September 21, 2016
Open Question and Answer

Summary: On September 21, 2016, we conducted an Ask-the-Contractor Teleconference. Below are the questions and answers addressed during this call.

Please note that questions and answers may have been rewritten for clarity.

Question: For beneficiaries entering Medicare FFS from another insurance and the supplier obtains a signed and dated statement by the beneficiary (or beneficiary’s designee) attesting that the supplier has examined the DMEPOS item and it is in good working order meeting Medicare requirements. What date is to be used for the date of service?

Answer: The date of service would be the date the beneficiary signed and dated the attestation obtained by the supplier once the DMEPOS item has been examined ensuring it is in good working condition and meets Medicare requirements.

Question: We are having issues loading multiple NPIs into the myCGS portal and have only one tax ID. Is there any resolution on this issue?

Answer: CGS Administrators, LLC (CGS) has implemented several fixes to the database over the last few months to correct issues involving suppliers with multiple NPI/PTANs. Although the vast majority of users are no longer experiencing these issues, we have found that handfuls here and there are still having problems. If you are one of those suppliers still experiencing issues please contact the provider contact center with examples for further investigation. As far as other issues, we are actively working on numerous fixes and improvements for the next version of myCGS (3.1), which will be released later this year.

Question: Are there any updates that are happening relatively soon regarding filing online electronically? Will this transpire soon with the upgrade?

Answer: Yes. We are currently in the end stages now and will publish as soon as we have a date for this upgrade. Currently suppliers may file claims, redeterminations and/or reopenings electronically.

Question: If the beneficiary or designee accidentally does not sign the proof of delivery documentation (method 1), is it acceptable to send the proof of delivery to them to sign after the fact? And how would you document that?

Answer: Yes, the beneficiary or designee’s signature is required for method 1 proof of delivery. If the error is found prior to claim submission, you can choose to send the proof of delivery to them and have them sign and date the correction.

Question: We are faxing our additional documentation requests (ADRs) sometimes on the due date but receiving no response CO-50 denials, is there a way to correct this? What should suppliers do if they receive a no response denial in error?

Answer: Upon receipt of an ADR response, if the claim cannot be stopped from auto-denying, the
ADR response is moved to be worked as an MR reopening. The supplier does not need to take any action for this to happen. When CGS completes the MR reopening, the claim is adjusted based on the new decision and the supplier will see that on their remittance notice. Suppliers should ensure that ADR responses are being submitted to the correct fax line for Jurisdiction B (615-660-5993), if using the fax option. CGS continues to receive many responses that are faxed to the Jurisdiction C fax line in error. The correct fax number is stated on the ADR. Also, ensuring that the 1st page of the ADR is included as the 1st page of the ADR response will further assist in quickly identifying and suspending the claim to keep it from auto-denying.

Question: For oxygen claims after the initial reasonable useful lifetime (RUL) has been met, what modifiers and narrative must be on the claim?

Answer: For initial rental month (and only the initial rental month) oxygen claims, the RA modifier (Replacement of DME item) must be appended to the HCPCS code for the equipment when there is a due to reasonable useful lifetime, or replacement due to damage, theft, or loss.

Claims for the initial rental month must include a narrative in loop 2400 or note (NTE) segment for electronically submitted claims or line 19 for paper claims an explanation of the reason why the equipment was replaced and supporting documentation must be maintained in the supplier’s files.

As a reminder, the RA modifier should not be used when billing for a new initial rental that follows a 60+ day break in need. Suppliers are also reminded that using the RA modifier when not required may result in a delay in claim processing.

Question: When faxing documentation, we are consistently receiving denials for no medical records but we are faxing the medical records. Can we call the customer care line and have a tier two reviewer look to see if the documentation was received? If it was received can we have the claim reopened and re-reviewed?

Answer: The tier two customer service representative is able to look for the missing documentation. If the information is noted to be present and the claim denied in error the representative does have the ability to send back and request to have the claim reopened and reprocessed. This does not ensure payment as there may be other reasons the claim denied.

If you are having issues with faxing documentation it is recommended to enter the total pages sent on the cover sheet (if you choose to create and send one) and number each page in the upper right hand corner so the reviewer is able to identify if something didn’t properly transmit over the fax.

Question: Does the detailed description on the detailed written order (DWO) have to be as extensive as the detailed description required on the proof of delivery (POD)?

Answer: The detailed description on the DWO must be detailed for all item(s) being ordered and provided to the beneficiary. The detailed written order detailed description must contain a detailed description of the item(s). For item provided on a periodic basis, including drugs, the written order must include; the item(s) to be dispensed, the dosage or concentration (if applicable), the route of administration, the frequency of use, the duration of infusion.
(if applicable), the quantity to be dispensed and the number of refills. The proof of delivery detailed description is not required to be as detailed but must contain a detailed description to identify the item(s) being delivered for example the HCPCS long narrative description.

**Question:** We have a physician who refuses to close out a patient's office visit by signing the medical records. When providing a PMD if the physician conducted a face-to-face exam for a PMD, then referred the patient to an OT/PT, signed the LCMP notes (on the 25th) and then the next day signed and closed out their own face-to-face records (on the 26th). Which date would be the face-to-face (F2F) date for the seven element order?

**Answer:** There are two components required for the face-to-face to be complete 1) the treating practitioner must conduct a F2F examination of the beneficiary and 2) the practitioner must sign, date and state concurrence after review of the licensed/certified medical professional (LCMP) report. In this scenario, both of these components occurred and therefore the F2F date would be the 25th, the date of the signed concurrence.

**Question:** In the past suppliers have been able to enter abbreviations in the Note (NTE) Segment of the electronic claim that were deemed acceptable. The list was published on the NGS website, could CGS also publish this list and do they accept these abbreviations such as; patient owned = PO, break in need = BIN?

**Answer:** CGS is currently looking further into this issue. As soon as a resolution has been made, this will be communicated via CGS Listserv.

**Question:** When we call the customer service line to figure out why our claim denied and going through the CTI process, if one line on the claim is denied and one line is paid we cannot access a representative. How do we get to an agent when it's saying that there's no information available for your particular patient and won’t connect you?

**Answer:** CGS experienced an issue with the original deployment of the CTI feature within our Provider Contact Center. As of September 12th, this feature has been corrected and deployed back into service.

**Question:** When billing gauze for a tracheostomy what modifier should be appended?

**Answer:** Per the surgical dressings policy article (PA), dressings used with tracheostomies (covered under the prosthetic device benefit) are included in the allowance for HCPCS codes A4625 (tracheostomy care kit for new tracheostomy) and A4629 (tracheostomy care kit for established tracheostomy). If billing gauze HCPCS under the surgical dressings LCD for a tracheostomy the claim will deny.

**Question:** When billing alcohol wipes HCPCS A4245 for a non-diabetic, appending the GY modifier and a narrative in the Note (NTE) Segment we are receiving CO denials instead of the previous PR denial. How do we bill for this scenario to receive the correct PR denial?

**Answer:** If A4245GY is billed to CGS the claim should deny as patient responsibility. If you are receiving contradictory denials, please contact the customer service department for further investigation.
**Question:** When billing for enteral nutrition by gravity with an IV pole (E0776) and the beneficiary is in a round 2 competitive bid area (CBA), what modifiers should be used? When billed with the RR and BA modifiers the claim denied.

**Answer:** The E0776 used for enteral nutrition in a CBA requires both the RA and the KG modifier along with the RR. This is required since the IV pole falls into more than one product category.

**Question:** When shipping DMEPOS via method 2 proof of delivery, what date is to match the date of service (DOS), the shipping date or delivery date?

**Answer:** When providing DMEPOS via method 2 proof of delivery the shipping date is to be billed as the date of service.

**Question:** When contacting the customer service department and the issue is raised to a tier two representative, we are being told we will receive a return call within 7 to 10 business days but we never get a call back. When we call back, we are told the issue was closed due to multiple attempts to call but we have no missed calls or voicemails. What is the process for tier two call backs?

**Answer:** When an issue has been elevated to a tier two representative they have 7 to 10 business days to call back. The name and number provided to the first level customer service representative will be used to reach someone. The tier two representatives must make at least three attempts to reach someone and these attempts must be at what is considered separate attempts (next day, etc.). We have found many times the number provided may either be a general customer care line which is difficult because the operator answering the phone does not know who the person is, the line is continuously busy, or a voice mail is left with no return contact. When providing your name please provide a full first and last name as well. There may be four “Angela’s” for example at your company and we need to be able to reach the correct person.

**Question:** In this scenario the clinic provides a bolus of their own that they bill separately. They then hook up our bag of 5FU and the pump to the patient and then the patient goes home. Is it proper to bill the DME MAC as a home infusion supplier for drugs that are delivered to the patient at the clinic?

**Answer:** CGS is currently seeking guidance from the Center of Medicare & Medicaid Services (CMS) on this issue. Once information is received, this will be communicated via CGS Listserv.

**Question:** Was documentation submitted previously to NGS due to additional documentation requests (ADRs) transferred over to CGS?

**Answer:** Yes the documentation previously submitted to NGS was transferred to CGS during transition.

**Question:** We are receiving ADR requests for all of our second ventilators we bill to CGS. Is CGS auditing ventilators?

**Answer:** CGS is not auditing ventilators at this time. You may be receiving ADRs from another auditing contractor, please make sure you are responding to the correct address on the ADR letter in a timely manner.
**Question:** Do the supplies for a PAP (i.e., mask, tubing, filters, etc.) need to be included on the detailed written order (DWO)?

**Answer:** The supplies do not have to be on the same DWO as the PAP device but if they are not then there must be a separate DWO for all the supplies to be billed to Medicare. The DWO for the supplies whether included on the PAP order or not, must have the following additional elements:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills

**Question:** Does the DWO for a nebulizer have to also include the drug to be used with the nebulizer if another supplier is billing for the drugs? If we put the drug to be used with the nebulizer does this secure payment in the event of an audit?

**Answer:** If you are only providing the nebulizer equipment and not the drugs then you are responsible for obtaining a DWO for the nebulizer equipment only. Having the drug(s) to be used with the nebulizer on the order does not justify medical necessity for the equipment. There must be documentation in the beneficiary’s medical record should include but is not an all-inclusive list; the diagnosis, condition, treatment, and drugs to be provided to support medical necessity. The supplier providing the drugs to be used with the nebulizer would need to secure a valid DWO for the drugs being dispensed.

**Question:** In the myCGS portal, what is a supplier to do if there are several inactive PTANS listed and the PTAN/NPI combinations are incorrect?

**Answer:** CGS has implemented several fixes to the database over the last few months to correct issues regarding supplier NPI/PTANs. Although the vast majority of users are no longer experiencing these issues, we have found that handfuls here and there are still having problems. If you are one of those suppliers still experiencing issues please contact the provider contact center with claim examples for further investigation. As far as other issues, we are actively working on numerous fixes and improvements for the next version of myCGS (3.1), which will be released later this year.