Introduction

Good afternoon and welcome to CGS Administrators DME MAC Jurisdiction B Billing Reminders 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 Jurisdiction B subject matter experts from various operational departments. For this particular ACT call you may ask questions related to billing aspects of DMEPOS Medicare.

Before we open the phone lines for your questions, I would like to provide you with a few reminders and updates concerning billing.

Break in Need and Break in Billing

Although the terms “break in need” and “break in service” are used synonymously by some, they are in fact, separate and have different meanings. “Break in service” means that you are unable to bill for a DMEPOS item due to other circumstances that impact billing the DME MAC claim. This is typically a conflict with a Medicare Part A stay or enrollment in a Part A program such as inpatient in a hospital, skilled nursing facility, Home Health episode, or enrollment in Hospice. In these situations, you should simply hold billing until the beneficiary is released from the stay. Here is an example: A beneficiary is in the middle of a capped rental for a hospital bed you provided. Your system submits the claim on the monthly anniversary, but you receive a denial for an inpatient stay in a hospital. You are unable to receive payment from the DME MAC due to the overlap of the hospital stay. You can resume billing after the beneficiary is released home and, if necessary, add a month to the end of the capped rental period so you can bill and be paid for all 13 months.

“Break in need” means the medical necessity for the DMEPOS item ends and you discontinue billing and pick up the equipment, if applicable. Here’s an example: A beneficiary broke her hip and is renting a manual wheelchair from you. After four months, she calls and asks you to pick up the wheelchair because she has been released from physical therapy and her physician’s care and doesn’t require the use of the wheelchair any longer. You arrange to retrieve your equipment, provide a pick-up ticket to the beneficiary, and discontinue billing the wheelchair. If the beneficiary has another need for the wheelchair in the future, new medical records, orders, delivery ticket, etc. would be necessary to begin a new capped rental period. In this scenario, add a narrative to the claim alerting us to the new need and let us know you want to begin a new capped rental. We can set up the HCPCS code in the system and allow you to get your 13 rental payments.

Recent Billing Issues

We have seen a recent trend in submissions to Reopenings or Redeterminations for denials from missing CMN or DIF (DME Information Form) with the claim. In either of these situations, you can simply attach the appropriate CMN or DIF and resubmit the claim to CGS. Resubmission takes less time and is much faster.

Most supplies provided on a recurring basis can be dispensed with a three-month supply. Please add a claim narrative in the NTE segment of your claim to let us know you are billing more than one month’s supply. For example, the brief statement “90 days” or “three months” on a PAP accessory claim will make CGS staff aware of your intentions and could prevent some denials.

There are, however, a few exceptions to billing a three month supply. The following items can only be provided on a monthly basis: surgical dressings, enteral and parenteral nutrition and related supplies, and ostomy supplies provided in a nursing facility. Immunosuppressive drugs, oral anticancer drugs and oral antiemetic drugs can only be dispensed on a monthly basis. Always review the LCD to assure you are billing in the appropriate manner.

While on the subject of recurring supplies, some DMEPOS items must be billed with a date span where the “from” date is the date of delivery and the “to” date is the date of anticipated exhaustion based on the quantity provided. You must span the dates for diabetic testing supplies, external infusion pump supplies, enteral nutrition, parenteral nutrition and the administration kits associated with the nutrients.

https://www.cgsedicare.com and myCGS

myCGS Version 5.3.3 was recently released. The biggest change in this version is the new ADR screen. The ADR screen, which is accessed via the Claims menu in the portal, gives you the ability to:

- Find all of your open and/or closed ADR (i.e., TPE) cases
- Check the status of your ADR cases
- View the details of your ADR cases
- View a copy of the ADR letter that was mailed to you
- Submit your response to an ADR (myCGS will accept the following file types: DOC, DOCX, PDF, RTF, and TIFF)
- View a summary of any education provided to you by CGS
This new enhancement will streamline the process when you respond to a TPE audit. It will also pave the way for future enhancements that will allow you to submit other documents via the myCGS Web portal. Please refer to the myCGS User Manual for full instructions and functionality of the ADR screen.

New Self-Service Tools

I also want to mention a few self-service calculators and tools that have been added to our website within the last couple of months. We will include hyperlinks to all of these tools when the final transcript is published on our website, https://www.cgsmedicare.com.

Since this ACT call focuses on billing, I want to remind everyone about our Claim Denial Resolution Tool (https://www.cgsmedicare.com/claim_denial_resolution_tool.asp). This tool was developed to provide you with guidance on how to address claim denials in the most efficient manner. Enter the Reason Code and Remark Code from your Medicare Remittance Advice into the search fields. The tool will provide the remittance message for the denial and the possible causes and resolution. This is a great way to research denials and help prevent billing errors for the future.

Our Advance Beneficiary Notice of Noncoverage (ABN) Form Instructions Tool (https://www.cgsmedicare.com/abn_formTutorial.html) now has a “hover” feature. Simply hover the cursor over a field within the ABN and a window with in-depth information and instructions will appear.

ADR Timeliness Calculator (https://www.cgsmedicare.com/dme/adr_calc.asp) - The ADR timeliness calculator will assist you in determining the date ADR documentation must be received in order to meet the time frame for submission. Enter the date on the ADR letter, click “Calculate,” and the result will be the date the requested documentation must be received by CGS.

Appeals Decision Tree (https://www.cgsmedicare.com/claims/appeals/decision_tree.html) - Do you ever question whether you should submit a request for a Redetermination or can you request a Reopening? Use the Appeals Decision Tree for guidance on the correct action to take. Answer a short series of questions to help you figure out which avenue to take.

End Stage Renal Disease 30 Month Coordination Period Calculator (https://www.cgsmedicare.com/esrdcalc/esrdcalc.aspx) - This tool calculates the 30 month coordination period prior to Medicare becoming the primary insurance for ESRD beneficiaries. Type in the date the benefit began to find out when Medicare becomes the primary insurer.

MSP Line Level Calculator (https://www.cgsmedicare.com/jb/help/msp_line_level_calc/msp_line_level_calc.html) - The MSP Calculator will assist you in determining the line by line claim payment for covered services when Medicare is the secondary payer. Input data into the table on the website. Also reference Chapter 11 (https://www.cgsmedicare.com/jb/chapt11.pdf) of the Jurisdiction B Supplier Manual for additional information and scenarios with MSP calculations.

Wrap Up

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

Alexis: I have a question about VirtuOx. We need to know if Medicare will accept the NocOx done by the physician? VirtuOx has an office-plus edition where the doctor can do the NocOx. The problem we see at the bottom of the report, it says “not a VirtuOx IBTF report.” We got a letter from VirtuOx saying Medicare accepts these. I have a copy of their letter and a copy of the example I am speaking about. I could fax it to you so you could look at it.

CGS: As far as DME goes…and I’m not sure you are using this particular test for oxygen. Is this an overnight pulse ox?

Alexis: Yes, it is a NocOx.

CGS: As far as coverage is concerned under the DME POS benefit for oxygen, the test to perform to qualify that particular beneficiary for oxygen must meet the Part A or Part B requirement for testing. If you have a specific question about that particular test, you can reach out to your Part A or Part B MAC and double-check to make sure that test is in line with the requirement under Part A or Part B.

Alexis: Okay. Thank you.

CGS: While we are waiting for additional questions, let’s jump ahead to Slide 5 and mention the in-person educational events we have coming up. These are Jurisdiction B Workshops. We will start out in July in Milwaukee. Registration is now open for that. Seating is limited so we encourage you to go to our website and register. This is considered to be a mega-workshop, so we will have a number of options for courses for you to select throughout the day.

We will start the day with some general documentation requirements and then as the day goes on, you can choose from more specific topics that might cater more to your business.

If you go to our website CGS.com, under “Education,” you will find information on all three of our workshops. From Milwaukee, we will be going to Columbus and then to Louisville.

If you are a supplier that cares for beneficiaries in both Jurisdictions B & C, Jurisdiction C is also in the midst of their
workshop season, so you can look in the same place on the
JC-DME website as well.

Helen: We work with a lot of compression garments (upper
and lower extremity). We received information at one point
that upper extremity would be covered by Medicare if there
was a breast cancer diagnosis. However, we are not finding
that to ring true. Is that true?

CGS: That is something I’m not sure about. Is any staff online
that knows about this?

CGS: Is this an upper extremity prosthesis?

Helen: It might be like a compression arm sleeve or like the
Bellisse bra.

CGS: Not for arm sleeves.

Helen: Not even with this cancer diagnosis?

CGS: We would cover for the bras with a mastectomy but not
the arm sleeves.

Helen: We have not been able to get coverage even for the
bras. Do you know what we might be doing wrong?

CGS: It is Diagnosis Code Driven. Did you review the LCD? It
does indicate it in there.

Helen: Will we use the AW Modifier?

CGS: No, that is for ulcers. Check out the LCD and it will give
you the coverage criteria and also the billing information for a
specific diagnosis. I don’t believe you need to KX Modifier. I
don’t believe it is required for a mastectomy. Everything else
will be listed in there.

Helen: I have another question. We billed for a garment for a
patient with ulcers with the AW Modifier. They did cover the
first two…one right and one left. Then they got an additional
right and left, and they denied but not to the patient. Should
we have not billed with the AW Modifier on the second line?
Is that why it didn’t deny to the patient?

CGS: I’m sorry…what was the code?

Helen: A6545.

CGS: Are you billing two for the right side and two for
the left?

Helen: Correct.

CGS: I think only one is allowed per side.

Helen: Yes and they paid the first line item, but the
second denied.

We used the same modifier on both lines…AW left and right.
The first line paid because they are allowed one per side
with the ulcer AW Modifier. We billed the second line the
same way and it denied with CO151 (does not support this
frequency of services). It didn’t deny to the patient, so
I wanted to know how to get it to deny to them. They know
they have to pay for the second set.

CGS: Did you get an ABN?

Helen: Yes.

CGS: Did you put the GA Modifier on the claim?

Helen: No.

CGS: Okay, that’s why. Any time you get the ABN, you need
to bill with the GA Modifier. That tells the system that the
beneficiary understands they will be responsible for the over-
utilization. Then the system will issue the PR denial.

Helen: So we would do the GA left and right or just GA?

CGS: Yes, do the GA right and left.

Helen: Okay, thank you.

Elisa: We have a question about diabetic shoes and the
process on the LCD where the MD or DO certifying physician
is required to have a diabetic management visit. We have
been asked by our endocrinologist to put forth this question
as there has been a lot of back-and-forth.

We were wondering if the certifying physician (MD or DO)
can see a patient in tandem with the Nurse Practitioner (NP)
or the PA. The NP or PA does the bulk of the notes. The MD
or DO writes a note within those notes saying he was in on
the visit. He is managing the patient’s diabetes and he agrees
with the NP notes.

CGS: The requirement is that the MD or DO has the visit
and is managing the patient’s diabetes. The policy does
specifically say that they are unable to just sign off on the NP
notes. In case of review, I don’t know what the reviewer would
say if they were working together. I don’t know what that
picture would look like.

Elisa: Let me give you a little background on this. We are in
urban area and I know in a rural area, a NP can do it. I know
all these rules. I am only asking this because I know (the
endocrinologists) are concerned.

They have practices here in the city where they have one or
two endocrinologists managing the patient’s diabetes. There
may be 6 or 7 NPs or PAs. It is impossible for the MD or DO
to see all the patients. The NPs are doing the bulk of the
visits, which are paid for by Medicare for any visit besides
what has to do with diabetic shoes. What needs to change for
them not to have the visit?

CGS: We would look at it as them signing off on the NP and
not that they had the overall care. In order for that benefit
policy to change, it would literally take an Act of Congress.
The statute that allows for therapeutic shoes to be covered
has a separate benefit. That is something Congress would
have to look at and then change the requirement. Our hands
are tied. We understand the issue for those beneficiaries
that are in the rural areas, but there is nothing the contractor
can do to accept that documentation other than the way it is

Elisa: I know there was a Therapeutic Shoe Act that was
enacted in 1999. I told them it is a law. We need to get the
AMA and the APMA involved and lobbies for this issue. There
was a bill put forth last year by a couple of senators. Then it got stagnant as it was attached to something else, so it is a no-go at this point.

Medicare pays for all the other visits so they (doctors) are asking why they are getting paid for everything else? I know the answer is that it is the law. It is very frustrating for our doctors and patients.

CGS: Understood and we hear that often. At this time, we have to abide by the statute for the shoes.

Elisa: Agree. We just wanted to hear what you had to say. Thank you.

Pam: My question is regarding Proof of Delivery when a patient changes from private insurance into the Medicare program. There was an MLN that came out in January. I understand that we need to inspect the equipment. What date of service do we start billing? Do we bill as of the date the patient was transferred into the Medicare program, or the date we inspected the equipment (even though they would have had the equipment that entire time)?

CGS: In that particular scenario, the beneficiary is new to fee-for-service Medicare and has equipment that was paid for by a private insurer. You are right. There is the option to go out to the home and the beneficiary would have the option to either receive new equipment with fee-for-service Medicare, or you can inspect that equipment, just to be sure it is in good working condition that would last the 5-year RUL under Medicare.

If that is the option chosen, you would start billing once you have that Proof of Delivery or attestation saying you did inspect the equipment. That would begin your initial date of service.

Pam: How did you come up with that conclusion? It is not documented in the MLN.

CGS: That would serve as your Proof of Delivery, similar to if you are delivering an item to a beneficiary. The same would apply if you were delivering a wheelchair to a beneficiary’s home. The date you deliver that equipment, the date of your Proof of Delivery, would be your date of service.

Pam: That part is understandable because that is the first time they have the equipment. The patients rarely ever call to tell us they have changed insurance. We find out the hard way. Time has lapsed but they were able to utilize the equipment and they did qualify for all the Medicare benefits based on the coverage criteria, etc. I don’t understand why we wouldn’t be able to bill date of service when they entered the Medicare program because all other coverage criteria was met.

CGS: Is this for a capped rental item?

Pam: Yes.

CGS: So you will be billing for 13 months? Other CGS thoughts?

CGS: I agree with your response. That is the date the supplier is compliant with Medicare requirements for Proof of Delivery, as of the date of assessment or the date the equipment was swapped out. What I can tell you is if you do choose to use another date, we may not see that on the front end.

In an audit, you would be at the mercy of the auditor if they are reviewing Proof of Delivery documentation and you have billed one date and your assessment indicates another, your claim could potentially be denied. We cannot guarantee how that would be interpreted. Based on the instructions we have received from Medicare, it gives you the two options and we interpret that to be the same. We hold suppliers delivering equipment to a beneficiary to use the date as their Proof of Delivery. For suppliers that have established beneficiaries who are new to fee-for-service, we hold them to the date of new Proof of Delivery or the date of that assessment. We understand that the beneficiary doesn’t always inform you in a timely manner. That is a business decision on your end as how you choose to handle that. But for Medicare purposes, those are our instructions. CMS did not give us any wiggle room to give an exception to that.

Pam: I just want to say that you are entitled to your full 13 months of rental. Were you talking about back-billing too?

CGS: Once they become eligible and you go out and inspect the equipment, they are entitled to the full 13-months rental.

Pam: Understood. Thank you very much.

Lisa: I have a question about what Medicare considers non-covered items or services. There is a list on Region B on the CGS website that says, for example HCSPC codes E0700 is non-covered. I looked in the HCPCS Level II Coding Book (from an outside source) and it said there is ‘special coverage’ criteria and they don’t have it coded as non-covered. When do we determine if we would need an ABN in that situation?

CGS: Is this code something that you have seen on a list we have for non-covered items?

Lisa: Correct.

CGS: If it is a recent/updated list for non-covered items, those are situations when an ABN is not required. An ABN is not required in situations where Medicare would never cover the item. Is it a 2018 or 2019 list you pulled up on our website?

Lisa: It came up on the Search right on the website.

CGS: I believe there are some dated ones out there.

Lisa: The reason I’m asking is because I’ve been doing this a long time. Prior to all these lists and all these changes, they are always coded in the HCPCS book. If it was coded pink, it was non-covered. The E0700 is highlighted yellow saying it is special coverage criteria. On the CGS website, it says it is a non-covered code. If it is non-covered, you don’t need an ABN. You can do a courtesy ABN.

So does the on the website takes precedence over the HCPCS Level II Coding Book?
CGS: If the website says it is a non-covered item, you would not need an ABN. As a courtesy, you could give the beneficiary a copy of the ABN. It is not something we are looking for.

Lisa: Thank you.

CGS: I did look at the website and it is an updated list.

Craig: I have a question on purchased items, specifically orthotics that the patient can only receive one every 5 years. We are having some difficulty just getting information on whether a patient has received a same-or-similar product within the past 5-year timeframe. It is my understanding that we can get on the CGS website and get that information for each individual prior to product delivery. Is that accurate?

CGS: Are you signed up for myCGS Web portal?

Craig: I am. I’m just in the process of getting my account re-activated. Once I do that I will probably be able to figure it out, but I thought I would take advantage of this call today to make sure it is possible to use the website for this information.

CGS: Within the myCGS Web portal, you can check on same-or-similar products that have been provided.

Also, you can use the IVR to check for same-or-similar items. I do encourage you to look under myCGS for the User Manual that will help with some of those things.

We are doing a webinar this month on Self-Service Tools and we talk a lot about myCGS. If you are just getting re-activated, you might consider attending. You can get the details by going to myCGS under “Education” and you can find it under “Webinars” or “Calendar of Events.”

Craig: Thank you.

CGS: While we wait, just want to remind you that this call is being recorded for transcription. Once I get the transcript, we will post it on our website in the “Education” section within the next couple of weeks. We will post a ListServ once that is available.

Mike: Our question is regarding the PAP policy. A patient has a CPAP and they failed their initial trial. They go back to their physician for a new visit. The physician wants them to be on the CPAP again. The doctor orders a new sleep study and the patient goes. The doctor orders the CPAP and we get a detailed, written order. We have to wait until the patient is compliant for us to continue billing the 4th month on for a new trial.

What date are we using for our 4th month billing? Are we using the date the patient went back to the physician? Are we using the date of the new order, or the date the patient becomes compliant? If the patient is compliant, do they have to go back into the doctor for another visit?

CGS: It would be the date of compliance.

Mike: So if the patient is compliant 21 days after, we will bill that 21st day? Do we have to go for another visit or get a new order?

CGS: The patient has to go back to the physician to show they met compliance, to have that in-person visit.

Mike: So they failed the trial. They go for another in-person visit. They go for a new sleep study. We get a new order. The patient is compliant. They have to go back to the doctor, and we will use that visit date?

CGS: Right. That is when the physician is documenting that the beneficiary is compliant with their CPAP device.

Mike: Okay, so it is the visit date and not the date of compliance?

CGS: Right. It is when the physician documents they are being compliant.

Mike: I have a second question. What happens if they destroyed their mask during their trial? We have had several issues…and the 4th month has passed. We can’t bill for supplies if the patient failed their trial.

Are we giving supplies to the patient free or do we get an ABN stating that since the patient was non-compliant, then it is non-covered?

CGS: You definitely want to get an ABN in that situation.

Mike: Thanks very much.

Renee: I have a question regarding the ABN. An online, interactive ABN tool came out the first of the year. I was hovering over the sections. They talk about Table D and all the D fields. It notes, ‘all blank D fields must be completed on the ABN in order for the notice to be considered valid.’

If you are filling in the smaller ‘d’ areas, like with the word ‘items’ to indicate the items you listed on the bigger D square area. Let’s say the patient chose Option 1 and you wrote items in there. But if someone didn’t write items in Option 2 & 3, then the ABN would be completely invalid?

CGS: That is correct. It has to be completed in its entirety. If you are missing any portion, it is considered an incomplete ABN. I understand what you are saying because the information is there near the reference, but before we can reverse liability to the beneficiary, that form must be completed as indicated on the tool.

That is a common question. That is why the tool is out there to try and make sure that it is executed properly.

Renee: If we got audited (because the ABN was incomplete), might it possibly get reversed and we might have to pay back Medicare?

CGS: Yes. Please make sure all those sections are completed.

Renee: So the word ‘item’ is sufficient?
CGS: No. It says you must list the information that is in Section D. Whatever items you have listed in Section D, should be listed in your options. You can’t just say ‘items.’

Renee: So in the smaller ‘d’ fields, you have to list each item?

CGS: When you click on that, it says ‘insert the wording used in the first D field.’ They don’t want you to reference that. They want you to insert that exact content into that field that is referenced as D.

Renee: When you click on the first ‘D’ field, it says ‘the following descriptors may be used in the first D field…Items, service, labs, etc.’

CGS: The box that shows what the item is has to give the description because the beneficiary doesn’t know what it is… it just says E1390 and they don’t know that is a concentrator. In that big Section D block, the reason has to say, ‘oxygen concentrator.’ All those other small ds could list items.

Everything has to be in layman’s terms, so the beneficiary understands what they are responsible for.

Renee: Right. So, you have the main description item in the big D box but then the smaller d’s (options 1, 2, 3), you can write ‘items.’ They all have to be filled out, even if they are only choosing one option.

CGS: Correct.

Ann: I just have a follow-up CPAP question if the patient failed the second trial period.

I am just trying to make sure I understand. Just what the previous caller said that the patient failed the first trial, went back to doctor, got a new sleep study and got their face-to-face of why they need another one.

I was told there is no time period in the second trial period. We can’t bill it until compliance is met. Let’s say on the second trial period, compliance has to be met within 30 days, correct?

CGS: As long as it is before the 90th day, that’s fine for the second trial.

Ann: Say we provided it to them on 10/25/18 and compliance was met within 30 days. Our next billing date for the 4th month would be 11/26/18, the day after compliance has been met on the 31st day? Right?

CGS: No, it would be when they met compliance 11/25/18.

Ann: Once they have met that on the 4th month, we are going to bill 4, 5 and 6. Before the 6th month is up (just like the initial period), do they have to be re-evaluated again before the 90th day on the second trial.

CGS: Yes, on the second trial period and the doctor has to document compliance.

Ann: And that has to be done between month 4-6 if month 1-3 was denied because they never met compliance.

CGS: Right. You just want to use the doctor documents compliance. You are starting all over again.

Ann: Okay, then our 7th month wouldn’t be until the date of the second face-to-face. Wow! It took a little while, but I got it! Thank you so much!

CGS: thank you for joining us today. We look forward to seeing you at our next event.

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