Operator: Good day and welcome to the CGS Jurisdiction B General Ask The Contractor Teleconference. Today’s conference is being recorded. At this time, I would like to turn the conference over to Nina Gregory. Please go ahead, ma’am.

Nina Gregory: Thank you, Ashley. Good morning everyone and welcome to the CGS Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor General Ask The Contractor Teleconference. My name is Nina Gregory and I am a Provider Outreach and Education Senior Analyst with CGS and will be facilitating today’s call. Other CGS staff is with me this morning to assist with questions after a brief overview of some recent changes and updates.

This call is being recorded. Within a couple of weeks, the call transcript and a question and answer document will be published to the CGS website. A ListServ message will be sent, advising when the documents are available. It is important that you and all of your staff are signed up to receive the CGS Jurisdiction B DME MAC ListServ messages. This can be completed by visiting our website at www.cgsmedicare.com.

Once you are on the Jurisdiction B DME homepage, at the very bottom lower left-hand side of the page in grey under the word utilities, you will see Join/Update ListServ. Click on this. You will then fill in the required information to sign up to receive ListServ message for each contract you choose. The objective of today’s teleconference is to provide information regarding general updates and allowing you to ask questions related to any aspect of DME Medicare. We will open the phone lines to take your questions, after providing you with information on some current updates.

I would first like to remind everyone about the CGS website satisfaction survey, help us improve our website. When you visit cgsmedicare.com, you should be prompted to take part in the Foresee website satisfaction survey. This survey was recently updated with all new questions and at helping, us learn how to improve your experience on our website. Please take a few minutes and let us know what you think taking the survey. Once taken, the survey should present itself every 30 days, so your feedback can stay current. Your feedback is very important to us.

We would like to remind suppliers that even though CGS holds both the Jurisdiction B and Jurisdiction C DME MAC Contracts, these are two separate contracts. There has been a large amount of documentation being sent to the wrong fax number or incorrect contract address. It is extremely important to make sure you are sending your documentation to the correct contract. We have noticed some suppliers are faxing all of their documentation together to one contract. When the documentation is tied to claims for both contracts, this slows down the time it takes the correct contract to receive the documentation and slows down response time.

You must ensure you are sending the documentation to the correct contractor using the correct numbers. Each contractor’s website and the additional documentation request letters provides the correct numbers or addresses. The Jurisdiction B additional documentation response letters or responses, should be faxed to 615-660-5993. If submitting responses via esMD, it is important to ensure the correct contract number is associated. The Jurisdiction B contract number is 17013. Please make sure you or your esMD contractor are using the correct contract number.

We have also noticed that refund checks CGS issues are being sent back to us. CGS sends suppliers a refund check but the letters explaining the reasons for the check is in separatly and at a later date. When suppliers receive a check from CGS, they should either wait on the letter explaining the reason the check was sent, or call customer service if unsure why the check was received. Please do not send checks back to CGS, prior to receiving a letter.

The medical review department is sending claim denial letters to suppliers specifically for oxygen and glucose claims based on review. If you receive one of these letters, the letter will provide specific reasons for denial. If you would like more details regarding the claim denial, you may access the MR Wizard.

This leads me to our next topic MR Wizard. The MR Wizard is now available for Jurisdiction B claims. The MR Wizard provides detailed information regarding why your claims may have denied, based on a medical review. This is the best way to obtain information regarding your specific claim denials. The application provides detailed claim line denials, instant access to the denial detail, it is available 24 hours, 7 days a week with no registration needed and all you are required to do, is to enter the claim control number or CCN in the appropriate field. If the application is similar to the previous NGS medical review denial tool, you may have previously used and reduces the need to contact provider contact centre.

CGS Connect is now available for Jurisdiction B suppliers. CGS Connect is a voluntary professional evaluation of your pre-claimed documentation for specific HCPCS codes. This is a great opportunity to have your documentation reviewed with feedback providing you with individualized education to prevent future documentation-related errors. The available policies and HCPCS codes can be found on the CGS website, under CGS connect.
CGS has also noticed a large number of claims denied due to RB modifier issues. The RB modifier must be appended to all wheelchair HCPCS, as part of a repair to receive payment. When billing the claim, you must append the NU, RB, KH and KX modifiers as well as LT and RT modifiers, if applicable. You may potentially have more than four modifiers to append. If that is the case, you will need to append the 99 modifier on a claim line level. When appending the 99 modifier, suppliers must enter the remaining modifiers in the note or NTE segment or loop 2400 for paper claims. The suppliers are strongly encouraged to enter all applicable modifiers in the note or NTE segment field or loop 2400.

CGS is currently working on the CGS GO mobile app for Jurisdiction B suppliers. We hope to have it up and running by the end of the year. The CGS GO mobile app allows you to stay even more connected. The download is free and allows access to important CGS Medicare information from the convenience of your mobile device. Some items you are able to access, include the local coverage determination policies, dear physician letters, MR WIZARD and DME product fee schedules right at your fingertips. Information will be provided to you regarding when the app will be available.

Before we open the telephone lines for questions, I would like to remind everyone that we cannot answer a question specific to individual claims. If you have a claim specific question, please contact the provider contact center at 866-590-6727 or if the information can be obtained via the IVR, contact IVR at 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 in the queue to ask another one. Ashley, we are ready to start with our first question.

Operator: Thank you. If you would like to ask a question, please signal by pressing *1 on your telephone keypad. If you are using a speakerphone, please make sure your mute function is turned off to allow your signal to reach our equipment. The voice on the phone line will indicate when your line is open. Please state your name before posing your questions. Again it is *1. And we’ll take our first question. Caller, please go ahead.

Jennifer: Hello, this is Jennifer calling. I have a question about resident and doing paperwork for incidence if the resident is examining a patient and they are under the supervision of another doctor, whether the supervising doctor can act as the doctor that’s done the face-to-face or does it have to be the resident?

Nina Gregory: Are you speaking of a specific policy?

Jennifer: For instance, diabetic shoes. If the resident has like done the bulk of examination but the attending states in there that they have been present at the examination with the resident and they agree with the conclusion from all the – can the attending, instead of the resident, do like the certification form or does it have to be the resident?

Nina Gregory: For therapeutic shoes, the policy is very specific that for the certifying physician it must be an MD or DO who is actually treating the beneficiary’s diabetes. So if the resident is not considered an MD or DO then they would not be able to complete that that evaluation and the statement of certifying physician.

Jennifer: So what if the resident is considered an MD or a DO but for whatever reason, like say they’re not PECOS certified or something, so we want to try to have the other doctor do the certification form, would that be allowed? Or does it have to be the resident, since they did the bulk of the examination but other doctor was present?

Nina Gregory: And which doctor is ordering the shoes?

Jennifer: It may be a podiatrist, it may not even be the diabetes doctor.

Nina Gregory: So you would have the MD or DO is completing –has documented the patient’s diabetes, has completed the foot examination and then they are completing the statement-certifying physician, correct?

Jennifer: Yeah, but I am just wondering if the certification statement can be done by the attending instead of the resident, even though the resident did the exam but if the attending was present at the exam and co-signed, would they be allowed to do the other paperwork?

Nina Gregory: Just one second, okay?

Jennifer: Mmm-hmm.

Nina Gregory: I was consulting with some other associates. As far as I understand it is that the resident that performs the visit, as long as they have an MPI that is enrolled and they are an MD or DO, they can be the one completing the examination and showing on the certifying physician’s statement. So that’s – as far as our understanding, that would be acceptable.

Jennifer: Right. I understand that’s acceptable, but my question is whether the supervising doctor can do it in case the resident is not PECOS certified or for whatever reason we can’t accept them as the face-to-face doctor?

Heather Abels: You know this is Heather. Yes, as long as the physician that’s overseeing the resident, actually with they’re in person and [inaudible] out evaluation and they can do the statement of certifying physician.

Jennifer: Okay, great, that’s why my question was. Thank you.

Nina Gregory: Thank you, Heather.

Operator: And we’ll take our next question. Caller, please go ahead. Caller, your line is open, if you can unmute yourself.

Kera Ireland: I am sorry. My question is that we’ve be doing a miscellaneous codes and repair codes and we keep getting PR 96 denials for the information and the narrative not being correct. When we call into customer service, we told that it’s missing modifiers. What is the proper way to be billing these for the narrative information?

Nina Gregory: That’s a very claim specific question. We would have to see examples to be able to help with that. Could
you please provide your information, so that I can get back with you and get some examples?

Kera Ireland: Certainly. What information do you need from me?

Nina Gregory: Do you have an email address?

Kera Ireland: I do, it’s – redacted-. 

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?

Patty: Hi, do you hear me?

Nina Gregory: Yes, hello.

Patty: Hi. So my question is with a new program the CGS Connect, we were given a call like a month ago to educate us on this new program. Well the thing is that we were told it will take about 10 days or two weeks to get a response from the medial reviews on documentations, but it’s been well over a month since I sent a document and there is still no response. Who should we follow-up with?

Nina Gregory: One second.

Patty: Sure.

Nina Gregory: And you are for Jurisdiction B, correct?

Patty: That’s correct.

Nina Gregory: We just started the CGS Connect program and got it running. Is there a way I can take your information, I hate to do that again, but can I take your information so that we can get back with you and get - figure out what’s going on with your claim?

Patty: Sure, I’ll just give you my direct phone number and you give me a call?

Nina Gregory: Sure.

Patty: Great. My direct line will be – redacted-. 

Nina Gregory: What was your name again, I am sorry?

Patty: Patty.

Nina Gregory: Great, thank you.

Patty: Great, thank you.

Nina Gregory: The next call.

Operator: We’ll take our next question. Caller, please go ahead.

Beth: Yes, hi. I am calling from DME Supplier Company and we sent healthcare supplies and [inaudible] supplies to nursing facilities. Can you hear me?

Nina Gregory: Yes.

Beth: Okay. Sorry, my name is Beth. And we were wondering regarding the policy that we need a proof of refill - before let’s say the patients has the same wound, month after months, I am sending the same supplies again and again. Medicare told us this is a policy that we need must have a proof of refill on hand showing the supplies I guess were being exhausted and they needed the supplies again.

Nina Gregory: Okay.

Beth: And it’s kind of delaying the members from getting the supplies that they need it because it takes a while, a couple of days to get a hold of the caregivers, and it’s like a large burden on the nurses especially when there are numerous patients that we have to go through each patient and ask the supplier how much they have on hand and to get the signature and all that.

In the nursing home the facility taking care the patients, it’s not like their home where patient might not take care themselves properly. The facility should be assumed to be caring properly and take –carrying our the doctor’s orders kind of like given other supplies are being used. I am just wondering if this would apply to us, if it really need this proof of refill, when our case is kind of different.

Nina Gregory: For all items provided on a periodic basis and if you are shipping them which is sounds like you are, you’re delivering to a facility, you would have to contact either the beneficiary, the beneficiary’s caregiver within 14 days prior to shipping or delivering and this is going to be your documentation. So you are going to document that the date of the contact, who you spoke with, each supply being requested and then the amount that they have on hand or remaining to show that they have neared exhaustion. So, there is no signature required for that. It just needs to be documented that you did have that contact, it was no sooner than the 14 days prior to shipping or delivery. That way, you can show that they have neared exhaustion.

Beth: Right, so that’s what we’ve been trying to do, but it’s not working out. Because it’s hard to get hold the nurses and if they send us the wound care notes to send us supplies, kind of like being on hold, being on hold, being on hold, then the notes are too late. And it’s like we’re doing it kind of mass scale, it’s not like we’re sending one order to one - tons and tons and tons of patients to go through each and everyone it’s just not reasonable, it’s not working out very well.

Nina Gregory: It is a requirement for the standard documentation language and in the policies for items provided on a periodic basis. It’s to ensure that the beneficiaries are not receiving excess supplies when they are not needed. So I am not sure, maybe you can work with your facilities to have one particular person that you can contact and say you know how much do they have on hand, how much is remaining? That way you are not shipping supplies when they really have not needed then because maybe they’ve had another event where
they went into hospital stay or they just aren’t using the supplies at the rate they are supposed to.

Beth: Right, right.

Nina Gregory: It is a requirement though.

Beth: Is a requirement. Okay. So I am looking at like you said think like L33831 policy and it’s saying on page 12, [inaudible] it says that a new order is needed if a new dressing is added or if the quantity of an existing dressing to be used is increased. A new order is not routinely needed if the quantity of dressing used has decreased. However, new orders record at least every three months [inaudible] being used. So is that saying that we don’t need it one every month, we can like every – we need only a new order every three months?

Nina Gregory: A new order is only required every three months unless there is a change for surgical dressing. But request to refill is a different piece of documentation.

Beth: Right, right, that we would need every single month?

Nina Gregory: Yes, unless you are doing three-month supplies but yes.

Beth: No, we do it every month. Okay, so it looks like there is no way getting out of it.

Nina Gregory: No.

Beth: Okay. Okay, thank you so much.

Nina Gregory: Alright, thank you.

Operator: And we’ll take our next question. Caller, please go ahead.

Speaker: Hello. We just have a question. We submitted the claim for a Medicare part B drug. And we received a denial stating there was insufficient medical records. How do we address that when we feel that there is [inaudible] medical records within the submission itself?

Nina Gregory: Any time you receive a medical review or decision that’s a denial, you do have the right to appeal the decision and file a redetermination request. When you do file that, I suggest you send in all supporting documentation to ensure that the reviewer has that information, but you do have the right to appeal.

Speaker: If this does occur when there is redetermination as well, how do we address that?

Nina Gregory: Then you have to go to the next level of appeals which is reconsiderations and go up the level of appeal.

Speaker: Is there a specific way we can identify what we found in the medical [inaudible] reviews so the reviewer may not have an easier time when they are reviewing it?

Nina Gregory: Well, there is some things you can do. One, we have MR WIZARD available to the Jurisdiction B suppliers now so you can look up that claim control number and see specifically why we denied your claim. If you don’t agree with that, then you can send in a cover letter when you also send in your appeal and indicate why you disagree, do you have that ability. Or you can contact your community coach for your state as well. Myself, I’m the community coach for Ohio, Indiana and Kentucky and that’s on our website who is the community coach for each state and we can try and work with you and then help with that education as well.

Speaker: Thank you so much.

Nina Gregory: You’re welcome.

Operator: And we’ll take our next question. Caller, please go ahead.

Speaker: Hello, can you hear me?

Nina Gregory: Yes.

Speaker: We have a general question. It is, we want to know if the link [inaudible] need on the disc? I have to match exactly what the DWO states or if the DWO states one month, but the MD indicated in the records that the need would be lifetime, I guess our question is we want to know what length of need represents the overall medical necessity that has to be proven with records. Or can we – do we need to strictly go off what the MD wrote on the DWO?

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

Nina Gregory: Your number of refills or length of need is based on your detailed written order. A DIF isn’t even completed by a physician, so we’re going to go by the detailed written order that’s completed by the physician and signed off.

Speaker: Okay. So even if the records indicate that the patients going to be on the therapy for lifetime say enteral or parenteral nutrition, we couldn’t use that?

Nina Gregory: No, not if you have an order that’s only valid for a month. You must have a valid order to support why the physician is ordering it and then why we’re going to – billing it and providing it. So the order would have to specifically state how long their need is.

Speaker: Okay. Even if – okay. Alright, thank you.

Nina Gregory: You’re welcome.

Operator: And we’ll take our next question.

Speaker: I have a question about catheters, we are receiving requests for additional information. And the feedback that we’re getting back is that a 99 script equals PRN and that we’re not allowed to use that and we had not heard that before. So if that is the case, we need some clarification on how long a catheter script is good for and how often we need to get a new one.

Nina Gregory: When you are getting the denial, is it specifically stating that 99 is not acceptable for the number of refills or?

Speaker: No, it’s when we call to verify why we are being denied based on the script. And when we call, they are telling us because it’s a 99 length of need and that Medicare considers that a PRN script which doesn’t seem right us but.
Nina Gregory: I am not aware of that. As far as I know, 99 is acceptable for a number of refills or length of need. And there are other requirements that are required and the frequency of use, duration, number, quantity and all of that is required. But - have you used MR WIZARD at this point? We do have that available now.

Speaker: No, we have not.

Nina Gregory: Okay. I suggest using MR WIZARD and if you put in your claim control number, it should provide you with the specific reasons why MR denied your claim.

Speaker: Okay.

Nina Gregory: Okay, and then if you still have questions or discrepancies, you can always contact the PCC and say this is what it states. You have the right to appeal or you can contact your community coach as well, okay?

Speaker: Okay. So as far as you know, the 99 is good and that there is no like we have to do three months for one supplies and that kind of thing, it doesn’t follow that?

Nina Gregory: Well, I mean some policies require you order more frequently, like surgical dressing, you have to in every three months. But in general, as far as I do know, 99 is acceptable but other contractors, I can’t speak for other contractors like [inaudible].

Speaker: Okay.

Operator: And we’ll take our next question. Caller, please go ahead.

Pam: Hi. My question – my name is Pam and I am calling from a pharmacy and I am calling about diabetic testing supplies. We currently are having issues when we are billing over-quantity. I mean we are not sure if – at the first time we bill them, can we bill with an ABN and separate those lines out? So if they get denied, we can bill the patient? Or do we have to wait for a denial or on subsequent fills, fill within ABN and separate the lines out, so we can bill the patient?

Nina Gregory: Well, Medicare does cover for a non-insulin dependent diabetic to test for one time per day and an insulin dependent diabetic three times per day. We do allow over that if the medical records support that. So, you would only be able to issue the ABN if you know that they do not need the medical necessity for testing over the limits. And if they don’t then yes, you do have the right to issue an ABN and bill the excess supplies in the upgrade type of fashion with the two lines with the GA modifier and GK, GZ. But – I mean you have to know specifically that they don’t actually – you can’t just issue an ABN. So there has been a regimen.

Speaker: The problem is as we are getting all the chart notes and everything in advance, but upon redetermination, we’re getting denied because the chart notes don’t clearly document the reason for a patient testing over quantity. So our hands are kind of tied because we’re not sure if we’re able to tell the patient from the beginning that, oh, the chart notes don’t clearly indicate that you should be testing this many time, so we’re not going to give you that many strips. We kind of feel like if we get the chart notes, then we demo, we need to do but they haven’t been good enough. So I guess I am asking for clarification on how do we handle these situations, are we allowed to look at the chart notes and say we don’t feel that it’s been documented clearly enough, so we’re only going to give 1X or?

Nina Gregory: We don’t require that you obtain them at a time but you can ask for them at a time to secure the right to know does the patient meet the policy and the coverage criteria. And if you see in the medical records that they do not have all the required elements, then you do have the ability to issue an ABN. You need to be specific on the ABN regarding why. It could be patients, physician did not - I don’t know - example the physician did not document that the patient is testing over the limits or has fluctuating blood sugars. Anything can be specific, but you can’t just give a general ABN because you assume they may not need it. Does that make sense?

Speaker: It does, but currently I don’t think any of our over quantity are being paid, even when we are getting notes. So we’re just writing things off. I guess with this maybe be something we need to talk to our community coach about because it’s probably a reclaim we do that’s over-quantity and we are getting notes, so we’re not quite sure, you know how to proceed.

Nina Gregory: You can contact your community coach and then that way, we can look at the claims and work with you and do some education and find out what it is that we are specifically kind of looking for and try and assist with it the education on what is needed.

Speaker: Yeah, the denial is always the same. It says the chart notes don’t clearly explain the need for 2X or 3X or whatever, the over-quantity.

Nina Gregory: Yeah, I -- we would need claim examples, I can’t really answer that.

Speaker: Okay. We were just curious like I say because it’s every claim so we’re try to nip in the bud from the beginning – the front end instead of the backend but -

Nina Gregory: Right. Yeah, I am sure we’d be more than happy to do some education.

Speaker: Okay, thank you.

Nina Gregory: Thank you.

Operator: And we’ll take our next question. Caller, please go ahead.

Speaker: Yes, my question is how long is a written order good for and where in writing does it state this?

Nina Gregory: Well, your detailed written order is in the length, depending on what the physician orders. So the physician orders that it’s only good for a month, it’s good for a month. If it’s good for lifetime and then you have to follow your state laws as well. So many state laws state that you have to have a new order every year. So you would have to look at all the different
regulations as well. And then in some policies, for example surgical dressing, states that you have to have a new order every three months.

**Speaker:** Okay. So in the program integrity menu in chapter 5.3.1, it does state that – wait a moment, back up – the delivery date of service in the claim must not proceed the initial date on the CMN or DIF or the start date in the written order. To ensure that the item is still medically necessary, the delivery date, date of service must be within three months from the initial date of the CMN or DIF or three months from the date of the physician's signature. So that three months is referring to the CMN and DIF not to the written order?

**Nina Gregory:** Correct.

**Speaker:** Okay, thank you.

**Nina Gregory:** That's under CMN and DIF requirements.

**Speaker:** Thank you very much. I appreciate that.

**Nina Gregory:** You’re welcome.

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

**Nina Gregory:** Hello?

**Mike:** Can you hear us?

**Nina Gregory:** Yes, hello.

**Mike:** Hi, this is Mike. I am calling in regards to the QF modifier. When we’re billing claims for oxygen that have a 1.5 use which is a higher leader flow and a patient has a portable, we’re billing it with a QF modifier on the claim and they are being denied. When contacting customer care, indicates – they were indicated to us that we have to add it to the CMN and we don’t know how we can add a QF modifier to the CMN. We’ve reached out and had these reviewed, they correct coded them and paid the standard rate for the concentrator and zeroed out the portable, but not the 1.5. So we are kind of confused on is CGS accepting the QF because it certainly seems like they are not paying on these?

**Nina Gregory:** I really think I would have to see some claim examples for that. Can I get your information, so we can get a hold of you?

**Mike:** My name is Mike. And would you like an email or phone number?

**Nina Gregory:** Email is usually best.

**Nina Gregory:** Okay, great. Thank you, Mike.

**Mike:** Thank you so much.

**Operator:** Next question.

**Ann:** Hi. My name is Ann. I have a question about CPAP. Can you hear me?

**Nina Gregory:** Yes, hello.

**Ann:** Okay. Here was our question. Say the initial date for the initial setup on a CPAP, say for example E0601, within - we have three months for the patient to meet compliance. Our question is, we have a patient. She didn’t meet compliance within the first three months because she had severe back pain that prevents her from being able to sleep for a very long time. The physician has documented her condition, the medical condition that she has. So our question is, for that compliance that they have to meet within the first three months, is there – would this an exception to extend that?

**Nina Gregory:** We’ve had that question [inaudible] time with at call the previous call, after time there is no exception to that rule.

**Ann:** No exception.

**Nina Gregory:** Yes.

**Ann:** No exception to that rule.

**Nina Gregory:** Yeah.

**Ann:** So the only exception that I know of and if you could correct me if I am wrong, the only extension that there is, is only if the patient is an inpatient or skilled nursing stay then that within that three month period gets extended, is that correct?

**Nina Gregory:** I have not heard of that exception either.

**Ann:** Okay. Is there any way you could find out for sure because I am not sure where, it’s not in the LCDs but it had come up a long time ago that say if the patient was an inpatient stay for five days, then that three months gets extended out or just for those five days.

**Mia:** Hi Nina, this is Mia. That is a correct statement, we would extend if the patient was an inpatient stay. And unfortunately, the only way if there is something going on with the patient’s medical condition, that’s preventing them from meeting compliance, you may have to appeal that. Probably at a higher level than just redetermination. I’ll look for a frequently asked question regarding the inpatient stay and we will follow-up with that in the minutes or the transcript for today’s call.

**Ann:** Okay, so the first question that I asked, I mean she said there is no exception to that rule on extending it due to severe back pain, she can’t sleep. Basically, if she doesn’t meet it within the three months, then she needs to do the trial period all over again.

**Mia:** Correct, but you always have – because if there is a medical condition, keep in mind you always have appeal rights. You could appeal it but at this time, it’s not likely that it’s going to be paid through the redeterminations level of appeal. You would have to go at a much higher level of appeal. But if she is not meeting compliance then yes, you would start all over again.

**Ann:** Okay, alright, so just because she had severe back pain and she can’t sleep and the doctor does document it, most likely it’s not going to get covered with that exception to this rule.

**Mia:** No, it is not, but you do have appeal rights.

**Ann:** Okay. Alright, thank you very much.

**Nina Gregory:** Thank you, Ann.

**Operator:** And we’ll take our next question. Caller, please go...
Kate: Hi, can you hear me?

Nina Gregory: Yes, hello.

Kate: So I am calling from a small DME company where we only ship insulin infusion pumps. And I actually have two questions. The first is about competitive bid, can you answer questions on that topic?

Nina Gregory: We can answer some questions if you have about our claims and billing, but in general competitive bidding questions really need to go to the CBIC.

Kate: Right, well let the ask the question and see if you have any information then we’ll move on. So we – so for an insulin infusion pump, the code is E0784 and for some reason there is some type of communication that I may have met. My sales team is telling me that competitive bid for E0784 which was put in place in 2014, is no longer going to exist. In other words all nine CBAs that had been winners for the competitive bid for insulin infusion pumps, no longer have to accept the contracted rates. So Medicare recently upgraded the fee schedule and that pertains to all nine CBAs for E0784, is that correct, do you know?

Nina Gregory: I am asking another associate.

Kate: Okay. And then while you are asking – while you are asking that question, can I just ask one other small question?

Nina Gregory: Hmm.

Kate: When we have patients who have a commercial insurance in the primary position and Medicare in secondary position or insulin infusion pumps, of course there is a medical criteria that they have to meet, should they be in a primary? I am asking if medical criteria has to also be met if it’s in the secondary position.

Nina Gregory: In order for Medicare to cover, yes all of our cover criteria has to be met, regardless for primary or secondary.

Kate: Okay, good. Alright, so we’re just waiting for the competitive bid to see if E0784 is no longer included in that competitive bid for the 9 CBAs that went in 2014.

Speaker: What round is that?

Nina Gregory: So it will be round one.

Speaker: One moment.

Speaker: Nina, if you want to get her information and we’ll answer back to her, because it’s taking forever -

Nina Gregory: Yeah, it’s complicated. Okay, great, thank you. What’s your information?

Kate: So my name Kate.

Nina Gregory: Right, we will get hold of you, okay?

Kate: Alright, great. Thank you so much.

Nina Gregory: Thank you.

Operator: And we’ll take our next question. Caller, please go ahead.

Natalie: Hi. My name is Natalie. I just had a question regarding the DIF for the external infusion pump. I have noticed that with every submission, I submit the length of need as 99 months because essentially, they are going to need the pump forever. And for whatever reason it gets entered into the system for exactly 13 months. So I found that every time a patient reaches their 13th rental month, I have to type a narrative on my claim, requesting that the expiration date of the DIF be extended so that the pump rental fee will pay. And I am wondering if that is something – if that’s the way that the system is intended to function or not.

Nina Gregory: One moment, okay.

Natalie: Okay.

Nina Gregory: Okay, Justin? I think Justin is going to step with that question.

Justin: Yes, so this is – my name is Justin, I work in the call center. The system is setup to allow it for 13 rental months because it’s a capped rental item. So if you go over those 13 months, you have to extend it out. That’s telling the system that you missed one of your payments due to an inpatient stay or whatever it may be, to where we can allow those additional months.

Natalie: It’s even on the 13th rental. Like the patients – if the patient started on 1 August 2015, when I bill the 13th on 1 August 2016 because the DIF expires on that day, I have to ask for it to be extended and I don’t understand why the system would allow something to expire when it is absolutely intended to still be used for that last claim.

Justin: So, can you send me some of those examples or give me your contact information, I’ll try to give you a call and we can work together on that because I am not sure if it’s the 13 rental months, why it’s doing that.

Natalie: Sure. Do you want my email or my phone number?

Justin: What’s your phone number?

Natalie: It’s –redacted-.

Justin: And what was your name again?

Natalie: Natalie.

Justin: Thank you.

Natalie: No problem. Thank you.

Operator: And we’ll take our next question. Caller, please go ahead.

Aria: Hi. My name is Aria and I just have a quick question. When will the new AFP drug pricing go into effect?

Nina Gregory: One second. As soon as we have that information, we will send out a ListServ message. If you haven’t seen a ListServ message [inaudible] yet, then we have not received it. I would suggest that you make sure you signed a
prior ListServ messages and look for that.

Aria: Okay, so just stay tuned. Thank you.

Nina Gregory: Yeah, thank you.

Operator: Caller, please go ahead.

Karen Pencee: Hi. Can you hear me?

Nina Gregory: Yes, hello.

Karen Pencee: Hi. My name is Karen. And we are a DME provider. We dispense oral anticancer medications for patients. My question is we started getting claims denials starting 1 April. We got a 151 which is payer deems the information submitted does not support this many frequency of services. And we kind of got a few different answers but finally what we found out is, starting on 4/1, you guys started using the conversion method where we had to build the conversion factor. And we’re specifically having problems with 2 NDC numbers where the conversion factor, first off, does not - if you divide the quantity by the conversion factor and it doesn’t equal a whole number, we can’t bill you know 1.32 or something like that.

But then I’ve also been noticing I don’t know if there is like a system issue that you guys are trying to resolve because all of a sudden, quantities for five and ten are getting paid just fine, but anything that we bill over ten, like say we bill 21 which is a normal quantity that we would bill, those are getting denied because we didn’t bill it with the conversion factor. But then claims that we have built with the conversion factor method, they don’t get processed with the correct NDC number.

I am not really sure. We were told that there was a system issue and that they were trying to work it out and they suggested we hold these claims, but I am not sure if that is actually true or not just because I’ve gotten a few different answers. We’ve got one NDC number where we’re supposed to use the conversion factor and the other NDC number for the same drug we don’t have to for a different strength, but if we bill those two drugs together, then they lump it together as one NDC number and then they deny us.

Nina Gregory: I am not sure if there was an issue previously with NGS and if it’s still continuing -

Karen Pencee: It’s all four jurisdictions.

Nina Gregory: Okay.

Karen Pencee: And I’ve got about $100,000 worth of claims aren’t getting paid.

Nina Gregory: Okay. Let’s take your information and then Natalie can get some claim examples and we’ll get to the bottom of it, okay.

Karen Pencee: Okay, sure. My email is –redacted–.

Nina Gregory: Right, I will get hold of you, okay?

Karen Pencee: Okay, thank you so much.

Nina Gregory: Thank you.

Operator: And we’ll take our next caller, please go ahead.

Kera Ireland: Yes, my next question is on the CGS website for Medicare Jurisdiction B and C, it indicates underneath general FAQs number 3 when you are - how to check for same and similar on a patient. It says I need to find out if a beneficiary has had a specific item in the past same or similar inquiry, what is the best way to find this information? I do understand that you would need to use the IDR, but the IDR doesn’t have any L codes or the A codes set up as of the correction – they should have the A codes, but they don’t have the L codes.

On the bottom, it says of that answer to the FAQ, if you are required to utilize my CGS to the IDR for same and similar increase unless you are enquiring on a same and similar item, that does not require the DME MAC to setup a CMN or DIF. For example, CPAP suppliers as well as other items that are cap rental or IRP contact customer service. When we call into customer service, they don’t check these for us, they tell us we have to utilize the portal.

Nina Gregory: I believe we have someone who can help with that question.

Julia: Hi. This is Julia. I am one of the supervisors in customer service. So when you are calling for A codes, our reps should be assisting you with those. They may encourage you to use the portal, but they should be assisting you with A codes. Now with L codes, we do require that you contact customer service for those via written request or on the portal. But with A codes, the reps should be assisting you.

If you do have an incidence when you are calling to check for A codes and a rep refuses, at that point I would encourage you to reach out to a supervisor so that we can do some education in coaching there. But as long as you’re claiming for A codes, the rep should assist you. Now they may strongly encourage you to use the portal because that is available and then you don’t have to wait to a rep or anything like that, but with A codes they should assist. And again with L codes, you do have to request that via written request.

Kera Ireland: Okay. So the A5500 to the A5513, they should be able to give us those in customer service?

Julia: Yes ma’am and if you have – I think those maybe available through the IVR.

Kera Ireland: I believe you are right, we have run into instances where the IVR states that there is nothing on file. We bill and we get a denial stating that the patient only received them in the allotted timeframe. I understand using the portal to check for the L codes, however, we have tried to get signed up with the portal and it’s been about three months now and we still have not received any information back stating that we are ready to go. And ringing into customer service to check for L codes takes a long time so therefore we are holding up the patient. We’re not being able to supply these items that they need because we can’t verify same and similar.

Julia: So - and I apologize for not being clear with the A codes. So for – [inaudible] usually can pull it up from IVR. For CPAP supplies, you can call us and get that. I understand that our metric for responding to written correspondence is 45 days, however we are processing those requests within 10 at this
point. So you shouldn’t be having to wait too awfully long for the response for the L codes. And as far as your application for the portal goes, if you just want to give us your contact information, we can have our processors look into your application to see what’s going on there.

**Kera Ireland:** Okay, I will give you my email. It’s –redacted–. Now going through written increase, we are not supposed to put any patient information in there, so how would we be able to obtain that information?

**Julia:** Are you sending the written increase through the email portal or you sending that through regular mail?

**Kera Ireland:** We haven’t attempted to do it either way. But if we were to do this, we would have to send it through regular mail, correct?

**Julia:** That’s correct. You cannot submit private health information on the email portal.

**Kera Ireland:** Right. So when we do that, once you receive it, does it come back to us in mail?

**Julia:** If you provide, yes, it would be through mail.

**Kera Ireland:** Okay, alright.

**Julia:** We could put you that claim information through mail.

**Kera Ireland:** Okay, thank you very much.

**Julia:** No problem, thank you.

**Operator:** And we’ll take our next question. Caller, please go ahead.

**Rachael:** Hi, my name is Rachael, calling from the DME office. My question is in regards to a patient that had a CPAP machine paid for by Medicare and then before the five years are up, they had a change in medical need and now require a BiPAP. I found out a few weeks ago through a different webinar that we can bill the BiPAP starting at month one, even though it’s same and similar with CPAP because of the medical need. How - what’s the best way to bill that to prevent the denial, or can we get it denial no matter what and then we have to do appeals?

**Nina Gregory:** So they had a CPAP device first and then their change in medical need now has led them to bi-level device. It’s – it is an E0470 that’s also in the PAP policies so yeah, it probably will hit up against same and similar. And then you would end up having to appeal and show why that is a bi-level device falling under the RAD policies that where you are trying to do?

**Rachael:** Well, I was wondering if there was like a narrative or something that can go into the claim that would prevent that initial denial?

**Nina Gregory:** Not to my knowledge. More than likely it would deny on the front end and you would have to appeal and show the justification for why they are now needing a capped rental.

**Rachael:** Okay and then if we have justification as to why they need it to bypass now, is that going to get paid?

**Nina Gregory:** Once it’s going to be for the OSA or is it for falling under the RAD policy?

**Rachael:** For OSA. So just the condition worsened and just the CPAP device, saying maybe they are maxing out the pressures on the CPAP or it is just not controlling their apnoea so the physician is ordering a BiPAP.

**Nina Gregory:** I am not a 100% at this time. I am asking if anyone else in the room knows, but I am not a 100% to answer that question. Give me one minute and let me see if anyone else have that answer.

**Rachael:** Sure, thank you.

**Nina Gregory:** I think Linda, can you answer that question?

**Linda:** Hi, yeah, this is Linda and I work here at the appeal department here at CGS. If the medical documentation clearly shows the change and need, as you’ve indicated then yes, we should cover that.

**Rachael:** Okay and would that be demonstrated through either physician notes and compliance or download from the machine or by the filtration - either one of those probably works.

**Linda:** Yes.

**Rachael:** Okay, right, perfect, thank you.

**Nina Gregory:** Thank you.

**Operator:** We’ll take our next question. Caller, please go ahead.

**Speaker:** Yes, I am calling in reference to the Cures Legislation that was passed and the president recently signed and I was wondering if CMS has given any direction to the DME MAC in reference to how the adjustments to the fee schedule for 2016 will be made?

**Nina Gregory:** At this time, we do not believe that we have had any notification. If once we do, we have any kind of information, we will definitely send it out via ListServ.

**Speaker:** Okay, so no direction has been given yet?

**Nina Gregory:** No.

**Speaker:** Thank you.

**Operator:** And we’ll take our next question. Caller, please go ahead.

**Nina Gregory:** Hello.

**Operator:** Caller, your line is open, if you can unmute yourself.

**Ann:** Hi, can you hear me? Hello.

**Nina Gregory:** Hello.

**Ann:** Hi, can you hear me?

**Nina Gregory:** Yes.

**Ann:** Okay. My question is if the MR Wizard is down where we need to verify and audit was received, if we call customer service, can they give us the information such as when an audit was received? Because we can call and say okay, well can you give me the date the audit was received. Because a customer service rep especially if they are new, they can just say, yeah I
think it was received. Can they actually tell us the date it was received or how many pages they received, so we can confirm that it was actually received?

Nina Gregory: I do believe that they can, yes.

Ann: Okay. Now, let me ask you one more question because when you get some new customer service reps on the line, they will refuse. And then if you get – if you still say, can I talk to level two, I had one the other day say no, I am giving you the information and I am not transferring you. I thought if a provider is not agreeing with the customer service rep, because I know she is actually wrong and I want to actually speak to a level two myself to get the correct answer, shouldn’t they pass us to a level two?

Justin: Yeah, this is Justin. I am the supervisor in the call center. So first, I want to apologize about that rep stating that they are not going to send you to level two. That not should not happen. Anytime you ask for a level two, they should send you to a level two.

Ann: Okay, I did leave a message because I requested from another customer service rep to transfer me and I did leave a message for a supervisor because I thought she was totally rude.

Justin: Okay.

Ann: I am sorry, it was just real frustrating that day, so I called back and I actually got a customer service rep that was a little bit more trained in what question I was asking and I did end up getting my answer. But – alright, I don’t know I just wanted to throw that out there.

Justin: Yes, and once again I do apologize about that. I’ll get with the other supervisors to look into that call and then I’ll also get your contact information and then I’ll give you a call about that. But when it comes to the medical review documentation, our reps cannot see when you – when we receive the documentation. We can only let you know the date that it went into nurse review.

Ann: Okay, yeah, as long as they could give us a date when it was either received or can they confirm how many pages because they will say no, we can’t – we can’t pay you any information, because I know you all can.

Justin: Okay, so when it comes to how many pages you received, unfortunately we cannot look into that over the phone, to let you know how many pages we received. The only information that we can really give is the reasons for denial when we sent the letter requesting the additional documentation and when your records went to nurse review. So we can’t tell you the exact date when we received your records or how many pages that we did receive.

Ann: Okay, what is a nurse review? So are you are saying that they can confirm, yes the audit was received and this is the date it was sent to nurse review?

Justin: Well, we can just let you know that this is when someone in the medical review department started reviewing that case.

Ann: Okay, so they can give us a date around about the date of when it was forwarded? So basically I can find out yes that was received and here is the date I got forwarded to the nurse review?

Justin: That is correct.

Ann: Okay, because they’re not – I don’t know what it is now because it’s been a little while since I called, but I just wanted to make sure that we can get that information if MR Wizard is not available.

Justin: Yes ma’am.

Ann: Okay, well, thank you very much.

Justin: Hey. Let me – can I have your name please?

Ann: Sure. My name is Ann.

Justin: And can I have your call back number please?

Ann: Sure. –redacted-, and my extension is 223.

Justin: Alright, thank you.

Ann: You’re welcome.

Nina Gregory: Thank you, Justin. Ashley, I think the next, we’ll take our last question.

Operator: There are no further questions at this time.

Nina Gregory: Okay. Alright, great. Well if you have not had the opportunity to ask a question, please contact the provider contact center at 1866-590-6727. 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 will be posted to our website within a couple of weeks. Watch your ListServ messages for information regarding when this information is available and information on other upcoming educational opportunities. Thank you all and have a good day.

Operator: And once again, that does conclude today’s presentation. We thank you all for your participation and you may now disconnect.

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