Jurisdiction B Ask-the-Contractor Teleconferences (ACT)

Provider Outreach & Education
Date: February 23, 2021

Moderator: Stacie McMichel
Time: 2:00 p.m. EST

Welcome & Introduction

Good Afternoon and welcome to the CGS Administrators DME MAC Jurisdiction B "Ask the Contractor Teleconference" (ACT). These ACT calls are hosted by the DME MAC Provider Outreach and Education team for Jurisdiction B. My name is Stacie McMichel, and on the call this afternoon are Jurisdiction B subject matter experts from various CGS operational departments. For this ACT call, we will provide a high-level overview of updates to the Medicare Program and specific update Jurisdiction B. At the close of our updates, we will open up the call to take your live verbal questions.

Please note that there is not a presentation for this call. This call is being recorded and the transcript will be posted to our website within 30 business days.

Webinar Instructions

If you would like to participate in the question and answer segment, please be sure to enter your audio PIN. Your audio PIN is located on the left-hand side of the navigation pane, right below your access code. Note that each audio PIN is unique and may not be shared with other attendees. In order for us to unmute your line, your PIN must be entered.

Disclaimer

Please note that while the Provider Outreach & Education team has put forth every effort to ensure that the information you received today is updated and accurate, it is your responsibility as a DMEPOS supplier to stay abreast and compliant with any changes within the Medicare program.

January 1, 2021 Fee Schedule Update

Our first update is the 2021 Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) has released the fee schedule for 2021. The CMS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule contains a list of the maximum allowable amount per unit of service for the associated Healthcare Common Procedure Coding System (HCPCS) code. Inclusion or exclusion of a fee schedule amount for any item or service is not a guarantee for payment or coverage or an item. The DMEPOS fee schedule is based on the DMEPOS and Parenteral and Enteral Nutrition (PEN) fee schedule files provided by CMS. Drug fees, pharmacy dispensing fees and pharmacy supply fees are based on the CMS quarterly average sales price (ASP) files, Change Request instructions, and instructions in the Internet Only Manual (IOM), Medicare Claims Processing Manual, Chapter 17. You may access the most current fee schedules for these items on the Jurisdiction B website at https://www.cgsmedicare.com Then, once you are on the homepage, you may select the "Fee Schedule" option in the left-hand navigation pane. You may also access the fee schedule in our CGS Medicare Mobile app. The CGS Medicare Mobile app is available for free download in both the Google Play and Apple Stores.

CR 11997 – Clarifying the Use of As-Needed/PRN Orders for DMEPOS

The Centers for Medicare & Medicaid Services (CMS) published Change Request (CR) 11997 to clarify the use of "As-Needed/PRN" on orders for DMEPOS items. Per this change request, effective for dates of service January 1, 2020, CMS amended order requirements for items of DMEPOS via recent regulations CMS-1713-F. The rule provides a Standard Written Order (SWO) with set elements required to be included for payment purposes. Under these new rules, frequency is no longer a required element on the SWO; therefore, section 5.11, chapter 5 of the Program Integrity Manual will be updated to remove the language stating that "PRN" or "as needed" are not acceptable frequencies to be included on the standard written order. Suppliers are reminded that evidence of medical necessity must be present in the event of an audit. If replacement supplies are needed for the therapeutic purchase of DMEPOS items, the treating practitioner must specify on the standard written order, or on the CMN, the type of supplies needed, in such a manner that the supplier is capable of calculating the appropriate amount to be dispensed and assessing the continued need for refills with the beneficiary.

The standard written order or CMN submitted for DMEPOS services may also serve as medical evidence for replacement items. However, when the standard written order for DMEPOS is renewed or revised, supply utilization information must be specified or updated by the treating practitioner as well.

Change Request 11997 may be viewed/reviewed in its entirety on our website at https://www.cgsmedicare.com on the "News & Publications" page under the January 2021 articles or you may access this transmittal on the CMS website at https://www.cms.gov. Once you are on the CMS home page you may select "Regulations & Guidance," then "Transmittals."

Nurse Practitioner & Physician Assistants Certifying Physician for Therapeutic Shoes & Inserts

The Centers for Medicare & Medicaid Services (CMS) has recently provided guidance to the DME MACs about the delegation of the certifying physician doctor or medicine (MD) or doctor of osteopathic medicine (DO) comprehensive management of diabetes responsibilities to nurse practitioners (NPs) and physician assistants (PAs) prescribing therapeutic shoes and inserts for persons with diabetes. **This clarification is specific to NPs and PAs who are practicing under the supervision of an MD or DO ("incident to") and does not extend to NPs who practice independently (bill under their own**

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NPs or PAs providing ancillary services as auxiliary personnel could meet the "incident to" requirements in their provision of therapeutic shoes to beneficiaries with diabetes if **all** of the following criteria are met:

- The supervising physician has documented in the medical record that the patient is diabetic and has been, and continues to provide the patient follow-up under a comprehensive management program of that condition.
- The NP or PA certifies that the provision of the therapeutic shoes is part of the comprehensive treatment plan being provided to the patient.
- The supervising physician must review and verify, sign, and date all of the NP or PA's notes in the medical record, pertaining to the provision of the therapeutic shoes and inserts, acknowledging their agreement with the actions of the nurse practitioner or physician assistant.

As a reminder, the Social Security Act §1861(s)(12) requires that an MD or DO certifies that the beneficiary receiving therapeutic shoes and inserts is under a comprehensive plan of care for their diabetes. As a result of the MD or DO restriction, NPs and PAs may not serve in the role of the certifying physician unless practicing "incident to" the supervising physician's authority. This updated CMS guidance does not change the situation in those states that allow NPs to practice independently (without MD or DO supervision). In states where the NP may practice independently, the NP's employment situation would require compliance with Medicare "incident to" rules in order to serve as the certifying physician. Please refer to your A/B MAC for further information. For more information on this subject, please see the article in the November 2020 "News" section of the CGS website at https://www.cgsmedicare.com. Once you are on the homepage, select "News & Publication" from the left-hand navigation pane.

November 5,2020 - Nurse Practitioners and Physician Assistants as Certifying Physicians for Therapeutic Shoes and Inserts: https://www.cgsmedicare.com/jb/pubs/news/2020/11/cope19409.html

Primary Care First Model Demonstration Project

Section 1115A of the Social Security Act established a new Center for Medicare and Medicaid Innovation or the Innovation Center within the Centers for Medicare & Medicaid Services (CMS) to test new payment and service delivery models that have the potential to reduce Medicare, Medicaid, and Children's Health Insurance Program expenditures while maintaining or improving the quality of care for beneficiaries.

Effective January 1, 2021 and extending through December 31, 2025, CMS is exercising its authority under the Primary Care First (PCF) model to waive Section 1861 of the Act and the implementing regulations at 42 Code of Federal Regulations (CFR) 410.12 to allow nurse practitioners to certify that an order for diabetic shoes is required. Under this waiver authority, beneficiaries with diabetes are eligible for the standard Medicare diabetic shoe and shoe inserts benefit if a nurse practitioner refers or certifies the beneficiary. Normally, these items are only paid under Traditional Fee-For-Service (TFFS) Medicare if a physician (MD or DO) refers or certifies the beneficiary. The model is not changing the benefit coverage or limits in any way other than that of loosening the requirements for the referring or certifying provider to include nurse practitioners as well as physicians. The PCF model is only applicable in 26 regions. The states in JB are Michigan, Northern Kentucky Region, and Ohio. You will find full information in the November 2020 "News" section of our website at https://www.cgsmedicare.com. Once you are on the homepage, select "News and Publication" from the left-hand navigation pane.

November 5, 2020 - Primary Care First Model Demonstration Project - Nurse Practitioners as Certifying Physicians for Therapeutic Shoes and Inserts: https://www.cgsmedicare.com/jb/pubs/news/2020/11/cope19408.html

Medicare IVIG Demo Extension 2023

The Medicare Intravenous Immune Globulin (IVIG) Demonstration was originally scheduled to end on December 31, 2020. The Centers for Medicare & Medicaid Services (CMS) has now extended this demonstration through December 31, 2023. Any Medicare beneficiary enrolled in the demonstration as of November 15, 2020, will not be required to re-enroll. New beneficiaries may continue to enroll in accordance with the demonstration procedures. Suppliers can continue to provide and will be paid for demonstration services to eligible and enrolled beneficiaries beginning on January 1, 2021. Additional information about the demonstration can be found on Noridian's IVIG web page at https://med.noridianmedicare.com/web/ivig.

October 21, 2020 - Revised: 01.05.21 - Extension of Medicare IVIG Demonstration through December 31, 2023: https://www.cgsmedicare.com/jb/pubs/news/2020/10/cope19256.html

Revised ABN, CMNs, DIFs, & EFTs

The renewed Advance Beneficiary Notice of Noncoverage (ABN) Form CMS-R-131 with the expiration date of June 30, 2023 became mandatory on January 1, 2021. Confirm that you are using the correct version of the ABN as the expired version will not protect you from liability. The revised Certificate of Medical Necessity (CMN) and DME Information Forms (DIF) now have an expiration date of February 2024. All of these forms and instructions may be found in the Forms section of the CGS website at https://cgsmedicare.com/jb/forms/index.html.

Effective February 28, 2021, suppliers must begin to use the revised CMS 588 Electronic Funds Transfer (EFT) form to request EFT of Medicare payments. The DME MACs will accept the current and revised version of the CMS 588 EFT form until February 27. CMS outlines the minor changes to this form in the Medicare Learning Network Connects news article dated January 14, 2021. You may access the MLN Connects Article on news and publication page on our website at www.cgsmedicare.com once you are on the JB home page select news and publication and look for the January 14, 2021 MLN Connects article.

MLN Connects® for Thursday, January 14, 2021- https://www.cgsmedicare.com/articles/cope20314.html

Billing Update – GW Modifier

Effective for claims submitted December 1, 2020 for dates of service (DOS) on or after September 7, 2020. If a beneficiary is currently enrolled in hospice and the need for the DMEPOS items provided is not related to their hospice condition, the GW modifier must be appended to the applicable HCPCS codes. Claims without the GW modifier will be denied. These claims may be corrected through the myCGS portal or resubmitted with the GW modifier. If more than four modifiers are required to be appended to the same HCPCS code, replace the fourth modifier with modifier 99 and add the overflow modifiers to Item 19 of the CMS-1500 claim form or its electronic equivalent. Please refer to the article in the "News" section of our website: https://www.cgsmedicare.com/jb/pubs/news/2020/11/cope19459.html.

Medical Review Updates – JB Post Pay

As the Targeted Probe and Educate (TPE) program remains on hold, medical review continues the widespread post-pay service specific reviews. The categories for Jurisdiction B are ankle-foot orthosis, diabetic shoes, urological supplies, knee orthosis, surgical dressings (specifically alginate), blood glucose test or reagent strips used with the home blood glucose monitor, and lumbar-sacral orthosis. A list of applicable HCPCS codes and links to the announcements can be found on the CGS Jurisdiction B website under the "Medical Review" tab and then "Post-Payment Reviews" at https://www.cgsmedicare.com/jb/mr/post_payment_reviews.html.

CGS Claims Reopening Guidelines

When claims are submitted with minor errors or omissions, you may request Medicare to reopen the claim so the error or omission can be corrected, rather than having to go through the appeals process. The easiest, fastest, and most efficient way to correct or reopen a clam is to utilize the myCGS web portal. All reopening request must be submitted within one year from the date of the Remittance Advice. Reopenings may be requested to correct modifiers (excluding the KX, GA, GY, or GZ), date spans, HCPCS codes, units of service, and/or place of service. Requests involving a CMN to be loaded without an associated claim may not be submitted for reopening. Suppliers must resubmit the claim and attach the appropriate CMN to the claim for reprocessing. Claim corrections for claims initially denied as not reasonable and necessary, such as medical necessity, same or similar, or over utilization may not be reopened and must be submitted as a redetermination request for any corrections to be made.

- **January 27, 2021 – Updated 02.19.21:** Claim Reopening Versus Redetermination: https://www.cgsmedicare.com/jb/pubs/news/2021/01/cope20430.html

Recovery Auditor Contractor Issues

We want to ensure everyone is aware of the CMS approved audit issues for Performant, the Recovery Auditor Contractor (RAC). Performant lists the CMS approved audit issues on the website to make all DMEPOS suppliers aware of their area of focus. The RAC conducts two types of reviews: automated and complex. With automated reviews, no medical records are requested. During complex reviews, Performant requests medical records to determine if coverage requirements are met.

Performant is conducting complex reviews on therapeutic shoes and inserts. The dates of service under review includes claims with a paid date less than three years prior to the Additional Documentation Request (ADR) date. Claims with dates of service on or after January 1, 2020 will be excluded. HCPCS codes under review for these type of audits include A5500, A5501, A5512, and A5513.

Performant is also conducting complex reviews on pneumatic compression devices. The dates of service include claims with a claim paid date which is more than three years prior to the ADR date, and also, it excludes claims with services dates on or after January 1, 2020. The HCPCS codes included in these types of review are E0651, E0652, E0656, E0657, E0667, E0668, E0669, and E0670. To review all of the CMS approved issues for Performant Recovery, you may link to their website from ours by going to https://www.cgsmedicare.com/jb and selecting "Other Contractors" from the navigation pane on the left-hand side and then selecting the Performant Recovery link.

- **Performant Recovery Audit Contractor (RAC):** https://www.performantrac.com/solutions/healthcare/cms-rac-resources/cms-rac-provider-resources/default.aspx.

myCGS Version 7.0 & myCGS Tips & Reminders

Hopefully everyone on the call today is registered to access the myCGS web portal. For those of you that may be new to Medicare or the myCGS portal, this is a web-based application developed by CGS and is available to suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) who serve our beneficiaries in Jurisdiction B. Using myCGS is a fast and easy way to get Medicare claims and billing information.

Based on the feedback from our supplier community, CGS has made some enhancements to the myCGS web portal. MyCGS version 7.0 will go live on March 1, 2021. To implement improvements to the myCGS, the portal will be unavailable February 26 starting at 4 pm EST until 7 am EST March 1. With this release, there are several upgrades:

1. In previous versions of myCGS, resetting your password required using a temporary password as instructed in the password reset email. In myCGS 7.0, you will receive a link that takes you directly to the "Change Password" screen in myCGS. You will no longer need that temporary password.
2. The portal will now offer a suggested password. Use it or make up your own – it's your choice.
3. The password rules have been relaxed so that you can reuse characters from your previous password, as long as they are in a different position. For example, if your previous password started with the letter P, your new password should start with a different character, but you can still use the letter P in a different position of the password.
4. There is a new Multifactor Authentication (MFA) option called the Google Authenticator. Users who download the free Google Authenticator app can save time when logging in. Rather than waiting for an MFA text or email, simply enter the 6-digit code displayed in your Google Authenticator.

February 17, 2021 - myCGS 7.0 will go LIVE on March 1,

2021! - https://www.cgsmedicare.com/jb/pubs/news/2021/02/cope20718.html

Wrap Up

As we prepare to queue your questions, please note that we will only take verbal questions as this call is being recorded for transcription purposes. If you would like to participate in the question and answer segment, please be sure to enter your audio PIN. Your audio PIN is located on the right-hand side of the navigation pane, right below your access code. To raise your hand simply click on the icon hand that is located to the left of your audio pane. When it is your turn to present your question, we will announce you by name and unmute your individual line so that you can ask your question. Please remember that no specific claim information or Medicare beneficiary's protected health information should be verbalized. I will now give you just a moment to prepare your questions.

Questions and Answers

Stacie: Okay. Kathy we are now ready to take the first question.

Kathy: At this time, there are no hands raised.

So again, you want to make sure that you input your audio pin into you telephone keypad. At this point, if you have not entered your audio pin, you will receive a message in your audio pane to hit the pound sign, put in your pin, and the pound sign again.

Okay, I think our first question comes from the line of Theresa. Go ahead, your line is unmuted.

Stacie: Good afternoon, Theresa.

Theresa: Hi, thanks for taking my call. Can you hear me okay?

Stacie: Yes, we can.

Theresa: Okay, I have a question on buy-in program that has to do with when the patient should be eligible for Medicare, but they get missed in the program altogether, and they stay with Medicaid. Medicaid then takes their money back. We've had one that went back 10 years. We've had several now, and finding the information in the Medicare policies is difficult to find, but I did find the information how to reprocess a claim that's up to 10 years old, but it doesn't work. Have you heard of the buy-in program through Medicaid?

Stacie: Not through Medicaid. Are you submitting those claims to Medicare for reimbursement? Are these retroactive benefits?

Theresa: The retroactive benefit. The patient wasn't eligible for Medicare at the time of service, and then Medicaid found that they should have been eligible. But the patient never applied for Medicare. So then Medicaid takes their money back from us and tells us that we have to try to get payment from Medicare for that time period.

Stacie: Okay, that portion of it I am familiar with, the retroactive benefits. So initially, when you submit your claim, they are going to deny for timeliness. You will then need to request a redetermination. Within your redetermination, be sure to include your documentation that supports your notification of the retroactive benefits. That is a scenario in which good cause would be considered to waive the timeliness, since those are retroactive benefits. There isn't a way for you to submit those claims upfront, and they automatically go through our system. The only way to resolve an untimely claims submission denial is through the appeals process. So just make sure that you include your documentation with your request.

Theresa: And I have done that, and they still get denied saying, this is way too old. You can't do this. So, when I submitted to redetermination, and it never went through electronically. So they totally wouldn't even look at it on redetermination. So I did submit it then through the electronic process and got a denial, of course, for timely filing. Then I went and did the redetermination, and they still denied it, stating it's too old. So, it's like, what do I do? Send it to reconsideration? That also denied, it just it doesn't work!

Stacie: Okay and you are in Jurisdiction B, right?

Theresa: I am, yes.

Stacie: Okay. Can you submit that scenario back to the email that you received your confirmation from?

Theresa: Sure.

Stacie: Okay, we will look at that individually. It's too specific. You are following the correct process, but without actually seeing the claim and what has transpired, I can't really give you any further direction than that. So, if you'll send that back to us, will be sure to follow up with you on that.

Theresa: Okay. That sounds great! Thank you, Stacie.

Stacie: All right, thank you for your time.

Kathy: Theresa, we are re-muting your line. Next question comes from Rebecca.

Stacie: Good afternoon, Rebecca.

Rebecca: Good afternoon, thank you. My question is regarding customization of braces. We're having a lot of questions from our customer in regards to: is a certified orthotic fitter or an athletic trainer able to be what you would call "qualified" to customize a brace?

Stacie: That's going to depend on your state and what they deem to be acceptable or authorized to be able to dispense those items. When you go through enrollment into the Medicare program, all of your licensures regarding state and federal must be submitted to the National Supplier Clearing House (NSC). In order for them to determine if you can provide those types of services, and you would be, your PTAN is flagged for that, two allow those HCPCS codes to be considered for payment.

Per CMS guidelines, it says that the entity that is dispensing that item must be trained, have this specialized training for that. That's in your accreditation guide, guidance. So, the short answer is, it would have to be, if your state allows you to do that, and you are authorized to do so through the NSC, then we would accept that.

Rebecca: Okay, and best for us to go to our state site to make sure, for that, in regards to making sure that they're accredited. Is that correct?

Stacie: Well, your accreditation allows you to dispense the customized items. From an auditing perspective, we look in the chart notes to see who actually performed the adjustments or the custom piece of that. And they must be certified to do so.

Rebecca: Okay, thank you.

Stacie: Alright, thank you for your question.

Kathy: Thank you, Rebecca, we are re-muting your line.

And the next question comes from Power Chairs & Scooter Store, your line is unmuted.

Stacie: Good afternoon!

Jackie: Hi, this is Jackie.

Stacie: Hi Jackie.

Jackie: Hi, that question in the beginning, we were talking about the standard written order, and just wanted to clarify in-regards to quantity. Once again, the standard written order comes to us, does it need to specifically state the quantity by the physician order? Or did that not need to state the quantity by the physician on that standard written order?

Stacie: Quantity is a requirement on the standard written order, frequency is not. So the update that we provided was that because we changed – CMS changed – the required elements on the standard written order, and frequency is no longer a requirement. We're going to look, if it's not on the order, we will look to the medical record to support the frequency in which the item is to be used, which would.

Jackie: Oh. Okay, yep. The next question, because I was looking at it, so, if the information that you require is the quantity be on the standard written order, the frequency is not, that yet we still need to be sure that the physician is noting that frequency in the progress notes.

If we don't have that sent to us right away, to clarify that, which we probably need to be requiring that we have it prior, so that we can confirm that the frequency is listed in the progress notes.

Stacie: Right, because that's… yeah. That's the way that we would be able to determine that the amount dispensed supports, the frequency that it's going to be used or the physician's intent. So yes, you are correct. It should be in the medical records if it's not on the order. It's okay to put it on the order, it's just not an element we would look for, but we do require it in total, in the bigger picture of the review. In knowing how that item is to be used, the frequency of use.

Jackie: Right. We've been trying to do that too. Right? It seems most often in the CERT audits or reviews that were receiving. Most of the time. We're running into that while, when we don't have the documentation, that physician has not documented that in the progress notes. And we did not ask for them three years ago, four years ago, or as a business, or whatever practice. And currently today, that's become a have-to-have.

Stacie: That's the best practice.

Jackie: Yep. I. Can I ask one more question, in regards to shoes and inserts? I'll be quick here.

Regarding shoes and inserts – where we're seeing reviews come in on them, and we're trying to refine our process on that. We find, again, the forms, I don't want to say forms, because I know that's not good for Medicare. But to get the documentation from the physician that is acceptable and will provide us in the audit, like a clearer review, we've gone to some different options. There's Doctor Comfort is most common in our industry, and they list an example of seven different separate forms. One for the certifying, one for the initial order, review, one for the post review. Is there any acceptable way to simplify that? We've tried to, in our present day, to put the certification on the bottom and the doctor signs once. Again you send them the seven forms as an alternative, and I think they're just pulling their hair out, calling us, like, "What is it? What is it that you people want?" And they're directing it to us. So, it's difficult.

Stacie: So are you're looking for a way to simplify the forms that you're utilizing through Doctor Comfort?

Jackie: Right. So when these audits come through and we're seeing, "You don't have proper documentation. You don't have certification," but we do have all this information on these forms. It just doesn't seem that it is to their liking. Does it have to be seven separate forms like Doctor Comfort is showing us? Is there some way that we can receive some instruction to better condense all of this to make it rather than sending the physician seven forms for a pair of diabetic shoes? That seems a little bit excessive, I don't know.

Stacie: Okay. We don't have, any type of approved template or forms, but let me check in with our medical review experts. Tina or Sheila, do you have anything to add to her question about how we are to receive the information in support of the therapeutic shoes and the documents that they're choosing to use?

Tina: Hi, Stacie, this is Tina. I would agree with what you originally said. We don't have an exact template that we would recommend, but we do have some checklist on our website that will help you in gathering that information from the physician. It doesn't have to be a separate document. If you have a document that you can provide that shows that the certified physician is in agreement and that he or she is caring for that beneficiary, we would accept it. So, I think seven documents would be a little overkill. I know on my end, it would be. I would recommend that you look at some of our resources that we have on our website or frequently asked questions that you could use to make your own form. But to answer your question, there's not a template that we would recommend that you use.

Jackie: I understand that, and I appreciate that input, Tina. Like you said, we're trying to shorten it up and we're putting a lot of information on one page and the physicians are failing to check things off and it's a constant back and forth until we finally get a phone call. They're like, "What do you want?" We just don't want to have our money taken back! That's what we want. So yeah, what's the easiest way to do that? So we're just working on a way to streamline that and appreciate your input. We have looked at those checklists on those websites trying to pick out what the best thing is. It seemed like Medicare is asking for a situation where, when the fitter goes in to deliver the shoes, that they specifically add a summary in there, specifically to that individual, stating that Mrs. Smith didn't seem like she had a limp anymore and she really loved her shoes, or you know. Something more specific to that beneficiary. So, we are trying to get our heads around that, but appreciate it.

Stacie: Alright. Thanks, Jackie.

Kathy: Jackie your line is being re-muted. The next question comes from Missy. Missy your line is unmuted.

Stacie: Good afternoon, Missy.

Missy: Hi Stacie. How are you?

Stacie: Good! Good.

Missy: Okay, good. Alright, my question is very bizarre, and for the life of me, I just cannot remember where I saw this. But anyway, we have a local physician who is a long-term CPAP user, and his current prescription has expired based on the physician he was seeing. He wants to write his own prescription for CPAP supplies. Everything I can find is telling me no, we can't accept it. Can we accept it for a Medicare patient?

Stacie: Dr. Brennan, I hate to put you on the spot, but I believe we have gotten this question, we may have addressed it. Do you have any input for self-referrals for physicians for us today, Dr. Brennan?

Dr. Brennan: Can you hear me? Yes. Okay. Hey Missy and everybody. So, the situation again, and I'm thinking, this happened about two years ago, is the physician is not using a template? Is that right and writing the PAP order. Did I catch that right?

Stacie: He's going to prescribe for himself.

Dr. Brennan: Oh for himself. I'm sorry, Yeah, hmm… you know this again. When I looked at this, this was actually not two years ago. This was more recent. There are state laws regarding a physician's license and what they may prescribe for themselves.

One place to look would be the state where that physician has his license. Is that allowing him to self-prescribe? Obviously, in my opinion, and in many people's opinion, it's not good medical practice. As far as the Medicare program goes, I don't think we could find any specific guidance on that. Do you remember when I looked?

Stacie: Yeah, I recall the questions but not the outcome of that. I think we might have to take this question offline and provide a response.

Dr. Brennan: What was the prescription written for? Was it for PAP?

Missy: Yeah, the physician has been a CPAP user and had his pulmonologist do everything initially. His prescription has expired, and I don't know if maybe he's not following up with the pulmonologist anymore, which is why the pulmonologist won't sign it. So, he wants to write his own prescription. He's Medicare age, still practicing, his license is still good, and you know there was just some red flags in the back of my mind saying you need to look at this a little bit closer, Missy.

Dr. Brennan: I was just thinking of something though, the prescription to continue on for whatever the items are, that has to show medical necessity, right?

Missy: Well there is continued use continued need. Continued use is them ordering it, and then continued need, I think, is a prescription.

Dr. Brennan: Here's the problem, if a physician writes their own prescription to show continued medical need, I don't think they can back that up if that were audited. We would expect to see records from the treating practitioner that this person was still having this particular medical condition. You see what I mean, Missy?

Missy: Yeah.

Dr. Brennan: Yeah, the prescription might be able to be accepted, but if it were audited, I don't think that there would be any documentation, that the prescription can be linked to, because that physician's writing it himself or herself and doesn't have a medical record on themselves.

Missy: Right and I totally understand and appreciate that feedback. My initial thought was, yeah, I'm not comfortable with it. We had a conversation with the physician and were getting pushback. So I just thought, oh, I'm on a call today and I'll ask. So thank you very much.

Dr. Brennan: Did you try to suggest that it doesn't have to be necessarily the pulmonary doctor who writes that? It could be his primary care doc?

Missy: Yeah, you know. I haven't been involved in the conversation; but I'm about to get involved, so I certainly won't go down that path. No. I just want to make sure that our poor little customer service person isn't crying at their desk right now. Yeah. So, thank you very much. I appreciate your assistance.

Dr. Brennan: Oh sure. Let us know what you did, I'm curious.

Missy: Sure!

Kathy: Thank you, Missy. Your line is being re-muted. Your next question comes from the line of Michelle. Michelle your line is unmuted.

Stacie: Good afternoon, Michelle.

Michelle: Good afternoon. How are you?

Stacie: Good, thank you.

Michelle: I have a question in regard to diabetic foot exams. We have a particular physician who does many, many, many, foot exams, and he uses a really nice check sheet. I mean, it's got pictures of feet and he circles everything and marks everything. He is horrible at dictating his notes. So, we always get those beautiful little foot exam sheets that he uses. It's very clear what he's done, what he finds. Would those hold up in an audit?

Tina: Hi, this is Tina again with Medical Review. Is there a signature on the exam? What we are going to look for to make sure that these are actually his, and he agreed with what was printed off is a signature so the reviewer can determine who conducted the foot exam and signed the form. Is there a signature on them?

Michelle: I'm not 100% sure on that. Thinking back…

Tina: Okay.

Michelle: Would something like that be acceptable if there is a signature?

Tina: Yes. We would accept that as long as it's documented, and they've signed and dated it. We can tell that he's the one that actually did it. So, yes, that would be acceptable.

Michelle: I mean, it's a great sheet, and he's the only one that uses it. But there's been a lot of back and forth in our office. You know, one person's like, no, we're not going to fight him, and, you know of course, I'm like, well, yeah you are, because I got to have this. So, as long as he signs it, and it's legible that he signed it, we can use that?

Tina: Yeah, and it has the elements of his exam, yes. And also, I forgot to mention to Jackie earlier, that in our Connect

program we have nurses that will look. So if you have documents that you're questioning, if they're acceptable or not with therapeutic shoes or with anything that we have on review, you can submit those documents through to our Connect Nurses, and they will look at each document and give you feedback on whether or not it meets criteria. So, that would be a good opportunity if you question whether or not this is good or not. There is a form that you include with your submission and they can be found on our website as well. But we understand that it can be very difficult getting exactly what you want.

Michelle: Well, like I said, he does these great sheets, but it takes us months sometimes to get his dictation.

Tina: Right.

Michelle: But I mean, as just the biller, not even, you know, kind of like the lay person, I completely understand exactly what he's saying about the feet. And so, if that, is acceptable, it's going to end a lot of fighting. So, I will definitely send those into the Connect Nurse and see what she thinks.

Tina: Okay, thank you.

Michelle: Perfect, thank you so much for your input.

Kathy: Thank you, Michelle, your line is being re-muted. The next question comes from Leann. Leann, your line is unmuted.

Leann: Hi, thank you. My question is regarding a custom fit orthotic and the documentation that needs to be done by the supplier at the time of fitting. So we understand that, you know, we need to be outlining what was done to the product. You know how it was bent, trimmed, molded. But I guess I'm just looking for some type of guidance as to how deep that needs to go. Can it just say that this was bent to fit the patient, or does it need to say exactly what type of tools were used, or what is the depth that needs to go in to?

Stacie: Okay, there should be enough information in the chart notes for our medical review team to identify that this was truly a customized process that would require someone that is specialized in that field to be able to appropriately construct and fit the item to the beneficiary. It could not just be, for lack of better words a regular personnel, fitting the patient, they have to have that expertise in order to do so, and your documents need to support that.

Leann: Okay, and then, does that person who is doing the fitting need to sign and date that form?

Stacie: Yes, and their credentials should be included in that, as well.

Leann: Okay. Ok, thank you.

Stacie: Alright, thank you for your question.

Kathy: Thank you, Leann. You line is being re-muted. Your next question comes from the line of Lori. Lori your line is unmuted.

Stacie: Hi Lori.

Lori: Hi there. I have a couple of questions regarding the Primary Care First Model project. I feel like we were getting some conflicting information coming out. So my first question's regarding the nurse practitioners. The Primary Care First practice they are in – is it a rolling enrollment, or has enrollment closed on that?

Kathy: I can answer that question.

Stacie: Thank you, Kathy.

Kathy: You're welcome!

At this time, enrollment has ended for the Primary Care First (PCF) Model Demonstration. So, there is an excel file out on the CMS website. When you click on the file, it will give you a list of the names of the practices that are enrolled in the PCF Model Demonstration. From there, you would just need to verify, if you do receive an order from that nurse practitioner, and that he or she is part of the Primary Care First model by contacting that practice.

Lori: Okay, because there was actually a change request, a CMS change request, that came out a couple of weeks ago that said enrollment was ongoing and that it would be updated on a quarterly basis. So, that's a little different information than we've been, we've been told.

Kathy: We can certainly look into that for you. I just researched it a couple of weeks ago in regard to that and it did states that enrollmenthas ended at that point. That's certainly a good question that we can research for you and get back to you on Lori.

Lori: Just a couple more follow-up questions from that. The CMS change request also said that beneficiaries need to enroll in the program. Is that true? I don't see anywhere on the website that, that allows a beneficiary to enroll.

Kathy: No. It's not that beneficiaries need to enroll. It's only that the PCF Model demonstration only covers 26 regions. So, not every single state in the United States territory is part of that PCF model, so that beneficiary would have to reside in one of the regions and be enrolled in Medicare for it, maybe that's where the confusion lies.

Lori: Okay, yeah, that's true. They didn't say what they needed to be enrolled in. I was just hoping it wasn't the project. Then last question on that, the change requests also refers to a certain code that these claims need to be billed with. A 96 code? Does that relate to us as DMEPOS providers of the diabetic shoes or is that for the nurse practitioners?

Kathy: That's a good question, and that would be referring to the nurse practitioner's Part B office visit and not to the DMEPOS DME MAC contractor for DME claims.

Lori: Okay, good., So, we bill, as usual. It just allows, in these 26 regions, allows the nurse practitioners to certify independently.

Kathy: Yes. Only in that PCF model independently, you are correct.

Lori: Okay, that's, that was my question. Thank you so much.

Kathy: You're welcome, Lori. I'm going to go ahead and mute your line.

Ok, the next question comes from the line of Janet. Janet I just unmuted your line for you.

Janet: Hello. Okay, I have a question about CPAP. Our patients that fail compliance, we pick up their machine and we have a stockpile of used machines. I was wondering if we're able to give these out again to new patients as a rental. I know it doesn't have a UE or anything on the fee schedule.

Stacie: For Medicare reimbursement purposes, your

obligation as a supplier is that any equipment that you dispense and bill for capped rental items, that equipment is expected to last the five-year reasonable useful lifetime, even if it's refurbished. So, all we could say is there's not an expectation, that every piece of equipment that is rented, that dispensed, is brand-new. I would encourage you to consult with your compliance internally just to make sure that you're meeting all of the requirements.

Also, your accreditation, that's in place to ensure that you are providing appropriate equipment and it meets those standards according to your accrediting body. And as long as that's a go, then Medicare would reimburse for those items that the beneficiary meets the coverage criteria for.

Janet: Wonderful, wonderful. Okay, that's a load off my back. I have kind of a follow up question to an earlier question on the written orders and the quantity type is required. So, if a doctor orders a nebulizer and just puts nebulizer tubing, we assume they order one, so that there are quantity of one, and then they would need a new script if they want more. Is that acceptable?

Stacie: So, for items that are one-time purchase for equipment such as a wheelchair or a nebulizer, that would be acceptable. For supplies, we would expect to see the quantity on the supplies.

Janet: Okay, so it's not good then. Okay, thank you very much.

Stacie: Alright, thank you for your question.

Kathy: Janet your line is re-muted. The next question comes from Greg. Greg your line is unmuted.

Stacie: Hi, Greg.

Greg: Hello, thanks for taking my call. I have a question regarding the pneumatic compression pumps that you mentioned earlier, in regard to the Performant audit. We are a dealer that does dispense compression pumps, and we do have a handful of the Performant audits that we submitted. Not so favorable reviews are coming back. Some I won't get into patient specifics, obviously, but some of the reasons that they're denying is, their denying simply, I'll give you an example is you know, in the LCD, it'll say, if a patient has lymphedema fail to interpret treatment, and the reason it failed is because of marked hyperkeratosis with hyperplasia and hyperpigmentation.

The reason Performant denied one is because it didn't have hyperplasia on there. It just had hyperkeratosis and hyperpigmentation in the note. Failed it for conservative treatment. They're denied it for not medically necessary.

We had another one that they met all the criteria for lymphedema. But as a doctor also diagnosed venous insufficiency. The patient didn't have ulcerations, but since it was diagnosed on the prescription as relevant to the condition, and on the CMN they denied it for not having ulcers.

The LCD was updated to include CVI as a contributing factor to lymphedema. So, we're getting these that are denied and in some of these we're talking 100 pages of notes, wound notes, lymphedema clinic notes, and they're still denying it. So, I guess as a supplier, going to these physicians and trying to explain who qualifies and who doesn't is becoming more difficult. And I guess I'm almost to the point now where, I mean, do they literally have to put in word for word the LCD somewhere in there note where it smacks Performant in the face? Or are we just going to continue to have to fight these after the Performant denial?

Stacie: No, we are not expecting that the documentation in the medical record would be verbatim per the LCD. Keep in mind that there are clinicians that are looking at the documentation, and they should be able to pull from what is submitted, whether or not the coverage criteria has been met.

Tina, do you have anything else to add to this scenario regarding the types of documentation for these devices?

Greg: We also, real quick, Tina, we also get a lot of these. We've had two of them that denied for not having before and after, four-week trial conservative method of treatment measurements. And I understand that. Increased documented length and size was the reason for the lymphedema pump. You have to show that, but it is only one of numerous things that would qualify the patient for the pump, and that's another thing we're seeing. So, I guess where I'm looking at a lot of this documentation is, I feel with reading the LCD, looking at the patient's limbs, evaluating the patient, they more than qualify for a pneumatic compression pump. But because the notes are so involved I just, I'm just shocked on some of the findings on these. So, I just, any guidance on it would be great.

Tina: Unfortunately, I don't have anything in addition to add Stacie. And it sounds like you're providing way more than enough information. Currently, that's not something that we have on review, but based on the information that you gave me, it sounds like it's a very in-depth review, and it could take a while for the nurses to go through it. But I can't think of anything in addition that you would need to add.

Greg: Okay, because, I mean, we're getting this, you know, just speaking with other suppliers and other states, they're not picking on me, right, I know this is national across the board with these audits. And speaking with other clients, in other states and even in Michigan, they're basically stating the same thing: Performant is denying all of these. You're going to have to take it to appeal with Medicare and potentially hearings to get your money. Companies that were audited a year prior to me on these pumps, so I just feel like Performant is basically denying and contradicting the LCD, and, you know, whether it be my rep, my physicians. They're looking at me going, "Greg, I don't know what else I can put in these notes, what do you want from me to get the patients' these compression pumps?" And then they become discouraged and not right for them. So.

Tina: Have you taken any of them to appeals yet?

Greg: Not the pneumatic, but we're not at that stage yet.

So, we're not at the stage. We're appealing with Performant first, and then depending on what they decide on our appeal there, then we take it to Medicare, which is you guys, but we have not gotten to that point yet.

But we're seeing that a lot too, and I don't I don't want to give too much more time. But we're seeing that a lot even with knee brace and back brace audits, where there's a joint laxity test in there, and they're denied it for no proof of joint laxity, and we're even writing cover letters now. On the Medicare cover letter it says page four of the doctors note, paragraph three, he examines the knee and discusses, joint laxity,

unfortunately died for not having joint laxity. So, with the increase of audits we've seen in Q4 and Q1 here, we're just going, what, is this just a numbers game where we send them 20 audits, you're going to approve 11 of them and we're going to get the appeal the RAC? That's kind a what we're feeling like as the supplier.

Did I lose you guys?

Stacie: My apologies, Greg, I was on mute. Thank you for your input on that. Hopefully, those types of things can be resolved through the appeals process, and its kind a hard to say "yay or nay" to any side of that without actually looking at the case. So, hopefully that can be resolved through the rebuttal process with the RAC.

Greg: Okay.

Stacie: Alright. Thank you for your question and your comments.

Greg: Thank you.

Stacie: Alright Kathy, I show we are right at the top of the hour. So, Greg will be our last question that we take for this afternoon.

End

Thank you for attending today's Ask the Contractor Teleconference and for participating in the live question and answer session. We will post the transcript to our website and send out a ListServ notification when it is available. I'd like to thank you all so much for attending today and we look forward to seeing you at future educational events. Have a great day

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