Introduction

Good afternoon and welcome to CGS Administrators DME MAC Jurisdiction B General "Ask the Contractor Teleconference." These ACT calls are hosted by the DME Provider Outreach and Education team for Jurisdiction B. Also on the call this afternoon, are CGS subject matter experts from various operational departments. For this particular ACT call you may ask questions related to any aspect of DMEPOS Medicare.

Before we begin taking your questions, I would like to provide you with a few recent updates to the Medicare program.

New Medicare Card Project

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS to remove Social Security Numbers from all Medicare cards. A new, randomly generated Medicare Beneficiary Identifier, or MBI, replaced the SSN-based Health Insurance Claim Number. The new MBIs will be noticeably different than the HICN and RRB numbers; they will be 11 characters in length and made up of only numbers and uppercase letters with no special characters.

CMS began sending the new Medicare cards with the MBI in April 2018. All new fee-for-service enrollees received the MBI only while current beneficiaries were mailed their new cards throughout 2018. This process is now complete. There will be a transition period that will allow claims to be submitted with either the HICN or the MBI. This transition period began April 1, 2018, and will run through December 31, 2019. When the transition period ends, suppliers must use the MBI for all claim submissions beginning January 1, 2020, moving forward.

You are welcome to check claims history, eligibility, etc. using the MBI within our Web portal, myCGS. If you access the website. https://www.cms.gov/newcard, for additional information.

Temporary Gap in Competitive Bidding

All Medicare Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) Competitive Bidding Program (CBP) contracts expired on December 31, 2018.

Starting January 1, 2019, CMS implemented a temporary gap that is expected to last until December 31, 2020. This means that any supplier can provide DMEPOS items to our Medicare beneficiaries residing in a former competitive bidding area. Competitive bidding suppliers must continue to furnish current capped rentals through the end of the rental period of 13 months. The same holds true for oxygen, but the former competitive bidding supplier must furnish oxygen through 36 rental months as well as the five-year reasonable useful lifetime. For all other DMEPOS items such as diabetes testing supplies or enteral nutrition, the supplier is not required to continue furnishing the items to the beneficiary on or after January 1, 2019, and the beneficiary can find a new supplier. In these situations, former CBA suppliers may transfer all documentation, including the order, to the new supplier. As a reminder, there are separate fee schedules (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html) for the former competitive bidding areas. A hyperlink for all fee schedules and the CMS Beneficiary Fact Sheet (https://www.cms.gov/Outreach-and-Education/outreach/partnerships/downloads/DMEPOS-Temporary-Gap-Period-Fact-Sheet.pdf) about the temporary gap will be added to the transcript of this ACT call at publication.

MSI Survey is Coming

Within the next few weeks, CMS will open the annual MAC Satisfaction Indicator (MSI) survey to solicit feedback from the suppliers. This is a wonderful opportunity to let CMS know how each MAC is handling your claims and issues. The MSI is typically available approximately 6-8 weeks in the spring, so be looking for it. We will alert you via ListServ announcements and website updates when the MSI becomes available.

Foresee Survey

I also wanted to mention the CMS Foresee survey (https://survey.foreseeresults.com/survey/display?cid=wtsU0tp0k hBZxlUgcpcMxA==&sid=browse-cigna_dme_mac_c-en) window that pops up when you access the CMS website. Your input is vital in making changes to our website that will positively affect all suppliers. Use the survey to tell us what you like about the website, what you don’t like about it and what you would like to see for future enhancements. If you leave contact information as part of your comments, we will follow up with you. Complete the Foresee survey the next time you visit our website to help us determine the changes you want to see on our website. It only takes a few minutes of your time and your contribution is very important to us.

https://www.cgsmedicare.com

I want to spend a moment today reviewing some of the benefits of our website, https://www.cgsmedicare.com.
We have a countless number of free tools, articles, and letters to help you. For example, within the Online Tools and Calculators Web page (https://www.cgsmedicare.com/jc/help/tools.html), we have the Claim Denial Resolution Tool (https://www.cgsmedicare.com/jc/help/tools.html#cdrt) and the DMEPOS Consolidated Billing Tool (https://www.cgsmedicare.com/jc/help/tools.html#consbill) to assist in handling your claim preparation and submission. I mentioned our Web portal, myCGS (https://www.cgsmedicare.com/jc/mycgs/index.html), earlier. If you have not done so, we encourage you to review the Registration Guide (https://www.cgsmedicare.com/jc/mycgs/pdf/mycgs_registrationguide.pdf) and begin the process to enroll in myCGS. We also have a number of Dear Physician Letters (https://www.cgsmedicare.com/jc/mr/doc_reg.html) authored by the DME MAC Medical Directors that you are welcome to print or email to your referral sources. That are all of these are free and very easy to use!

**Conclusion**

As I prepare to queue your questions, please note that we will only take questions over the telephone as this call is being recorded for transcription purposes. To raise your hand, simply click on the icon of the hand. Then, I will announce you and unmute your individual line so that you can ask a question. Also remember that no specific claim information or Medicare beneficiary’s private health information should be verbalized. I will now give you just a moment to prepare your questions.

**Questions**

**Steve:** We have 1 or 2 physicians that still opt to do hand written medical records/office notes. If they are deemed “illegible”, what can be done?

**CGS:** Medicare program rules require all medical record documentation to be legible regardless of format. We must be able to read the documentation to ensure all coverage and documentation requirements are met to allow payment. For illegible medical records, you may request from the provider a transcribed copy of the medical record.

**Christine:** Can we use our Certificate of Medical Necessity (CMN) as a Written Order Prior to Delivery (WOPD)?

**CGS:** Yes, the CMN may used as the WOPD as long as all of the required element of the WOPD are captured on the CMN.

**Judy:** If the referring physician has died or retired, is it acceptable to get documentation from the beneficiary’s family physician?

**CGS:** It is acceptable to request documentation to support medical need from other entities such as a hospitals, OT/PT, skilled nursing facilities...etc. However suppliers must be mindful that if the original prescriber is no longer managing the care of the beneficiary due to death or retirement, this may impact the status of their NPI causing subsequent claims to deny.

**Nancy:** Now that the temporary gap in competitive bid is in place, how does this affect the shipping areas that were not in a CBA?

**CGS:** Prior to the temporary gap in competitive bid, the national mail order suppliers were the only suppliers that could ship diabetic testing supplies to Medicare beneficiaries. Now that the temporary gap is in place, any DMEPOS supplier may ship diabetic testing supplies to any Medicare beneficiary regardless of their residential location.

**Kathleen:** Can the DME supplier complete the physician’s order with all of the required information and then fax it to the prescribing physician to sign and fax back?

**CGS:** Per the Standard Documentation Requirements article (A55426) it is acceptable for someone other than the prescribing physician to create the detailed written order. However the prescriber must review the content and sign and date the document.

**Janet:** When the beneficiary switches from a private insurance to Medicare primary, if the beneficiary has met all of Medicare guidelines, can we just switch our billing over to begin billing Medicare or are we required to requalify the beneficiary with new documentation even if the existing documentation meets the guidelines?

**CGS:** When beneficiaries become newly entitled to Medicare benefits, existing documentation may be used to qualify the beneficiary for Medicare coverage. Suppliers are encouraged to consult the related LCD and Policy Articles to ensure the timeliness requirements for documentation is also met.

**Susan:** If a patient has oxygen ordered coming out of a medical facility and the hospitalist will not sign the CMN, is it acceptable to have the beneficiary’s primary physician sign the CMN?

**CGS:** Yes it is acceptable to have the primary physician complete and sign the CMN. The primary physician signing the CMN must have access to the medical records related to the information being provided on the CMN.

**Nicole:** How does the supplier seek reimbursement from the hospital when a brace is provided prior to surgery?

**CGS:** Reimbursement for items during an inpatient stay would be included in Part A coverage. You may reach out to your Part A MAC for questions on Part A reimbursement.

**Missy:** How would we go about billing a salvage claim for a customized item the patient refused after fabrication had been completed or the patient passed before fabrication was completed?

**CGS:** Suppliers may bill salvage claim for custom fabricated in the event of a change in medical necessity, death, or cancellation of the order by the beneficiary. Supplier must only bill for unsalvageable materials and labor. The date of service used on the claim must be the date of notice in change of condition, date of death or the date of cancellation of the order. In the scenario the supplier must have documentation to support the reason for the salvage claim.
Lisa: Does the physician need to document why a custom brace is needed or is the orthotist documentation enough?

CGS: When custom items are provided, there must be documentation within the medical record to support the medical necessity related to the custom item. The detailed written order must also indicate that a custom item was ordered. In addition to the medical record documentation, the Orthotist must also assess the beneficiary and document the need for the custom item versus the off the shelf item. If the item is custom fitted, there must documentation in the orthotist records of the fitting process to make the item custom fitted.

Conclusion

Please watch our Listserv for the ACT transcript to be published. When this transcript is published, we will add it to the Jurisdiction B ACT call Web page as a PDF formatted document and you will be able to download it at your leisure. At this time there are no additional questions in queue. Thank you all for your participation in the JB ACT call. This concludes today’s call.