Introduction

Good afternoon and welcome to the CGS Administrators DME MAC joint Jurisdiction B and Jurisdiction C “Ask the Contractor Teleconference”. These ACT calls are hosted by the CGS DME Provider Outreach and Education team. This particular ACT call will focus on the forthcoming First Claim Review of Serial Claims.

Background

In July 2018, CMS published Medicare Learning Network (MLN) article MM10426 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10426.pdf), “Implementation of Auditing First Claim Review in Serial Claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.” The MLN article was uploaded to the News sections of the Jurisdiction B and Jurisdiction C websites on July 19, 2018. This new initiative is intended to reduce supplier burden, contractor burden, and the overall appeals backlog by increasing the consistency of medical review decisions when the same item/supply is provided to the same beneficiary on a recurring basis, i.e., serial claims. The DME MACs will perform a prepayment complex medical review on selected claims. Based on the results of the review, the DME MACs will either:

1. Pay subsequent claims in the series, assuming the claim passes existing validation edits in the system, or
2. Deny subsequent claims in the series unless the DME supplier submits additional documentation with the subsequent claim line.

Process

So…how will all of this work?

Beginning November 20, CGS will hold any other rental claims if the initial rental month claim has been submitted to the DME MAC, chosen for a review and has not completed processing. We will publish a list of applicable HCPCS codes, titled “Addendum A” (https://www.cgsmedicare.com/jb/pubs/news/2018/11/cope9880_addendum_a.xlsx), that will be valid from November 20 through January 6, 2019. Once a Medical Review decision is made on the first rental claim, any held claims will be released and either paid or deny based on what occurred with the first rental claim. Here’s an example: a supplier provided a hospital bed on September 1 and billed CGS for that date of service. That claim was subsequently chosen for review and an ADR letter was mailed out. The supplier billed the hospital bed claims for October 1 and November 1 as scheduled in their system. CGS will hold those two claims until after the supplier responds to the ADR letter associated with the September 1 claim and that claim completes processing. The October and November claims will pay or deny based on the CGS Medical Review decision from documentation submitted for the September 1 claim.

If the initial claim in the series is not chosen for review by CGS Medical Review, then no other rental or serial claims will be held.

Suppliers may choose to submit additional documentation on any of the subsequent denied claims and that documentation will be reviewed by CGS Medical Review. If the documentation constitutes enough information to change the decision, that claim will be allowed and any other prior denied claims will be reopened and adjusted. Please note that all standard Appeals timeframes apply and you can submit a Redeterminations request within 120 days of the date on the Medicare Remittance Advice statement.

Suppliers are encouraged to submit additional documentation on subsequent claims in the series by using esMD or the PWK segment on the electronic claim. You also have the option of submitting the documents with a paper claim. When using the PWK segment on an electronic claim, let CGS know how you are submitting the additional documentation. In the PWK02 indicator, input one of the following based on how you plan to submit documentation:

- “FX” for any documents faxed to us
- “BM” for any documents you plan to mail
- “EL” for any esMD documents using X12 Standards
- “FT” for file transfer of esMD documents in PDF XDR format

You must add the word “Serial” in the NTE02 segment on the electronic claim form. To ensure the additional documentation is submitted timely, CGS should receive it within seven days if faxed submitted via esMD or 10 days if mailed. When using esMD, suppliers should follow standard procedures with their gateways. The claim will be processed based on existing information if the additional documentation is not received within these timeframes or if the claim is not billed with the PWK indicator and “Serial” in the NTE02 segment.

From January 7, 2019, and forward, this process will be in place for a specific list of HCPCS codes. By January 7, 2019, another list of HCPCS codes, “Addendum B”
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CGS Medical Review can review either the first claim in a capped rental series (i.e., the KH rental month) or the first claim selected by Medical Review from a series of recurring supplies, such as a urological catheter claim, submitted to the DME MAC.

The fax numbers, mailing addresses and links to the PWK coversheet for both Jurisdiction B and Jurisdiction C are included on the PDF in the Handouts section of your GoToWebinar dashboard. They will also be added to the final transcript when it is uploaded to the CGS websites.

**Note:** The following information was added when the call was transcribed:

- **Jurisdiction B PWK Fax Number:** 1.615.782.4511
- **Jurisdiction B PWK Mailing Address:**
  - CGS – Jurisdiction B  
  - PO Box 20007  
  - Nashville, TN 37202
- **Jurisdiction C PWK Fax Number:** 1.615.664.5954
- **Jurisdiction C PWK Mailing Address:**
  - CGS – Jurisdiction C  
  - PO Box 20010  
  - Nashville, TN 37202

CGS published a “PWK Reminders” article on October 24. This article can be found in the News sections of the Jurisdiction B and Jurisdiction C websites and contains links to cover sheets and related Medicare Learning Network publications. The article summarized recent supplier errors in using PWK including submitting documents with no related claim on file as well as sending documentation to the wrong contractor. Remember to complete the PWK template in its entirety and use it as a cover page when sending documents to CGS. Only submit documentation after a claim has been filed. The DME MACs will not forward any documentation submitted via PWK for crossover claims.

It is imperative for you to watch our ListServs and website updates for the lists of HCPCS codes included in this initiative. These HCPCS code lists will very likely include some of the commonly billed capped rental and recurring items such as manual wheelchairs, PAP and RAD devices, hospital beds, oxygen, inhalation medication, and urological supplies.

**Note added after the teleconference:** A reference article was published in the News sections of the Jurisdiction B and Jurisdiction C websites on November 15. The article was titled, “First Claim Review Initiative for Serial Claims” and contains helpful information and as well as links to the two lists of HCPCS codes.

**Conclusion**

This ACT call is being recorded for transcription purposes so all questions must be taken verbally. If you want to ask a question you must input your audio PIN into your phone before we can unmute your individual line. Before we open the telephone lines for your questions, no specific beneficiary information or Medicare numbers should be part of your question. This is necessary to protect the personal health information of our Medicare beneficiary population. We are unable to answer any specific claim inquiries during this ACT call, so please reach out to your DME MAC Provider Contact Center. We will now pause for a moment to give you time to prepare your questions and raise your hands.

**Questions**

**Andrea:** If we have a patient who comes on service for enteral nutrition for example (we have a pump, etc.) and it gets to Medical Review and it is a claim that has a medically unlikely edit (more than what would normally be expected but there is solid medical documentation proving the necessity). Once it is reviewed and approved, are we going to run into denials for medically unlikely edits on subsequent claims or would that also be taken care of by this process?

**CGS:** Medically unnecessary edits are not included in this. Medical Review is conducting probe reviews. We notify suppliers in advance that we will be doing probe reviews and we are selecting a 20-40 claim sample.

I don’t believe that enteral supplies are on either of the addendums. That is one of those categories where the patient’s condition may change frequently so it would be difficult to apply a decision on one claim for future claims.

**Note added after the teleconference:** CGS Medical Review is conducting Targeted Probe and Educate (TPE) audits and this is the only audit strategy for DME MACs approved by CMS at this time. Additionally, any claim whether involved in a TPE probe review or not, must pass all system edits in place. CMS has system edits called Medically Unlikely Edits (MUE) for a number of HCPCS codes. This is what the caller is referencing in the question above.

**Andrea:** Understood. That helps a lot.

**Jerri:** You gave some information earlier that I could not hear...there was a little disruption.

You mentioned we could get some of this information on the news on CGS website and the dates.

Where are the HCPCS codes you mentioned?

**CGS:** The CMS resources link included that list. That MLN is MM10426 and it was published on CGS websites’ News section on July 19, 2018. You can find it as part of the PDF available in the Handouts section of GoToWebinar during this call or on the News section of our websites. Scroll down to July 19. The HCPCS codes have not been published yet so watch our ListServ and website updates for those as well.
Note added after the teleconference: A reference article was published in the News sections of the Jurisdiction B and Jurisdiction C websites on November 15. The article was titled, “First Claim Review Initiative for Serial Claims” (https://www.cgsmedicare.com/jb/pubs/news/2018/11/cope9880.html) and contains helpful information and as well as links to the two lists of HCPCS codes.

Judy: If we have been excluded by TPE audit for a specific HCPCS code that might be included on this list by PTAN combo, can we still be selected for these prepay or pre-screen reviews?

CGS: We are not planning to make any changes to current exclusions. We are normally seeking first claims for beneficiaries so I don’t believe that will impact that those which we excluded from past reviews.

Judy: How will these claims be selected?

CGS: It is all done within our VMS processing system which is the standard system that we use for the DME MACs. There are editing capabilities within that and it selects claims for us.

Note added after the teleconference: Just to verify, only claims selected as part of the TPE probe are impacted. There will not be a new type of audit for serial claims.

Judy: How does this process differ from TPE?

CGS: It is TPE; it is the same. We are still doing our probe reviews. None of those processes change. The change is that we will be applying the decision moving forward to subsequent claims in the series.

Judy: I guess I am confused in that if I have a TPE that I passed for a wheelchair in a specific PTAN, you could still pull a wheelchair in that PTAN even though I passed that TPE and supposed to be free from audit for a year?

CGS: No. If you have completed an audit review and they have excluded you, we are not going to select any more claims. We are only selecting claims right now as part of our probe reviews. Unless you are selected for a new probe review on a different HCPCS code, this won’t change any of that.

Judy: Thank you for the clarification.

CGS: Let me add just a little clarification to that information. If you recall the example I used for hospital bed claim for a September 1 date of service. Let’s say that initial KH rental was chosen for review. You submit documentation to Medical Review. The nurse reviewer looked at it and denied for a missing delivery ticket.

In the interim, your system continued to automatically bill on a monthly basis the next two months. In my example, it was October and November. When you get that September date of service denial and you take a look at the documentation you originally submitted, you realize the delivery ticket was upside down so you faxed us a blank page. So, in your fourth month claim (November 1 following my example), you could send us that delivery ticket. We’ll take a look at it and see that was the document that was missing on the previous months we had to deny. We can now pay that fourth month claim and go back and adjust those previously denied claims to pay as well. Does that help?

Judy: Yes, but I would just add that when I receive a TPE audit, I don’t release subsequent claims until my TPE is resolved. I believe we would follow the same process. I would assume I would be getting a request for documents on my parent claim pretty quickly. Then, I would be able to stop subsequent rentals before those claims dropped.

CGS: Technically, we have 30 days to complete our review and process the claim once you respond to our request for documentation. However, our turnaround rate right now on claims processing is very quick and we understand the impact if it holds up other claims. We do everything we can to keep our processing rate as current and quick as we can.

Judy: Thanks very much. I appreciate the help.

Luis: I believe you answered the question but will ask it again.

The Serial Claim Initiative is directly related to the TPE process so if we get a denial directly on an EOB (maybe PR-51 or CO-50) that is not part of this initiative. Correct?

CGS: This initiative is related to claims selected and reviewed by our CGS Medical Review team. There are a lot of other claims that get selected for review by other contractors. This just applies to the ones that CGS Medical Review does. Right now, our focus is strictly on the TPE probe claims.

Luis: Thanks very much.

Linda: I have several questions. Will there be a specific identifiable denial reason code or remark code assigned to any serial denial?

CGS: It would be the same as you would see on the initial claim.

Linda: So it is not specific to say this is a serial denial.

CGS: Correct.

Linda: We thought that would be good since we have so many NPIs - over 9,000. We would want to be able to query those so a remark code would be a nice feature if that could be done so we could see if there is any process we are missing and could improve.

Second question. The serial claims are defined as same beneficiary, same HCPCS, subsequent date of service.

Is the serial claim if denied specific to the supplier NPI as well? In other words, if a patient goes to ABC supplier for pharmacy one month and their claim is denied by TPE audit, would that claim deny at the new supplier too if they go to a different supplier in subsequent months? (Say they went south for the winter.)

CGS: I believe it is strictly related to the beneficiary and the HCPCS code but let us research this further to be sure our response is correct.
Note added after the teleconference – As we stated for capped rental items, any subsequent claims submitted will deny if CGS Medical Review audits and denies the first rental month. For claims billed for items that are part of a recurring series (i.e., intermittent catheters), we are doing some internal system testing to verify how the denials will take place. Remember, any of these HCPCS codes are found only in Addendum B, which will not be applicable until January 7, 2019.

**Linda:** Third question. One of the other callers asked about providing proof of delivery which takes care of their claims for previous months. However, they were talking rental equipment and mine is pharmacy claims and that is every month or every quarter if it is diabetic supplies. Would we have to appeal each claim that is denied? We would have a separate monthly or quarterly proof of delivery and we might have a different set of doctor notes that applies to that claim. Correct?

**CGS:** I don’t think you would have to do that. Keep in mind, Addendum A which will be in place November 20 is just for rental items. Addendum B will be in effect on January 7, 2019, and we will see some different items that are not rental. There will be some additional supply items on the Addendum B HCPCS code list.

Once we apply that decision and it denies subsequent claims in the series (if you’ve sent additional documents that satisfy the initial review and we are able to pay that claim), we will go back and identify other claims in that series that were denied and we will adjust them to pay also (if it is set up as a series.)

The key is if it is considered in the series. When you see Addendum B, there are some items that are not on there at all. This will not apply to every HCPCS code. We tried to consider such things as enteral nutrition where the patient has a lot of medical changes. We tried to be selective in that. We hope to get that published by next week sometime.

**Linda:** I have seen the original MLN article and gone and looked at the actual directive from CMS and they initially had a spreadsheet of HCPCS codes that would be impacted. If that is being updated, that might change the landscape for us.

**CGS:** It is probably the same list but we will get it published to verify it. I want to be able everyone understands the ability to send additional documentation. Hopefully this is an easier and quicker option than Redeterminations but that option still exists also.

Keep in mind, if you wait many months before you send in that additional documentation to allow us to change our decision, you may have lost the time limit for the appeals rights on some of those earlier claims. This does not change any of the appeal rights.

**CGS:** We’ll try to get you an answer to the takeaway question and we will make sure to add it to the transcript before we publish it on the website.

**Chrissy:** My question is about the example you gave earlier about an ADR letter related to the KH claim. If you get an ADR letter and return it and you are processing... you said something about that the claims would get held on that end. If we keep billing on the monthly anniversary date, would we continue to get ADR letters after every one of our claims would go through or only on the first KH claim?

**CGS:** You will only receive an ADR letter on the first claim we review. We will hold the other claims but we won’t send additional ADRs. You will just have to send documentation one time.

**Chrissy:** Thank you.

**Gerri:** Did this initiative actually start in 2017?

**CGS:** We have been reviewing the initial rentals for quite a while.

**Note added after the teleconference:** TPE began in 2017. This new initiative to submit additional documentation with subsequent claims is new.

**Gerri:** When prepay started and something was denied and subsequent months were paid, we had a recoup for those months. The initiative now is if you have an audit in process, those claims will be held. There won’t be any payment and recoup. It sounds like you would go back and re-process any that have been denied instead of us having to call Reopenings to get them re-processed?

**CGS:** That sounds correct. As Michael said, this should be an easier process for you to reduce supplier burden. It will be beneficial for us as well. Currently, that only applies to rental items. We are making some system changes to allow decisions to apply to non-rental items. That change will start January 7, 2019.

**Gerri:** If we have a favorable decision from Reconsiderations level, instead of calling Reopenings can we re-submit those claims with ‘serial’ in the narrative so you can reprocess them?

**CGS:** If it is in the appeals process, this does not apply. This would only apply to denials in Medical Review. If it goes to Reconsideration, at any time the decision is made to overturn the denial and it can be in a pay status, the system is updated so that any other claims that come in should also pay based on that decision.

**Gerri:** Thanks.

**Tamra:** My question is regarding using the process of using the paperwork segment. I just want to clarify. Once the prepay ADR has been sent out, we would only submit using NTE or PWK segment in response to one of these requests, correct?

**CGS:** You would respond to the ADR letter with documentation like you normally do today. If subsequent claims are billed down the road and you realize you have additional documentation to submit, that’s when you would use the PWK segment and add the word ‘serial’ to the NTE segment of the electronic claim. That will alert the Medical Review team that there are more documents forthcoming for that series of claims.
Tamra: OK. Thank you.

Evelyn: Will urology and ostomy HCPCS be affected by this come January 7?

CGS: I believe urological supplies are in Addendum B but I’m not sure about ostomy supplies. I don’t have the list with me or I could verify that for you.

Judy: You probably said this but…what date in January will this start?

CGS: The new processes where you can send additional documentation if we are holding claims beginning November 20 with HCPCS codes in Addendum A. On January 7, the same processes will continue but will apply to HCPCS codes in Addendum B.

Addendum B should include the HCPCS codes that are in Addendum A, however, it has additional HCPCS codes.

Judy: Are those addendums attached to today’s materials?

CGS: They are not. Those will be published on the CGS websites so watch the ListServ. We will also publish them on the News pages for Jurisdictions B and C.

Please watch the ListServ for this transcript to be published. When this transcript is published, we will add it to Jurisdictions B and C ACT call Web pages as a PDF formatted document and you will be able to download it at your leisure once that becomes available.

There are no other calls in the queue; thank you for your time this afternoon. This concludes today’s ACT call.