgsmedicare.com/jc/pubs/news/2008/1008/cope8653.html

Gabriella: Okay, perfect. That answers that question. And furthermore, I have an additional question regarding this same scenario. Another reason why it was denied is because the Standard Written Order, the SWO, is missing a detailed description of the item. However, based on literature, it is my understanding that we do not have to have a detailed description. So, the order actually stated air mattress, however the reviewer denied it for not detailed. Has that changed?

Judie: Again, without being able to look at that specific order, I cannot say that it didn't meet the requirements. Do you utilize the documentation checklists, available under prior authorization, to make sure that your claim meets all of the documentation requirements prior to submitting your prior auth?

Gabriella: Okay. The order was included, and it does say hospital bed with air mattress, so I'm just wondering if air mattress is not sufficient enough.

Judie: Well, it is. A general description is acceptable. It can be a general description, a HCPCS code, a HCPCS code narrative, or a brand name and model number. So, any of those are acceptable. So, I would definitely want to take a look, to see exactly what your specific order stated. But it does need to be specific so we can identify what you're actually providing. Because air mattress could be a group I or a group II, or a group III. So, we would want to be specific to identify the actual mattress that you're providing. But it can be a general description, but it does need to be clear what item the beneficiary is going to need.

Gabriella: Okay.

Dr. Hoover: This is Dr. Hoover again. I think Judie makes a very good point that, you know, I really encourage all suppliers to be as specific as possible. While CMS and the federal register notice said we do allow a general description of the item, one of the things that medical review does in part of their review of claims is not only looking at medical necessity, but also correct coding. And it makes it very difficult to do correct coding tasks with a general description of the item. In most cases, the supplier is preparing the Standard Written Order for the physician's signature. And so, if that's the case, you know the specific information about the item that's being provided, and we strongly encourage you to put that specific information in your Standard Written Order.

Gabriella: Okay, perfect. Thank you so much.

Judie: Thank you so much, Dr. Hoover. Do you have any other questions, Gabriella?

Gabriella: No, that was it. Thank you so much.

Judie: Okay, thank you. Okay, Julie, your line is off mute, go right ahead.

Julie: Yeah, thank you so much. One of the questions I had was for oxygen under Group I criteria. I have a patient who was qualified, and the doctor's office qualified them using the three tests. They were 89% at rest, they did the exercise test and they did desat to 84 during exercise without oxygen. They placed them back on oxygen while continuing to walk, but the note the third test documents 91 to 92%. I remember a couple years back at the Medicare meeting in Nashville, we were told that it couldn't be a range, that it had to be a specific percentage. So, in talking with this referral source, they asked me to find out where that was documented. I can't seem to find it anywhere, in the LCD or Documentation Checklists, or Policy Article. So, I was just wondering am I asking for something I don't need to ask for, or does it have to be a single percentage and not a range. And if so, is there anywhere that's documented where I could provide that for them?

Denise: Yeah, and that's something you do have to have the specific test result. You can't have a range. So, I'm not sure if it's even documented in the LCD, I don't think it is. But we need to have the specific test result, we can't do ranges.

Julie: Right, and that's what I thought. For this specific referral who wants proof that I'm not lying and that this is CMS' guidelines. Is there any place that I could take them or show them? Because you're right, I cannot find it in the LCD anywhere, and it's not on your Documentation Checklists.

Denise: If you want to send us an email, we could reply to your email letting you know that.

Julie: Okay, yeah that would be great. Just anything that would be helpful.

Denise: Yeah, so you could just send it to the cgs.jbjc.learningondemand@cgsadmin.com, do you have that email address?

Originated September 10, 2020

Julie: I do, yes.

Denise: Alright, great.

Julie: Thank you.

Denise: You're welcome.

Judie: Thank you Julie, do you have any additional questions?

Julie: Nope, that's it. I appreciate it.

Judie: Alright, I'm going to re-mute your line and put your hand down. Okay, I'm not seeing any other questions in queue at this time. So again, if you have any other questions about the material that we have covered or any questions to ask the contractor, go ahead and raise your hand and we will unmute your line. I'll give you a moment to gather your questions. Beverly go right ahead; your line is off mute.

Beverly: I'm sorry I missed at the very beginning where you were talking about the CMN form. Is that going to be, was that the form that you said was going to be mandatory as of January 21st?

Judie: No, that is the Advance Beneficiary Notice of Noncoverage (ABN) that is mandatory for use on January 1st of 2021. We would strongly suggest that every time you used an ABN, you want to go out and get that most recent form. CMNs and DIFs have been updated, and you could start using those as soon as possible. We have not received a required date or mandatory date as of yet.

Beverly: Okay. Thank you so much.

Judie: You're welcome, thank you. I'll re-mute your line and lower your hand. Great question. We've received lots of great questions so far. Anyone who has any questions, go ahead and raise your hand and we would be more than happy to answer them. Again, CGS is here to answer any questions that you may have regarding any of the material that we covered or any questions regarding the DME MAC, whatsoever. Okay, Kristin, I do see that your hand is raised, but you do need to enter your PIN number into your telephone, so I have resent you your PIN number. Okay, great, I see you've entered your PIN. Kristin your line is off mute, go right ahead.

Kristin: Okay. I have a question about qualifying oxygen and when a physician writes or has the patient that 6 liters or some of the time, lets go a little lower because it's a different scenario, or 4 liters. And they want us to wean their stats, or let's say they're at 2 liters and at times they need 4 liters. How is that written acceptable on CMNs?

Judie: Just to clarify your question, has different liter flows at different periods, I'm assuming during the day, how do you document that on the Certificate of Medical Necessity? Is that your question?

Kristin: Yes, it is.

Judie: Okay, we do have an article about how to address liter flow issues. I can identify that article. Just give us one moment to obtain that article for you and provide you that resource.

Kristin: Sure, thank you. While you're looking for that, does that work up as well as down? Like if I have a patient that has a pulse oximeter and they're on oxygen and they go to desaturate. The doctor wants to write a prescription that they can increase the oxygen as well as an order to wean. Does that article cover both scenarios?

Denise: Judie, it's Denise, and hi Kristin. Is your scenario if the beneficiary has different daytime and nighttime oxygen flow rates, that's what you were stating to Judie before. That's where you're going to use the average documented flow requirement from daytime when they're at rest and the flow rate from the oxygen at night. So, you're going to use the average in there for that. That's where those new modifiers came into play, the QA and QB modifiers, QE, QF. Are you familiar with that Kristin?

Note added after the teleconference: Physician's should follow the instructions on the CMN for question 5: Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter an "X".

Kristin: Yeah. Yes ma'am, thank you.

Denise: Okay. You're welcome. And what was your other question? I apologize.

Kristin: So, if I have a patient, for example, a patient that has a pulse oximeter, and their normal resting liter flow is at 2 liters. But if they were to desaturate to the low 80s, a doctor could write an order to increase their oxygen level to compensate for that desaturation.

Denise: Right. That's correct. They'd have to have, I'm sure they would of course be getting a new test to show that they are desaturating. That new test if you were audited would need to be provided as well, but the new order as well for the increase in liter flow. There's actually, in the LCD on that, Kristin, it does give you scenarios as to when a revised CMN is required and needs to be submitted or just to be on file. So, they are out there for you to review as well.

Judie: There is also an article, dated September 27, 2018 regarding revised billing instruction with the Q modifiers and medical documentation that can assist with that. Kristin's line is muted. I'm sorry Kristin, your line got muted. Go right ahead. Did you have an additional question, or did that answer your questions?

Note added after the teleconference: The referenced article is located at: https://www.cgsmedicare.com/jc/pubs/news/2018/0918/cope9338.html

Kristin: I think that answers it, thank you.

Judie: Okay, you're welcome. Sorry, I don't know how you got muted. Sorry about that. Thank you. I'm going to go ahead and put your hand down. Okay, I don't see any hands raised at this point. So again, if anyone has any questions. It looks like Gabriella has a question. Gabriella, your line is off mute. Go right ahead.

Gabriella: Yes, hi. It's me again. So, I have two questions. We just actually received a referral for an oxygen patient and the medical documentation actually states hypoxemia, possible COPD. However, the COPD has not been, you know, diagnosed. It just says possible COPD. Would that be qualifying, can we go with that? Or does it have to be confirmed that he does have COPD?

Denise: Gabriella, this is Denise. It has to be a confirmed lung condition. There has to be some kind of diagnosis of a severe lung condition.

Gabriella: Right, and hypoxemia is just a symptom. So, it has to be something that will cause that hypoxemia, which will be the COPD. They haven't really confirmed it.

Denise: Right. The treatments for the COPD first, the alternative treatments which is in the LCD, tried first before ordering oxygen.

Originated September 10, 2020

Gabriella: Okay, perfect. So that was one question, and then my second question is regarding the PHE. I know there hasn't been, I'm not sure if there has been new guidance on how or when they're going to resume the auditing. I know there are some LCDs that are not being enforced. So, I was just wondering if there's any new information regarding that, and if they're going to start auditing retroactively, during the, you know…

Judie: Okay. Actually, two separate questions. First, regarding the policies or LCDs that are not being enforced during the PHE, we have not received a date on when that's going to end.

Gabriella: Okay.

Judie: Okay. So, the second question, regarding the medical review audits, so I'm assuming you're referring to Recovery Auditor, as well as CERT. So, we have begun to resume so post payment audits at the DME MACs. And it's going to be for items and services provided before March 1st.

Gabriella: Okay.

Judie: And that's for A4253, which is blood glucose test strips, and L0650 which is the lumbar-sacral orthosis or spinal orthoses.

Gabriella: Okay, so you're starting with those two codes.

Judie: That is correct for post-pay.

Gabriella: Okay, awesome.

Judie: Okay. And additional information will be sent out through listserv and available on our website as things come out.

Gabriella: Okay, great. Thank you.

Judie: No, thank you. Great question. Okay, I'll go ahead and put your hand down. Okay, Julie, your line is off mute. Go right ahead.

Julie: Yes, I had a question regarding replacement of PAP devices. We had an order come over for a replacement device. Same and similar showed that the patient had a PAP machine that was paid for by Medicare about seven years ago, but the provider has gone out of business, the sleep center has gone out of business, and we have not been able to get a copy of the sleep study. Since the device was paid for by Medicare, is that treated differently as far as like, can I assume, do you assume that the patient's sleep study qualified then, because the original machine was paid for by Medicare? Or do I have to have a copy of that qualifying sleep study? And if not, the patient has to go back and get another sleep study?

Denise: Hi Julie, this is Denise. Medicare paid for the original device, and you're replacing it after five years, right?

Julie: Correct.

Denise: And there's no gap in between anywhere, they've been consistently using that and been compliant with the…

Julie: Yes.

Denise. Yeah, you do not need the sleep study at that point.

Julie: Okay, that's what I thought. I just wanted to make extra sure. Thank you, Denise. I appreciate it. That was my only question.

Denise: Okay, you're welcome.

Judie: Okay, great. Thank you very much Julie and Denise. I'm going to go ahead and re-mute your line and put your hand down. I know we've covered quite a bit of information throughout the beginning of the presentation. Do you have any questions, again, about anything we've previously covered or any questions for the DME MAC? Okay, Lisa, go right ahead, your line's off mute.

Lisa: Is this for Lisa?

Judie: Yeah, that's for you.

Lisa: Okay, thank you. So, if Medicare pays for the PAP unit for five years, we don't have to have another sleep study? Say another company purchased it, or another company gave it to them, and now they're coming to us because they need a new PAP machine? We wouldn't have to have the sleep study on file? Or did I misunderstand that last question?

Denise: No, if Medicare paid for it, and we already paid for the PAP device and you're replacing it after the five years, you don't have to get a new sleep study. You do have to have access to it, I should say. Do you have access to that sleep study?

Lisa: No, because the business closed, so we can't get to it that way.

Denise: You don't have to get a new one as long as we paid for it. There does have to be, again, a visit with the physician. That has to be done, but the sleep study does not have to be done.

Lisa: So, I would just need the face to face from the doctor stating the patient...

Denise: Showing that the patient has OSA, and that they're compliant with the PAP device.

Lisa: Oh, I'll make note of that. I did not know that. Thank you.

Denise: You're welcome.

Judie: Okay, great question. Thank you very much, Lisa. Let me go ahead and re-mute your line, and thank you for putting your hand down, Lisa. Okay, we do have about ten more minutes, so please feel free to ask any questions that you may have. Carol, your line is off mute, go right ahead.

Carol: Okay, I have a question regarding enteral and parenteral delivering, versus discharge from a hospital. Patient's due to discharge today, they're due for a feeding at 5:00 this evening. So, we naturally would get everything together, and get it over to the home. It turns out the patient was not discharged on that given day, on today's date. My question now, is it, what can we do with that delivery? It's a product that we cannot take back because it is enteral nutrition, or it is the TPN for parenteral. But the understanding here has always been that if we deliver a day or two prior to discharge, it is strictly for training purposes. Home health in most cases goes out to train these patients on the equipment. So, can I or can I not bill my enteral or parenteral for the date of discharge?

Judie: When was the beneficiary discharged?

Carol: Okay, one to two days later. I haven't verified that, it kind of came up today, and I've always questioned whether or not that is something that should be billable, and I've always been told we can never bill it, because of that, because it's something that's delivered ahead of time, so that the patient, so it can be for teaching and training. Okay, in these cases it's not quite the same thing. Mostly, either the patients already know how to use it, because they've been on it prior, or the home health is usually involved with these types of patients. So, they do all the teaching, instructing, and sometimes they actually run all, say the TPN. So that's where I run into an issue and I really need some clarification. If they were supposed to get out yesterday

Originated September 10, 2020

and we delivered, based on the fact that they were supposed to get out, and then there at the end, they didn't. They got out today. Could I bill starting from today?

Judie: You can provide the item to the beneficiary's home in anticipation of discharge, within that 48-hour period. If the beneficiary is not discharged when they were initially supposed to, you can bill the date of discharge as your initial date of service.

Carol: Even though it's for enteral, because they always had to, the people here always said no, we can't do that, and I always thought it was two days regardless. We can't control the discharge date. So, regardless, even though it's enteral or parenteral, we can adjust it?

Judie: Yes. Does anyone else have any feedback on that from CGS' side? Yes, absolutely.

Carol: Okay, wonderful.

Judie: You're welcome, thank you so much.

Dr. Hoover: This is Dr. Hoover. Just one, you raised a good point, and it's critical that suppliers stay in communication with the discharge planners at the hospital to coordinate and make sure that, you know, before something is delivered that your aware of any potential delays and situations that might, you might be required to modify your date of service, in order to avoid a denial for overlapping Part A stay.

Carol: Okay, wonderful. So, that is good to do. Thank you very much. That's been very helpful.

Judie: Good. Thank you, I'm going to re-mute your line, Carol. Thank you. Okay, I'm not seeing any additional questions at this time. We do have a few more minutes. So, it looks like some of you are attending just to hear other suppliers' questions. If you've not heard a question that you've wanted to ask, please don't hesitate to do so. That's why we're here, to address and answer any questions that you have. And again, if you don't know how to ask a question, you can just go ahead and raise your hand. If your hand is down, it is green. If your hand is raised, you'll see a red icon. Ok, Renae, your line is off mute. I see you put your hand down. Do you have a question, Renae? No? Okay, I'm going to just re-mute your line. If you do have another question, or you do have a question, I'll go ahead and re-raise your hand unmute your line again. Okay, we'll try again. Renae, do you have a question? Okay, you've self muted yourself if you do. Okay, you're off mute Renae. Okay, may have just been trying out that hand option. I don't see any additional questions at this time. So, I'll give it another minute or two.

Dr. Hoover: Judie, you may want to give that email address again for the Provider Outreach and Education question line, just for those people that may come up with a question after the call, that want to ask.

Judie: Absolutely, and another option is, that information is available under Community Coaches on the CGS section website. All of your Community Coach resources are available, again, under education, and that Web address is also located there. And if you would like to send an email to the outreach team, the email address is cgs.jbjc.learningondemand@cgsadmin.com. That information will also be available in transcript from today's call. Denise, did you have something?

Denise: I'm sorry, yes. I just wanted to let everybody know, I sent them the email address through chat, so everybody has that as well.

Judie: Great, thank you very much, Denise. Okay, looks like Lisa has a question. Lisa, your line is off mute. Go right ahead.

Lisa: Do you know when the transcript for the call will be available for us?

Judie: Yes, it is required to be available within 30 business days. Usually it's much quicker than that, but we'll send you a listserv just as soon as it posts.

Lisa: Awesome, thank you so much.

Judie: You're welcome, great question. Okay, let's see. We have time for one more question. So, if anyone has a question, this is your last chance. Okay, let's see if we have anyone. Okay, I do see Renae's hand up again. Renae, go right ahead.

Renae: Can you hear me this time?

Judie: I can hear you now.

Renae: Okay, thank you so much. I was calling, we just recently started doing negative pressure wound therapy, and for audit purposes, if they're documenting the patient is diabetic, but at this point they're also documenting, say chronic three or four pressure ulcers. Do we need to satisfy all of those requirements for like number one and number two, the chronic stage three and four, and diabetic patients that have turned, is on a comprehensive diabetic management program, etc. Do we need to meet all of those requirements then, or do we fall back to the root cause of the actual ulcers, say the diabetes? Does that make sense?

Judie: Yes, it does. So, the complete wound therapy described in criteria one and two, three, or four has to be met. So, the documentation to substantiate that must be available.

Renae: Right, okay. So, you're saying that we would fall back to the root cause and we would try to satisfy the number two, the diabetic ulcer requirements.

Judie: You want to meet all the, it's criterion one and two, three, or four. So, you want to make sure they meet criterion one, and two, three, or four. So, you want to have documentation of both in the negative wound pressure therapy LCD.

Renae: Okay.

Judie: Does that make sense? You sound more confused. That's the last thing I want to do is confuse you more.

Renae: No, you're fine. We do all auditing, so I just want to make sure that when I'm writing these audits that I'm satisfying the requirements.

Judie: Yep. So, you want to confirm that there is documentation to substantiate criterion one in the NPWT LCD, as well as two, three, or four.

Renae: Okay, alright. Thank you so much, I appreciate your help.

Judie: You're welcome. Great question.

Renae: Have a good day.

Judie: You too, thank you. And it looks like we are about out of time. So, I would again like to thank you all so much for attending today and participating through asking all of your great questions. Again, we will post a copy of this transcript to our website, and send out a listserv when it is available. So again, 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.

Originated September 10, 2020