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Jurisdiction B Ask-the-Contractor Teleconferences (ACT)

Operator: Good day, ladies and gentlemen, and welcome to the CGS Jurisdiction B - Ask The Contractor Teleconference, JB Transition and Standard Documentation Language conference call. Today’s conference is being recorded. At this time, for opening remarks, I’d like to turn the conference over to (Nina Gregory). Please go ahead.

Nina Gregory: Thank you, (Keith). Good morning everyone and welcome to the CGS Jurisdiction B durable medical equipment Medicare administrative contractor ask the contractor teleconference. My name is Nina Gregory and I am a Provider Outreach and Education Senior Analyst with CGS. I will be facilitating today’s call. Other Provider Outreach and Education staff as well as other CGS staff are with me this morning to assist with questions.

This call is being recorded. Within a couple weeks, we will publish the call transcript and the question and answer document to the CGS website. A ListServ message will be sent advising when the documents are available. So it is important that you and all of your staff are signed up to receive the CGS jurisdiction B DMAC ListServ messages. You can do this visiting our website at http://www.cgsmedicare.com. Once you’re on the Jurisdiction B DME homepage at the very bottom lower left-hand side of the page, in gray, under the word utilities, you will see join or update ListServ. Click on this. You will then fill in the required information to sign up to receive a ListServ message for each contract you choose.

The objective of this teleconference is to provide an overview of the Jurisdiction B transition and updates to the standard documentation language. We will then open the phone lines to take your questions. We would like to advise that many myCGS issues are currently being addressed at this time and we may need to take any new issues back to the technical team.

Before we begin, I would like to remind everyone about the upcoming Jurisdiction B DME MAC workshop. It will be held on October 19th in Indianapolis, Indiana. The workshop will be a one-day event providing education on documentation, repairs, policies, and transition updates. Please take a moment to register at as soon as possible to secure a seat for the event. You can register on the CGS Jurisdiction B website on the workshops and seminars page under the education tab.

So let’s get started. Jurisdiction B transitioned from National Government Services to CGS on July 1st. One transition change included suppliers moving from using Connex to myCGS. Since implementation of the myCGS version 3.0 for Jurisdiction B users, we’ve received a number questions and feedback from the DME MAC Jurisdiction B community. We’ve also discovered a few issues that we will be addressing in future versions of myCGS.

One known issue is when myCGS users login to check eligibility for consecutive beneficiaries. Users state they have to log out and log back into myCGS each time they want to search for a different beneficiary. This is not the case. In order to perform consecutive beneficiary eligibility searches, you must follow a few steps. First, perform the search for the first beneficiary and obtain the eligibility information you need. Then go back to the main beneficiary eligibility search screen by clicking on the beneficiary information menu. Press the clear button to remove the previous beneficiary search criteria then perform a search for the next beneficiary and repeat these steps for as many beneficiary searches as you need.

In order to sign up for myCGS, you must first sign up for Enterprise Identity Management or EIDM through CMS. Once you’ve signed up through EIDM and received approval, you can then sign up for the myCGS portal. Since the transition there has been two new government security updates to affect the myCGS portal. Effective September 2016, CMS is updating the EIDM system to begin requiring a new Multifactor Authentication or MFA process when users log into the DME myCGS web portal. MFA is the use of two or more different authentication factors to verify the identity of a user. One authentication factor is the password that goes along with your EIDM ID to get into myCGS. MFA will require a second completely separate authentication method.

If you are an existing user of myCGS and have not already done so, you will need to register an MFA option in your EIDM account. Aforementioned, the MSA option became effective September 2, 2016. Options for MFA include using credentialed software on your computer or phone, text message, voice message, or e-mail. You can register up to five devices for MFA and CMS recommends that you register at least two devices. It is strongly suggested that you use the free credentialing software as your first MFA choice. If you are unable to use the credentialing software (for instance, because you use a shared computer), then text message is suggested. Using email should be your last resort for authentication. It is both the least secure and the slowest method for receiving access authentication and therefore may cause delays in the myCGS login process.

You may currently register your MFA devices in the EIDM external website While MFA use is required as of September 2, it is important to complete the registration of your MFA option as soon as possible. Failure to register an MFA option will result in delays accessing My CGS. CMS has also added another level of security for all EIDM users, including all-new DME and My CGS registration beginning
September 2, 2016 called remote identity proofing, RIDP. RIDP is the process of validating sufficient personal information that uniquely identifies you. For example, a credit history, personal demographic information, and other indicators. In other words, RIDP is a process that helps ensure that you are who you say you are.

Please note that if you are a brand new My CGS user prior to the September 2, the option to sign up for MFA may not have been immediately available. The option to register an MFA device became available beginning on the first Friday after use becomes available on the first Friday after you’ve registered in EIDM.

If you are registered for My CGS in an approver role, designated for approval, authorized official or backup authorized official it is especially important that you register your MFA option as end users in your organization may have issues with MFA if their approvers are not registered.

The next topic to cover is a standard documentation language. The most current standard documentation language article was published on April 28, 2016. There were a few changes to note at that time. One is the use of prescribing or treating practitioner from physician. This revision is consistent with the verbiage within the program integrity manual, or PIM, 100-08 chapter 5. Another revision is regarding the order for items under the Affordable Care Act, or ACA 6407. The order had previously been termed a written order prior to delivery and followed the elements required for the detailed written order with the addition of the prescribing practitioner’s NPI and a date stamp or equivalent receipt by the supplier. It is now termed the five element order. The five element order must still be received by the supplier prior to dispensing. Must be completed within six months after the required face-to-face examination, but only has to have the five required elements. The elements are more consistent with what we typically call a dispensing order and must include the beneficiary’s name, a description of the item being ordered. This may be general, for example. It could just be a hospital bed. The prescribing practitioner signature. The prescribing practitioner’s NPI and the date of the order. If you have a detailed - if you have a more detailed order such as a detailed written order, and it includes all the required five element orders, you may use this order and are not required to obtain these separate five element orders. While on the topic of orders, suppliers should be aware that the previous star date requirement is different from the date of the order has been removed.

The face-to-face documentation continues to be required within six months prior to the five element order. The face-to-face documentation is still required but does not have to be in the supplier’s possession prior to delivery and therefore no longer requires a date stamp or equivalent per the revised “Face-to-Face Examination and Prescription Requirements Prior to the Delivery of Certain DME Items Specified in the Affordable Care Act Article,” that was revised on April 28, 2016.

Proof of delivery has three methods, method three is delivery to a nursing facility on behalf of a beneficiary. The documentation for this method has been changed. The documentation may demonstrate receipt and/or usage of the item or items by the beneficiary. The quantities delivered and used by the beneficiary must justify the quantity billed.

The last addition to the standard language documentation is the correct coding section. Correct coding is a determination that the item or items provided to the beneficiary are billed using the appropriate HCPCS code for the item. Suppliers are required to correctly code for the items billed. When requested, suppliers must provide documentation that is sufficiently detailed to unambiguously identify the specific product delivered the beneficiary and the HCPCS code used to bill for that item.

Before we open the telephone line for questions, I would like to remind everyone that we cannot answer questions specific to individual claims. If you have a claim specific question, please contact the provider contact center at 1.866.590.6727, or the information can be obtained via the IVR, contact the IVR at 1.877.299.7900. Due to the number of participants dialed in, we are limiting each caller to one question at a time. If the operator opens your line, you will be given the chance to ask your one question. If you have more than one question, you can go back into the queue to ask another question. We are ready to start with our first question.

Operator: Thank you. Ladies and gentlemen, if you'd like to ask a question, you may do so by pressing the star key followed by the digit 1 on your telephone keypad. If you're using a speakerphone, please make sure your mute function is turned off to allow your signal to reach our equipment. A voice prompt on your phone line will indicate when your line is open. Please state your name before posing your question.

Again, star 1 for questions. We'll pause a moment to allow everyone an opportunity to signal. We'll take our first question from...

Natalie P.: Hi, I have a question about the PODs that are required when a patient has commercial insurance and transitions to Medicare.

Nina Gregory: Okay. So they've already received a DME item?

Natalie P.: Right, they have a pump and let's say they have a commercial payer and they become Medicare effective. When the patient writes the letter explaining that they've had the equipment, and they've examined and that it's in good working order, when the patient writes that letter, they're signing it as of the day they write it. Is that considered a valid POD from that date going forward for us?

Because we may not find out the patient actually has Medicare let's say maybe a month or so may pass in between that time. What is considered a valid date if the patient has already had the pump when they write the letter?

Nina Gregory: The supplier is responsible for assessing the equipment to make sure it is in valid working order. The supplier is to go and assess the equipment and when they assess the equipment they can then write up that they've assessed that equipment, it is still in good working order and
good condition, and then the date that the beneficiary signs and dates that or the date that occurs and the beneficiary signs, that would then be your first date of service.

**Natalie P.:** Okay. That’s what I’m asking. The day after we do our assessment and we do the letter, the patient agrees, signs and dates the letter from that date would be considered a valid POD. And then we would be able to use that billing in our rental going forward.

**Nina Gregory:** Yes that is correct. If your date of service is prior to that date then it would be invalid.

**Natalie P.:** Right, right. Okay. I just wanted to confirm that. Thank you so much.

**Operator:** We’ll take our next question from...

**Christina P.:** Hi, I was wondering - I have been having some significant issues related to our NPIs being loaded into the portal and I have been calling since the middle of July to get them corrected and so every one of our claims, we have to contact the IVR. We’re not able to utilize any access for any of our other locations, which we have 12, to get information.

**Nina Gregory:** So you’re saying that your NPI is being considered invalid?

**Christina P.:** They have not loaded so they had data that they were having issues loading all NPI numbers for multi-locations and that they were addressing it. This has been ongoing since the middle of July, since we transitioned. I didn’t even get my portal access until the middle of July.

**Nina Gregory:** What portal are you speaking of?

**Christina P.:** The CGS web portal.

**Nina Gregory:** Okay. The myCGS?

**Christina P.:** Yes, I’ve been on with the help desk. I’ve been emailing people. I cannot get any resolution to getting the rest of - the remaining of my locations NPI numbers loaded so that we have access to reviewing claims status and information.

**Nina Gregory:** Okay. I think Kevin is going to respond to that question.

**Christina P.:** And I also just wanted to give a little tip to somebody else about - because we’ve been having issues with the eligibility. However, what we have just found out is that you guys need to do - if you’re having issues not being able to get through it, do a clear history on your browser and that frees it up as well. So I just thought I’d share that because we just found that out after a month of having eligibility issues.

**Nina Gregory:** Kevin, did you want to add something?

**Kevin Jackson:** Yes, initially we weren’t having issues with getting the NPI and PTANS loaded. One of the things we need to keep in mind too that is generated based off your tax ID. So if you’re a location that has multiple tax IDs that may be one of the issues.

**Christina P.:** We only have one tax ID.

**Kevin Jackson:** You only have one and you’re still having issues as far as having them loaded?

**Christina P.:** Yes, I still can’t get them loaded. I only have one out of 12 locations loaded. So I can’t check claims status on anybody.

**Kevin Jackson:** Okay. If you can, Nina, can you take her information or I don’t know how we would need to do this but I can...

**Christina P.:** Can I get your email and I can email you or?

**Nina Gregory:** I believe we’ll have your information from where you dialed in and we can get a hold of you. What was your name again, I’m sorry?

**Christina P.:** My name is Christina P.

**Nina Gregory:** I think we’ll have your information from where you dialed in so we’ll be able to call you.

**Christina P.:** Okay. Thank you.

**Kevin Jackson:** But a vast majority has been taken care of. There are one-offs that we need to actually look at and see what’s going on with it, but yes, for the vast majority of it, it should be taken care of.

**Christina P.:** Okay. And is there any updates that are going to be happening relatively soon regarding filing online with electronically? Is that going to transpire soon with their upgrade?

**Kevin Jackson:** Yes, we’re actually in the ending stages of that now, of finalizing and coming up with a date and everything. But yes, that should be coming up real soon here.

**Christina P.:** Okay. Okay.

**Operator:** We’ll take our next question from...

**Woman 1:** Hi, I have a question about proofs of delivery. We dispense glasses for Medicare recipients after cataract surgery and just checking to see if let’s say we dispensed a pair of glasses today and the person picked up them today. And the optician forgot to have them sign a proof of delivery. Is it okay to send out the proof of delivery to have that person sign them after the fact if it’s just missed or forgotten on the day it’s dispensed?

**Nina Gregory:** The date that the beneficiary signs the proof of delivery is your date of service. So the date they receive it. Now, what you can do is have a corrected proof of delivery that the beneficiary can sign and ate as well the corrected date. So the beneficiary does not have to date the proof of delivery. They have to sign it. But if there was a correction to it, the beneficiary would have to asset to that correction.

**Woman 1:** Okay. But if you had the proof of delivery there and like I say they just forgot to sign it or the optician forgot to have it signed. And then proof of delivery isn’t really corrected can they sign it later just so that we have a signed proof of delivery?
Nina Gregory: If they sign it and they date it when they sign it, then that's going to be your date of service.

Woman 1: Okay.

Nina Gregory: Does that make sense?

Woman 1: Yes, I just wanted to clarify because sometimes - like I said, if they forgot to sign it and if we sent it to them in the mail to have them sign it and then they sent it back to us. Even though I know, like let's say they got it today but then they just dated it for the date they signed it, that's what we would have to use as our billing date.

Nina Gregory: If they dated it, yes, but you should make sure that they - I would definitely document what happened in the scenario so you have that as well.

Woman 1: And where would you document that?

Nina Gregory: Wherever you choose, in your system or something like that, something that you can print off in case of an audit.

Woman 1: And say I forgot to have the patient sign, sent it, and they sent it back signed or something to that matter.

Nina Gregory: And then on the proof of delivery, if there are any changes or corrections made then that has to also be attested to by the beneficiary.

Woman 1: Okay. All right. Thank you.

Operator: We'll take our next question from...

Leslie M.: Hi, my question is about additional documentation requests. We are currently in the process of registering all of our NPIs and under myCGS, but we have quite a few. So apparently, we can only register those one at a time. So we're still faxing our submissions for ADRs. But there seems to be a delay. We are faxing - sometimes we don't get the documentation - I mean we're a big provider so we have a lot of these ADR requests.

I have one full-time person just dedicated to that alone. So sometimes we don't get everything from the physician. We are the pharmacy. We're depending on the medical records coming from the physician and a lot of the times they don't get back to us right away or whatever the case might be.

We might be submitting the ADR on the due date. So we're still getting it in on time but we're receiving a lot of CO50 denials. So I don't know - and then so we always call every time we receive that CO50 denial and say we did submit this. This is when we submitted. We have the proof. We have the fax confirmation. We get one of two responses to that.

Some reps won't even indulge in looking for the documentation. They say, well, you know, that's pretty much too bad. You have a denial, you need to submit an appeal. Other reps might look for it and they say, well, we do see that you have - that you did receive it and depending on the scenario, they say, well we're delayed for however long. It's not scanned in the system yet or whatever the case might be.

So we're getting different answers but regardless, I don't - I'm just wondering a way to handle this because that's counting as an error against us and it shouldn't be because we got everything in on time.

So I'm looking for some advice on how to handle that, if there's a specific thing we need to ask the reps when we're calling in when we have that situation or is there - the due date is the due date but is there maybe a time limit of the day that it needs to be in before. Any advice you can give to help us proactively not receive those denials and therefore errors against us.

Nina Gregory: So if you send it in on the date that it was due, the 45th day, are you receiving a denied claim for no response?

Leslie M.: Yes.

Nina Gregory: You are receiving a no response. Okay. I can take that back internally to see what our system is set at, a lot of the no response typically deny out because of the system. So if the system doesn't have a tag on the claim that we've received the ADR information, the documentation, then the system automatically denies it out. But I'm unsure how medical review currently works those claims.

So typically, n the past when we get the documentation, it gets faxed in, has to get loaded into a database so that then it can be - it's called indexing. It has to be indexed to match the documentation to the claim itself. So that can take a day or two. But you still should not be receiving those denials if you're faxing it in on the date that it's due.

I will have to look into that. I do believe our cutoff time is 4:00 p.m. Central for our faxes. So if they're being received after that time then maybe it's going to the next date and defaulting for no response.

Leslie M.: And some of the reps have told us exactly what you've said that it has to be scanned in the system and then the system automatically denies - if there's nothing indexed in the system to show that we sent something in.

So I guess my question then is, shouldn't there be a delay then in that system denial? If it takes some time to get those things loaded shouldn't the system them on your side take that into consideration so that it's not sending out a denial when it really might be the documentation just hasn't scanned in your system yet. I don't know if that's an option.

Nina Gregory: I will have to look into that and take that back. I agree that there should be some kind of a window. But that is something I'll have to take back as I don't work in that department. So I will definitely take that back. Okay?

Leslie M.: Okay. And so I guess when you take that back too, I guess like I said, a lot of the reps tell us basically, well, too bad. There's a denial. You have to respond to it and appeal and that just takes - not only does it delay the process but it takes away one of our appeal levels if we do need that for something else in the future.

So is there any way to maybe just - I don't know the training goes on your end as far as if they're supposed to do that or if they're supposed to look for us to clarify whether it has been
received or not. Because that’s what I’ve instructed my team, call on every one but we kind of just have to go with whatever they’re telling us. If they’re not going to look for it then we just have to submit a redetermination.

Nina Gregory: If you’ve already received your denial, I would automatically go through the appeals process.

Leslie M.: Well but we shouldn’t have to file an appeal if it was denied incorrectly.

Nina Gregory: I know we’ve had a lot of new training because of the new transition. Maybe that’s a training issue that we need to just address and make sure that they know to make sure to answer the question and look for the documentation to say yes, we have received it but you still have to file an appeal or to inform you of your rights.

Leslie M.: But I guess that’s my point. We shouldn’t have to file an appeal and it does delay - it doesn’t delay our appeal time. It delays our reimbursement. So we shouldn’t have to waste an appeal level when we did submit what we needed to on time. And that’s I guess what I’m trying to get at here.

Nina Gregory: Until I can see some examples too, to make sure you sent them in, you know, prior to that 4:00 pm cutoff or that they were sent to the correct fax. I know that’s an issue that we have heard is that we’ve had a lot of faxes have been sent to the JC fax line versus the JB fax line and that does delay the process - so make sure you’re sending it to the correct fax number. But yes, my suggestion is to go ahead with your appeal. I do know what you mean but I definitely have to take that back. That’s not something I cannot correct at this time.

Leslie M.: Do you want me to provide you some examples of ones that’s happened too? Would that help?

Nina Gregory: But what was your name, I’m sorry?

Leslie M.: Leslie M.

Nina Gregory: Okay. And then I will try and get a hold of you after the call. Okay?

Leslie M.: Great. Thank you.

Operator: We’ll take our next question from...

Woman 1: Yes, we have a problem with billing. The restart on the oxygen, like if it’s an RUL situation when it was NGS, when I would bill it, I would bill using the RA modifier and have my narrative. Well, when the first one that I got through CGS I was doing it the same way I did it before but it kept rejecting it in the adjudication process for incorrect combination for HCPCS and modifier. So what is the proper way to bill it, the E1390, when you’re doing an RUL situation to start the 36 month process over?

Nina Gregory: So there was a break in billing?

Woman 1: No, no. After the five years is a new initial and they’re getting another - they were starting a new round of billing. The modifier I’ve always used was the RA modifier on the initial claim.

Nina Gregory: You would not need to use the RA modifier on an initial claim if it’s past the five-year RUL.

Woman 1: Well, I called, they told me I had to use the RA modifier but I also had to use the RR modifier as well. So I’m confused on that one.

Nina Gregory: The oxygen is a capped rental item but I do not believe you would use it because it would be in a new capped rental period. So it would be past the five year. Oxygen is a capped rental item so the RR would be correct but you don’t append the monthly modifiers, the KI, KJ, KH.

Woman 2: I know that because after that it’s just supposed to be the RR. But for the initial month in an RUL situation it says you’re supposed to use RA modifier only for the first month only. And then when I did that it was rejecting - kept rejecting. So I called the customer service and they’re telling me to use an RR/RA modifier and I just never heard that combination.

Nina Gregory: You’re not replacing within the five year RUL correct?

Woman 2: No, no. This is after five years is up. Patient is requesting a new concentrator. We’re setting them up, starting the second round of the new 36 month billing period. And on that initial claim, I had my narrative and then I had my RA modifier and it wasn’t letting it go past the adjudication system. It was saying invalid modifier combination.

Nina Gregory: Yes, I’m not sure. There’s an article we have out here regarding replacement oxygen in RA. It says it was given the RA modifier oxygen equipment only if there was the following applied and it says if it is the initial rental month and it is a replacement due to reasonable useful lifetime or reasonable replacement due to damage, theft, or loss.

Should not be used when billing for a new initial rental that follows a 60 plus day break-in need. So do you know if you’re having that 60 plus day break in need?

Woman 2: No, it was nothing to do with a break-in need. It was an RUL situation. It was a reasonable, useful lifetime situation.

Nina Gregory: But is there - okay.

Operator: We’ll take our next question from...

Nina Gregory: I’m sorry?

Laurie: Hi, my name is (Laurie). My question - well, first of all I want to make a comment about the faxing of the ADR responses. We’ve had a number of issues where we’ve gotten denials for - specific denials regarding no MD medical records from prescribing physicians when we have included those records in the response. Is there a way that we can go back and have a tier two reviewer look at the number of pages that were actually received, were getting fax cover sheets with complete 16 pages having sent you guys don’t seem to be receiving all 16 pages.

Is that an issue that we could have a tier two person take a look at?
Nina Gregory: Yes. They can look to see what we received and if the medical records were in there, then they can send it back to have the claim reopened and reprocessed. If it was not received then you would have to go through the appeals process with all the documentation just for the need of the item.

For faxing, I strongly suggest to do anything else other than faxing because faxing always seems to cause issues. So definitely place the total number on the front page that you’re faxing - on the cover letter helps and then I always suggest numbering in the top right hand corner all your patient numbers as well because then a reviewer can see that page five through seven are missing. But it seems strange that they would always be missing only the medical records unless you’re always putting them at the end maybe.

Laurie: Right. Yes, that could be. Okay. That’s good information to hear. My question actually is regarding the detailed written order requirements. Does the detailed description of the product on the detailed written order have to be as extensive as the description that’s needed on a proof of delivery?

Nina Gregory: No, the order would be more descriptive than the proof of delivery.

Laurie: The order would be more descriptive than the proof of delivery?

Nina Gregory: Yes, a proof of delivery based on change request 9487 can be just a long narrative description of an item. For a detailed written order, for example, if it’s an item provided on a periodic basis, it has to also have frequency, duration, not duration - frequency, number of refills, route administration.

Laurie: This is just for if we’re just talking about prosthetic devices so not the seven elements.

Nina Gregory: For the orthotics and prosthetics, especially if you’re providing - if the physician is ordering a custom item, it must state custom. Otherwise, it’s a physician ordering a prefabricated item. And then the detailed written order must also be more detailed and in fact it has to have all additional items and equipment that’s going to be provided.

Laurie: Okay. When we were with National Government Services, I believe our experience has been that the information on the detailed written order can be a short description, but the proof of delivery had to include more of a narrative make model number type of thing, or the long narrative descriptor.

Nina Gregory: With the proof of delivery that was a change that happened. I believe it was back in April or May that the proof of delivery for the detailed description of the proof of delivery could only be just a long narrative description. It does not have to have a manufacturer name, model number, and that information as of that change. Previously, we had required all of that information. The detailed written order description has not changed.

So it depends on the item that you’re - that the physician is ordering. If they’re ordering custom, like I said, they must stay custom. If the item that they are ordering has additional components that will be billed separately, they also have to include all of that. Many times it’s the supplier that creates the detailed written order. Therefore, you have the ability to make sure everything that’s required is on that detailed written order.

Laurie: Okay. So the detailed written order does have to include the long narrative descriptor?

Nina Gregory: It has to have enough information to know specifically what’s being ordered, quantity, all of that information. So it depends on the item because each item is unique. So orthotics is pretty simple. It doesn’t have as many additional things to it so it can be a long narrative description for an orthotic. If it’s custom though it must state custom. And then your proof of delivery can just be the long narrative description as well. But I can’t give a general statement because there’s other types of providers on the ACT call.

Laurie: Okay. Thank you.

Nina Gregory: You’re welcome.

Operator: We’ll take our next question from...

Sarah R.: Hello, I just wanted to go back on a call earlier, state that we too are also having problems with myCGS and only being able to pull up one NPI and we have eight, and it’s - we’re having the same issues. And we do also just have one tax ID number.

Nina Gregory: Okay. Thank you. We can take that back.

Sarah R.: Yes, please and I agree with her that we’ve been told that it’s going to be fixed and it’s really a hindrance at this point.

Nina Gregory: I understand. We will definitely take that back.

Sarah R.: Appreciate it. Thank you.

Operator: We’ll take our next question from...

Joe: Hello, this is (Joe. I got a question here on the PMDs. We have two doctors here that absolutely refuse to sign and close out a patient’s office visit without having everything back that they ordered during that office visit.

And one of the things is when we were with NGS, they understood that and they accepted the office visit date as the date when the doctor signed the office visit date as the face-to-face exam date, even though he signed the physical therapy one the day before he signed the office visit one.

I’m trying to figure out which date do we go by now.

Nina Gregory: So the physician saw the patient then referred them to a PT/OT?

Joe: Let’s say the physician saw the patient on July 10th, okay. He ordered the physical therapy evaluation for the power wheelchair. We got the eval back and he signed it on the 25th, but he did not close out the office visit by signing it until the 26th. Well, with NGS, when we were with NGS, they said the
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latest date, which would have been the 26th, is the date of the face-to-face exam because that’s when he actually signed and closed out the face-to-face.

Well, we just processed one through CGS and they’re saying that it’s either - well, this is what’s confusing about it, that it was either the date of the patient exam that he signed it or the date of the physical therapy when he signed the physical therapy into the record, okay.

But he signed the physical therapy into the record before he closed out the office visit. And like I said, when we were with NGS, they understood that and they took that one date saying date difference and said okay, that’s when the face-to-face exam ended.

But this one with the CGS are saying, like, no, it’s when he signed in the physical therapy exam.

Nina Gregory: The date of the face-to-face should be the date of the completed - the whole completion of the face to face. So that’s not really considered always just the date that they see the doctor. It could be the date but if they had not signed off on their records yet, I do believe it would have been the date that they fully completed and they signed the final record. So I can take that back to medical review.

Joe: Well, we got it through because I took and I submitted it with the 26th date, okay, and they sent it back saying the day of the face-to-face exam was wrong. And I’m saying wait a minute, that’s when he signed the face-to-face. I even called them on it and they said no, it has to be when - well, I’m sorry, but we can’t tell you what to put in there. Okay. So I went ahead and resubmitted through the process again with the 25th date on it and they approved it.

And that’s the other hitting at is going from NGS to CGS, there are some differences and it seems like the customer service people that we’re talking to, they’re not willing to take that into consideration that hey, look, we’re going from like Blue Cross Blue Shield to Humana. Okay. There’s differences.

Even though it’s Medicare the same, there’s differences and they’re not taking that into consideration, saying yes, this is what - this is how CGS wants it. Their answer I’m getting is we can’t tell you what to put in there. I said, well, I’m not asking you to tell me what to put in there, you know. I’m asking you what to - what CGS requirements are. Even though it’s Medicare but there’s differences.

And the other thing was when we were with NGS, they had a list of abbreviations that you can put into your NTE segment, in other words when you’re saying, like, okay, this is patient owned equipment, PO, the HCPCS code type thing and they knew what PO was. It was patient owned.

And when we went over to CGS, I said okay, yes, this is the codes that we were using for NGS and CGS says, well, we don’t know anything about that. We don’t know what these codes are. We don’t understand that. It’s like, well, you know, can they transfer over because we’re used to saying when we have patient owned equipment is PO, E0601, the date or when we have a break in need, it’s BIN whatever, whatever, whatever. And it’s like they’re going we don’t understand what that is. So is there any way they can be transferred over?

Nina Gregory: These are all good. I was not aware of some of these discrepancies or changes. We can definitely take it back internally and if there is something that is different from previously NGS to CGS that we’re going to adopt the CGS away, CGS did win the contract, then we can look to do some education on that. So I do appreciate this because we were not aware of some of these changes.

Joe: Okay. Yes, it’s confusing.

John Kelly: This is John Kelly. Sorry to interrupt you. Sir, did I hear you say you were a PMD?

Joe: Yes.

John Kelly: Are you familiar with our Medicare Minute MD video series?

Joe: No.

John Kelly: I would encourage you to take a look at the education section of our Jurisdiction B website, http://www.cgsmedicare.com. Go into the education section and the videos and you’re going to see a series of videos called Medicare Minute MD. And one of them is called Power Mobility Pearls for the practicing physician. And it gives some specific information actually relative to what you’re speaking about in terms of face-to-face, and dates, and those types of things, that are of value to a physician.

So they understand the impact to you as a supplier. So you may want to take a look at that and if so it may be something to encourage the physician to review as well. This is a national education that we created and CMS is currently offering it as well and it’s served to provide both physicians and suppliers relevant information related to dates and face-to-face and documentation requirements.

Joe: And one other thing then I’ll get off the phone. On eligibility, we actually saw were ((inaudible)) if you guys can get on ((inaudible))). You can pull up Medicare eligibility instead of going all the way through the IVR line. I don’t know if that helps anybody out there. That’s it.

Operator: We’ll take our next question from...

Jake: My name is (Jake) and everyone kind of already touched on it. We are also a company that is having issues with the multiple NPIs and we only have one TAX ID number as well. So but I mean it - you guys all kind of touched on it and said you’re working on it.


Operator: We’ll take our next question from...

Jordan: Hi my name is (Jordan). Just real quick for the NPI issue, I know that we tried using something like Google Chrome as a browser and then switched over to Internet Explorer and I was able to change between NPIs when searching. I don’t know if anyone else has tried that yet. My question has to do with the customer service line.
As of within about the last week, I can have a patient with a claim where maybe one line denied and one line paid. When I try to call the customer service line to try to figure out the reason behind the denial, I can't access a representative. I enter in all the needed if and it reads it back to me and it says everything was correct but there's no information on the beneficiary and then I have absolutely no way to talk to anybody.

I was wondering if anyone else was having the same problem, aware of the issue.

John Kelly: Hi, this is John Kelly. I actually don’t work in the call center area but I’m familiar with the tool that you're referencing, the CTI tool. Are you saying that when you entered the information to try to get to the agent that it’s saying that there’s no information available for your particular patient, so therefore it’s not connecting you to an agent?

Jordan: Yes, it doesn’t give me the option. It just asks me to enter in the information for a different beneficiary.

John Kelly: I’m sending a note off to our director of call center management and I will see if there is a bigger issue there. And we will try to troubleshoot. I’m trying to find a way to troubleshoot without asking you for information that you can’t give on the public phone. May I give you my email address and have you send me a little bit more information? And then I’ll try to follow-up with the call center manager on that?

Jordan: Yes, sir.

John Kelly: Do you mind? Again, I don’t work in the PCC but I’m glad to kind of get it over there because I’m familiar with the system. If you would, it’s john.kelly@cgsadmin.com.

Jordan: Okay. Thank you very much.

John Kelly: Thank you.

Operator: We’ll take our next question from...

Michelle: Hi, this is (Michelle) and we’re having issues with our HCPCS codes that we send through with the GY modifier. And it’s for - the main one is for alcohol wipes and gauze it’s for trach cleaning. And I keep getting told that it’s requiring a wound modifier but it’s not actually a wound. It’s a trach and so I’m not getting any of these processed with the correct denials and it’s happening also with the alcohol wipes that are used.

The patient is not diabetic and again, we’ve always billed them with the GY modifier and they’ve gone through with a PR denial but that is not happening anymore. We’re getting a 106 denial and they keep telling me I need different modifiers but nobody will help me with what modifiers I need when it’s not a wound. Any suggestions?

Nina Gregory: Correct. It’s not a surgical dressing.

Michelle: Correct, yes. And it keeps getting denied stating that it requires a wound modifier but there is not one. And normally, we would bill those with the GY modifier because the secondary will pay for them. And we’ve never had an issue until we switched over. And now, I can’t get a correct denial. I can’t get anybody to tell me what I’m supposed to do with this.

Nina Gregory: Well, if you’ll give us just one minute, we’re checking to make sure because we believe that there are a couple of modifiers that do apply in this situation.

Michelle: I’d appreciate it. Thank you.

Nina Gregory: Give us one minute.

Operator: And we’ll take our next question from...

Nina Gregory: No, no, no. One second.

Operator: My apologies. For the lady that just queued up, if you can hit star zero and I’ll get your line opened up. Thank you.

Nina Gregory: (Michelle), are you there?

Operator: One moment, I’ll get that line opened. Thank you. Okay. Michelle, your line is now open again. Please.

Nina Gregory: Hi, (Michelle).

Michelle: Hi.

Nina Gregory: I believe the modifier that they’re looking for is the AU modifier. The AU modifier is for items furnished in conjunction with a urological, ostomy or tracheostomy supply.

Michelle: I’m sorry, what was that?

Nina Gregory: The AU modifier in the tracheostomy policy states use the AU modifier is for items furnished in conjunction with a urological, ostomy or tracheostomy supply.

Michelle: Okay. Because it doesn’t include that modifier. That’s why I was questioning that. And then for the A4245s, the alcohol wipes, when they’re not used for diabetics, again we would normally bill those with a GY modifier but they’re all being denied now without PR denials. And I am putting a narrative in there stating that it’s for trach cleaning, not for diabetic supplies. But is there a modifier that I would have to use for those?

Nina Gregory: I can’t think of one for that. I’ll have to take back to our systems people as well just to make sure that they’re set up. I almost wondered if the first situation they were looking for an AU modifier just to know it’s not a surgical dressing, it’s not for a surgical dressing. It’s for a tracheostomy, ostomy, or urological, which could be it. I’m not sure it’s the way that the system is set up so I’ll have to take these back to our systems people and see if there is some kind of issue that has to be addressed, we will look to put out a ListServ message. Okay?

Michelle: Okay. That would be great. Thank you.

NOTE: Please see the published Q&A document for the corrected response.
When billing for interim nutrition by gravity and billing for an IV pole, what modifiers should be used? I attempted to bill with a RR and a BA, which is what I found online but that was denied.

Nina Gregory: Do you know what denial you received because there's many different possibilities?

Amira: It was denied. We had picked a modifier combination does not match or is not correct.

Nina Gregory: Okay. I'm not 100% sure if this is a competitive bid item but I do know we've seen competitive bidding issues where those modifiers are not being applied to claims as well. Let me look real quick.

Amira: So if it is a competitive bid item then do not use modifiers.

Nina Gregory: No there's other competitive bidding modifiers. The BA modifier is for items furnished in conjunction with parental enteral nutrition services. And there's specific provisions and I'm looking. I apologize for the delay. I don't want to give an answer based on what I believe it can be if might be incorrect.

Okay. When an IV pole is used for enteral nutrition administered by gravity or a pump, the BA modifier should be added to the code. HCPCS code E0776 is the only code in which the BA modifier may be applied. So that is correct. I will have to look further because we do not provide the education on competitive bidding, we are not the competitive bidding contractor (CBIC). Have you ever checked the CBIC website?

Amira: No.

Nina Gregory: Round two competitive bid items are posted on there. Let me look to see if this is one of them.

Amira: Okay.

Nina Gregory: If you go to the CBIC website, you will select round two. Round two recompete and then you can pull up the HCPCS code that are part of round two recompete. It allows you to do that on the CBIC website there on the left hand side. And yes, HCPCS E0776 is an item in the round two recompete for competitive bidding. So I believe that they're looking for a competitive bidding modifier. Do you know if you're beneficiaries are in a competitive bidding area?

Amira: Yes.

Nina Gregory: They are and are you competitive bid supplier?

Amira: Yes.

Nina Gregory: Okay. All right. You will need to go out to the website to find out what modifiers you will need to append to your claim. It's taking a little bit of time and I don't have that memorized myself. But I'm guessing that you've got the correct modifiers for billing to the DME MAC contractor except you need a competitive bidding modifier on there as well.

Amira: Okay. That sounds good. Thank you.

Operator: We'll take our next question from...

Leslie M.: Hi, this is Leslie again. I had another question as far as denials and reviews by rep twos. We are getting a good bit of denials. It seems like a lot of them are POD but there's other examples too that they're not accurate denials. So for example we're a mail-order pharmacy. The date of service we are to bill with is the shipped date.

We are getting denials after we submit an ADR let's say in with is the shipped date.

We received some denials that say the date of service, the delivery date is after the date of service and it denies for that reason, and that's not accurate because the date of delivery has nothing to do with our date of service. So we're actually fighting denials such as this with things we pulled directly out of the provider manual.

So we're actually sending you a copy of your own guidelines. And in those instances - and like I said, that's only one example. I just wanted to give you something so you knew what I was talking about there as far as inaccurate denials.

But in my mind, also, that shouldn't be an error against us. That shouldn't be something we need to appeal. I would think that we should be able to request that someone re-reviews that denial.

Okay. And then we just had opened up another person's line. Please go ahead.

Woman 1: Did you ever give an answer on that RA modifier question a while ago?

Nina Gregory: The representative that was assisting had some technical issues with her phone, so I said I would look into it - the question was an oxygen claim if the first month after the five year RUL has ended and they were billing the RA modifier only but receiving denials stating that they needed the RA and RR. Is that correct?

Woman 1: Yes. I didn't hear where you said - I mean we didn't get any kind of answer on it. Didn't realize the phone had issues so.

Nina Gregory: Stacy, have you heard of this issue? Stacy?

Operator: And Stacy, you may need to hit your mute button. I do show you are still connected.

Nina Gregory: I think she's having phone issues again. If we cannot get this answered on the call or if she's able to come back in, if we have more issues we will look to put out a ListServ message or something on Facebook as well.

Woman 1: Okay.

Nina Gregory: We will get the answer out there to you if it's something different than what you had been taught at NGS.

Woman 1: Okay. All right. Thank you.

Nina Gregory: You're welcome.

Operator: And we'll take our next question from...

Amira: When billing for interim nutrition by gravity and billing for an IV pole, what modifiers should be used? I attempted to bill with a RR and a BA, which is what I found online but that was denied.

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Okay. When an IV pole is used for enteral nutrition administered by gravity or a pump, the BA modifier should be added to the code. HCPCS code E0776 is the only code in which the BA modifier may be applied. So that is correct. I will have to look further because we do not provide the education on competitive bidding, we are not the competitive bidding contractor (CBIC). Have you ever checked the CBIC website?
Nina Gregory: Have you called the contact center and had them address the incorrect denials or take it to a level two?

Leslie M.: Well, that’s my next part of the question. So we do, yes, always - we call and try to get it worked out in a way that we don’t have to proceed to the next appeal. And so this is kind of a general concern as well.

So when we’re asking to speak to a rep two, or level two, tier two, however you say. We’re told that they need to return our call and that will happen within 7 to 10 business days. We never get that return call.

When we call back again to follow-up, we’re told there’s a note in here that says they tried to call. Well, we have no missed calls. We have no voicemails.

So I’m not sure and it just seems strange that all of them we don’t receive regardless of which one of my reps has requested it, et cetera.

And also that same issue is happening when we do maybe get to the point where we’re having a special investigator look into it and we’re told that that turnaround time for a call back time is 45 days, but again, we never get a call back. So I think it’s kind of combination of issues and I’m just not sure how to handle it.

Nina Gregory: I have personally been working some of those callbacks. What I have found as an issue that we have, is the number that is given to call back is sometimes just the general customer care line and so we wait and wait, and I’ve been hung up on several times. Maybe not your company, I don’t know your company but that’s an issue that we’ve had or someone will take a message and then you assume a message was taken. I suggest that they give an actual desk number and their full name.

Leslie M.: And my reps should be doing that. So that’s why we were kind of confused.

Nina Gregory: We attempt to call three times before we close it out to say we’ve made three contacts and have not received anything back. And then some that I called and I went to leave a voicemail message, I found where their voicemail message is full so you can’t leave a message.

Leslie M.: Yes, that shouldn’t be the issue.

Nina Gregory: Yes, that seems odd because but I can guarantee you CGS has been making those phone calls.

Leslie M.: Okay. Yes, I’m not sure how to see why that would be happening to us. And that was going to be my other question. So you would leave a voicemail if you got to a voicemail, right? Okay. Because I thought maybe that would be the issue that we’re just not - okay. But is that the proper process anyway as far as, like I said, like getting a denial that’s not really accurate, we should be able to have someone review that, right?

Nina Gregory: Yes it is. The level two person will look at the claim and try and determine whether the claim processed incorrectly or if we will be calling back. Typically the level two is calling back to say hey, this was the issue and how you need to correct if possible. Sometimes you don’t get a call back if they’ve actually sent the claim to be reopened and reprocessed.

Leslie M.: And like I said, we do call back and follow-up. And in that instance, they would tell us that if it’s been sent back. But we’re finding we’re not getting calls back and then things just aren’t going anywhere as far as being looked into. And I don’t know if, like I said, you know, that proof of delivery example I gave you, we get a good amount of those denials. I mean is there anything that - any way I can escalate ones that we’re seeing repeatedly?

Nina Gregory: I will have to have you go back into queue because there’s several callers on the line. But I will take that back to the medical review department.

Leslie M.: Okay. Thank you.

Operator: We’ll take our next question from...

Valerie: (Valerie) and my question is, hello?

Nina Gregory: Hello, (Valerie).

Valerie: My question is, is it proper to bill the DME DMAC as a home infusion supplier for the 5FU drugs that we deliver to the patient at the clinic? There was an MLN1609 with some verbiage that says if it started at the clinic it has to be billed. We can’t bill it. It has to be billed to the other plan, the pharmacy. They’re the outpatient chemo clinic would have to bill it.

But it says CMS states that it does not apply to suppliers, claims submitted to DME equipment. So if the infusion clinic is not billing for the administration of the drug and they’re actually - the patient is in the clinic getting treatment from the physician, but then we deliver the stuff. They hook up the patient to the pump and the medicine and the patient goes home for 48 to 72 hours. Is that still incident to the physician or is that something that we can still bill?

Nina Gregory: So the drug is being started in the care setting and then they go home with it?

Valerie: Well, what happens when they give them a bolus dose of their own that we have nothing to do with. But then they are hooking our bag of 5FU and the pump up to the patient and then the patient goes home. And we’re getting differing interpretations of that. It was MLN1609 and we’ve been researching it and its just conflicting information. So it’s not clear.

Nina Gregory: Okay. Yes, if they’re beginning the drug infusion in a care setting and it’s with an external infusion pump, correct?

Valerie: I’m sorry, what?

Nina Gregory: It’s an external infusion pump and they’re beginning the drug infusion in the care setting, correct?

Valerie: Right, before they send them home.

Nina Gregory: Okay.
Valerie: And if they have a problem, if the pump isn’t infusing right, they call us and someone goes out or - I mean we’re not home health. We don’t do that but we do take care of our own pumps.

Nina Gregory: And is this during the physician’s office visit?

Valerie: No. They start it there at the outpatient cancer center and like I said, they give them a bolus dose of the 5FU there of their own that has nothing to do with us. But then before the patient goes home, we deliver the stuff to them while they’re at the cancer center. And then before they go home, they hook up the 5FU in the pump for the patient and then the patient leaves.

Nina Gregory: I’m looking at the article myself right now. Because it says, however, because prolonged drug and biological infusion started incident to a physician’s service using an external pump should be treated at an incident to service. It cannot be billed on supplier’s claims to DME DMAC.

So that’s why I asked if it was being started incident to the physician’s service. It does not sound that it is. It sounds like in the situation above, that’s where it says in some situation a hospital outpatient departmental physician office may and one of those is being the drug infusion in the care setting using an external pump. And then it says in this case, the drug or biological, the administration and the external infusion pump is billed to your MAC.

Valerie: Because we’ve checked it. In the one line it says in the event the facility is billing for - which would be the cancer center, is billing for the administration of the drug or the cost of this drug, which we don’t bill them. It bills - they have nothing to do with it and they’re not - and we’ve checked with the cancer center. They’re not billing any kind of administration fee. They’re not just for their services - they’re not considering what they’re billing for that patient up to their service.

Nina Gregory: It’s not being billed as incident to the physician service then yes, I believe you would bill it to the DME DMAC even though thing started there falls into the category above that. As long as it - being started is - so what happens a lot of times is in the physician, they go into the physician’s office. The physician starts it. They bill their service as incident to - they went and have seen the patient, and they started this. So they’re getting payment for that visit. That is different but that is considered incident to. Does that make sense?

Valerie: Right, so ours is not incident to because they’re not billing anything for it.

Nina Gregory: Correct.

Valerie: You sound hesitant.

Nina Gregory: That is correct. Have you received denials for this?

Valerie: No, we just - we try to stay on top of things and like I said, our boss - our manager was researching and came across this. So we’ve kind of wanted to make sure.

Nina Gregory: Okay. Yes, and it does have the however in here. In some situation, a hospital which is you’re doing or an office may begin the drug infusion. So if they’re not paying for the drug, they’re not buying the drug.

Valerie: No, no. So yes to the DMAC. It’s not incident to the physician if they’re billing for anything.

Nina Gregory: They’re not billing it. They’re not providing the drug. Correct.

Valerie: And what was your name again, I’m sorry?

Nina Gregory: Nina Gregory.

Valerie: Nina?

Nina Gregory: Yes.

Valerie: Thank you very much.

Nina Gregory: You’re welcome.

NOTE: CGS is currently seeking guidance from the Center of Medicare & Medicaid Services (CMS) on this issue. Once information is received, this will be communicated via CGS Listerv.

Operator: We’ll take our next question from...

Margie O.: My question, well, first let me just echo what (Leslie) her concerns about the level two reps not calling back. I know that my billers don’t get calls back either. But my question goes to when we were with NGS, we have ventilator patients and our second vents, we submitted all of the documentation to NGS. These are patients that have been with us for years, and years, and years and since switching to CGS, we’re getting denials on the second ventilators requesting the documentation that was already submitted to NGS. So my question is, I was under the impression that all of the documentation that was originally submitted to NGS would cross over to CGS. So what happened to that documentation because we’re not getting paid for these second vents and getting requested for the documentation.

Nina Gregory: The documentation was brought over from NGS for the transition, so that is correct. The second thing is that CGS does have the ability or right to request or submit an ADR request for any other claims that are submitted to them. CGS does does have the ability to audit the claims, even though you may have had a previous claim that was audited. If this is a future claim, CGS has the ability to review for that documentation and medical necessity because things do change over time. So they are there within their rights to do that.

Margie O.: Okay, but for every single claim?

Nina Gregory: They can do that. Is every monthly claim is being audited?

Margie O.: Yes, every single one. Every single one is being audited. Even with the narrative that’s being submitted on the claims. Everything is being audited. We are getting more ADRS than we have ever gotten before and it’s almost impossible. We are a small company and without getting these payments it is hitting our bottom line. And it’s really frustrating that things were going along smoothly. We switched to CGS
and honestly it becomes a nightmare. We're not getting paid for anything. And it's really frustrating.

Nina Gregory: I can imagine and I am sorry. They are able to audit each claim and I would just make sure I am responding to those audits and responding timely.

Margie O.: We're doing what we're supposed to do and we're submitting the redeterminations but it's time-consuming and it delays our payments.

Nina Gregory: Yes, I understand. I will take it back to make sure that there's not a glitch in the system or anything like that either. We do have the ability to audit those claims. I just suggest that you respond as soon as possible.

Margie O.: We're responding pretty much as soon as we get them. So that's not the issue. The issue is on the CGS side. It's not on our side and it's just really frustrating. We are so frustrated over here. I can't even, I don't even know if I'm expressing it right, but we are not happy with CGS, just like (Leslie) said in not so many words. She's not happy either obviously. So I don't know, something's got to happen because this is going to affect a lot of businesses with this constant ADR and they shouldn't be doing every single claim. I understand doing one claim, requesting an ADR on one claim and holding the other ones but to request an ADR on every single claim every single month is not appropriate.

Nina Gregory: I will definitely take your concerns back to the company internally and see what we can do.

Margie O.: All right. Thank you.

Nina Gregory: Thank you.

Operator: We'll take our next question from...

Joe: Hey, this is (Joe) again. Back to the DWOs. I have two questions on that, on the PAPs because they said that the used supplies needed to be put on there. Do the paps supplies like the mask, the tubing, the filters and stuff, do they need to be put on, like the refills? Do they need to be put on the DWO for in other words, refills for a year? Does that need to be put on the DWO?

Nina Gregory: So you have to have a detailed written order for everything that is billed to Medicare. Yes, you would have to have a detailed written order for the supplies. If you're previous order has become invalid, if it's passed its one year. If there's a one year for your state or federal laws.

Joe: One year here in the state of Kentucky.

Nina Gregory: Then yes, you would have to get a new detailed written order for all those items as well. You must follow your state and federal laws as well as the applicable Medicare laws and regulations.

Joe: Okay. All right. That was what I was wanting to know. And then on the other one, nebulizer. I know that Medicare only authorizes the nebulizers for certain medications and we put that on the DWO.

But do we have to have the frequency of use and the frequency of dispensing on that medication on the DWO? Or do we just leave some kind of combination between our DWO and the pharmacy's DWO?

Nina Gregory: If you're only providing the nebulizer and your order is for the nebulizer then that's what you need on your detailed written order is the nebulizer. Your medical records and information need to support what drug is to be billed with your nebulizer. The pharmacy billing for the drugs would have to have the drugs and the frequency, route, quantity, number of refills, all of the applicable elements for the drugs on their order.

Joe: Okay. So we don't need to have a crossover on the DWOs then?

Nina Gregory: No.

Joe: Okay. All right. That's what I was wanting to make sure of because I was asked that question by a pharmacist and a patient as to whether we need to have all that in our DWO or not.

Nina Gregory: The nebulizer policy is very difficult when you have two different suppliers because if the drug is considered not covered, not medically necessary, then we don't pay for the nebulizer.

Joe: That's why we have the drug listed on the DWO because we make sure the drug is listed.

Nina Gregory: If the drug was audited and it's found to not be medically necessary based on the physician's medical records and it doesn't meet any elements that's required then the nebulizer is not covered. And the same goes for the nebulizer. If the nebulizer denies, which is an ACA requirement for specified items in the nebulizer policy, if you don't have all the elements required and the nebulizer is not covered then we will not also pay for the drugs or supplies.

Joe: Okay. Even though the drug that was ordered is on that list of approved drugs and we have the medical records that say what that drug is?

Nina Gregory: If for some reason in a review, something is found not to be considered medically necessary then we won't pay for the drugs and supplies. If the drug is considered not payable, not medically necessary then we won't pay for the nebulizer and supplies. But just having it on the order does not.

Joe: Okay. Even if it's on the medical records it still wouldn't be covered then.

Nina Gregory: As long as all the medical records support the need for the nebulizer and the drugs then you're good to go.

Joe: Okay. All right. That's what I was wanting to make sure. All right, thank you.

Operator: As a reminder to our audience, star one for questions. We'll take our next question from...

Katie H.: My concern is that we have a whole bunch of our inactive PTANS listed and our PTANS and NPI combinations are also incorrect.

Nina Gregory: Where is this at?
Nina Gregory: In the CGS database, with the NSC?
Katie H.: When we have all of our NPI numbers and our PTANs, the listing of one - the accounts that we have, the NPI number - we have NPI numbers that are inactive. And then we have a combination...
Kevin Jackson: Are you referring to within myCGS?
Katie H.: Yes.
Kevin Jackson: Okay. And when you - okay, I understand as far as the inactive ones. When you say that they are inaccurate, that they’re not correct, what do you mean?
Katie H.: We have PTAN - we have NPI number and PTANs that are not associated with each other that you guys have together. The PTAN and NPI combinations are incorrect.
Kevin Jackson: This is going to be one that we’re going to need to take a look at because that shouldn’t take place. It’s generated according to the tax ID.
Katie H.: Correct, I get that.
Kevin Jackson: And PTAN is associated with the tax ID. But yes, this is one that we’re going to need to take a look at. Nina, do you have her information so we can get?
Nina Gregory: No. You said - what was your name again? It’s Katie, K-A-T-I-E.
Katie Heiman: Correct.
Nina Gregory: Okay. All right. I will send your information off. Thank you.
Katie Heiman: Thank you.
Operator: We have no further questions in the queue at this time.
John Kelly: Nina, it’s John Kelly. May I say something very quickly?
Nina Gregory: Yes.
John Kelly: I’m sorry, have two answers to questions that were posed earlier in the call. One was for the gentleman who was having difficulty getting to an advocate through CTI with the CTI system indicating that even though his information was correct, there was no information available. The director of our call center operations said that if that happens to you, you should press option four, which will then let you go directly to an agent if you’re experiencing a problem in CTI.
So for the gentleman that called with that question, if that should happen to you again, press option four during that time and that should connect you directly to an agent. And that’s of course for anybody else that may have a problem.
I also confirmed with the director of the call center that for those of you who questioned whether you could request a transfer to a tier two to take a look at the ADR documentation to confirm whether or not we had received the page count that your fax system said we’d received, the call center director said absolutely, you can request that. So those are two questions that I wanted to follow-up with Nina before we closed the call.
Nina Gregory: Thank you. We are past time now, so I’m going to go ahead and close out the question and answers queue. If you have not had an opportunity to ask a question, please make sure you contact the provider contact center at 1.866.590.6727.
On behalf of CGS, I would like to thank you for participating in today’s ACT call. It has been a pleasure to speak with each and every one of you and to help with your questions. The transcript and the questions and answers received today will be posted to our website within a couple weeks. Please watch for your ListServ message for information regarding when this information will be available and if on other upcoming educational opportunities.
Thank you all and have a great day.
Operator: Ladies and gentlemen, this concludes today’s conference. We appreciate your participation.

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