Ask-the-Contractor Teleconferences (ACT)

Provider Outreach & Education
Date: November 18, 2020

Moderator: Lisa Addison
Time: 1:00 p.m. CST

Introduction

Good afternoon and welcome to CGS Administrators, LLC (CGS) DME MAC Jurisdiction C Widespread Post-Pay Service Specific Reviews "Ask the Contractor Teleconference" (ACT). These ACT calls are hosted by the DME MAC Provider Outreach and Education team for Jurisdiction C. My name is Lisa Addison, and on the call this afternoon are Jurisdiction C subject matter experts from CGS Medical Review department and various operational areas. For this ACT call, you are welcome to ask questions specifically related to the Widespread Post-Pay Service Specific Reviews currently being conducted by the Medical Review department here at CGS.

The latest CGS Jurisdiction C News is located under the 'News & Publication' section of the CGS website. 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 we open the call for your questions, I will provide a brief overview of why the "Widespread Post-Pay Service Specific Reviews" are occuring. I'll talk about requirements to help when responding to requests for additional documentation and things to avoid that could cause a delay or an unfavorable decision on the selected claims.

Jurisdiction C Contract Announcement

The first item I would like to talk about just before we get to the post-pay process is the Jurisdiction C Contract Announcement. On August 20, 2020, the Centers for Medicare and Medicaid Services (CMS) announced CGS Administrators, LLC as the Jurisdiction C DME MAC for seven more years! The contract period is September 1, 2020 through August 31, 2027. Because CGS currently holds the contract, this will result in a seamless transition for DMEPOS suppliers. This means no anticipated interruptions in claims processing, contact information, cash-flow issues, transition related dark days, enrollment changes, etc. CGS has a transition web page for suppliers to obtain additional information if needed. To access the transition page, go to https://www.cgsmedicare.com. Once on the Jurisdiction C website, on the left-hand navigation panel, select "JC Transition".

Widespread Post-Pay Service Specific Reviews

CGS is conducting these reviews because the data analysis shows the allowed dollar amount for the selected HCPCS codes were significantly above expected amounts. The audit process is used to protect the Medicare Trust Fund against improper payments. The initial notification was sent out on August 12, 2020 alerting suppliers this process was to begin. The medical review staff will be auditing claims with DOS prior to March 1, 2020. As a supplier, it is important that you respond to any request for additional documentation to avoid receiving an overpayment demand letter for lack of response.

The Targeted Probe and Educate (TPE) program at this time is suspended at CMS direction. The TPE program will resume at a date to be determined by CMS.

In the interim, CGS will conduct the Widespread Post-Pay Service Specific Reviews on the following policies:

- Ankle-Foot Orthosis
- Ostomy Supplies
- Urological Supplies
- Knee Orthosis
- Surgical Dressings
- Blood glucose test or reagent strips
- Lumbar-Sacral Orthosis

Suppliers will be notified of the selected HCPCS Codes through ListServ messages and the notifications will be posted under the "News & Publication" section of the Jurisdiction C website. The randomly selected suppliers will receive an Additional Documentation Request or ADR letter which will contain a list of the required documents. The ADR letter will advise suppliers with specific instructions on how and when to respond as well as contact information for Medical Review.

ADR Response Guidance

Next, we will discuss important reminders to assist suppliers when responding to ADR letters. When you receive an ADR letter, you must respond within the specified time frame identified in the letter. Send responses as soon as possible. Suppliers are encouraged to review the ADR letter to ensure full understanding of what is being requested and when documents must be returned. Place the ADR letter on top of the documents as the cover sheet and return the documents to CGS as instructed. Clearly identify the documentation being returned. This can be accomplished by utilizing the "Claim Documentation Divider Sheets" to label the documents. The divider sheets are available on the left-hand navigation panel of the Jurisdiction C website under the "Online Tools & Calculators" tab.

When responding to ADRs, be sure the response contains all the documents that are applicable. Verify the documents are clearly labeled, identified and legible. Respond only once and send separate responses for each claim. Do not combine responses or send duplicates. There are several options for responding and they include:

- Mail
- Fax
- esMD
- Encrypted CD or DVD

If an enrypted CD or DVD method is selected, the response must be in the TIFF or PDF format.

Suppliers can utilize these tips to avoid unnecessary denials. Do not use your own cover sheet, because these forms are not recognized by our system and may result in delays. If you

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are missing the ADR cover letter, you can create your own in this situation. Include the information on the cover sheet; indicate "ADR Response" and include: the Medicare Beneficiary Identifier (MBI), the claim control number and the date of service of the claim. It is important you do not omit requested information as this may result in a denial. Never combine multiple requests into a single response. Do not miss the deadline for responding and never send your original documents as we are unable to return them. Ensure your copies are clear and legible.

Post-Pay Specific Frequently Asked Questions (FAQs)

Medical Review received a few questions regarding the post-pay process that we would like to share:

Question: Is the Widespread Post-Pay Service Specific Review the same as Targeted Probe and Educate (TPE)?

Answer: No, although they both involve ADR letters, the similarities end there. This process looks at the documentation used to support claim payment on a post-payment basis.

Question: How is this different from TPE?

Answer: TPE is a pre-pay review and suppliers have the option of receiving up-to three rounds of one-on-one education to address errors identified during the review process. Suppliers submit a corrective action plan to show understanding of the errors and the steps they will take to reduce or eliminate those errors.

Question: What is considered a curable error?

Answer: Submitting or correcting information that was missing in the documentation. The majority of curable errors are found and corrected before claim submission.

- Sending documents omitted from the initial submission.
- Corrections to documents would have to go through the appeals process.

Question: What options are available if we receive an unfavorable decision?

Answer: You would follow the normal appeals process.

Suggested Intake Form

The best preparation for suppliers to handle any audit situation, is to have a strong intake process in place. This will assist suppliers in responding to requests for information. If you do not have an established process, we have a suggested intake form to assist suppliers in getting started. Now, the form itself is not required; it is a guide if needed. The "Suggested Intake Form" can be used as is or modified to meet your business needs. The form can be found under the Forms/Checklists/ Guides tab located in the left-hand navigation panel of the Jursidiction C website.

CGS Connect™ and CGS Xchange℠

At CGS, we have information about two medical review education programs that our suppliers can utilize to increase their knowledge on documentation requirements and lower their claim error rates. CGS Connect™ is available for suppliers to submit their pre-claim documentation on specific policies to have a member of our medical review department review and provided educational feedback. This feedback will indicate if the documentation meets the necessary requirements outlined in the policy or if the documentation is insufficient for payment and why.

Next is the CGS Xchange℠ program, which offers suppliers the opportunity to receive individualized education. During this process, suppliers submit questions regarding the types of documentation that is acceptable or if clarification is needed on certain sections of a policy. A nurse reviewer will review the questions and arrange a teleconference to discuss the issues. Details of these programs are located in the left hand navigation panel of the Jurisdiction C website, under the Medical Review section, then select "Education Programs".

The Provider Outreach and Education department will continue to collaborate with Medical Review to provide webinars on policy specific HCPCS codes selected in the ongoing Widespread Post-Pay Service Specific Reviews. Suppliers will be notified via ListServ announcements of the date and policy category of the webinars. Suppliers can also find a list of webinars on the Provider Outreach and Education Events Calendar. The Events Calendar is located in the left-hand navigation panel, on the Jurisdiction C website, under the Education tab.

Wrap Up

As we prepare to queue for 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 your question. To raise your hand, simply click on the icon of the hand. Again, I will announce you and unmute your individual lines so that you can ask your questions, you may have to unmute your individual lines in order for us to hear you. Also, remember 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.

OK, let's go to the audio so that we can check for any questions. If you have a question, remember to click the hand icon so that we can unmute your phone line so we can hear your question and answer your question.

Remember, we have members from the Medical review department on the line to assist with any clinical questions that you may have. Again, you might need to enter your audio PIN.

Belinda: Are you ready for me to start unmuting line and see who's raising their hands?

Lisa: OK, yeah, go ahead. Go ahead. Belinda is going to manage the phone lines, and she will unmute your line and announce you, and then we'll check for your questions. Thank you, Belinda.

Belinda: You're very welcome, um, looks like we've got a hand up with Chrissy. Chrissy, I'm going to unmute your line. Do you want to go ahead?

Chrissy: Hi, thank you. Belinda and Lisa, can you hear me?

Lisa: Yes.

Belinda: Yes, we've gotcha.

Chrissy: Okay, good. I have a question The Medical Review Education program for the CGS Xchange℠, can that be any LCD medical policy? Can you ask for advice? And can you have multiple members of your staff attend the conference call if you get individual education?

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Lisa: OK, on the CGS...I'm sorry, will someone from medical review… Go ahead…

Chrissy: Yeah. So like, if I wanted to do, if I had questions, let's say, as an example, for changes that were made to the LCD for surgical dressings, and I wanted to pose those questions and then have, maybe a group of our operations staff of 10 or 15 people, want to listen in to that education. Is that how that works?

Lisa: For the CGS Xchange℠ Program? Thank you. We do have that, on the website, under the education, it has the instructions for submitting your questions, you'd e-mail your questions. A member of the Medical Review staff will review those. They will arrange for a teleconference in order for you to discuss any of the questions that you had posed, and you can arrange, or you can have as many staff members as you would like present during that call. So, just go out to the education, to the Medical Review tab, and click on the Education Program. Anyone from Medical Review want to add anything to that?

Ed: Hi Lisa, this is Ed Knapp from Medical Review. Just to add to that, I think, you know, the way that you describe that question was exactly what CGS Xchange℠ was intended for. Its provided as an opportunity for, for any supplier to submit questions about, any policy specific questions, in regards to the clinical nature, etc. So, that way, you know...(interruption). I apologize about that. So, it is intended for you to sit down with the Medical Review staff, ask the questions; and whomever you would like to have on the phone, we would encourage that, because it is intended for a general education session for the supplier with Medical Review.

Chrissy: Okay. Excellent. Okay, I just want to make sure I was reading into that, right. So, use that opportunity so, thank you.

Lisa: Thank you, Ed.

Lisa: Belinda? Belinda, do we have any additional questions from our attendees this afternoon?

Belinda: Yes, let's see here we've got Carol. Carol, I'm going to unmute your line. Do you have a question?

Carol: Okay. Can you hear me?

Lisa: Yes.

Carol: Okay, perfect. My question is regarding a denial I received. Of course, they couldn't read the DWO. But I'm seeing that we can't just go ahead and do a redetermination at this point. We now have to wait for an overpayment recovery letter. Am I, is that correct? Before we can do anything. It states that we must wait for that?

Andrea: Hi Carol, this is Andrea Rittmann with Medical Review. We do ask for you to wait for that overpayment demand letter; but if you've already received your denial letter from Medical Review, and you feel like it's, you know, it's been a few days, I'd be happy to check for that, check on that letter for you. If you want to e-mail our JC Inquiries Mailbox with the CCN, I can take a look and see where we're at with that.

Carol: Okay. Yeah, it's just, you know, it's pretty cut and dry, the denial reason is that they couldn't read the DWO. So, it's a matter of just resubmitting a copy. I have no idea how long it would take for the letter to actually come from overpayments. So...

Andrea: Yeah. It's usually, you know, the letters do go to the address that's on file with the NSC, and usually once you receive the denial reason letter from Medical Review, it's not too terribly long after that that you receive the overpayment letter. So, like I said, I can take a look and look at that for you, if you want to e-mail the CCN, we will just check and see where we're at.

Carol: Absolutely, that would be great. Thank you!

Andrea: Okay, great.

Lisa: Thank you Andrea.

Lisa: So, for the mailbox for the inquiries the address is JC.TPE.inquiries@CGSadmin.com. Again, that's JC.TPE.inquiries@cgsadmin.com.

Lisa: Okay Belinda.

Belinda: Okay, let me see who else I've got here with a hand up? I'm getting more of you so be patient, I'll get to everybody as I can. Roxanne, I've unmuted your line.

Roxanne: Hi guys, thank you. So, we received a couple of denials due to the order, let's say had 200 units on it, but the frequency was changed to five times a day. So now with the order not needing to have frequency listed, would you look to the medical record to support that order in the same manner?

Andrea: Hi, this is Andrea again. Yes, we usually do look to the medical record to corroborate what's on the written order.

Roxanne: Okay, so you would use that medical record documentation; and let's say the doctor ordered 200, but you only put five times a day and you still go by that five times a day?

Andrea: Well we're looking, we're looking to the medical record to kind of corroborate what the detailed written order is saying. Like you mentioned, what there is, we are looking just to make sure that the order has, it what the... Excuse me, let me start again. We are looking at your order to make sure that that matches what's being billed to Medicare. And then we're looking at the individual medical records just to corroborate what the doctor is saying. So, if there was, if there's kind of some specifics, that you want us to take a look, we can also take a look through the Inquiries Mailbox if you have a CCN.

Roxanne: Okay, thank you, and I just have one other question.

Ed: I'm sorry, just one quick thing, just to follow-up on that also too. So, I think if you are seeing orders that are different from what is in the medical record, I would encourage you to go out and get a new order. Um, I wouldn't. I'm very hesitant about the suppliers relying on medical records to kind of verify what's on an order, what is billed. You know, the order is a document that you guys control. So, it's kinda like your safety net. So, I would highly encourage you to, if an order is verified, needs to be verified in the medical record I mean, if you see that, I would encourage you to go out and get a new order. So, that way, it kind of covers yourself too.

Roxanne: Okay, thank you so much, that's helpful, and then just one other question; I don't know if you guys are familiar with what an MBBS is, it's like a Med Bachelor of Medicine and Bachelor of Surgery. Do you accept documentation and orders from that type of clinician?

Ed: I'm sorry, can you repeat those credentials again, please?

Roxanne: Yeah, it's MBBS.

Ed: MBBS. I mean, in terms of Medical diag… is this in regards to medical documentation? Or, now, what, what we would consider a medical record?

Roxanne: Right, so for example, it's not an item you're auditing right now, but like for the MD DO, that's what it has to be, for

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therapeutic shoes let's say, and there's just no information on MBBS. When you kind of Google it, it just says that it's equivalent to an MD; but we're just kinda wondering how you…

Ed: So, I mean, I guess my main question is, are they able to bill Medicare for their services?

Roxanne: They are on the Data.CMS.gov as being able to order for DME, yeah.

Ed: Okay, I mean, if they're able to, to bill Medicare, and you know Medicare has considered them, you know, kind of a clinician, in terms of medical records, you know, then we could accept that. But, you know, I would just verify that, you know, they're able to write orders specifically. Because, I mean, sometimes it sounds like that, that clinician's scope of practice is limited, and when scopes of practice are limited, their ability to do orders, etc., is also limited. Depending, usually, it's depending upon the scope of practice; but it might also be dependent upon their ability to write an order, etc.

Roxanne: Okay, thank you. That's all I have.

Lisa: Thank you Roxanne. One thing I wanted to ask is was that specialty billing, were they billing the DME MAC? Or were they just ordering items?

Lisa: Belinda, you may have to open her line again. I was just curious.

Belinda: You snuck in on me. A long list of people. Go ahead, Roxanne.

Roxanne: I'm sorry, can you repeat your question?

Lisa: Do you know if that specialty is billing the DME program? Or are the just ordering items?

Roxanne: They would be more ordering items and documenting those items. We did check with our credentialing department and they are enrolled in Medicare. I did find them on Medicare.gov as a participating provider. So, there's just no information on an MBBS. So…

Lisa: Okay. Okay.

Roxanne: And, I haven't received a denial necessarily from that; but we did have some where they're ordering for therapeutic shoes, let's say, and we weren't sure if that would qualify as an MD or a DO.

Lisa: Okay. Okay. Yeah, just follow the information that Ed was giving on that specialty, or that particular credentialing for that individual.

Roxanne: Thank you.

Lisa: You're welcome.

Addition after the call: Regarding the MBBS, this is equivalent to a U.S. MD degree – it's "Bachelor of Medicine, Bachelor of Surgery". It's the professional medical degree that is conferred in the UK and current/former UK colonies like India. Anything ordered by a MBBS would be considered the same as ordered by an MD or DO.

Lisa: Okay Belinda

Belinda: Our next question is from Rebecca. I've unmuted your line Rebecca.

Rebecca: Hi, yes, I am actually, I'm asking a question regarding submitting the audits. So, it looks like we're having difficulty for you guys actually receiving it via fax. Do you guys have like a backlog? Or, or, what is the turnaround time? Because when I call to follow up on it, everyone I talk to says that you guys have not received it.

Ed: Hi, this is Ed Knapp from Medical Review. So, I guess, are you saying that you're calling over a couple week period of time and we're saying we haven't received it? Or...

Rebecca: Yes, because, like, like in your slides, it says to only submit it once, but when I call to kinda get like a status to make sure you guys receive it, everyone keeps saying: "no we have not received it, please re fax it"; and then I re-fax it and then follow-up a couple of weeks later and nobody has received it. So, like, now, we're going on, like, months of when it was due, but, and I have, like 4 or 5 different confirmations saying that it did go through, and you guys have still not received it.

Ed: Are you calling Customer Service?

Rebecca: Correct.

Ed: If you can send an e-mail directly to the Inquiries Mailbox for that Jurisdiction, either JC or JB inquiries mailbox, with the specifics of your, you know the CCN etc., we will follow up with you on that.

Rebecca: Okay, all right. Well, thank you.

Ed: Thank you.

Lisa: Okay, just as a reminder, the mailbox address is JC.TPE.inquiries@CGSadmin.com.

Lisa: Okay Belinda.

Belinda: Yeah, let's see, I've muted Rebecca again. Let's see who else is here. Jonathan H, I've opened your line, do you have a question?

Jonathan: Yes, I do. Thank you all so much for this. The question is, and it might be tied to the very first question, but the, the call with Medical... the teleconference, we're going through the CGS Medical Review tab, in Education. Is that available for just suppliers? Or are manufacturers able to set up those calls as well?

Ed: Hi this is Ed Knapp from CGS again. I'm sorry, was your question in regards to Xchange?

Jonathan: I suppose, I mean, the question is, is tied to the coverage for intermittent catheters, the policy for intermittent catheterization and specifically for the A4353; it lists some very specific criteria; on one it's considered covered under that sterile technique; and that second criteria is where there's some confusion among suppliers, where it's, the beneficiary is immunosuppressed; and then it lists some examples; but it's, it also points out that it's not an all-inclusive list. So, that's where we're trying to get some clarification on what, what are those? What is the all-inclusive list? What would meet that criteria of a patient being considered immunosuppressed? So, I'm thinking we would go through that, know, the inquiry process, to start that and possibly get a call with the kind of the people that, that need to have that information and the physicians prescribing and under those conditions. That's where this is coming up, and it's not often, but it's come up a number of times now.

Ed: Okay. I appreciate that clarification. So, you wouldn't go to the Inquiries Mailbox. I think it's the CGS Xchange℠ Program. That's kinda what you're looking for. You know, that is, that is where you pose questions to the clinicians in Medical Review and the nurses; and then they would, they would set up a session; they review your questions with you, provide you with answers; it's kinda like an educational session. That you're kind of looking for. So, if you want to reach out to the CGS Xchange℠

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folks; it's on our website; and then, you know, we can follow up with you on that.

Jonathan: Perfect. Perfect. That sounds good. Thank you so much.

Ed: Thank you.

Lisa: Anything else Jonathan?

Jonathan: No, that was it.

Lisa: Okay, thank you.

Belinda: Okay, we have Jackie. I'm unmuting your line.

Jackie: Hi, just wondering if these ADR letters are going to be available on the portal at any point?

Lisa: Currently, currently, they are not available in the, in the portal. We are working on trying to get that updated, where we can have that information in there. But right now, it is not available through the portal.

Jackie: Okay, we are working towards that, good. Okay, that's all I have. Thank you.

Lisa: Okay, thank you.

Belinda: We had a hand up from Laura but I'm not showing that you've input your PIN. I have sent that to you. If you want to input that PIN, when I see that you have done so, I'll come back and unmute your line, so you can ask your question. In the meantime, Ophelia, I'm unmuting your line. Did you have a question?

Ophelia: Yes, can I? This is Ophelia, I want to know; can I get that e-mail address again? I'm not sure if I heard JC.PE or .PPE. inquiries? I'm not sure.

Lisa: Okay, okay, the address is JC.TPE.inquiries@CGSadmin.com.

Ophelia: Okay, and my second question is, we have a DME company, I work for a DME company, and we're trying to see if we can do an 855I add-on for Licensed Clinical Social Worker. And she asked me if a, could a Master's in Clinical Gerontologists via the DME MAC? That's what I would ask because I was online with you guys today. I guess she wanted to know if she could, if we could have a Clinical Gerontologist sending DME orders to us in place of, you know, working under this Licensed Clinical Social Worker?

Lisa: Ed, do you have any thoughts on that?

Ed: This is Ed Knapp from CGS Medical review. So, licensed clinicians, can write orders, in Medicare. You know, I think that, I've not seen social workers having the ability to write orders. I'm not sure who is working in conjunction with the social worker. Typically, I have not seen a Master's level person have the ability to write orders. You know, DME orders are the same as all other Medicare orders; there's not a special niche. You know, you need to be a Medical Doctor, Doctor, a Doctor... DO, I can't pronounce the long name, I've said a Nurse Practitioner, in order to write orders in DME. So, you know, I'm not, again I'm not familiar with a Master's, in particular, in Gerontology, but the fact that it's a Master's program, and I don't hear anything associated with Nurse Practitioner, or Medical Doctor. It could be, I mean, they could be a Nurse Practitioner that I also has a, you know, a Master's in Gerontology. I mean, I would encourage you to check with that provider to see what credentials they have and if they have the ability to write orders in that particular state.

Addition after the call – In addition to an MD or DO the following practitioners may document the medical necessity of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) items, including completing orders and Certificates of Medical Necessity (CMNs), in place of a physician provided that they meet the practitioner requirements defined in Chapter 15 of the Benefit Policy Manual (Publication 100-02), the services performed are within their scope of practice as defined by their state, and they are treating the beneficiary for the condition for which the item is needed.

- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist

Ophelia: Okay, thank you.

Lisa: Great questions. Just remember if you need to ask a question or would like to ask a question, you would do, if you haven't entered your audio PIN, you would need to do # enter the PIN and then press # again in order for the phone system to take that number so that we can open your phone line. So if you have question, click on the hand and Belinda will get your line unmuted and so we can take your question.

Belinda: Okay, we've got a question from Debbie. I've unmuted your line. Debbie, go ahead.

Debbie: Thank you. I have two questions. The first one is in reference to a curable error. We've had a change in personnel structure that's occurred in the company and the previous contact is no longer in that position. My question is, how and where do we have to go to update this information, so that the contact for the curable errors is updated correctly and we get these curable errors to the right person in our company in a timely manner?

Andrea: Hi, this is Andrea Rittmann from Medical Review. I can help you with that, and if you are able to send an e-mail to our Inquiries Mailbox, we can get that information and get it updated for you.

Debbie: Thank you, Andrea, and is that that CJ.TPE.inquiries@CGS.com?

Andrea: If you're talking about Jurisdiction C, it's JC.TPE.inquiries@CGSadmin.com, and then if it's Jurisdiction B, it would be JB.TPE.inquiries@CGSadmin.com.

Debbie: Okay, thank you. And then my second question is, we received the ADRs in August of 2020, with deadlines due in October 2020. We have not received any further ADR since then; and we're getting audited on the a A4253, the test strips. Are the ADRs being sent in waves.

Andrea: Well, honestly, I would, I would refer to our website for any updates, as far as volume or when ADRs would be received. These are widespread reviews, so we make announcements on when we're starting reviews. But you would also just monitor the mailing address that you have on file with the NSC, because that's where all the ADR letters would be going to.

Debbie: Okay, thank you. Those are my questions.

Lisa: Okay, thank you, Debbie. Just as a reminder, this is an ongoing process. So, it really depends on what items that you are providing, you know, when you receive the ADR letters. So, you may have, you know, some have gone out, so you may still be receiving ADR letters at a later date. So, just keep that in mind.

Lisa: Okay Belinda, any other questions?

Belinda: Yeah, hold on I'm having problems trying to unmute.

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Laura, you've put in your PIN but you are self-muted. If you can unmute yourself, you can go ahead and talk about your question.

Laura: Okay, can you hear me know?

Belinda: Yes.

Laura: Okay, we received a letter about Redeterminations, and I've gone into the system to try and look it up, it gives me an AR number and that's it, because we don't know which patient this is attached to. How do you? Where do you go to look for that? To put in the AR number?

Andrea: So, this is Andrea with Medical Review. So, you are, so, you've received a denial letter, or? I'm sorry, I don't think I'm understanding.

Laura: I guess we had a Redetermination, we sent additional stuff, and it says all collection processes have ceased on the unpaid balance of the accounts receivable until further review, and it gives me an AR number and my NPI number, but it doesn't tell me exactly who it's attached to patient wise. I didn't know where within the system, because I was looking on the system today to see where it took that number to determine, I didn't know if it was all of them, or that we've grabbed for review, or a particular patient.

Andrea: Do we have anybody from Provider Outreach that could help her with that question?

Lisa: I think, well, I think what we would need to do is, let us get your contact information and we'll reach out. Because, we're, at this point, I'm not really sure whether it's tied to the to this process or if it's something else. So, let us, let me get your information and we'll reach out to you after after the call.

Laura: Okay.

Note: Supplier provided contact information..

Lisa: All right, I'm ready. Okay, we'll reach out to you after the call. Okay?

Laura: Okay, thank you.

Lisa: Thank you.

Lisa: Belinda.

Belinda: Lisa, we have a call from Michelle. Michelle? Are you there?

Michelle: Yes, hi I'm here. Sory about that. Okay, so my question was, we've gotten several TPE audits and they went through the process, they were denied, and we did the appeals, and we went all the way to MAXIMUS, and we've got a couple of calls from MAXIMUS where they overturned it. Because the reason they were denying was because they were saying there was no doctor signature on file or there wasn't a valid prescription, or something like that, and it was all there. But every appeal that it went through it was denied until it went to MAXIMUS and it got overturned. Well, we've only received two phone calls from Maximus on the audits that we've sent in. So, where do you go if you don't receive a call from that level of appeals, and there, it's still denied for something that you know is there, because you're looking at it? So, what do you? What is your next step after that? When it's still being denied.

Lisa: Hmm... Okay, so you have appealed it to MAXIMUS and they have overturned. So, did you have any that's still pending with MAXIMUS? Are you? I mean, are you asking what happened?

Michelle: Yeah, because we've gotten more than just those that have went all the way to MAXIMUS, and we've only received phone calls on two of them; where I could get on the phone with them, be like, look, it's right here on this page; and they're like, "yeah, see it." Well, there's a couple of them that went to MAXIMUS that we didn't receive calls on, even though we requested it, and so MAXIMUS send us a letter back saying it's denied; and it's still for something that is actually in the chart. So, where do we go after that? When you get that final letter from MAXIMUS saying that it's still denied?

Judie: Hi, this is Judie from CGS POE. So, the telephone demonstration is, it's not always considered on each of your specific requests. So, they did offer it on the ones you requested it on, but obviously did not offer it on the additional. But if you've received a denial or a non-affirmation from MAXIMUS; unfortunately, the next level of appeal is the Administrative Law Judge. So, you would have to request an ALJ.

Michelle: Okay, got it, that's what I needed to know; if there was anything you could do before going to the ALJ. Okay.

Judie: Unfortunately, if you've received a denial or non-affirmation from them, that's the next step.

Michelle: Okay, that's what I needed. Thank you so much.

Judie: You're welcome. You too.

Lisa: Thank you Judie for your clarification.

Lisa: Okay Belinda, do we have any other questions this afternoon?

Belinda: Yes we do. Paul, your line is unmuted. You have a question? Go ahead.

Paul: Actually, more of a comment than a question. I'm a podiatrist recommend, I'm sorry, representing the American Podiatric Medical Association. Just a clarification on what was said earlier, Podiatrists are physicians under Medicare and can order DME within the scope of their state scope of practice. That's really all I wanted to add. The question I did have had to do with this new therapeutic shoe policy. There's two separate pathways for nurse practitioners to prescribe; and I just want clarification that they would be eligible, under the Demonstration Project, as of January, to attest, agree, sign off on the notes of the eligible prescriber. That's the first question. So, I'll let that question be answered; and then I'll ask a follow-up question.

Andrea: Okay, so this is Andrea from Medical Review. So, you're asking if a Nurse Practitioner is able to, to sign off? Is that what you're asking for?

Paul: Yes, sign off on it. So, let's assume that the Nurse Practitioner under the Demonstration Project is treating the patient under the Comprehensive Plan of Care for Diabetes. Okay, the patient then goes to a podiatrist, an endocrinologist, the vascular surgeon and an orthopedic surgeon, who prescribes a therapeutic shoe. So, typically, under the present circumstances, the MD or a DO has to sign off on those notes, because those practitioners are not treating the patient for diabetes. So, I just want clarification, that now you're suggesting that, I mean, this new project is suggesting that a physician extender, the Nurse Practitioner is going to be able to sign-off on the notes of a physician prescriber. That's what it sounded like to me.

Judie: This is Judie again with CGS, and under the demonstration, the Primary Care First Model Demonstration Project, if they are enrolled in that project, according to the

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article that is available on our website, effective January of 2021, January 1st, the change would be that the NP would be certifying. So, they would be able to certify for the diabetic condition. If a DPM was to...

Paul: DPM

Judie: I'm sorry, go ahead.

Paul: No, no, it's all right. Go ahead. I'm sorry. I don't mean to interrupt you.

Judie: No, I didn't intend to interrupt you either. So, if a DPM did the order for the shoes and it had to go historically to the MD or a DO for the certifying physician to sign-off on the foot assessment, is that what you're referring to?

Paul: Yes, exactly what I'm referring to.

Judie: According to that specific article, it states that they can be certifying, but I do know that there are some questions that are currently pending with our Medical Directors, and they will be responding from you, and they will be responding to in the near future.

Paul: Okay. All right. Yeah. I think I had about 10 questions that I, that I had submitted to them; but this was one that I had not, um, had not submitted, because I wasn't fully up to date on the Demonstration Project. Now that I am. So, this is an additional question.

Judie: Okay, so again, so you're good on the question?

Paul: Yeah, yeah. Okay. Thank you very much.

Judie: Great. Good question. Thank you.

Lisa: OK, thank you! Thank you, Paul.

Lisa: Belinda, did you or are there any other hands in the que?

Belinda: Yes, I'm gonna go back to Jennifer. I think we're set now. You've got your PIN in and go ahead and ask your question. Jennifer, are you there?

Jennifer: Hey, can you guys hear me?

Lisa: Yes.

Jennifer: Hi, thanks so much for taking my question. So, we are an orthotic and prosthetic facility, and we are being inundated with denials for same or similar, for, specifically, mostly lower extremity orthotic devices; and the problem, there are a couple of problems, is, it seems that Medicare is not distinguishing between off-the-shelf devices that doctors provide, either immediately post-surgery or when they take off a cast. So, what happens, so the patient goes to follow up with their surgeon, you know, after surgery, they take off a cast, or they take off a dressing, and they'll put a temporary non-custom off-the-shelf boot, or you know, cloth off-the-shelf gauntlet on, until the custom-fit ankle/foot orthosis can be fabricated by us. So, it takes some time for that to happen. So, what's happening is we submit our claim to Medicare and it's denying for the same or similar rule. When we submit our documentation, which includes physician medical records that states, the boot or, you know, AFO that was provided today in clinic, was provided for temporary stability, and is not meant to be worn, weight bearing, or long term, and custom brace is needed for, you know, all of the reasons that meet criteria. Even when we do that, we're getting denied, denied, denied, and having to go, in most cases, all the way through a hearing; which I mean, we've had things submitted for a hearing date, for months, and we still haven't had it assigned; and it, so, it just seems that Medicare, is not understanding the difference between, an off-the-shelf brace, given by a doctor, and then the custom brace, that we are providing within a five-year period. Now, we've had some appeals that have been favorable, like it actually looks, that they look at the documentation, and they say, "oh, yeah, a custom brace is not the same as an off-the shelf-brace that's provided in (our) clinic. Yes, this meets medical necessity." So, that's one of my questions. If you could maybe speak to that and help us understand. It seems like there's just, it's on autopilot right now.

Judie: Well, this is Judie again from the Outreach and Education department, and I'm not sure if you utilize some of the new tools, that we've posted to our website, regarding same and similar during the reasonable useful lifetime; and if there is a change in condition. Utilizing, there is a checklist under our checklists, as well as, under Medical Review, under Resources, and it is specific to providing orthoses, replacement orthosis, during the Reasonable Useful Lifetime, due to a physiological change in the condition of the beneficiary. So, the documentation that we'd be looking for in your medical records, or in the physician's medical records, as well as, the orthotist. First, we'd be looking for documentation of a change of medical necessity, as to why that item would no longer be sufficient for the beneficiary's condition. In addition to that, we would be looking for documentation to substantiate why that previous item cannot be used; and that could come from the orthotist; to confirm why they need a custom-fitted, or custom-fabricated, or whatever the scenario may be. Now, if your medical records don't reflect all of those items, you can see a denial through, through the Appeals process.

Jennifer: Okay, so, we are seeing, I don't know; I'll look at the checklist, thank you so much for that resource. We do have significant documentation. We've got measurements, you know, especially if there's a change in conditions. So, there's like two main scenarios. There's a scenario when a doctor orders a temporary brace, that same day that they order a custom brace, and the temporary brace is really meant to get them through until the custom brace is made. So, that's one type of scenario. And then we have the scenario, that's a little bit more cut and dry, which is, okay, they got a brace two years ago and then had surgery; and here are the physiological and functional changes that required a different brace; and we've got all that documented; and, so, I feel like the second scenario is a little bit, a little bit easier to document, although, we still have had denials, even with, I mean, we've got X-rays on some of them, we've got doctor's notes, we've got our notes, we've got pictures; we've got a lot of information and they're still not, they're still not processing properly. I think that first scenario, when the doctor provides an off-the-shelf brace, the same day that they order the custom brace, because they know the need for the custom braces is there. Do you feel that the tools and the resources that you're talking, that you're referring to, which I'm super excited to look at, would that work for those scenarios? Because there's not like a timeframe difference, the off-the-shelf, provided by the doctor, the same day that they ordered the custom.

Judie: No I, in all honesty, Medical Review, please interject if you feel this is incorrect, but I think, due to that first scenario, because it's a temporary item, and there would have to be sufficient documentation to substantiate the need for that temporary item prior to the custom fitted item being provided, and that would have to be individual consideration. The second scenario, where the beneficiary receives an orthosis, say a walking boot for one condition, and then a month later had another injury, and that, that is much more clear cut, and those tools really do refer to that scenario.

Sienna: Judie, this is Sienna. Can you hear me?

Judie: Yes.

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Sienna: I just want to add to that, that you are correct, that very much so. In the Appeals department, we would be considering a change in condition, as well as, if there is a device that could be used, previously, that the beneficiary already had. So, for the same exact diagnosis, the exact same reason, it is a much more... documentation would need to be noted, as well as, potentially not able to be overturned. It would have to be an individual consideration.

Jennifer: Do you have any guidance? As far as what to document. Do you have any guidance? As far as wording. Or is there somebody that I can talk to, you know, outside of this webinar, to kind of talk that through, so that we can educate physicians, and kind of, I mean, because it's a real, it's a real no win situation for us. We get these patients and, a lot of the times, the same or similar doesn't even print out yet, that claim hasn't even been processed yet, so we're not even really aware that that a temporary brace was provided. So, is there someone I can follow up with afterwards about that, and kind of problem solve?

Lisa: I think, this is Lisa, I think, in this situation, and Ed, and you could kind of jump in, the CGS Connect™, would be the... the CGS Xchange℠ would be, probably, a good avenue to kind of discuss those issues. Don't you think in this situation?

Ed: So, hi, I'm sorry, this is Ed Knapp from Medical Review, are they, do you have particular claims you can reference? That CGS reviewed?

Jennifer: Yes.

Ed: You do? Okay, if you'd like, you could, you could send a specific CCN, that was denied for that particular reason by CGS, to the Inquiries Mailbox? And, you know, we can kind of research that a little bit, and then we can respond back to you. These types of questions are also kind of challenging to, to answer, because, particularly with individual consideration, medical records are going to be different for each patient, and we would be taking that into consideration during our evaluation. So, you know, to, to generally say something is very challenging; and particularly when it comes to individual consideration. So yes, I would, I would encourage you to reach out to the Inquiries Mailbox for that particular jurisdiction, reference the CCN, and then we can follow-up with you and provide you with that education.

Jennifer: And the inquiries mailboxes is?

Lisa: JC.TPE.inquiries@CGSadmin.com

Judie: And we did send that to everyone in the chat feature, as well. So, it is in chat. You can copy it from there.

Jennifer: I appreciate that. Thank you, guys. Thank you so much.

Lisa: Thank you. Okay, Belinda, I think we are nearing the top of the hour.

Belinda: We are. It just hit 2:00.

Closing

Well, I would like to thank you all for attending and participating in today's ACT call. We will post the transcript to our website and send out a ListServ notification when it is available. We look forward to seeing you at future educational events. Again, thank you so much, and have a great day.

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