Jurisdiction B Ask-the-Contractor Teleconferences (ACT)

Provider Outreach & Education
Date: May 25, 2021

Moderator: Teresa Camfield
Time: 2:00 p.m. EST

Welcome & Introduction

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

Please note there is not a presentation for this call. This call is being recorded and a complete transcript of today's ACT telelconference will be posted to our website within 30 business days at https://www.cgsmedicare.com/jb/education/act.html. An electronic mailing list will be sent out when the transcript is available.

Our ACT Participation Instructions

If you would like to participate in the question and answer segment today, please be sure to enter your audio PIN # into your telephone keypad. Your audio PIN is located in your webinar control panel, 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 during the Q/A portion, your PIN # must be entered.

This Is Our Disclaimer

Medicare does change frequently. The Provider Outreach & Education team has put forth every effort to ensure the information you receive today is accurate and up to date. However, it is ultimately your responsibility as a DMEPOS supplier to stay informed and compliant with Medicare program guidelines. Just a quick reminder, attendees may not record this teleconference for any reason or purpose.

Let's move on to the latest Medicare updates and reminders.

Jurisdiction B Post-Payment Service Specific Reviews

The audit process is used to protect the Medicare Trust Fund against inappropriate payments. The Medicare Administrative Contractors (MACs) are continuing post-payment service-specific reviews.

Jurisdiction B DME MAC is currently conducting post-payment reviews on the following items: ankle-foot orthosis, blood glucose test strips for home blood glucose monitors, immunosuppressive drugs, knee orthosis, lower limb prostheses, lumbar-sacral orthosis, manual wheelchairs, ostomy supplies, surgical dressings, therapeutic shoes and inserts for diabetics, and urological supplies.

A list of applicable Healthcare Common Procedure Coding System (HCPCS) codes and links to the announcements can be found on the CGS Jurisdiction B website at https://www.cgsmedicare.com, left-hand blue navigation panel, Medical Review tab, Post-Payment Reviews; then Service-Specific Review Announcements.

As a supplier it is important that you respond to any requests for additional documentation to avoid an unfavorable decision on the selected claims.

Keep in mind, the Targeted Probe and Educate (TPE) program is currently suspended and will resume at a later date to be determined by the Centers for Medicare & Medicaid Services (CMS).

CGS Medical Review recently published quarterly status reports by policy; these reports can be found on the CGS Jurisdiction B website at https://www.cgsmedicare.com, left-hand blue navigation panel, Medical Review tab; then TPE Quarterly Reports by Policy, which includes Service Specific Post-Payment Reviews.

The MACs will continue to provide detailed review decisions and offer education as appropriate.

myCGS Post-Pay ADR Submission

A major enhancement with myCGS 7.1 is the addition of Post-Pay to the Additional Documentation Request (ADR) screen.

When CGS requests additional information to process a claim correctly or review a previously processed claim, CGS sends an additional documentation request (ADR) letter. If you receive an ADR letter, you must respond to the request in the given timeframe within the letter, in order for your claim to be processed correctly and/or avoid denial (or recoupment).

myCGS gives you the ability to check ADR status, view ADR letters, and submit your ADR response directly within the web portal.

To access additional information about myCGS registration and myCGS functionality, please visit the Jurisdiction B DME MAC website at https://www.cgsmedicare.com left-hand, blue navigation panel, myCGS tab.

COVID-19 Public Health Emergency (PHE) Reminders

To provide status of the ongoing COVID-19 Public Health Emergency (PHE) – There have been no recent updates from (CMS) as to when non-enforcement will end and no additional information regarding continued coverage after the end of the PHE.

If your claims are impacted by the PHE, for coverage, coding, or documentation requirements; suppliers are instructed to append the (CATASTROPHE / DISASTER RELATED) CR modifier and the NTE note narrative

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"COVID-19" to all PHE affected claims. This instruction is to ensure proper claims processing.

You can access current COVID-19 PHE information and instructions on the CGS website at https://www.cgsmedicare.com, left-hand blue navigation panel, COVID-19 tab.

Sequestration Suspension Extended

The Coronavirus Aid, Relief, and Economic Security (CARES) Act suspended the two percent (2%) sequestration payment adjustment applied to all Medicare Fee-for-Service (FFS) claims. Congress recently extended the sequestration suspension period through December 31, 2021.

Medicare Administrative Contractors (MACs) have released any previously held claims with dates of service on or after April 1, 2021 and the MACs will reprocess any claims paid with the 2% payment reduction applied.

No action is needed by suppliers.

Competitive Bidding Round 2021 Modifier Reminders update

Round 2021 of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) is effective for dates of service January 1, 2021, through December 31, 2023. Competitive Bidding will only be in effect for off-the-shelf (OTS) back braces and off-the-shelf (OTS) knee braces. These items must be provided by a competitive bidding contract supplier to a Medicare beneficiary who resides in a competitive bidding area (CBA) unless an exception applies.

These exceptions include Medicare Secondary Payor (MSP) claims, repairs to the affected HCPCS codes, and traveling beneficiaries.

Three important Competitive Bidding Program (CBP) rules to know when a beneficiary needs an OTS back or knee brace while traveling are:

1. Payment is based on the beneficiary's permanent residence; this is the address on file with the Social Security Administration (SSA).
2. Which supplier may furnish the OTS back or knee brace is determined based on where the beneficiary purchases the item.
3. The supplier that provides the OTS back or knee brace to the Medicare beneficiary must accept assignment (i.e., accept Medicare payment as payment in full) unless the beneficiary's permanent residence is not in a CBA and the beneficiary travels to an area that is not a CBA.

There must be documentation as to the reason it is necessary for the beneficiary to receive a bid item prior to returning home.

In this instance a contracted supplier must affix the HCPCS modifier "KT" to DME MAC claims for OTS back or knee braces that are furnished to beneficiaries who permanently reside in a CBA and need a competitively bid item when they travel outside of the CBA where they reside to another CBA.

Physicians or other practitioners (e.g., physician assistants, nurse practitioners, clinical nurse specialist) **who are enrolled Medicare DMEPOS suppliers** may furnish competitively bid OTS back and knee braces to their own patients without submitting a bid and being selected as a contract supplier. The OTS back brace or knee brace must be furnished by the physician or other treating practitioner **to his or her own patient as part of his or her professional service**. The brace must be billed by the physician/practitioner on the same day/date as the practitioner's office visit to a DME MAC. **In this instance the KV modifier should be appended to the DME MAC claim.**

Physical therapists and occupational therapists in private practice who are enrolled as Medicare DMEPOS suppliers have the option to furnish off-the-shelf (OTS) back braces and OTS knee braces without being a competitive bidding contract supplier, provided that the items are furnished only to the therapist's own patients as part of the physical or occupational therapy services.

On the claim billed to the DME MAC, the OTS back brace or OTS knee brace line item must have the same date of service as the physical or occupational therapy service billed to the Part A/Part B MAC. **In this instance the J5 modifier should be appended to the DME MAC claim.**

Hospitals may furnish competitively bid OTS back and OTS knee braces in a CBA to their own patients without submitting a bid and being selected as a contract supplier. **In this instance the J4 modifier should be appended to the DME MAC claim.** This hospital exception does not apply to hospital-owned DMEPOS suppliers.

If a non-contract supplier provides a competitive bid item to a beneficiary that resides in a Competitive Bidding Area (CBA), they must obtain an Advance Beneficiary Notice of Non-coverage (ABN).

CGS has created a webpage providing all Round 2021 Competitive Bidding Program information located in the Education section of the CGS website. It includes information on the affected codes, how to identify if the beneficiary resides in a CBA, information for non-contract suppliers and much more. This information is available under Education in the left-hand blue navigation panel of the CGS website at https://www.cgsmedicare.com.

Custom Fitted Orthoses without a Corresponding Off-the-Shelf (OTS) Code

This update is regarding the coding and billing of custom fitted orthotics that do not have a corresponding off-the-shelf equivalent. A helpful news article titled "Custom Fitted Orthosis without a Corresponding Off-the-Shelf Code" was published on March 11, 2021 and is available on the CGS website at https://www.cgsmedicare.com, left-hand blue navigation panel, News & Publications tab.

This article provides a list of custom fitted orthotic codes that do not have a corresponding OTS (minimal self-adjustment) HCPCS code and provides guidance to utilize the applicable orthotic miscellaneous HCPCS codes. When billing a miscellaneous HCPCS code be sure to include a narrative on the claim which includes a description of the item or service, manufacturer's name, product name and number, supplier price list (SPL) amount, and the HCPCS code of the related item (if applicable). If it is a customized option or accessory, the statement must clearly describe what was customized.

The article states, "Custom fitting requires the expertise of a certified orthotist or an individual who has specialized

training in the provision of orthoses to fit the item to the individual beneficiary at the time of delivery. These items **cannot be mailed or shipped to the beneficiary**, without documentation of prior custom fitting of the item."

If you have additional questions on the correct code to bill or clarification on coding, contact the Pricing Data Analysis and Coding Contractor (PDAC), their website is https://www.dmepdac.com.

Certified Fitters of Orthoses

Both "off-the-shelf" (OTS) and custom-fit items are considered prefabricated braces for Medicare coding purposes. In regard to the requirement for certified fitters, CMS regulations at 42 CFR (Code of Federal Regulations), 414.402 also defines the term "minimal self-adjustment" to mean an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and does not require the services of a certified orthotist (that is, an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification) or an individual who has specialized training.

Please note that in some cases there are two HCPCS codes that may both describe a particular prefabricated orthotic product, one code for when the device is furnished off-the-shelf (OTS), and a second code for when the device is furnished with custom fitting.

The Ankle-Foot/Knee-Ankle-Foot Orthosis (AFO/KAFO) Local Coverage Determination, Policy Article (52457) on our website https://www.cgsmedicare.com under Local Coverage Determinations tab, in the left-hand blue navigation panel, states; "In contrast to "minimal self-adjustment," "more than minimal self-adjustment" is defined as changes made to achieve an individualized fit during the final fitting at the time of delivery of the item that requires the expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthotics in compliance with all applicable Federal and State licensure and regulatory requirements."

This fitting at delivery does require the expertise of a certified orthotist or an individual who has specialized training in the provision of orthosis to fit the item to the individual beneficiary.

In these cases, and in the case of any code for a prefabricated orthotic that requires more than minimal self-adjustment and requires expertise in fitting or customizing, the code that describes a custom fitted orthotic cannot be used unless the custom fitting services have been performed and the supplier is in compliance with Appendix C of the DMEPOS Quality Standards.

Suppliers of any orthotic other than an OTS orthotic must be incompliance with Appendix C of the DMEPOS quality standards, which specifies, "individuals supplying the items identified in this appendix (e.g.; custom-fabricated and custom fitted orthoses, prosthetic devices, external breast prostheses, therapeutic shoes, inserts, accessories, and supplies, custom-made somatic, ocular, and facial prostheses) must have certification, and/or licensing, and specialized education, training, and fitting experience.

Therefore, suppliers should refer to their state laws and certification requirements to comply with federal regulations and the DMEPOS Quality Standards.

The DMEPOS Quality Standards can be referenced at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/DMEPOSQuality/DMEPOSQualBooklet-905709.html

Same/Similar Orthoses and Change in Condition

Items that are identical or similar to items previously paid for by Medicare may be provided when the item is lost, stolen, irreparably damaged, or there has been a change in the beneficiary's medical or physiological condition.

When an orthosis is denied as same/similar the denial may be submitted for a redetermination.

For a change in condition, the supplier should submit the following documentation with the redetermination request, a standard written order (SWO) for the device and proof of delivery (POD) along with the medical record documentation to substantiate a change of the medical or physiological condition of the beneficiary which includes information such as the diagnosis, prognosis, duration of condition, functional limitations, clinical course, and past experience with related items and the reason why the previous orthotic device is no longer functional or appropriate for the current condition.

The DME MACs will review the documentation to determine if there was a change in the beneficiary's medical/physiological condition in this circumstance.

CGS has developed a helpful documentation checklist for replacement orthotics for a change in condition located on the Jurisdiction B website at https://www.cgsmedicare.com, left-hand navigation panel, Medical Review tab, then Resources, then Documentation Checklists titled "Replacement Orthotics for Change in Condition During the Reasonable Useful Lifetime."

CGS Educational Opportunities

CGS is very pleased to offer multiple online and web-based educational opportunities to our supplier community.

Suppliers can access the Education tab located on the left-hand blue navigation panel at https://www.cgsmedicare.com. Once on the education tab suppliers can access Online Education Courses (OECs), for example, our Welcome to Medicare series, multiple DMEPOS OECs, such as walkers, commode chairs, ostomy, and our newest additions Continuous Passive Motion Devices (CPMs) and Pneumatic Compression Devices.

Also available, are video education courses such as Medicare Minute MD (produced by our medical directors), the additional Medicare Minute and CMS Provider Minute videos.

Under Calendar of Events, Provider Outreach and Education (POE) lists the upcoming live webinars. We also offer Encore Webinar events. Encore events are recordings of our most popular webinars, including our three-part series on Documentation Requirements. The Encore webinars will be updated when a new presentation on that topic is held, so you always get the most up-to-date information.

CGS website is available twenty four hours a day, seven days a week with the exception of maintenance and service. You can access CGS Tools & Calculators and educational offerings at your convenience.

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Wrap Up

This concludes our Medicare Updates. As we prepare to queue your questions, please note 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, be sure to enter your audio PIN # into your telephone keypad. Your audio PIN is located in the GoToWebinar control panel under the audio drop-down.

To raise your hand, simply click on the icon of the hand that is located to the left of the audio pane. When it is your turn to present your question, my co-moderator Kathryn Torro will announce you by name and unmute your individual line, so you can ask your question.

As a reminder no specific claim information or Medicare beneficiary's private health information (PHI) or personal identifiable information (PII) should be verbalized.

To give everyone a chance to ask their question, we will only be taking one question when your phone is unmuted. After your one question is addressed, please raise your hand again for each additional question. Our goal is to address as many questions as possible during our scheduled time.

I will now give you just a moment to prepare your questions.

Kathryn, we are now ready to take the first question.

Q/A Session

Kathryn: Thank you. The first question comes from the line of Amy. Amy your line is unmuted.

Amy: Hi there. My question is regards to sleep studies. We have a facility that is oh gosh. A replacement CPAP order for a patient who had a study back in 2012. However, the study is not signed by the physician, and the physician now, seeing them, signed the document, and has sent that in, to avoid the patient being re-slept. They say other providers are accepting that, but I don't see where it specifically specifies that it has to be original. I'm assuming that shared, so, is that somewhere in the documentation for us?

Teresa: As a general rule, the original physician who ordered the sleep study or who scored the sleep would be signing off on that sleep study. However, I'm going to let Ed with Medical Review, jump in and give you further clarification. Go ahead, Ed.

Amy: Thank you.

Ed: This is Ed Knapp from Medical Review. Did the original sleep study meet the qualifications for Medicare coverage at that time?

Amy: Other than the signature. Yes.

Ed: My suggestion would be if they are currently seeing a physician now, they can sign the sleep study and incorporate those findings into a current note.

Amy: Ok That's what I needed to know. Thank you.

Ed: You will need to provide both documents in the event of an audit.

Amy: OK.

Kathryn: Thank you, Amy.

I am going to check; Teresa give me one moment to check to see if anyone's hands are raised. I do not see any hands raised. Give me one moment, someone just raised their hand.

Lori: your line is now unmuted.

Lori: Hi There. I actually have two questions if you will allow me.

The first question I have is regarding the change to the diabetic shoe documentation process, where they now allow nurse practitioners and physician assistants that are working incident to a supervising physician to certify the need for shoes.

If we have a scenario where we have an NP that is working incident to physician, sees the patient, treats the patient for the diabetic care, you know, documents that we have the sign off from the supervising physician who would be the appropriate person to sign the Statement of Certifying Physician (SOCP) in that case?

Teresa: The Statement of Certifying Physician (SOCP) would be completed by the nurse practitioner; that's incident to; then the attending physician would also need to sign the SOCP as well in agreement.

Lori: OK, so if we have, if the MD actually signs the SOCP that wouldn't be accepted?

Teresa: That would be accepted.

Kathryn do you have anything to add to that as far as this scenario?

Kathryn: He/she should be practicing incident to. He or she signs off on the medical documentation, writes, the order. For some reason he or she does not complete the certifying statement, but the, treating physician overseeing that nurse practitioner is the one who completes the certification statement. That's the scenario?

Lori: Yes.

Kathryn: That would be acceptable, as long as that same physician that signed the agreement, signed off on the medical record. OK.

Lori: OK. That's a good information. Thank you for that. My second question is regarding the provision of the custom fit devices, by an individual who has specialized training. So, the certified fitters are certified by ABC, and they also have specialized training, but they are not licensed. As long as we follow the DMEPOS supplier standards that says they're both certified and have this specialized training they are still allowed to custom fit or supply custom fit devices?

Sienna: This is Sienna with CGS. To clarify that; it would depend on your state, and it would depend on their licensing requirements.

Lori: OK,

Sienna: So, if your state required a state license, and they were a certified fitter, but not licensed then they would not be eligible to provide those devices. Correct.

Lori: OK, even though they're certified?

Sienna: Correct. It's based on your state license and all your state regulations. That's correct.

Lori: OK. OK, Thank you.

Kathryn: Thank you, Lori. Those were very good questions. I am remuting your line. Give me just one moment. I am just checking for you Teresa to see if there is anyone with their hand raised. Give me one moment please.

Teresa: Thank you.

Kathryn: Teresa, I am going to go ahead and unmute your line. Your line is unmuted.

Teresa: Hey, I have a question about the CGM continuous glucose monitors. The patient, in the documentation it states the patient is on sliding scale and as far as insulin goes, would that be considered four times a day testing? In the in-patient world, that's usually what we do with the sliding scale is check their glucose every six hours. But I was wondering from outpatient with glucose monitoring, if it was still looked at the same?

Teresa: Ed, do you want to take this question, please?

Ed: Sure.

I guess your question is sliding scale indicative of testing four times a day? Is that correct?

Teresa: Or receiving insulin four times a day. They are on Humalog insulin per sliding scale, would you consider that four times a day insulin?

Ed: No. We would need to see some kind of indication of frequency. It could be sliding scale at meals only, at meals or at nighttime. The particulars of individual diabetic treatment varies nowadays. So, my suggestion would be to try to get specific as possible in terms of frequency. So that way, we can determine the amount of testing per day.

Teresa: And along with what they are doing with the results of those tests as far as insulin is concerned. Because usually if you are on Humalog and on a sliding scale you are testing, then you are receiving Humalog according to what your blood glucose results are at the time.

Ed: You can definitely use that as the indications of why you're testing more than three times a day or one time of day testing, You know if you're doing a sliding scale and you need to be administering insulin now, that can be indicative of why you're testing more than three times a day and you need testing four times of day, etcetera. If you're doing insulin adjustments based on that anything that you feel is indicative of why they are testing more frequently, I would encourage that to be in the notes so that we can look and it and make sense of why they are testing more than what the normal utilization guidelines are for that particular LCD.

Kathryn: The next question comes from Terri Metcalf.

Terri: I have a question about Oxygen CMNs. If we have a referral for Oxygen that meets all of the Medicare guidelines and the beneficiary wants to switch to a POC (Portable Oxygen Concentrator) and the doctor signs off that a conservable option is able to be used and we can put out a POC, what exactly do we do with the CMN? Is that a new initial or is it just a revised? That is where I get confused.

Teresa: That is addressed in the Oxygen policy. We will go through that for you.

If the beneficiary has been on oxygen and they were certified for stationary oxygen on their initial CMN and then portability or portable oxygen is added, then a revised CMN would be required to add portability. If they have a home stationary system and portable oxygen is being added with a conserving device and it is portable oxygen, then you would need a revised CMN to add the portability. Your recertification schedule would follow suit.

Terri: So, even if they already had portability with the tank and we are going to switch them to the POC, then you still need to do a revised CMN?

Teresa: No, I apologize. I misunderstood. I did not think they had portability previously. If they had portability with their initial CMN, they had oxygen stationery and a portable system and now they are switching the method of administration, you need an order for that, unless it is due at the same time as your recertification and then you would indicate that on the recert. It is a switch mode of administration to another. As long as they are both certified initially, you just need orders unless your recert is due.

Terri: Do you have to bill the E1390 concentrator, home stationery concentrator and the E1392 together?

Teresa: Yes. That is correct

Terri: On the same claim?

Teresa: Yes. That is correct

Terri: That makes sense. I did not want to mess up a CMN because it was a new code being billed. I did not know if I needed something else with the claim. Basically, we drop the E0431 and add the E1392?

Teresa: That is correct.

Terri: Thank you so much.

Teresa: I see one hand raised for Kevin Hammond.

Kevin: I have a question about home oxygen and outpatient ordering. Is there a timeline requirement from the time of testing to the time of delivery? For example: if testing was done February 1st, do we have to get it delivered within 30 days or could it be delivered April 1st?

Teresa: Pay close attention to your testing and initial date on the CMN. Your date of service does not have to be the same day as your initial order date on your CMN. You want to make sure that any required face to face exam, testing that occurred within the 30 days on/or before your initial date on the CMN and then the delivery can occur after the fact.

Kevin: Thank you

Teresa: We do not have any hands raised. If you have questions, do not hesitate to gather your thoughts, and questions and raise your hand. We will be happy to take those today.

Carrie: I wanted to ask about where we run into a situation where the rural health clinics, especially with oxygen, it is a problem where one physician at the clinic puts them on oxygen and then when we send the recert and some other physician will sign it. Is it okay to have the other physician sign it on the recert if we have face to face that they have seen that patient?

Teresa: Yes, you want to make sure that your Recert CMN lists the physician's name who is signing in section D and dating the CMN.

Carrie: If they sign a CMN that we see does not have their name on it, then we need to redo it?

Teresa: Yes, because the name printed on the actual Certificate of Medical Necessity, CMN 484, must be the physician that signed in Section D of that CMN.

Carrie: Thank you.

Teresa: We will give everyone a few more minutes to decide if they want to gather their thoughts for some questions and then we will take those questions.

Teresa: Our next question comes from Lisa.

Lisa: Just a quick question on when I see a CMN. How long can we take once they get a dispensing order to deliver the item? Is that signed order valid for 30 days or 3 months or a year? If we have a dispensing order from the physician starting today, how long is that order valid for Oxygen or CPAP supplies?

Teresa: Keep in mind for CPAP supplies and the CPAP orders, it talks about that six months requirement. Of course, as long as you have your order within six months of those required exams and sleep studies, then you should deliver the equipment within a reasonable timeframe after the actual receipt of the order. I am going to let Ed weigh in on this and see if he has any additional direction as far as timeframe. Also, you want to pay close attention to your state law requirements because some state laws have specific timeframes where the order is only good for 90 days, six months or 12 months.

Ed: I agree with what you just said. The only thing I would add is that the beneficiaries are receiving oxygen because it is life sustaining at that point or it has been determined that by a physician. So, it is for the benefit of the beneficiary to get that equipment to them as quickly as possible.

Stacie: To add to that, there is a section in the Internet Only Manual (IOM) that states it should be dispensed within three months of the signature on the actual CMN. I can't quote the actual reference right now. I know that it is in the Program Integrity Manual and we can add that to transcript if you would like.

Teresa: Thank you, Stacie. I recall the 90 days, but I was not sure if it was documented. Thank you for bringing that to everyone's attention.

Lisa: So, that is 90 days from the date of the signature on the CMN?

Teresa: Yes.

Lisa: Where do I find that in the Program Integrity Manual?

Teresa: In the Program Integrity Manual, I believe that is Chapter 5.

Lisa: Thank you.

Kathryn: The next question comes from Missy. Missy, your line is unmuted.

Missy: Hi Teresa. Hi Stacie. Along the line of that question. We've seen that come up quite a bit recently. I've just done some provider emails and I think what is happening is that some people who had some orders during COVID and maybe did not fill them; whether it be a walker or some sort of supply item. So, I know that's been a hot topic and we did look that up in the PIM and it's like 5.2.3 or something along those lines. But it only references a CMN. It doesn't reference orders and many items require an order and not a CMN. That might be something that if there is any additional clarification that can be put out. I think it might have been in the most recent Q and A as well.

Teresa: The JB Council, Missy, was it in the Q and A?

Missy: Yes. I think so. I've seen a number of emails on this same topic, so that might be something somewhere down the road that maybe an education article would be helpful.

Teresa: Okay. Thank you. We will definitely take that into consideration but at this time it needs to be within that reasonable amount of time for other items besides oxygen, which would be the 90- day requirement.

Ed: I would reinforce that I understand the orders get a little bit longer in a particular circumstance. I think it is always beneficial to have medical records around at that point of time and currently to demonstrate that you know that the item is reasonable and necessary.

Teresa: Missy, did you have anything additional?

Missy: No, that was it. Thank you.

Kathryn: At this time, there are no more hands that raised.

Teresa: I want to thank you all for participating in the Jurisdiction B Ask the Contractor teleconference. We're going to leave the lines open just a little bit longer, to see if anyone else has any additional questions or comments. I'm going to give you just a few more moments before we close out the ACT call for today.

Kathryn: There are no hands that are raised at this time.

Teresa: I want to thank you all for attending today's Jurisdiction B Ask the Contractor teleconference and for participating in the question and answer session. We will post the transcript to our website and send out an electronic mailing list when it is available. Thank you again for attending today. We look forward to seeing you at future educational events. I'm going to go ahead and let you have back your afternoon. Have a wonderful rest of your day!

Originated June 15, 2021