Operator: Good day and welcome to CGS' Teleconference Call covering ACA 6407 requirements. Today's conference is being recording at this time I would like to the meeting over to (Mr. Michael Hanna). Please go ahead sir.

Michael Hanna: Thank you, John. Good afternoon and welcome to CGS Administrators' first "Ask the Contractor Teleconference" call in 2015. All of these calls are hosted by the CGS DME Provider Outreach and Education team. This particular call will focus on Section 6407 of the Affordable Care Act (ACA) and how it impacts the DME supplier community. We will refer to CGS Administrators, LLC, as simply CGS throughout the remainder of the call. Thank you for taking time from your schedule to participate in this teleconference; we hope you find the information beneficial for your particular business model.

Background on ACA 6407

Before we open the lines for your questions, I want to provide some background and important dates surrounding ACA from a DME perspective. This legislation was passed by Congress and became law on July 1, 2013. There are 155 HCPCS codes, including the most common capped rental items, which are affected by ACA 6407. The list of HCPCS codes can be found in the Jurisdiction C Supplier Manual, Chapter 3 (http://www.cgsmedicare.com/jc/pubs/pdf/chpt3.pdf), or the Medicare Learning Network (MLN) Matters article, MM8304 (http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/minnmattersarticles/downloads/mmm8304.pdf).

First, there must be evidence of a face-to-face encounter with the treating physician within six months before the orders are written. The face-to-face visit must indicate the Medicare beneficiary was evaluated for a condition that supports the need for the durable medical equipment ordered. The physician may be an MD, DO, nurse practitioner, physician assistant or clinical nurse specialist. If the physician that conducted the face-to-face visit is a nurse practitioner, physician’s assistant, or clinical nurse specialist; an MD or DO must co-sign and date the pertinent portion of the medical record.

Second, for all HCPCS codes on the list, the supplier must have valid, detailed written orders in their possession prior to delivering the DME item. According to MM8304, these detailed written orders must include the following:

1. The Medicare beneficiary’s name
2. The item of DME ordered
3. The prescribing practitioner’s National Provider Number (NPI)
4. The signature of the prescribing physician
5. The date of the order.

It is also important to note that all other aspects of a detailed written order as outlined in Chapter 3 of the Jurisdiction C Supplier Manual or the CMS Program Integrity Manual, Chapter 5 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Downloads/pim83c05.pdf), must be followed to consider these written orders “valid” in the eyes of the DME MACs. For example, if the physician’s printed name must be on the orders. Additionally, there must be a sufficient description of the DME item ordered. “Bed” or “Hospital bed” will not suffice; the orders must indicate the type of hospital bed being ordered, such as “semi-electric hospital bed” or “variable height hospital bed.” Suppliers must also show receipt and possession of the detailed written orders prior to delivery of the equipment by use of a date stamp or equivalent.

Important Dates Surrounding ACA 6407 Requirements – Chronological Order

Now I’m going to cover some important dates surrounding ACA 6407 requirements. These will be in chronological order. Please do not feel the need to write them down as we will have URLs posted along with the dates when the transcript is uploaded to our website.

On December 19, 2013 (http://www.cgsmedicare.com/jc/pubs/news/2013/1213/cope24158.html), CMS instructed the DME MACs to begin enforcing the written order prior to delivery aspect of ACA 6407 for all dates of service on or after January 1, 2014. The face-to-face portion of Section 6407 is not yet being enforced by the DME MACs.

On December 19, 2013 (http://www.cgsmedicare.com/jc/pubs/news/2013/1213/cope24158.html), CMS instructed the DME MACs to begin enforcing the written order prior to delivery aspect of ACA 6407 for all dates of service on or after January 1, 2014. The face-to-face portion of Section 6407 is not yet being enforced by the DME MACs.

CGS Medical Review posted an article on the CGS website on February 18, 2014 (http://www.cgsmedicare.com/jc/pubs/news/2014/0214/cope24733.html), which detailed a pre-pay review of certain HCPCS codes included in ACA 6407. This article was later revised on April 22, 2014. These pre-pay reviews are considered documentation compliance reviews as medical records are not being requested. When an ADS letter is received, the supplier is expected to respond by submitting the detailed written orders and delivery documentation to show they are in compliance with ACA 6407 compliance concerning the detailed written orders.
On February 20, 2014 (http://www.cgsmedicare.com/pdf/f2f_wo_requirements_highcostdme.pdf), the DME Medical Directors published a “Dear Physician” letter that outlines the tenets of ACA 6407. The title of this letter is “Face-to-Face and Written Order Requirements for High-Cost CME” (http://www.cgsmedicare.com/pdf/f2f_wo_requirements_highcostdme.pdf).

On May 29, 2014, via a News item on the DME ListServ and uploaded to the CGS website, CMS clarified a February 20, 2014, article (http://www.cgsmedicare.com/jc/pubs/news/2014/0214/cope24758.html) that physician conducting the face-to-face examination did NOT have to be the prescribing physician. The prescribing physician, however, must have knowledge that a face-to-face examination was conducted. The “Dear Physician” letter from February 20, 2014, was revised to reflect this clarification.

On August 7, 2014, with a revision published on August 28, 2014 (http://www.cgsmedicare.com/jc/pubs/news/2014/0814/cope26691.html), a DME ListServ and accompanying News item was published that outlined the steps to handle corrections and amendments to the face-to-face and written order prior to delivery. If errors are found prior to delivery of the DME item, the supplier may request the treating physician amend the face-to-face notes or detailed written orders. Or, a new face-to-face may be conducted and a new set of orders written, whichever is applicable.

If errors in either document are found after delivery, the supplier may recover their items until proper face-to-face examination and/or detailed written orders are received by the supplier. If the supplier has already billed the Medicare program when the errors are found, that supplier must pick up their equipment and another DME supplier must complete the transaction.

On November 21, 2014 (http://www.cgsmedicare.com/jc/pubs/news/2014/1114/cope27550.html), CMS reaffirmed the delay in enforcement of the face-to-face requirement by the DME MACs, although other auditing entities may enforce the law.

Social Media

Find the CGS DME MAC Jurisdiction C POE page on Facebook®. Become a fan and get all of the latest DME MAC POE information and more on the CGS DME POE page on Facebook® at: http://www.facebook.com/CGSadminDME.

Provider Outreach and Education is also on Twitter®. Search “@JCDMEOPOE” on your Twitter account to follow us! Our “tweets” will include reminders about Medicare requirements, helpful tips and POE events.

MR WIZARD

On July 1, 2014, CGS introduced the MR WIZARD Medical Review denial explanation tool (http://www.cgsmedicare.com/medicare_dynamic/jc/denials.asp) as a way to provide clear, concise information to suppliers concerning their denied claims. Suppliers can check MR WIZARD to see detailed claim line denial information on claims denied following a CGS Medical Review pre-pay audit. MR WIZARD is free and suppliers don’t have to sign up for any service; simply type the 14-digit claim control number in the box titled “CCN.” MR WIZARD will display detailed reasons why your claim was denied and it will provide you with education and resources specific to those denials. Suppliers may also input a date range and receive a spreadsheet of all their claims where CGS Medical Review requested additional documentation. MR WIZARD is used only for claims denied following a CGS Medical Review pre-pay audit. Suppliers should check the explanation provided on the Medicare Remittance Advice statements for other types of claim denials. Suppliers can find MR WIZARD on our website at http://www.cgsmedicare.com or via our mobile app, CGS Go Mobile, which is available from the Apple App store or the Google Play store.

CGS ListServ

The most effective way to keep up with current topics at CGS or changes in the Medicare program is the CGS DME ListServ. All of the dated items I have mentioned today were included in our daily ListServ transmissions. We usually send one email in the afternoon with pertinent information for our supplier community. ListServs may include information about new MLN articles, draft LCDs proposed by the DME Medical Directors, Provider Contact Center Closures, or notification of POE webinars and workshop locations. If you have not signed up, or you have staff that would benefit from our ListServs, go to our website and click “Quick Links” on the right-hand side of the Jurisdiction C home page. From the pull-down menu, click “Join the ListServ.” It only takes a moment to sign up!

ICD 10 Testing

The Centers for Medicare and Medicaid (CMS) has indicated the need for more DME suppliers to conduct ICD-10 end-to-end testing. Suppliers should review Medicare Learning Matters article MM8858 (http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/mm8858.pdf) and special edition article SE1409 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1409.pdf) for additional information about opportunities to participate in testing.

Conclusion

Before we open the phone lines for questions, please be aware that we are not able to answer questions about individual claims. Do not mention a beneficiary’s name or Medicare number in your question as we want to assure confidentiality and protect the member’s health information. If you have a question regarding a specific claim or beneficiary, our Provider Contact Center representatives are available from 7:00 a.m. – 5:00 p.m. Central time Monday through Friday at 1.866.270.4909.
A transcript of today’s call will be added on our web site. When the transcript becomes available we will alert you via a ListServ announcement. Where applicable, links to the articles and documents discussed in this call will be added to the transcript.

We are now ready to begin the question and answer portion of the call. I will now turn the call over to our teleconference specialist, John, to prepare the lines and queue your questions.

Operator: Thank you. Ladies and gentlemen, if you would like to ask a question please signal by pressing Star 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. A voice prompt on the phone line will indicate when your line is open. Please state your name before posing your question. Again press Star 1 to ask a question.

We’ll pause for just a moment to allow everyone an opportunity to signal for questions. We will now take our first question. Please go ahead.

Lewis: Yes good afternoon. My name is (Lewis). In your introductory remark you seemed to interchange the written order prior to delivery WLPD versus the DWO - detailed written order. My understanding is that these are two different documents, are they not?

Michael Hanna: They are not. Those two terms are synonymous when we’re talking about ACA 6407. You must have a valid detailed written order prior to delivery and that’s sometimes called a written order prior to delivery.

Lewis: Okay because in Chapter 3 they have different sections on verbal and preliminary written orders, detailed written orders, and written orders prior to delivery all with different elements on them. And your detailed written order - one of the elements on it - there is the duration of need yet that is not one of the elements that’s required on a written order prior to delivery before dispensing.

Michael Hanna: From an overall standpoint, if you have an order that follows the guidelines per detailed written orders in Chapter 3, which includes the treating physician’s or prescribing physician’s NPI you should be fine. Length of need is not necessarily required for all detailed written orders.

Lewis: Okay because what is happening with our prepayment audits is that we have two documents. One is what we call the dispensing order which is the written order prior to delivery with the required elements, and then afterwards we send a detailed written order to the physician that includes all the required elements in the detail written orders sections such as frequency and duration and quantity refills.

Yet when we submit them and clearly mark this is the written order prior to delivery and circle all the required elements and in conjunction also give you the detail written order which is received after delivery we’re being denied as no written order prior to delivery being included in the package when it’s clearly labeled. One is a detail written order, not the written order prior to delivery, this is the written order prior to delivery so what’s the problem?

Michael Hanna: Well without seeing your claim I would just have to assume that there are elements missing in a written order prior to delivery. Is there a certain category...?

Lewis: They are not. I circle the five elements. We know what the five elements are. We date stamp it. The NPI number is on there, the doctor signature and date is on there. The description of the equipment is on there. We know that for a fact.

I think what’s confusing then is that we’re including a second document that arrives to us after the delivery date that is a detail written order that includes the patient’s name, their HIC number, the duration of need, the frequencies, the quantity of refills so forth and so on and yet it’s being ignored.

Michael Hanna: What category of equipment are you billing for example?

Lewis: Say standard wheelchair and elevating legs.

Michael Hanna: Okay there is not quantity of refills for a standard manual wheelchair.

Lewis: But there’s a duration, lifetime, or two months or three months.

Michael Hanna: Okay, so...

Lewis: That’s one of the required elements of a detail written order, but it’s not required on your WOPD.

Michael Hanna: The written order prior to delivery must include the five items listed in MM8304 and the requirements listed in Chapter 3 of the supplier manual. If you follow all of the requirements for detail written order found in the Supplier Manual Chapter 3 and it includes a physician’s NPI it should be a valid detailed written order prior to delivery.

Lewis: It should be but it isn’t and then we go through Redeterminations and they overrule it and wind up giving us the money. So I don’t understand what the problem is at the prepaid level when at Redetermination they see it and overturn the prepaid level and it’s just very time consuming.

Michael Hanna: Without seeing a specific claim example I would unable to hazard a guess as what the problem might be.

Lewis: Okay thank you.

Michael Hanna: Thank you.

Operator: Ladies and gentlemen, if you find your question has been answered you may remove yourself from the queue by pressing Star 2. We will now take the next question. Please go ahead.
**Ask the Contractor Teleconferences (ACT)**

**Michael Hanna:** Go ahead please.

**Sarah:** Hi there. Yes, this is (Sarah) and I’m just wondering if you have any sense when CMS will announce an enforcement date for the face-to-face portion of the amendment?

**Michael Hanna:** We have received no indication at this time. As soon as we hear something from CMS we will definitely pass it along to our supplier community via a Listserv announcement.

**Sarah:** Got it, thank you.

**Michael Hanna:** Yes ma’am, thank you.

**Operator:** Thank you. We will now take our next question.

**Katie:** Hi my name is (Katie).

**Michael Hanna:** Hi Katie.

**Katie:** I have a question. Recently we have had someone have a face-to-face visit, and there were two physicians involved in the care of this person, and one of the physicians signed a detailed written order and they’re both mentioned in the chart notes, and the other physician signed the chart notes. Would that be acceptable?

**Michael Hanna:** Yes. The prescribing physician does not have to be the same doctor that conducted the face-to-face, that is acceptable.

**Katie:** Okay thank you.

**Michael Hanna:** Yes ma’am.

**Operator:** Thank you. We will now take the next question.

**Michael Hanna:** Good afternoon.

**Male:** Hello. For patients who have a non-billing pack or non-billing nebulizer and they need replacements because of the (inaudible) failure. Do those patients need to have DWOs for getting a loaner device?

**Michael Hanna:** So you’re repairing the patient on the equipment?

**Male:** Correct, but they’re getting a loaner while they’re waiting for the repair to get completed.

**Michael Hanna:** You don’t need orders for repairs.

**Male:** Okay.

**Michael Hanna:** That’s my references, Chapter 5 of the Jurisdiction C Supplier Manual.

**Male:** And if they get a loaner device they do not need a DWO?

**Michael Hanna:** No. You’re providing that loaner piece of equipment while you’re repairing their beneficiary on the equipment, so you’d be billing the temporary replacement code (K0462).

**Male:** Or not billing at all.

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**Emily:** Hi this is (Emily) and can you guys hear me okay?

**Michael Hanna:** Yes Emily, go ahead please.

**Emily:** Okay. We’re wondering on the detail written order it’s required that the specific mask is chosen, but when the provider writes the order they don’t necessarily know which mask the patient is going to pick so we’re a little unsure on what your expected procedure for that is.

**Michael Hanna:** Well, following ACA6407 guidelines and LCD guidelines, it’s not uncommon for suppliers to actually have two orders, one for the actual device that is received prior to delivering the device and accessories, and then once the patient is fitted and chooses a mask et cetera then the supplier will create a detail written order for all the supply items that includes their frequency of refills, et cetera.

And they will send that back to the physician, have the physician sign and date that and then they’ll bill the claim. So you have an order that meets ACA 6407 guidelines for the PAP and then a detail written order for all the accessories that includes the frequency of use, the type of mask et cetera. And you’ll have both of those in your possession before you bill the claim because you can dispense all the accessories based on the dispensing order, but you can’t bill until you get the DWO.

**Emily:** Okay so the DWO for the supplies doesn’t have to be necessarily before the patient receives it then.

**Michael Hanna:** The orders for the supply items are not part of ACA 6407 so it’s highly likely actually that you will not have the detail written order from the physician before you provide the supply items.

You must have it for the PAP device but you’ll need a dispensing order, of course, for the supplies if applicable. Sometimes you get an order that will have say…. “PAP at 10 centimeters plus humidifier and supplies including mask of choice.”

**Emily:** Right.

**Michael Hanna:** So, if everything else is on there like the NPI and the other elements, that would be valid for the written order prior to delivery for the PAP device and as a dispensing order for the accessories or supply items. Then, once you fit you patient, they chose the mask, the type of tubing, et cetera; you would complete a detailed written order for those supply items, send it to the physician have him or her sign and date it, get it back to you and then you bill the claim.

**Emily:** Okay.
Michael Hanna: As long as you have a valid detailed written order for those accessories before you bill the claim you’re fine.

Emily: All right thank you.

Michael Hanna: No problem Emily, thank you.

Operator: Thank you. We’ll now take the next question.

Christina: Is it me?

Michael Hanna: Yes, go ahead please.

Christina: Hi this is (Christina). I have a question. First of all, I’m 100% on board with that first guy that was talking about getting denied for the detail written order when it’s right there.

My question is specific to that. We have a major problem with wheelchairs. What is it they’re looking for a K1? I have “manual wheelchair” written. If the doctor wanted a hemi he’d write “hemi,” if he wanted lightweight, he’d write “lightweight.”

A manual wheelchair is a standard manual wheelchair. And something has changed with the advanced determination requests because I had no problem up until about two months ago, I’m in constant contact with one of the managers of that department and it’s been a battle - big, big battle.

Michael Hanna: I don’t know if I would consider just the word standard wheelchair...

Christina: Not standard, manual.

Michael Hanna: I would definitely not consider the words “manual wheelchair” valid for a detail written order because every HCPCS code in that LCD are manual wheelchair basis.

Christina: Well no. If I wanted a hemi manual wheelchair he would write “hemi.” So are they looking for the words “standard manual wheelchair?” I mean we changed our policy and said that everything has to say that, but I mean I’m taking them all to court because there’s nothing that indicates to the suppliers what exactly has to be dictated.

If the doctor wants to write for a manual wheelchair any HCPCS above a K1, there’s an additional description required. So, like I said, if he wanted to write a hemi, he’d write “hemi manual wheelchair.” If he wants a lightweight, he’ll write “lightweight,” “ultra-lightweight,” “high-strength lightweight,” “bariatric” - whatever.

There’s an additional description in addition to manual wheelchair for anything above a K1 so there shouldn’t be an issue but there is and there wasn’t three months ago.

Michael Hanna: I really don’t have a response Christina, because just the words “manual wheelchair” is not a definite description of the type of manual wheelchair base you’re going to be providing to the beneficiary.

I think the word “standard” added to the detailed written order would definitely increase the chances in a prepay review because that’s part of the description of the HCPCS code for a K0001 standard manual wheelchair.

Operator: I apologize. The customer has removed herself from the queue. We will now take our next question.

Kim: Yes this is Kim, can you hear me?

Michael Hanna: Yes, go ahead, please.

Kim: Thank you. My question is you mentioned that a start date is required. We had a problem previously where there was a date at the top of the order where the patient information was listed and then the signature at the bottom, and they said that we didn’t have a start date. A doctor is not going to write several dates on the order they’re just going to put one date and that’s it whether it’s printed or hand signed.

Michael Hanna: Did the order come from the physician’s office or is it something you created?

Kim: It comes from the patient’s assisted living facility so he created that order at that assisted living facility.

Michael Hanna: The physician did?

Kim: Yes. And it had every item listed that he wanted individually, and they said I did not have a detailed order. Everything was clear on that order, it said wheelchair, wheelchair seat cushion, back cushion, elevating leg rests, and listed every item and it said I did not have a detailed written order.

The NPI was there, the date was at the top above all the other items. The signature - the handwritten signature - was at the bottom but there was no handwritten date. But you know the provider said I shouldn’t have to put another date it’s already dated. So I don’t understand why I received a denial for that.

Michael Hanna: Again, without seeing specific claim documentation I’d be hesitant to hazard a guess. Keep in mind you do have appeal of rights so you can take that through redeterminations.

Kim: Most of the time it seems as if once it gets to them they just kind of follows the first decision and so you know I don’t always get the second look I’d be hoping for. And you know when I send it in I’ll put a cover sheet and say “this is this” and “this is this” and it still came back to me the same way.

So I guess the start date of the order as it’s only one date there, do you consider that the start date or do it have to be start date, signature date? Most providers are not going to do that.

Michael Hanna: In Chapter 3 it states there be a start date and order date if that start date is different so that’s probably where they are coming from. Again, without seeing the actual documentation I’d be hesitant to hazard a
Michael Hanna: Good afternoon (Marie).

Marie: Good afternoon. I’ve got a - it’s kind of a two-phased question. I, too, do agree with the gentleman the first time. We receive a written order prior to delivery with the five elements on it. We deliver the equipment, but prior to submitting a claim to Medicare we do wait for the detail written order to ensure that we have dosing, route of administration, frequencies used, and so on.

When we submit our documentation for prepay audits - the WOPD and the detailed written order we’re being told - just like the gentleman said, that we didn’t have a good enough order to deliver. From what I’m hearing you say is we really do need a detail written order with the NPI prior to even delivering the equipment; is that correct?

Michael Hanna: That’s correct. The five tenets, if you will, listed in MM8304 will not necessarily give you a valid detail written order. All of the requirements are outlined in Chapter 3 of Supplier Manual and the LCD for that particular equipment category and must be met in order to consider it valid.

Marie: So I guess we get confused on the definition of WOPD and DWO. What you’re telling is I need a detailed written order prior to delivery with dosing, route of administration, length and need prior to the patient signing our delivery ticket.

Michael Hanna: That’s correct, and make sure it’s got the NPI of that practitioner on it as well. If you follow the guidelines in Chapter 3 of the Supplier Manual and the LCD and make sure that the physician puts his or her NPI on there you should be fine. The problems that we’ve seen mostly come from the orders lacking a detailed description of the item.

So, let’s just say you have orders for a hospital bed or manual wheelchair, but there’s no indication via a date stamp or equivalent from the supplier that they were in possession of that detailed written order prior to delivery before the delivery date of the equipment. So that date stamp or equivalent is vitally important.

Marie: I understand that. If I have a detailed written order or a WOPD prior to delivery, and we have submitted a claim to Medicare and realize then that we forgot to do frequency of use; for example oxygen didn’t have continuous on the detail written order prior to a claim. Is that when we also need to switch this patient to a different DME provider?

Michael Hanna: If there are problems with the orders or face-to-face after you’ve billed the program, yes you’d have to pick up your equipment and another supplier would have to provide it and get the documentation.

Marie: And even though the face-to-face is not being enforced if I find that it did not occur within the six months I also - you’re saying I also have to switch patient to a new DME provider?
Michael Hanna: Correct following ACA guidelines. Keep in mind as well because you mentioned oxygen. Some LCDs have other requirements with time requirements in addition to ACA 6407 - oxygen is one of those. So even though the portable oxygen codes are part of ACA 6407, the oxygen LCD states that the test must be within 30 days or the initial CMN certification. So you've got to meet the LCD requirements as well.

Marie: Very well. I do understand that so let's take that to a nebulizer. A patient switches to us - just switching providers. We're going to give the patient a new nebulizer which requires a written order prior to delivery now that I'm hearing you I actually just have to have a DWO with NPI on it. I don't find -- I release a claim to Medicare now I've trying to find my face to face that might have occurred within 6 months and that never occurred. I know that to give that patient up to another provider.

Michael Hanna: Well from a face to face aspect only, we are not yet enforcing that. Other auditing entities might such as the CERT or RAC contractors, but the DME MACs are not. So if you find that didn't happen at this point in time, you're okay from a DME MAC standpoint, but you may not be okay if that's chosen as a post-pay review from one of those other auditing entities.

Marie: Okay thank you.

Michael Hanna: Yes ma'am. Thank you.

Operator: Thank you. We'll now take the next question.

Female: Hi I have two questions. A beneficiary is entering Medicare, do they have to have the face to face and DWO after they become eligible or can it happen prior to that - becoming eligible for Medicare.

Michael Hanna: There's nothing in MM8304 that discusses Medicare eligibility. You just have to it before you provide the equipment.

Female: Okay. What about - is there a time frame for after you have the face to face and DWO as to when you set that person up on that equipment?

Michael Hanna: There's not one specifically listed in the MLN Matters article, but it should be a reasonable amount of time. For example, if the beneficiary has orders in their possession but nine months later the beneficiary brings those orders to you - I would probably question the necessity of the equipment.

Female: Okay. Thank you.

Michael Hanna: Yes ma'am.

Operator: Thank you. We will now take the next question.

Ricky: Yes this is Ricky can you hear me?

Michael Hanna: I can Ricky, go ahead please.

Ricky: My question was on the face to face where a nurse practitioner or physician assistant has done the face to face and now physician's signature and date is required. Is that physician's signature and date required prior to the delivery of the equipment also?

Michael Hanna: I don't think that's listed in the MLN article, Ricky. It just says it need to be co-signed by and MD or DO if the face to face was conducted by a nurse practitioner, physician's assistant, or clinical nurse specialist.

Ricky: So if we have the face to face from a nurse practitioner, for example, we can go ahead and deliver it based off of that even though the physician hasn't reviewed it signed and dated it?

Michael Hanna: You have detailed written orders prior to delivery from the nurse practitioner?

Ricky: Yes.

Michael Hanna: From a DME standpoint since we're yet enforcing that face to face requirement, you would be fine.

Ricky: Okay. Another question are you all - is there anything where it's been considered where home health agencies visits are going to be allowed when a patient is not able to get in to the doctor for the face to face?

Michael Hanna: There's been no clarification from CMS regarding home health visits.

Ricky: Okay thank you.

Operator: Thank you. We will now take the next question.

Angela: Hi this is Angela Ward with (company name removed from transcript). I just want to confirm on the date stamp for receipt of the face to face and the WOPD. Is CGS Medical Review currently reviewing for this requirement on documents and would a date stamp from a receiving fax machine suffice for this requirement?

Michael Hanna: It will suffice. I would caution anyone using fax headers or fax footers as proof that they received it prior to delivery. We need to be aware that the particular fax header is the one we should be looking at because sometimes there will be multiple fax headers or when documents get faxed back and forth; those headers become covered up or distorted. So if you're going to use fax headers you need to be really careful.

Angela: Right or we need to just make sure - point it out before the documents are submitted?

Michael Hanna: Correct like for example if you have a fax header that says received from Smith Medical Practice, February 10th, 2014 at 1:30 pm, I would make some mark like a circle or asterisk or something like that - and then maybe write the word “received” or “RCVD” so that it would let a reviewer know this is when the supplier got it.

Angela: Right. Okay thank you.

Michael Hanna: I would be really hesitant focusing only on fax headers because we see a lot of problems with them.
Michael Hanna: It doesn’t sound like it would be acceptable. You may want to reach out to that physician with the DME Medical Directors’ “Dear Physician” letter.

Jessica: Yes we’ve already done that. So I don’t know. I was just wanting to verify that in the medical records - it’s not saying anything about having a face to face encounter. They qualify based on their clinical, but it doesn’t say anything about a wheelchair in the clinicals.

Michael Hanna: It doesn’t sound like, from what you’re telling me, that the face to face would be valid if there’s no indication where they discussed - in this example - mobility needs that would follow LCD guidelines or even ACA guidelines.

Jessica: Okay thank you.

Michael Hanna: Yes ma’am.

Operator: Thank you. We will now take the next question. Heather please go ahead your line is now open. We will skip this question and proceed with the next question. Please go ahead.

Female: There we go. Yes can you hear me?

Michael Hanna: Yes ma’am.

Female: Yes. Is the signature date required on the DWO in addition to the order date?

Michael Hanna: The day that the physician signs it? You mean by signature date? Yes.

Female: Yes. And that’s in addition to the date at the top of the order on the prescription?

Michael Hanna: Is it like a prescription pad like a 3 by 5 script pad?

Female: Yes. So the physician writes the order and typically adds the date on the right side. They’ll have a date that they captured that they wrote the order, but then is it still required at the bottom where the signature is - is it required to also have a date?

Michael Hanna: Just a moment please. Ma’am?

Female: Yes.

Michael Hanna: I was speaking to other staff members here in the room. If we can easily tell the order came from a physician, for example, their 3 by 5 script pad, we will not need an additional signature date by their signature.

Female: Okay.

Michael Hanna: If the reviewer is unable to ascertain if the orders came from a physician we would definitely need the physician’s signature and signature date. For example, it was an order created from your system which might be Brightree or CPR Plus or something like that; it would definitely have to have their signature and date.

Female: Okay.
Michael Hanna: It has to be easily, easily recognizable that it came from the physician, and the prescription pad is one of the easiest ways to tell this is their document because suppliers don’t use prescription pads.

Female: Right. We’re just getting a significant number of denials for that that’s why we were asking.

Michael Hanna: Did you have a follow up?

Female: Where would we find reference to that for clarification?

Michael Hanna: I can’t provide you a written reference in this case; I know that’s how our Medical Review staff are looking at it. The CERT contractor may not look at it the same way, but I know how our Medical Review staff are looking at it.

Female: Okay all right, thank you.

Michael Hanna: Yes ma’am.

Operator: Thank you. We will now take the next question.

Female: Yes. My first question is kind of following up with the lady that was talking about the item description. We’ve been getting manual wheelchair audits for I don’t know how many months now, and about a month and a half ago I started getting denials for the item description.

Our item description has the size 18 inch, 16 inch, and et cetera lightweight wheelchair which is what what K3s are listed in the system on CGS’s LCD for that item, and they’re telling me that it’s not descriptive enough. Is there another place I can go to get a verified name for these items because we’ve tried to put our item description as what it is listed as in the LCD? I’ve been denied on hospital beds and on these wheelchairs, and I’m just trying to figure out if there’s another resource for us to figure out what they want in the prepay review.

Michael Hanna: Based on my experience and the documentation I’ve seen, “the words 18 inch lightweight manual wheelchair” should suffice as being descriptive enough. Now is that the only reason the claim is denied?

Female: Yes for three of them. On one, they said that my signature date didn’t match the delivery date and it most certainly did. So that kind of leads into another question for me is there a way - I mean do we ever have access to - I mean it’s really frustrating when you send in this prepay stuff and you make a cover sheet, you note everything and you go through all this and you fax it in to them.

They deny, you have to turn around and send it to redetermination and it just ties up the money longer when initially everything that we sent to redetermination was sent to the initial review and yet redetermination saw that we did in fact have everything. I mean we’ve had a claim from 2013 that just now paid that from the get go we’ve had everything.

Is there like a complaint line or is there a way for - I mean I don’t know if any providers are having this issue but we have several claims that in all honesty we take it as far as we can, and in the second or third stage we end up winning and we haven’t changed anything from the initial review.

Michael Hanna: You always have appeal rights on those claims. So the definite process is to use your appeal rights and go to redeterminations. If you see a specific trend of the same issue over and over, I guess I would suggest you contact the Provider Contact Center and escalate it to be connected with one of the manager’s voicemails.

Female: Okay.

Michael Hanna: The Tier 1 and Tier 2 representatives will not look at documentation. That’s not their job - their job is not to decide if a document is valid or not. If it’s a one-off situation, you should definitely follow appeals process.

But, if you see a trend of the same thing 10, 12, 15 claims in a month for the same issue, then I guess my suggestion would be to contact Provider Contact Center and see if they can escalate it as such.

Female: Okay. I think that was it. Actually no I have one more question, can I ask one more question? (inaudible). The face to face… I’ve heard several people ask about that so as it stands in the individual LCDs the face to face requirements are to be upheld, but if there is none the 6-month thing is kind of limbo right now; is that correct?

Michael Hanna: That’s correct. If there’s specific timeframe guidelines listed in the LCD you should definitely follow those. If not the DME MACs are not yet enforcing the ACA face to face requirement. We’re waiting on instructions from CMS. As soon as we get instruction we will let you guys know via a ListServ announcement.

Female: All right thank you.

Michael Hanna: Yes ma’am.

Operator: Thank you. We will now take the next question.

Female: Hello?

Michael Hanna: Yes ma’am.

Female: Yes sir, we’re trying to figure out we have been getting denied for - I’ve had a couple of patients that go into the doctor and the doctor said they need the wheelchair and literally I get everything I need detail written to order notes, everything first thing in the morning, and I’m able to deliver it the same afternoon. Why am I getting denied for delivering it the same day I get it written?

Michael Hanna: I don’t know… I need to see specific claim documentation. If you get the orders in the morning and you date stamp them, are you adding a time like “9:43 am” and then on your delivery ticket which shows a “3:15 pm” or something so we’d be able to differentiate between documents? That might help you out.

Female: Yes there’s never a time of delivery or anything printed on the tickets or anything just the date that it comes printed on it.
Michael Hanna: That would be the only suggestion I have - make sure you note the time when you receive the detailed written order.

Female: Okay so next to when - when I date stamp it - because I had that just went in there desperately they needed it doctor told me - anything he needed to get that wheelchair to her, and so I was able to get it got me everything by like 10:30 and we got it out to her about 2 and so I actually - when I stamp it put what time that I received everything?

Michael Hanna: Yes we just need to be able to tell that you definitely have the orders in your possession before you deliver the equipment.

Female: Okay so that's the only way because that's what I mean they're not coming from a hospice. I mean they literally just went into the doctor and needed it right then and there. You know what I mean, because I've had a couple that they'll just call me that she needs it now you now they just saw her and everything.

Michael Hanna: Yes, add the time to the date stamp.

Female: Just time to the date stamp. And then so when my guys go to deliver the chair and everything so they need to notate a time that she signed it and everything off so have the customer notate the time?

Michael Hanna: Or the delivery tech can.

Female: Or the delivery tech can, okay.

Michael Hanna: Sure.

Female: I'm sorry one more question. They asked me a question regarding the - when the doctors have - we have a couple old school doctors still that it's handwritten notes. We really can't read them, but that's all the notes that they have in the charts. What do we do on those situations because I have a couple of old doctors that that's all they do - everything is handwritten?

Michael Hanna: If they're not legible to you they likely will not be legible to any reviewer that looks at them. I know some suppliers have reached out to the physician's office manager and have them transcribe the notes, type them out, and then get an attestation statement from the physician that states "these typed notes are what I wrote" or something similar.

Female: Okay. Okay thank you.

Michael Hanna: Yes ma'am.

Operator: Thank you. We'll take the next question.

Female: Hi can you hear us?

Michael Hanna: Yes we can. Go ahead please.

Male: Okay. Got a couple of questions here. One is... if we have a PA that signs the face to face and we get a co-signature from the MD the PA writes the prescription. Does the MD have to cosign the prescription?

Michael Hanna: No, that's not necessary.

Male: Okay. Next question. Why would we be held accountable for having the face to face with the RAC and the CERT, but right now no one else is holding us accountable?

If we get a CERT request and we do not have the face to face then we're going to get denied for the claim but right now Medicare is not saying that we need that.

Michael Hanna: They are different contractors with specific contracts than CMS so I wouldn't be able to answer why they would do something. Just remember if they deny it for a face to face you have appeal rights and the D M E MACs are not yet enforcing the face to face aspect of ACA 6407.

Male: Okay just one more question. I'm a little concerned the last lady you were telling her she needs to put a time stamp, we'll probably receive 50% of our orders and deliver the same day, and there's nothing that says that we need to have a time on there other than a date. Is that splitting hairs or what?

Michael Hanna: If the reviewer is unable to verify that you have the detailed written order prior to delivery versus when the beneficiary signed the delivery ticket, they could deny the claim because that’s one of the requirements - that you must have the detailed written orders in your possession prior to delivery.

If it’s the same day, and that’s highly possible that it can happen, you should help yourself by adding the time just to show when you received those orders if you plan on delivery of the equipment the same day.

Male: Well I’m sure that happens to a lot of providers, why isn’t that something that Medicare is filling out for us to help us out a little bit rather than us having to have all these denials and go to redetermination and ALJs. They’re not doing anything to make this simple, and it’s frustrating on our end. We spend more time working denials redeterminations than we do processing claims.

Michael Hanna: If that’s what your issue is, it only takes two seconds to write the time on the two documents versus much more time spent submitting documents to Redeterminations.

Male: But why not require it?

Michael Hanna: CMS has not made that clarification to the DME MACs.

Male: Wow. That’s all I got, no answers. Thank you.

Operator: Thank you. We'll take our next question.

Michael Hanna: Go ahead please.

Operator: Thank you. We'll move forward to the next question. Please go ahead.

Female: Yes. Can you hear me?
Ask the Contractor Teleconferences (ACT)

Michael Hanna: Yes ma’am.

Tiffany: Okay. My question - my name is (Tiffany) and I have a question concerning the face to faces. I’m questioning exactly what is needed in those face to face notes concerning like a replacement PAP unit whether the patient’s unit is no longer functioning or if the patient has lost it or not currently using it and going back PAP therapy.

Michael Hanna: In this question we’re actually blending a lot of things because you’re blending LCD requirements along with ACA requirements. The LCD for PAPs details what must take place or what we expect to see in notes regarding replacement devices so you should follow those guidelines?

Tiffany: Okay. That’s it.

Operator: Thank you. We’ll take our next question.

Carol: Hi this is Carol. I know we’ve been going through these dates repeatedly, but I wanted to clarify something because it’s happened to me. We put on our own generated form for the doctor a start date, an order date, a physician’s signature date and I wanted to know if it’s okay if those dates are all different and the face to face for the chart notes is also different. Is that going to be okay that all these dates are different?

Michael Hanna: That should be fine as long as the face to face date is the very first one in the process.

Carol: Yes. Okay thank you.

Michael Hanna: Yes ma’am.

Operator: Thank you. We’ll take our next question.

Jennifer: Yes this is Jennifer, and I have a question.

Michael Hanna: Go ahead, Jennifer.

Jennifer: Okay. I know that had talked about this before but if you would please just reiterate. Let’s just say that we have a detailed written order that we’ve attained but it has an error on it and we know that - like for instance let’s say the NPI was missing - can we obtain a new detailed written order and a bill a new date of service or do we have to pass the patient off to a new provider?

Michael Hanna: Have you billed the Medicare program?

Jennifer: We have.

Michael Hanna: If you’ve already billed the Medicare program you’ll have to pick up your equipment and another provider will have to supply it.

Jennifer: Okay. Thank you.

Michael Hanna: My reference for that is a News item dated August 28, 2014.

Jennifer: Okay. Thank you so much.

Operator: Thank you. We’ll take our next question. Please go ahead your line is now open. Thank you we’ll move forward to our next question. Please go ahead. Heather you may go ahead your line is now open. We will take our next question. Please go ahead. We will take the next question, please go ahead your line is now open.

Female: Hi Michael. Our question is assuming we have a valid face to face and written order prior to delivery for six months, then at the end of that six months the physician wishes to extend length of need, will we require a new face to face or is the initial face to face acceptable?

Michael Hanna: The initial face to face should be acceptable because you’re just basically revising those orders to change the length of need.

Female: Correct. So if the patient has our equipment for 10 months and there are three orders and they’re extending for 10 months, is that acceptable so we’ll just write on the initial face to face?

Michael Hanna: Yes that should be fine because the DME MACs are not enforcing the face to face rule. I don’t know how the CERT contractor would look at that but from a DME MAC standpoint that is definitely acceptable.

Female: Okay so then it’s not considered a change in the prescription if the length of need changes to extend is that use?

Michael Hanna: Well you’d need new orders because the length of need has changed, so you’d go back and get new orders from the physician every time the length of need changes.

Female: Okay but the actual face to face is good from the first - the initial.

Michael Hanna: Yes. Really the only thing doing is simply just extending the timeframe that beneficiary needs the equipment. The initial face to face indicated the need for the orders because we’re talking about the same condition and the same equipment.

Female: Correct, yes. Okay that’s actually all we needed to know. Thank you so much Michael.

Michael Hanna: Thank you.

Operator: Thank you. We’ll take our next question.

Anne: Hi my name is Anne. I do have a question.

Michael Hanna: Go ahead please.

Anne: This is my question… Say we’re replacing a patient owned equipment and prior to us replacing the equipment billing it to Medicare we were supplying the patient, for example, CPAP supplies and I’ll just give dates so you can understand my question.

Say we have a valid detailed written order for the supplies say 9 of 2013. Okay, and at that time we also have a safety checklist signed for the supplies because he had his CPAP and we had all that. Now we’re going to be supplying him a new CPAP, the EO601 which is a WOPD item. Is that detailed written order say that we have 9 of 2013...
which is valid for 99 months, is that going to be sufficient and our safety checklist for the new equipment that he's going to be getting or do we have to get all that new, the new safety checklist for the current equipment and then an updated detailed written order for the supplies that he's getting with the WOPD items?

Michael Hanna: That is correct. You'd need to have new orders – maybe two orders – one for the PAP device prior to delivery and one for the PAP accessories prior to billing the claim to Medicare.

Anne: Even though we were billing Medicare for just the supplies and our written order was valid for a lifetime, and now the only thing we're doing is just replacing his patient-owned equipment.

Michael Hanna: But you've got new equipment so you'd need new orders for the supplies as well.

Anne: So what we have on file that was acceptable to pay for the supplies or patient-owned equipment that's no longer valid?

Michael Hanna: That's correct. You'd get new orders moving forward for the new capped rental for the PAP and the supplies that go with that new piece of equipment.

Anne: And so, therefore, also that would include a new safety checklist for the piece that he just received?

Michael Hanna: Yes. New delivery ticket and everything like that.

Anne: Okay because the customer service rep they'll give you different answers, and I've gotten so many different answers saying we got your detailed written order as sufficient for all the supplies because it's not like he changed insurances.

Is the only thing difference was is he owned his CPAP, but what you're saying when we supply him with that new CPAP the day of that new order for the CPAP going forward from that, say 01-01-2015, we're also going to have to get a new order for the supplies too?

Michael Hanna: That's correct because those supplies are now being utilized with a different piece of equipment.

Anne: Oh okay I got it. Okay. And let me ask you one more question. I understand that now okay. What happens say if you have a date of service that was under audit and something happened you missed it, you missed the whole thing.

Maybe you didn't get the paperwork or whatever and you were getting paid and say the fourth month got denied out it's not medically necessary because they turned off the CMN, right? Can you review that even if you have all your paperwork, can you still get that on a payable status?

Michael Hanna: You'd have to send the documentation to the redeterminations department because if you didn't respond to the prepay review audit that claim would deny as a medical necessity denial, a CO-50.
An addendum should provide additional explanation or extrapolate on the information in the initial face to face document; it shouldn’t be a whole new set of facts and figures, if you will. So I can’t really tell you what needs to be there as it will depend on the individual medical record of what the physician neglected to write.

Rhonda: Well I guess that what we’re getting told is they won’t say so we’re going to prescribe (bla bla bla) piece of equipment you know they just go ahead and tell you know what’s going on with the patient. So if they just put in the addendum that you know addendum this piece of equipment is being prescribed.

Michael Hanna: I guess I’m not following you. I’m sorry. So the only thing they put in the addendum is I’m prescribing this equipment?

Rhonda: Yes because you know they went through and you know in the notes they said we saw this patient (bla bla bla) day, this is what’s going on with him you know and that’s the end.

So when we get it, they don’t put in there you know so we are going to you know we are prescribing this piece of equipment for this patient you know because of what’s going on with the patient. Can they just do an addendum that says we are prescribing (bla bla bla) piece of equipment - you know because they neglected to put it in in the first place.

Michael Hanna: I don’t think they need to...

Rhonda: Don’t they have to document what piece of equipment that they are prescribing in the notes?

Michael Hanna: ACA 6407 says that the face to face examination must document that the beneficiary was evaluated and they are treated for condition that supports the need for the item or items of DME ordered.

Rhonda: So it doesn’t have to be in the notes?

Michael Hanna: It has to be in the face to face.

Rhonda: But what if they...

Michael Hanna: They don’t have to say “thus, I am prescribing a semi-electric hospital bed.”

Rhonda: Okay so they don’t have to say that we’re prescribing (bla bla bla) as long as it’s on the order.

Michael Hanna: Correct because that’s what the order entails.

Rhonda: Okay thank you.

Operator: Thank you. We’ll take our next question.

Barbara: Yes this is Barbara, can you hear me?

Michael Hanna: Yes Barbara go ahead please.

Barbara: Yes. On the nebulizer order face to face do you have to have the medicine listed and the frequency of the medicine on that order?

Michael Hanna: For the nebulizer equipment?

Barbara: Yes.

Michael Hanna: No it’s not necessary. Keep in mind that the inhalation medication used by the beneficiary is the catalyst for the equipment to be allowed. You must have documentation somewhere that the beneficiary is using an inhalation medication for one of the conditions in that LCD that meets guidelines.

So you don’t have to have, for example, “Albuterol,” on your nebulizer detailed written order prior to delivery, but there must be medical records or something indicating that the beneficiary is using an inhalation medication that is covered by Medicare.

Barbara: Okay. And one more question. Like if somebody is getting a CPAP 5-year rule and they need another one and it’s been 5 years, and they go to the doctor and he makes notation you know that he’s still using it and still need it. Do they have to have that face to face order just like they would have on a new one?

Michael Hanna: I’m sorry, the face to face order?

Barbara: Yes on the CPAP. Do they have to have all the elements like they would have if this had been an initial you know on a RA.?

Michael Hanna: The detail written order must meet all Medicare requirements even though it’s replacement equipment.

Barbara: Okay. All right thank you.

Michael Hanna: Yes ma’am.

Operator: Thank you. We’ll take our next question.

Female: Hi yes, sir. Can you hear me?

Michael Hanna: Just barely. Can you speak up a little bit please?

Female: Okay. So if we ((inaudible)) face to faces that are at least within 6 months, they see the doctor 5 months ago for COPD he can write an order today for a wheelchair?

Michael Hanna: Yes.

Female: So it does not have to state in those progress notes that he needs a wheelchair?

Michael Hanna: It must discuss the condition that supports the need for the items ordered.

Female: Okay thank you.

Operator: Thank you. We’ll take our next question.

Female: Yes I have a question regarding an order a detailed written order and it comes from a rehab hospital. It’s filled out, the physician signs it, dates it, and it has the NPI and everything. On it the “wheelchair rental 13-month” is checked, it does not say standard or lightweight. It was denied.
We went back to the physician and got an attestation of the order for this patient and he attested that the order should reflect that I ordered the following wheelchair and accessories, and he put “standard wheelchair with dimensions” and it was denied. What’s my next step?

Michael Hanna: So you didn’t have valid orders when you delivered the equipment as there was no narrative description of the item.

Female: Well it had “wheelchair” then “13 months.” So and if he goes back - so in other words it doesn’t matter that he says that’s what he meant a “standard wheelchair.”

Michael Hanna: Correct, because you didn’t have the detail description on the front end.

Female: If we had a verbal order that said that, would that work or not?

Michael Hanna: A verbal order is not a valid detailed written order prior to delivery that meets ACA 6407 guidelines.

Female: Okay all right. That answers my question, thank you.

Michael Hanna: Yes, ma’am.

Operator: Thank you. We’ll take our next question.

Female: Hi I had a question about a detail written order for diabetic supplies. Can you hear me?

Michael Hanna: Yes I can, go ahead please.

Female: Okay thank you. Does the signature date on the form is that sufficient for the start date or must for diabetic supplies or does it have to be a separate start date? Can we not use the signature date as the start?

Michael Hanna: When you say “the date on the form,” what form do you mean? The detailed written order?

Female: Yes. So a detailed written order for diabetic supplies and the doctor has signed and date it, but there’s no area on the form that says start date or order date.

Michael Hanna: First, who’s that document coming from - you or the physician?

Female: From us.

Michael Hanna: There has to be a start date on there then.

Female: So there has to be a start date on all detailed written orders. So if we have a form and we send it over blank the doctor fills out all the questions we have on it there’s got to be an area on the form that says start date?

Michael Hanna: That’s correct.

Female: The signature date is not sufficient.

Michael Hanna: That’s correct - or an order date because Chapter 3 of the Supplier Manual says “start date if different form order date.” If there’s no order date and the only thing you have is a signature date, that’s not valid. We need the physician’s signature and signature date and an order date.

Female: Okay. So that’s not when you’re dealing with a dispensing order because like with us we don’t provide anything until we have a detailed written order on file. So we don’t use any verbals or dispensing orders so it’s just obtain our detailed written order and then provide the product, but you’re saying we have to have a date on the order.

Michael Hanna: How do get orders if you don’t have any type of dispensing order?

Female: Well all of the information needed is on our detailed written order. The diagnosis, testing frequency, approved products, all that stuff is on the same form, and we obtain that completed before we provide any products. And that form doesn’t have a date on it other than the date the doctor signs it, the signature date.

Michael Hanna: How do you know to provide that order to the doctor?

Female: Well when a new customer walks in we send the blank one to the doctor, and he fills out all the information and then we use it for the length of need, the number of refills the doctor approves and then we get a new one on file. We send a new blank one over when we’ve exhausted all the refills on the previous one.

Michael Hanna: You’re still going to need an order date or start date on there.

Female: Okay. I was looking at the LCD and the guidance we’ve been given on the glucose monitors supplies the article, and you had mentioned just a minute ago that the start date was only required if the start date was different than the signature date, that’s what I’m reading.

Michael Hanna: If it’s different from the order date.

Female: Okay. So I must have something then that is out of date because what I’ve got says Number 9 start date of order only required if the start date is different than the signature date. What is it referring to?

Michael Hanna: I’m referring to the Supplier Manual, Chapter 3 and in the LCD where it state if the start date if different from the order date.

Female: Okay and I’m seeing that too and then some of the other guidance I’ve seen that it said that if different and the signature date. The start date was only required if different then the signature date, but you’re maintaining that the start date is required regardless.

Michael Hanna: An order date is required regardless.

Female: Okay. All right. I did have another question about the same thing this detailed written order for diabetic
supplies. The word strips, and lancets, and batteries and test solution and all of that is on there. Is the word strips not sufficient as a description?

Michael Hanna: Hold on just a second please. As long as all those items are listed on the orders - strips, lancets, test twice a day. If it just says “diabetic supplies including strips, lancet, solution” that’s not valid. If they’re listed separately with the correct frequency of testing associated with each one that should be acceptable.

Female: Okay so the frequency of testing is listed, and it actually dictates an amount of supplies that are approved and then the supplies are individually listed as strips, lancets, and the doctor can approve or mark out whichever one they want. But you’re saying they have to be together?

So one item or one number on the detailed form says frequency of use, one time a day equals 100 strips to 200 et cetera. And then the next separate block shows these are the items that are approved you can select or mark the ones that are not approved. Strips was listed, lancets, and everything else individually.

Michael Hanna: Okay, that’s fine as long as the physician follows through and marks out what he or she is not ordering. If they leave everything blank or circle the whole section, it will be considered a blank order by CGS Medical Review staff.

Female: Okay. And I’m sorry to take up so much time, but to clarify my previous question about the start date, what I was referring to was listed under the medical review resources, and there’s two webinars from last year that have a slide that show the bullet points of everything that’s required on the written order for testing supplies, specifically about diabetic supplies is what I’m referring to. And that last bullet point on all these materials say start date if different than the signature day, but it doesn’t list order date as a necessary item except for the (EO607) the meter itself, but I’m referring to the testing supplies.

Michael Hanna: I stand by what I said before because detailed written orders are detailed written orders.

Female: Okay so the slides that we’re looking at - the information under Medical Review Resources again it says for testing supplies and it doesn’t have order date listed as one of the bullet items.

Michael Hanna: I will follow up with Medical Review and we will take a look at those documents.

Female: Okay thank you.

Operator: Thank you. We’ll take our next question.

Female: Yes. I’m still confused when you say that the face to face is not being enforced because every audit requests medical documentation to support medical necessity.

I have four K4 denials sitting on my desk because the documentation even though they had a face to face before the order for the condition that didn’t cane or walker and they didn’t specifically go into the mobility like you would a power chair.

So are you telling me that my grounds for appeal then would be that the face to face is not supposed to be enforced?

Michael Hanna: Well the face to face not being enforced is overall for ACA 6407 however we are doing a comprehensive medical review on the K0004s, and we are going to be requesting medical records that support the need of the equipment.

Female: Every audit requests medical records every single one.

Michael Hanna: For the K0004, yes, but not for the K0001, K0002, or K0003. On February 18, 2014, we put out a couple of articles about the two different types of reviews. One was a documentation compliance review that included the K0001, K0002, or K0003 and the other was a comprehensive medical review for the K0004, and it will include the need for the medical records to show why the K0004 is necessary versus another type of manual wheelchair because there are specific LCD guidelines for that particular piece of equipment.

Female: Okay so we have to keep sending the patient back to the doctor until they write it all in the face to face?

Michael Hanna: The face to face should indicate the need for the K0004 on the front end.

Female: The what?

Michael Hanna: The need for the K0004 should come from the medical records prior to the orders for the K0004.

Female: That’s what I’m saying. So if the doctor is not putting that in the initial face to face, the patient must keep going back to the doctor until the doctor gets it right?

Michael Hanna: Well then you’re just trying to make it work around a denial.

Female: No I’m not talking about a denied claim; I’m talking about an initial claim now.

Michael Hanna: Okay. So if the medical records don’t support the need for the equipment and you can see how LCD guidelines aren’t met, you can request a physician to have another visit with the beneficiary and show the physician what we’re looking for based on LCD guidelines.

Female: So really what you’re saying is some face to faces are not being enforced and some are?

Michael Hanna: From an overall aspect of ACA 6407 the DME MACs are not enforcing the face to face portion of it. That being said, there’s a portion in Chapter 3 of Supplier Manual that says medical records are required if they are requested by an auditing entity. In this case we are specifically requesting the medical records that show the need for the K0004.
Female: I don’t think I’ve ever gotten an audit that didn’t request medical records, not a prepay audit. I get them on beds, I get them on chairs, and I get them on cushions. I mean - I don’t think I’ve ever gotten one that didn’t request medical records.

Michael Hanna: The ADS letters for the K0001, K0002, K0003, or the E0607 will not request medical records; they will request a detailed written order prior to delivery and the delivery ticket. The ADS letters for the K0004 and the wheelchair cushions will request medical records because those are comprehensive medical review prepay audits.

Female: Okay. Where do you get a list of those things that they are enforcing?

Michael Hanna: They’re on our ListServs and our quarterly status reports that we publish on our website at http://www.cgsmedicare.com

Female: So there’s no really list anywhere that says...

(Crosstalk)

Michael Hanna: We let suppliers know via a ListServ approximately eight weeks prior to any new audit that we’re going to begin. The CGS Medical Review staff will send out a ListServ letting people know which codes we’re going to be reviewing via a pre-pay review initiative. We’ll let them know what type of documentation they’re going to request. If you go to our News item for February 18, 2014, you’ll see a couple of those ListServ listed there.

Female: Okay thank you.

Michael Hanna: Yes ma’am. John, that’s going to have to be the last question. We’ve allotted all of our time for this particular call.

Operator: Okay thank you sir.

Michael Hanna: If anyone else has any additional questions or concerns please reach out to our Provider Contact Center during normal operating hours. I would like to reiterate that a transcript of this call will be available on our website just as soon as we can get that published. You will be made aware via ListServ announcement. Thank you so much for your time this afternoon, we really appreciate it. I’ll turn the call back to you, John.

Operator: Thank you. Ladies and gentlemen that does conclude our conference call for today. We thank you for your participation you may now disconnect your lines and have a great day.

Post-call clarification: DME suppliers should be aware that even though the DME MACs are not yet enforcing every aspect of Section 6407 of the Affordable Care Act, they should follow the law as it was enacted on July 1, 2013. Thus, suppliers should have a valid detailed order prior to delivery and the face-to-face examination in their possession prior to providing any equipment to a Medicare beneficiary if the HCPCS code in question is listed in Section 6407 of the ACA.

END