Jurisdiction B Ask-the-Contractor Teleconferences (ACT)

**Introduction**

Good afternoon and welcome to CGS Administrators, LLC (CGS) DME MAC Jurisdiction B Medicare Updates "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 ACT call you may ask questions pertaining to the Medicare Update topics discussed here today. The topics include the New Medicare Card Project, Adjudication Process of Serial Claims, the National Expansion of the Condition of Payment Prior Authorization and lastly an update regarding the CR9968 Cures Act Mass Adjustments.

At the close of the update we will open the line for questions.

**New Medicare Card Project**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the Centers for Medicare & Medicaid Services (CMS) to remove Social Security Numbers from all Medicare cards by April 2019. A new, randomly generated Medicare Beneficiary Identifier or MBI will replace the SSN-based Health Insurance Claim Number (HICN). The new MBIs will be noticeably different than the HICN and Railroad Retirement Board (RRB) numbers, they will be 11 characters in length, and made up of only numbers and uppercase letters with no special characters.

CMS will start sending the new Medicare cards with the MBI in April 2018. There will be a transition period that will allow claims to be submitted with either the HICN or the MBI. This transition period is scheduled to begin April 1, 2018 and run through December 31, 2019. Once the transition period is over, suppliers must use the MBI for most transactions.

Once CMS starts mailing out new Medicare cards, people new to Medicare will only be assigned an MBI. Look at your practice management systems and business processes and determine what changes you need to make to use the new MBI. End-to-end testing with Medicare is not necessary as you’ll be able to use either HICNs or MBIs to submit claims during the transition period. Use the transition period as a live test and make adjustments as necessary. If you use vendors to bill Medicare, you should contact them to find out about their MBI practice management system changes.

As of June 2018, suppliers can use myCGS to look up MBIs and starting in Oct 2018 through the transition period, if suppliers submit a valid HICN, CGS will return both the HICN and MBI on the remit. We recently mailed letters to all Medicare Fee-For-Service providers. Your letter will tell you about the new Medicare card project and how to use myCGS so that in June 2018, you’ll be able look up MBIs for your Medicare patients who don’t have their new cards when they come for care. Carefully read your letter and the fact sheet to learn more about how to get ready to use the MBIs by April 2018.

To help you prepare for using the MBI, we will be conducting monthly webinars, and the first one is scheduled for October 17. You can register to attend by going to the Webinars page located under Education on the Jurisdiction [B/C] Medicare website.

We suggest you visit the CMS web site for more information at [http://www.cms.gov/newcard](http://www.cms.gov/newcard).

**Adjudication Process of Serial Claims**

The Improvements to the Adjudication Process of Serial Claims was release in MLN Matters Special Edition Article SE17010 and published in CGS News on May 2, 2017. The process became effective April 7, 2017. This MLN provides the DME MACs with instruction on handling the adjudication process for serial claims. When CMS renders a favorable decision on a redetermination case, we will identify other claims for that beneficiary that were denied for the same or similar reason that can be reopened to apply the favorable decision. CGS will look for claims to apply the favorable decision that are within one year of the claim’s initial determination date.

The goal of this new improvement is to prevent future claims from unnecessarily entering the appeals process by identifying claims that have not yet been appealed and applying the favorable decision. This process ensures that claims subject to Medicare review have been determined to meet medical necessity standards will continue to be paid consistently when the decision is applicable to other claims in a series.

CGS will reopen the applicable claims and make the necessary adjustments. Suppliers do not need to take any actions and should not reach out to their DME MAC to request that their appeal be considered for this initiative.

**National Expansion of the Condition of Payment Prior Authorization**

Condition of Payment Prior Authorization began on March 20, 2017, for beneficiaries residing in Illinois, Missouri, New York, and West Virginia for the K0856 and K0861 Group 3 power wheelchairs. This program was expanded to all claims nationwide on July 17, 2017. Suppliers that intend...
to provide a K0856 or K0861 must receive prior authorization from the DME MAC before the item is furnished or a claim is submitted. There are four claim types excluded from this condition of payment. The claim types are limited to:

- Veterans Affairs
- Indian Health Services
- Medicare Advantage
- Part A and Part B Demonstrations

Based on recent submissions, here are the top reasons that CGS must provide non-affirmation decisions:

1. The documentation did not include verification that the supplier’s Assistive Technology Professional (ATP) has a current Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification or that they were employed by the supplier, and had direct in-person involvement in the selection of the power mobility device for this beneficiary.

2. The face-to-face examination was not signed; therefore the identity and credentials of the author cannot be authenticated.

3. The documentation did not indicate that the beneficiary meets coverage criteria for a power tilt and recline seating system and the system is being used on the power mobility device, or that the beneficiary uses a ventilator which is mounted on the power mobility device.

4. The documentation did not indicate the beneficiary’s mobility limitations are due to a neurological condition, myopathy, or congenital skeletal deformity.

5. The face-to-face documents contained corrections/changes that do not comply with accepted record keeping principles.

6. The 7-element order contains an invalid date of the face-to-face examination or was not received within 45 days of the completion date.

CGS has a webpage dedicated to the Condition of Payment Prior Authorization. It can be found as a sub-section of Medical Review on [http://www.cgsmedicare.com/jb](http://www.cgsmedicare.com/jb)

For those of you that provide these items to Medicare beneficiaries, I’d like to provide you with a few reminders:

- If submitting a Condition of Payment Prior Authorization request via esMD, the content type must be 8.4 for condition of payment. Suppliers may be required to contact their Health Information Handler to confirm the content type 8.4 for their submissions.

- When a supplier submits a Condition of Payment Prior Authorization claim for the base equipment with accessories, to avoid receiving a rejection, the supplier must enter the Unique Tracking Number (UTN) in loop 2400 REF02 (REF01=G1). This is an indication that the authorization is for the base and not the entire claim.

- CGS will send decision letters that include the UTN within ten business days of receiving your initial request. Resubmitted requests will receive a response within 20 business days.

- Suppliers should no longer submit any documentation for K0856 and K0861 to the Advanced Determination of Medicare Coverage department. Instead, the prior authorization request and documentation must be sent via fax to 1.615.660.5992 or to the dedicated Jurisdiction B post office box addresses on our websites if you prefer to mail the documents to CGS.

- The cover sheet templates list the fax number and mailing address for each jurisdiction; feel free to refer to them. The template is available on the Forms page of our website at [http://www.cgsmedicare.com](http://www.cgsmedicare.com). Click the appropriate DME MAC tab at the top of the homepage.

- When submitting a prior authorization, include applicable face to face encounter medical records, the LCMP evaluation, ATP notes, the seven-element order, the detailed product description and the home assessment if it has been completed.

- When the specialty evaluation supports the need for specific options/accessories that are needed to address a Medicare patient’s particular limitations, these options/accessories will be considered as part of the PAR. However, a separate decision will not be issued for the options/accessories.

- All Medicare documentation requirements and local coverage determination (LCD) coverage criteria have not changed and are applicable for any claim submission based on a prior authorization request.

**CR9968 Cures Act**

**Mass Adjustments - Update**

CGS has received 100% of the claims expected under the 21st Century Cures Act. While some claims are still in varying stages of the adjustment process, CGS is nearing the completion of the initial Cures Act adjustment phase. As the final adjustments make their way through the Medicare Claims Processing System, CGS is inviting the suppliers impacted by these adjustments to begin submitting Reopening requests to add the KE modifier to their adjusted claims.

Based on the Cures Act, the KE modifier can be added to certain accessories used with a non-competitive bid base for dates of service July 1, 2016, through December 31, 2016. Claims that meet the criteria for addition of the KE modifier under the Cures Act must be submitted using the special Cures Adjustment KE Modifier Reopening Request form ([https://www.cgsmedicare.com/pdf/dme_reopenings_cures_adj_2017_re.pdf](https://www.cgsmedicare.com/pdf/dme_reopenings_cures_adj_2017_re.pdf)). Note that prior to preparing your spreadsheet, you are required to confirm that the adjusted claims have completed processing.

Many of you may have multiple claims requiring addition of the KE modifier. CGS will accept those via the spreadsheet. If
using a spreadsheet, CGS asks that you use the KE Modifier template (https://www.cgsmedicare.com/pdf/cures_act_form_re.pdf) we have created OR you may create your own as long as it contains the following information:

- The beneficiary’s name
- The Medicare Health Insurance Claim Number (HICN) of the beneficiary
- The specific date(s) of service
- HCPCS code
- The supplier’s Provider Transaction Access Number (PTAN)
- Clearly state what addition or change is needed
- The printed name and signature of the person filing the request

Please be mindful that regardless of the spreadsheet you opt to use (CGS spreadsheet or your own), our maximum is 250 claims per spreadsheet. Each spreadsheet submitted must be for one PTAN.

If you have multiple locations impacted by these adjustments, you must separate your request by PTAN.

Jurisdiction B suppliers may fax their KE Modifier Reopening Request form and spreadsheet to 615-660-5978. If you wish to mail the information to Jurisdiction B, please send it to:

   CGS Jurisdiction B  
   PO Box 20017  
   Nashville, TN 37202

CGS has published this information to our dedicated MM9968 webpage! Click on the banner on the jurisdiction homepage to see the most recent information as well as related links!


Conclusion

As we prepare to queue your questions, please be reminded 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. If it’s red, your hand is raised. I will unmute individual lines so that you can ask your question. No specific claim information or Medicare beneficiary’s private health information should be verbalized. I will now give you just a moment to prepare our question roster.

Question and Answer Section

Jennifer: I have a question regarding the CMS update to clarification of billing of immunosuppressant drugs that was sent out on September 1.

Stacie: Jennifer, the topics for today are limited to those that we discussed. What I would encourage you to do is contact our Provider Contact Center to see if you can get that question answered or you may submit that directly to your Community Coach.

Tracy: I am calling on one of the slides, referenced on prior authorization regarding E0486. The slide didn’t go through on my side. Did I hear the right code…E0486?

Stacie: The prior authorization is limited to the Group 3 power chairs and that limited to HCPCS codes K0856 and K0861.

Tracy: Ok. I didn’t know if I heard E or K. Thank you.

Josh: I have a question regarding wound care supplies.

Stacie: I have a question regarding wound care supplies.

Stacie: That is correct.

Terry: Thank you.

Megan: Do you know with the new Medicare ID if clearing houses and vendors will have access to do eligibility with the new MBI?

Stacie: We are encouraging you to contact your clearing houses and vendors to see what their processes will be for that. They would be required or responsible for making sure that they have access to that information and working with you to do so.

Megan: Thank you.

Terry: The Cures Act is on the docket today so you are saying it is pretty much done for the initial phase? Have you had any feedback with anyone having the same issue as we are with the reversal being counted again with the secondary payer? I haven’t found one where Medicare is necessarily counting the reversal as part of the oxygen 36-month rental or a 13-month rental for a capped rental item, but it is counting when it goes over to the secondary.

Dustin: So you are saying the secondary insurance is counting that payment twice towards your oxygen rentals?

Terry: Well, I have not seen it necessarily with oxygen but with capped rentals, say with a hospital bed where Medicare is primary and the secondary insurance is denying claims saying that we have exceeded monthly rental. When I ask sometimes they will say we are at 17. When I go back, I see where the
17 is coming from. The secondary is counting the Medicare adjustments from 2016, as additional payments.

**Dustin:** There is nothing we can do about them counting it twice. I would recommend contacting them to make sure they know that it was an adjustment and it was not another initial claim.

**Terry:** Right. I just wanted to get some feedback to see if there was some kind of specific way to handle it even though it is not necessarily a Medicare issue, it is a crossover issue. I guess tell them it is part of the Cures Act and it is being counted twice.

**Dustin:** Yes ma’am. Sorry I don’t have more for you.

**Terry:** Thank you.

### Ending

**Stacie:** Thank you for your participation and listening in on the JB Ask the Contractor Teleconference for Medicare Updates. Hopefully, everyone will be able to make adjustments to become compliant with the updates we provided you today. In a few weeks, we will publish a transcript of today’s call that will include all of the links we referenced today. With that, we will close out the call. Thank you.