Introduction

Good afternoon and welcome to CGS Administrators, LLC (CGS) DME MAC Jurisdiction B 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 any aspect of DMEPOS Medicare.

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

The ACT calls are recorded for transcription purposes. Questions must be asked verbally over the telephone. You will need to input the audio PIN on your GoToWebinar dashboard into your telephone keypad. It’s very important that you do not verbalize any Medicare beneficiary’s private health information or claim information during the call.

Condition of Payment Prior Authorization

Now, as you see on the slide, CMS has added the following five HCPCS codes for Group 2 Pressure Reducing Support Surfaces (PRSS) to the Required Prior Authorization List: E0193, E0277, E0371, E0372, and E0373. Prior authorization for PRSS will be implemented in two phases.

Phase I began July 22, 2019 for beneficiaries residing in California, Indiana, New Jersey, and North Carolina. CGS began accepting requests for the affected codes on July 08, 2019.

Phase II will expand prior authorization of these codes to the remaining states and territories October 21, 2019. CGS will begin accepting requests October 7, 2019.

CMS has also added the following seven HCPCS codes for PMDs to the Required Prior Authorization List: K0857, K0858, K0859, K0860, K0862, K0863, and K0864. Prior authorization for PRSS will be implemented in two phases.

Coding, Modifier, and Billing Updates

Next, effective for claims with dates of service on or after March 1, 2019, suppliers must submit bilateral items on two separate claim lines using the RT and LT modifiers and 1 Unit of Service (UOS) on each claim line. Do not use the combination RTLT modifier on the same claim line and bill with 2 units of service (UOS). Claim lines for bilateral HCPCS codes requiring use of the RT and LT modifiers, billed without the RT and/or LT modifiers or with the RTLT on a single claim line, will be rejected as incorrect coding.

Claims for any of the items listed here that are submitted on the same claim OR overlap any date(s) of service for
E0467 is considered unbundling. There is an article titled Correct Coding and Coverage of Ventilators – Revised April 2019 (https://www.cgsmedicare.com/jb/pubs/news/2019/06/cope11985.html) for more information on this topic.

Next I want to talk about the class III devices for CGMs. The HCPCS modifier KF is required when billing claims for class III DME. Therefore, effective for claims with dates of service on or after January 1, 2019, that are processed on or after July 1, 2019, modifier KF must be billed on claims for therapeutic CGMs (code K0554) that are class III devices as well as claims for supplies (code K0553) used with the class III devices. Fee schedule amounts for codes K0553 and K0554 with the KF modifier are added to the fee schedule to pay claims for class III therapeutic CGMs and related supplies only, based on the mandated covered item update factors for class III DME items.

Also, effective for claims with dates of service on or after January 1, 2019, that are processed on or after July 1, 2019, for therapeutic CGMs (code K0554), such as the Dexcom Mobile G6 device, and related supplies (K0553) that are NOT class III devices, these claims must be submitted without the KF modifier. Fee schedule amounts for the K0553 and K0554 without the KF modifier are available to pay claims for therapeutic CGMs that are not class III devices and related supplies, based on the mandated covered item update factors for DME other than class III items. The calculation of the fee schedule amounts for code K0553 without the KF modifier does not include an allowance for calibration supplies and equipment because therapeutic CGMs that are not class III items no longer need to be calibrated. More information on the Class III CGMs can be found in Change Request 11334 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4321CP.pdf).

**New Medicare Cards – MBI**

It's very important that you start using the Medicare Beneficiary Identifier or MBI as soon as possible. After January 1, 2020, only MBIs will be accepted on claims and related documentation. So if you are billing rental claims on a rental cycle, it’s very important to start using the MBI as soon as you can to prevent denials on rentals that go beyond December 2019.

CGS does have an MBI Lookup Tool (https://www.cgsmedicare.com/medicare_dynamic/jb/ivr_mbi_converters/ivr_mbi_converters.aspx) where you can convert the 11 digit alpha/numeric MBI number to receive the characters necessary to enter using your telephone keypad when accessing information through the IVR system.

There are additional resources available on CGS and CMS’ website for more information.

**Miscellaneous Updates**

Effective September 1, 2019, MAXIMUS will be responsible for processing new reconsideration requests of initial Medicare claim determinations for Medicare DME claim appeals in the DME MAC Jurisdictions A, B, C, and D. MAXIMUS will also serve as the Demonstration QIC for the DME QIC Formal Telephone Discussion and Reopening Process Demonstration.

Reconsiderations requested in these jurisdictions on or before August 31, 2019, will continue to be processed by the existing DME QIC, C2C Innovative Solutions. Since C2C will process appeals received prior to September 1, 2019, there will be a short transition period during which both C2C and MAXIMUS will be issuing decisions.

Next we have CGS Connect™ (https://www.cgsmedicare.com/jb/mr/cgsconnect.html) which offers Jurisdiction B suppliers the opportunity to receive professional review and evaluation of pre-claim documentation before submitting an initial claim to Medicare. It is a voluntary program that provides you with a higher level of assurance that your supporting documentation meets the necessary requirements to process your claim for payment consideration.

I do want to point out that CGS Connect™ is not a prior approval or authorization program. Participation in CGS Connect™ does not exempt suppliers from the audit process. Our review and recommendations under the CGS Connect™ program are for educational purposes only and do not guarantee payment for services billed. It does provide you with individualized education to prevent future documentation-related errors.

In all cases, you will be provided with documented, detailed feedback regarding your submission. You will then have the opportunity to correct the errors in the documentation (if possible) and submit the claim for processing. CGS Connect™ allows subsequent submissions for a review request after the supplier has had the opportunity to make improvements.

Clinical reviews of medical records are currently limited to the following policy groups;

- Continuous Glucose Monitor, CPAP, CPAP Accessories, External Infusion Drugs/Pumps, Glucose Testing Supplies, Hospital Beds, HS Lightweight Manual
- Wheelchair, Immunosuppressive Drugs, Knee Orthosis, LSO, Nebulizer and Related Drugs, Oral Anticancer Drugs, Oxygen, Surgical Dressings, Therapeutic Shoes, and Urological Supplies. This is a great resource to assist in ensuring your documentation is correct and compliant.

Lastly, I want to mention that the JB POE team will be conducting our last workshop in Columbus, OH on September 18th. This year we partnered with our AB MAC counterparts as an added effort to bridge the gap between physicians and suppliers with DME documentation requirements. We are also offering AB educational sessions for our AB providers who attend our DME MAC workshops. Some of the topics included at the workshops are: Documentation Requirements, Life of a Claim, Oxygen, Self-Service Tools, Medicare Updates and much more. We also have a Question and Answer panel at the end of the day to assist in answering
any remaining questions. The feedback we received from the previous workshops we conducted this year has been extremely positive. So, if you can, we strongly suggest you sign up for this workshop as space is limited.

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

Amanda: I have a question regarding Supplier Standard #5 where you have to notify the beneficiary of the rent-to-purchase option. If the patient waives the Medicare billing, for example signing Option 2 ABN, are we still required to prove that we notified them of the rent-to-purchase option?

CGS: So they are signing that they will be responsible on the ABN? Is that what you are saying?

Amanda: On the rent-to-purchase option. There would be no Medicare billing done.

CGS: I would check with the National Supplier Clearing House, as they house those requirements. This claim isn’t billed to us so we wouldn’t audit it. It is their standard in case they came in and looked at your records. I suggest contacting the NSC.

Amanda: Thanks.

Stephanie: My question is related to the refill requirements, specifically about CPAP supplies for disposable filters (A7038 HCPCS code). Many times, the patients seem a little taken aback when we ask them the reason for replacement (the condition of their filter). They say ‘well, it is dirty.’ Is that what you will be looking for in regard for a refill requirement for a filter, or does that absolutely have to be documented for that type of disposable item?

CGS: It does for that because it is an item with the CPAP and it should last longer, not just soiled by the oil on their skin. Whatever the functional conditional is that they need new ones. So, if it is contaminated or filthy dirty…just have that documented. Are you talking about the cushions or the filters?

Stephanie: More for the white, disposable filter.

CGS: Okay, what is causing it to not function as it should? It is all again to protect the Medicare trust fund. Even though the policy says once every 3-6 months, these items should be lasting longer. That is why we are looking for the functional condition. If they are coming into your store front, you don’t have to have the functional condition.

Stephanie: Is that just for the simple fact that we are viewing the item?

CGS: If the beneficiary is coming into your storefront, we assume they need those items. You don’t have to document what is wrong with that item. That even goes for consumable items (urological items, ostomy, etc.). If they come into your storefront, you wouldn’t even need the quantity on there. Just make sure on your Proof of Delivery invoice it shows they picked it up in the storefront.

Stephanie: Thank you.

Robin: We have called the CGS Helpline a few times on the same question and we get conflicting answers every time. A patient had a CPAP paid for by their commercial insurance and now they have Medicare and they need a replacement. It has been 5 years and we have all the qualifying documentation. Would we use the RA Modifier on the claim line narrative on that? Medicare did not pay for the first machine. In the face-to-face notes it does state that.

CGS: No, you would not use the RA Modifier in that situation. It is not considered a replacement since it was not paid for by the previous insurer, so we don’t have that documentation. Were you getting supplies through us?

Robin: Yes, they were getting replacement supplies and things like that on Medicare.

CGS: Right. You are not going to put an RA Modifier on there because it is not a replacement. It would be a new CPAP machine through Medicare.

Robin: Thanks.

Sandy: Can you tell me the exact date that Proof of Delivery signature from the patient was put into effect?

CGS: For therapeutic shoes or just in general?

Sandy: Just in general.

CGS: Their signature has to be on the Proof of Delivery if you are delivering it in person or if they come to your storefront. If you are shipping it, you don’t need the signature.

Sandy: Is that going back in time or when did that go into effect that was required?

CGS: The standard documentation requirement language was always in effect. We posted it just to clarify and have it available for suppliers. You aren’t talking about the signature date are you…just the signature itself?

Sandy: Just the signature.

CGS: If you were audited, they would still be looking for that documentation.

Sandy: Thanks.

Terry: I have a question about oxygen. Is there a different reimbursement rate for E1390 maintenance and service, or are providers not to be paid the reimbursement fee schedule rate? Is there a percentage off for the maintenance and service when you bill with that modifier?
**CGS:** It depends on the location and I think it has to do with competitive bidding.

**Terry:** We are rural, and we only do local. I have been told there has been some zip code transitioning that was incorrect. I have been looking at my reimbursements per code to make sure we didn’t get thrown into a non-rural rate by accident. I just noticed that the reimbursement for E1390 (for maintenance and service) was lower than just the regular E1390 (36-month cap). That is the reason for my call.

**CGS:** We actually need to see examples so if you would send to our outreach email box at this address CGS.jbic.learningondemand@cgsadmin.com. If you could send some examples, I am going to ask if Ashley or someone can email that address to you. Just send the CCN…we can’t have any PHI. We will look at that for you. The maintenance and service rates are different than the rental rate, if that is what you were questioning.

**Terry:** (Lost connection.)

**Tammy:** Going back to the replacement equipment when the patient has had a prior insurance company purchase, like a CPAP machine, and now they need a new one and have Medicare. You said to bill that as new equipment, but doesn’t the patient have to go through the qualifying criteria again as a Medicare patient?

**CGS:** Yes, they would. You would follow the instructions for beneficiaries entering Medicare criteria for replacement. You do want to have documentation to show they are still using that device.

You will need a sleep test to document that they meet the Medicare requirements and that they are Medicare eligible. There would have to be a clinical evaluation. There would have to be a face-to-face visit with a physician who documents that they do have OSA and that they continue to use the device. They would not have to go through the trial again.

**Tammy:** Would they have to get a new sleep test or (for oxygen) a new blood gas test?

**CGS:** No. For a PAP device (as long as the sleep test they had previously met Medicare requirements), that is fine. They do not need a new sleep test.

**Tammy:** Even though they did the sleep test before they became Medicare eligible?

**CGS:** Yes, that is acceptable because they are still using that item.

You said something oxygen. That is different. It is only if it was an Advantage plan that you can use the test.

**Tammy:** Okay. Thanks for clarifying that.

**Jennifer:** I have a question about diabetic shoes. I have been sending to CGS Connect™.

They have been telling me I need to have a documented full foot exam. Where is this stated in the LCD policy? Apparently, it is insufficient to say what the foot condition is if there is not a full foot exam.

**CGS:** It does say ‘the in-person evaluation of the beneficiary by the supplier at the time of selecting the items that will be provided must include the following: An exam of the beneficiary’s feet with a description of the abnormalities that will need to be accommodated by the shoe inserts and modifications.’

**Jennifer:** That is on the form that the fitter fills out. They have been sending it back to me if the doctor’s notes don’t have that.

**CGS:** So the physician’s documentation identifies there is a deformity or ulceration?

**Jennifer:** Yes, but that is insufficient if there is not a full foot exam by the doctor. I Just wondered where that is in the literature.

**CGS:** We will check with Medical Review on that. You didn’t submit this claim…is was just through CGS Connect™?

**Jennifer:** Yes, CGS Connect™. I have had several sent back to me with that same stipulation that there was no full foot exam by the physician, even though we had notes qualifying the condition.

**CGS:** Send us an email with that question and we will check with Medical Review. The doctor would need to support that all the coverage criteria had been met. We would be looking for that documentation as well. Send an email to CGS.jbic.learningondemand@cgsadmin.com

Or you can send an email to the email address that sent your confirmation for today’s webinar.

**Lisa:** I have a question about CPAP and patients entering into Medicare when they have already been on the machine. I believe the requirement states that their sleep or diagnostic study must meet the current policy today. The medical policy mentions a 4% desaturation for hypoxia. For a lot of the tests, that has not been programmed into the sleep study applications for that period of time in the dictations, etc.

If they are able to get the raw data showing that, does the interpreting physician for the sleep study way back when have to re-dictate that sleep study or can it be another certified sleep physician?

**CGS:** Yes, it could be a different physician re-interpreting or re-certifying that test result.

**Lisa:** What if the actual sleep study shows the 4% hypoxia desaturation but the physician dictated the whole thing off 3% but you can definitely see the AHI off the 4%. Does that have to be re-dictated?

**CGS:** Even though the data shows that, the interpreter has to be a certified specialist interpreting it. Because it is conflicting, I would definitely suggest having it re-dictated.
Lisa: Okay. It clearly shows 4% desaturation and it shows the AHI. Even though it is that clear, does it still need to be re-interpreted and signed off on?

CGS: I personally would. Even if the DME MACs say okay they accept it this time. I can’t speak on behalf of Cert or Recovery audit or any other auditing entity that is out there. Your best option is to get it re-dictated, re-scored.

Lisa: And if we can’t get that done, is the only option is to have the patient do another whole diagnostic sleep study?

CGS: I would suggest that as well. That way, you know if it is going to show the 4% decrease. There is a “Dear Physician” letter out there about sleep scoring. I don’t know if you are aware of that.

Lisa: I think it just came out last week.

CGS: Yes. Hopefully, that will help. We have been getting quite a few questions about re-scoring and the 3% decrease versus the 4% because of testing that was done way back when.

Lisa: Yes, and the problem is that ASM is 3% and Medicare put in their policy 4%. That is a huge problem with the physicians. I think the “Dear Physician” letter didn’t indicate that they could re-dictate an existing sleep study. I just wanted to get a clarification because we are going to meet with all the sleep labs and pulmonologists to explain it to them again.

CGS: That is very good that you are doing that just to avoid anything going forward.

Carol: I have a question about electronic signatures. I know the policy states it needs to be approved by/authorized by/electronically signed by’. Sometimes we get prescriptions through our pharmacy system and it says ‘transmitted’ with the date. When I called the software company, they said there is an SSID on there that means the doctor has been verified. Is that acceptable?

CGS: Is that Surescripts?

Carol: I think so.

CGS: Yes, we will accept that. You can always get the electronic signature protocol from your physician protocol and send that in with your audit.

Sharon: This is about an ongoing situation that I can’t get resolved.

myCGS shows there is not a PECOS enrollment, but CMS.gov says there is. We are always told to have the provider re-trigger their PECOS record. I am the one responsible for doing this. It’s a nightmare. They don’t know anything. I am actually working on one and had sent it in to your email address. I got a response in March that it was sent over to the region to re-trigger and you would let me know. I have never heard anything back. I have sent multiple emails. This is an ongoing thing. We are not getting any satisfaction. We need help.

CGS: I understand. I can feel your pain. We have been discussing this internally to see if anything can be done. Did you escalate it in the Call Center?

Sharon: No. I don’t want to throw anyone under the bus, but I went straight to the person we are supposed to talk to for our region. That is who sent me an email in March. I have my notes. They said they would reach out to that region and let me know. I didn’t hear anything. I was off and when I came back, I started sending emails and still didn’t get a response. Then, I went to our billing company who sent an email to their person. They then forwarded it on to the person I had contacted (this was in July). No answers yet and I don’t know how to help anybody.

CGS: Don’t think I am giving you the runaround. Do you have our email address?

Sharon: Yes, and I just found the Community Coach information. I had been dealing with this one particular person since March, and that is not acceptable anymore.

CGS: You can send our manager an email and also contact Customer Service and tell them you want to escalate it. You want to speak Tier 2 or Tier 3 to get this resolved. Within two days they should have this resolved for you.

Sharon: So you are telling me now that I can escalate. Last year when I escalated, it was very sad and that is why I ended up hopping onto one of the educational webinars. I was literally told by an escalator person that CMS.gov was not an official place, it is just so you can get the correct spelling. I just want to be sure I get the help I need this time and am not going to get smacked around.

CGS: My email address denise.winsock@cgsadmin.com

Sharon: Okay. I will start there and see if they will escalate to one of the tiers. I have one specific one now and I have a slew I have not dissected yet to see if they fall within this category. How long do I wait to see if I’m escalated before I say I’m done? Do I send you an email?

CGS: If they are not escalating you, please send me an email. Please give me one or two days as we have been travelling a lot. Within three days, I promise I will get back to you.

Sharon: Thank you.

CGS/Judy: Denise, may I add something? For any suppliers that have issues with PECOS where it says in PECOS that the information is correct, but they are having issues with CGS, you can always contact the correct A/B MAC contractor and have them re-trigger the record. You can also contact the physician’s office and let them know the records need to be re-triggered. We see that a lot.

Sharon: I did all that. I reached the AB Contractor myself because when I reached out to the provider and told them of the problem, what I got was an email confirmation that we are truly enrolled. I couldn’t get in anywhere, even with Customer Service. That is why I am here today.
CGS: Try Customer Service and send me an email and I promise we will get it resolved for you.

Renee: We billed for refractive lenses for post cataract surgery and the only code Medicare accepts is Z96.1 for those to be covered. Most of the commercial payers are requiring ICD10 code to be out to the 5th or 6th digit. I just wondered if Medicare is going to the higher degree of specificity of ICD10 coding to use on the claims. Then what happens is that Medicare auto-forwards the claim to the secondary and then our claim will be denied because the diagnosis code is not one they are accepting.

CGS: Medicare will consider coverage for refractive lenses Aphakia and Pseudophakia for the diagnoses listed in the policy. Those are the ones that are currently considered. As we receive ICD10 updates from CMS, we do add additional codes. You can also request policy reconsideration if you would like to add the additional diagnosis codes, and that can be individually considered. This information is available on the Local Coverage Determination page.

Renee: Okay, but there is nothing out there right now that is in the works?

CGS: If there is, I have not seen it. Usually any ICD10 updates are available on the Change Request page. That affects all policies and is usually an annual update. You can also contact the secondary payers and let them know and provide them with a copy of Medicare's policy. That may help as well. You can also list both codes on there as well.

Renee: Thank you.

Robin: We have had a few situations where a patient has had oxygen (E1390) for a few months maybe a few years ago and then returned it (let’s say 3 months in 2017). They now need to get setup again. The LCD says you can do the 60-day break in service, but we can never get the documentation to prove there was that change in medical necessity (example, they got better), and now they need it again. We usually don’t start a new 36-month rental. We have been told we need to get a recert CMN because it is over 12 months from the initial date of service. Does that mean they need to have a recert again at month 12?

CGS/Ashley: Excuse me, we have run into this before. Let’s say they only had it for 3-4 months and returned it…not a true break in medical need but just a break in billing or service. A year or two later, they go back on oxygen and you start billing again. Systematically, when you start billing again (if it is past when that original 12-month recert is due), the system will start looking for the recert and it will deny it. Even though you have only been paid 3 or 4 months, the system will need the recert.

Robin: Okay, so we get the recert CMS44. So, we don’t need to get another one in a few months. We just get a continued need prescription. Once we hit the 36 months, our billers would ask to extend the CMN to get the remaining...

CGS: Exactly.

Robin: One other question…is there a third CPAP trial or are they done after the second one until 5 years?

CGS: Your re-trial is that you have to get a new sleep test and qualify within that 3-month period. Once you qualify, then you can bill us for the 4th month with the KX Modifier.

Robin: So, let’s say they had the first trial the first month. One, two, three, they failed. They got a new sleep test, face-to-face, and then are now in their second trial but then they failed compliance again.

CGS: You won’t bill us, but they can go for another sleep test again.

Robin: Thanks.

Terry: (disconnected earlier) - You said earlier there is some kind of sleep scoring article for CPAP. Maybe that will help me understand what I am missing.

CGS: There is a new ‘Dear Physician’ test scoring letter that just came out. Are you on our Listsrv? (Yes.) You should have gotten an email for that. What is your question on that?

Terry: They get approved for sleep apnea and for the CPAP machine and they use it for the first 3 months. If their compliance isn’t at 70%, you are saying we can’t bill a 4th month?

CGS: If they are not using that CPAP machine for 70% of the night, they don’t meet compliance. They would have to get a new re-trial. We need a new sleep test, a new face-to-face and they would have to go through that trial within 3 months to meet compliance.

Terry: Do we use the KH1 Modifiers again?

CGS: No. We already billed for the first 3 months. Your KJ will be billed now going forward (4th through 13th months).

Terry: As a supplier, if you gave a 30-day extension to pull their compliance up, is that acceptable? Then, you don’t bill the 4th month until…essentially you are getting an extra month with no billing.

CGS: They have to meet compliance within 31-91 days. What is the reason? I think it is only if they go into the hospital.

Terry: They all have a million reasons why they don’t meet compliance!! With prior authorization for some of the commercial plans, that is something we have done in the past when they are pretty much in compliance but not quite there. We give them a 30-day extension to get there. Once they get it up, we re-apply for the PA and go forward. You are saying CMS will not allow that. Three months…period, and if not, they have to be re-evaluated?

CGS: Yes but let me verify that. It is only if they have to go into the hospital. Otherwise, it had to be within the 90-day period. There are a lot of FAQs on our website about this.

Terry: Thanks.
CGS: Thanks everyone for attending. This transcript will be published on our website within 30 days. If you need to email any additional information, please be sure you do not send any PHI...just the CCN Number or send your phone number.

Don't forget the JB POE workshop in Columbus Ohio on September 18, we would love to meet you face-to-face. Please register!

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