CGS

Introduction
Good afternoon and welcome to CGS Administrators, LLC (CGS) DME MAC Jurisdiction C General “Ask the Contractor Teleconference.” These ACT calls are hosted by the DME Provider Outreach and Education team for Jurisdiction C. Also on the call this afternoon, are Jurisdiction C subject matter experts from various operational departments. For this particular ACT call you may ask questions related to any aspect of DMEPOS Medicare. Before we begin taking your questions, I would like to provide you with a few recent notifications and updates.

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

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

Once CMS starts mailing out new Medicare cards, people new to Medicare will only be assigned an MBI. We urge you to look at your practice management systems and business processes and determine what changes you need to make to use the new Medicare Beneficiary Identifier (MBI). You’ll need to make those changes and test them by April 2018, before new Medicare cards are mailed out. If you use vendors to bill Medicare, you should contact them to find out about their MBI practice management system changes.

We recently mailed letters to all Medicare Fee-For-Service providers. Your letter will tell you about the new Medicare card project and how to use myCGS so you will be able look up MBIs for your Medicare beneficiaries who don’t have their new cards when they come for care. Carefully read your letter and the fact sheet to learn more about how to get ready to use the MBIs by April 2018.

To help you prepare for using the MBI, the CGS POE team will conduct monthly webinars through the end of 2018. The first one is scheduled for October 17. You can register to attend by going to the Webinars page located under Education on the Jurisdiction C Medicare website.

We suggest you visit the CMS website for more information at http://www.cms.gov/newcard.

Information on Natural Disasters
CGS has added an informational section titled “2017 Disaster Declarations” to the Jurisdiction C homepage for our suppliers affected by Hurricanes Harvey, Irma, and Maria. Look on the right side of the CGS homepage and click the box titled “2017 Disaster Declarations.” Available information includes details on billing replacement items for those DMEPOS items lost or destroyed as a result of the hurricanes, blanket waivers, Appeals Administrative relief and much more.

Condition of Payment Prior Authorization
Condition of Payment Prior Authorization expanded nationally on July 17, 2017. Suppliers billing Group 3 power wheelchairs K0856 and K0861 must get prior authorization for the wheelchair base before submitting a claim. We have a Web page full of resources dedicated to the power mobility devices prior authorization program. Please go to the Jurisdiction C homepage at http://www.cgsmedicare.com, and then click the JC DME tab. Click on Medical Review in the left-hand column of navigational words and phrases. Then, click on “Condition of Payment Prior Authorization Program K0856 and K0861.”

MLN Matter MM9968
MLN Matters MM9968 – CGS began Cures Act mass adjustments on July 3, 2017, and we adjusted thousands of claims per day through late September when the vast majority of the claims processed through the system. We are researching a few minor issues and will adjust those claims as research completes.

Please review your Medicare Remittance Advices for Cures Act adjusted claims and look for remark code N689. The message associated with N689 is “Alert: This reversal is due to a retroactive rate change.” If you have received your adjustments and feel the KE modifier should be added to certain mobility claims, please request a Written Reopening. We have a KE Modifier Reopenings Request form as well as a template titled “Cures Act – Addition of the KE Modifier” on the Forms page of our website. Be sure to fax the completed template to Written Reopenings at 1.615.782.4649 for Jurisdiction C or 1.615.660.5978 for Jurisdiction B. If you prefer, you may submit a spreadsheet if there are multiple claims involved, but be sure to include the following information:

- Provider Transaction Account number (PTAN)
- Health Identification Claim number (HICN)
- Name of the Beneficiary.
- Date of Service
- Claim Control Number
- HCPCS code.
- Must clearly state to add the KE modifier.
Please do not include more than 250 claims per Reopening request whether it’s an Excel spreadsheet or the complete template. We will add links for the templates when the transcript of this call is uploaded to our website.

Foresee Survey

I also wanted to mention the CMS Foresee survey window that pops up when you navigate to the CGS website. Please take a few moments to complete the Foresee survey. Your input is vital in making changes to our website that will positively affect all suppliers. Use the survey to tell us what you like about the website, what you don’t like about it and what you would like to see for future enhancements. If you leave contact information as part of your response, we will follow up with you. Complete the Foresee survey the next time you visit our website to help us determine the changes you want to see on our website. It only takes a few minutes of your time and your contribution is very important to us.

As I prepare to queue your questions, please note that we will only take questions over the telephone as this call is being recorded for transcription purposes. To raise your hand, simply click on the icon of the hand. Then, I will announce you and unmute your individual line so that you can ask a question. Also remember that no specific claim information or Medicare beneficiary’s private health information should be verbalized. I will now give you just a moment to prepare your questions...

Questions

Amy: We are seeing a lot of hospitals reporting VBG results versus ABG results. Do you know of anything in the works to add qualifications based on VBG into the LCD or anything on your end where there may be some guidance issues on VBG instead of ABG?

CGS: I have not heard anything from the medical directors regarding that. There is a process in Chapter 9 of our Supplier Manual about LCD reconsideration. That would be a question you could ask the Medical Directors to add that to the LCD.

Amy: I have one more question. We were able to receive audit exclusion for our CPAP but I have heard that is no longer going to occur. Our audit exclusion just ended. We were initially told when we received it that if we were able to maintain a high pay rate for the first quarter that we should be able to be excluded again. We heard through some other contacts that CMS would no longer be offering those exclusions. Is that the case?

CGS: CMS has authorized a new program for the DME MACs called Targeted Probe and Educate. There is a new page that has been added on our website under “Medical Review” that talks about that particular auditing strategy. In essence, it is going to be looking more at supplier-specific rather than widespread probes. I do invite you to go to our website and click on “Medical Review” from the left-hand navigation column on the Jurisdiction C website and it’s the very bottom sub-menu item within “Medical Review.”

Amy: We were part of the AESOP program is how we were able to obtain that initial exclusion. It sounds very similar to the AESOP program that we went through. We were told they would not be offering exclusions through the new program.

CGS: It is a new program for Jurisdiction C and we are still putting everything together, we received authorization just a few weeks ago. We have been alerting suppliers that on October 2, we were making some changes on the ADR aspect. You mentioned that you were with AESOP. Do you mind telling me what supplier you were with?

Note added after the call: The supplier’s name has been removed from the final transcript for privacy purposes.

Maria: I am looking for some clarification. We are looking for sub-contractors for placing our equipment directly in patient homes. I have heard from them that they have gotten denials around same or similar when the patient has a same or similar item to our equipment that has been paid off for the 13-month rental but is still within the 5-year period. I wanted to get some clarification on that because I am not quite sure why that is happening.

CGS: The lifetime for DMEPOS equipment is 5 years unless stated specifically in the LCD or related policy article that it is not. Items such as hospital beds, walkers, manual wheelchairs, CPAP devices and that type of thing are all 5-year reasonable useful lifetime. Is that the type of equipment you were talking about?

Maria: Yes, it is under the patient lift category. Specific HCPCS codes are E0135 and E0136.

CGS: They have a 5-year reasonable useful lifetime per the LCD, so that is most likely why you are getting the same or similar denials.

If the beneficiary’s condition has changed so that the previous lift no longer meets their medical needs, you can definitely file an appeal through Redeterminations and present them with the medical records explaining what has changed with their condition so they need something else rather than what is on file.

It is probably hitting the system edits and that is why you are getting denials.

Maria: It seems to me like the equipment is viewed as a prescription so it is kind of a refill 5-year rule. Am I understanding that correctly?

CGS: No. it is classified as DMEPOS equipment. It is based on that initial claim submitted to DME MAC. For example, if someone submitted a claim on October 1, 2012, then they would not be eligible for new equipment until October 1, 2017, unless there has been a change in the condition. It is a calendar five years for something along those lines.

Maria: Is there any way to call out the change in condition that exists? I am seeing these notes too and they most often reflect that there has been a change in condition or that a patient has a progressive condition.

CGS: You are welcome to use the PWK segment on the electronic claim form but the claim approvers are not clinicians so they won’t be looking at it from that aspect. Redeterminations is your best avenue. That would be where you would send the medical records to give them an opportunity to review those medical records and new orders and how that patient has declined over time. Is that the case?

Maria: Yes, that equipment is only appropriate for people who are very debilitated or very ill. That does clarify that part of it for me. The only other thing that I have heard is that some of the
sub-contractors have been asked to pick up the equipment that is within the 5-year rule.

CGS: It is not their equipment to pick up. The patient owns it.

Maria: Yeah, that’s what I thought.

CGS: My reference for all of this is Chapter 5 (Section 9) of the Jurisdiction C Supplier Manual.

Maria: Thank you. I do have another question. It is regarding the ACA 6407 about the face-to-face requirement. I am getting some pushback from sales people who are saying that the face-to-face requirement if the patient is on Home Health has naturally been met because you must have a face-to-face for Home Health. In essence, what they are saying is that it would be understood there is a face-to-face so our partners do not necessarily need to get those face-to-face notes and have them on file.

CGS: There was nothing in MLN Matters Article MM8304 that is based off the ACA 6407 that talks about Home Health in any specific face-to-face encounter. The MLN stated there must be a face-to-face within six months prior to ordering any of the items on that list.

Maria: So you are confirming that even if a patient has PT notes or an oasis, there must be a separate and individual face-to-face?

CGS: There must be a face-to-face encounter with a physician that talks about the condition that would require that DMEPOS equipment. In Medicare’s eyes, physical therapists are not physicians and they cannot order that equipment.

Maria: The signatures on the orders are coming from the clinicians for Medicare. It is just that I am getting some pushback around do we need the face-to-face notes? Does it have to be a separate face-to-face from the one that was done for Home Health?

CGS: If they visited the physician regarding adding on Home Health as an aspect and it talks about the condition and the problems the beneficiary is having, a separate one just to meet ACA guidelines would not be necessary because the information is all contained in the medical records from the prescribing physician.

Maria: OK. That helps me out a lot.

Selena: I am calling about orders for artificial limbs. Can that be written by a physician’s assistant as long as it is overseen by an MD doctor?

CGS: Medicare considers a physician’s assistant as a physician. They can write orders. There might be some nuance to that based on the individual state because some PAs have different limitations based upon the state in which they practice. For our purposes for Medicare, if that PA is overseeing the patient and treating them for that issue, we would accept orders from them. Keep in mind that you guys complete the detailed written order and have the PA sign and date the order. Be sure you have that in your possession before you file a claim for that limb.

Selena: Yes, we have been doing that. Are you saying that the PA can also sign the detailed order?

CGS: Yes. The reference for that is Chapter 3 in the Jurisdiction C Supplier Manual. There is also a new policy article that DME MAC Medicare Directors published earlier this spring. That policy article is A55426 and there a link for it at the bottom of every LCD and its related policy article. It is titled “Standard Documentation Requirements for All Claims Submitted to DME MACs.”

Selena: Very good. Thank you.

Diane: I have a couple of questions. First, I want to get some clarification on a question asked previously. It was in regard to CPAP supplies. I think the question was something about a 3-month supply if you billed the full face mask, you could only get 2 cushions for the 3-month supply because the mask already comes with a cushion.

CGS: Correct.

Diane: So, you can’t bill for the third cushion because it is included in the mask but only for 2 additional cushions.

CGS: Correct.

Diane: So it would be the same way with a nasal mask as well?

CGS: Yes, because every mask comes with the cushions already, at least with the major manufacturers.

Diane: You can’t include that cushion because they are packaged together?

CGS: Yes, I believe there is an edit in place in the system and that is what is stopping it.

Diane: Second question. If a patient is living in a long term nursing facility, can we bill Medicare for their DME equipment…like a vent?

CGS: Possibly but it will depend on how that facility is classified. If it is classified as an assisted living facility, you would be able to bill the DME MAC but you would need to verify their classification. Some assisted living facilities have different arms where maybe one section might be a complete skilled facility where another portion might be assisted living. You would need to verify their classification.

Diane: OK. One last question. You had said if the patient gets the supplies in our office, then we are to use our address as the delivery address and not the patient’s home address.

CGS: Correct. Most supplier systems automatically input the beneficiary’s address on the delivery ticket, but if they pick the supplies up at your business, you would have your address on there.

Diane: As the delivery address?

CGS: Correct. If we have both, you are good – we will not deny if a delivery ticket has your business address as well as the beneficiary’s home address.

Michael: My question kind of piggybacks on a previous one and is a three-part question. They are all related to CPAP supplies.

We have someone who works for us that used work for one of our competitors. It is about the billing of the cushion with the CPAP mask. If a person gets a CPAP mask, we bill for the mask, the cushion and the head gear. I said ‘no’, we don’t bill for the cushion because it is part of the mask. He said why do you bill for the head gear separate? I didn’t know so I am asking you. That is part one of the question.

Second part of the question…if someone just wants filters or just CPAP tubing, is it acceptable to say we can’t just give that
because we don't make any money off just a hose. Obviously, I know the answer but I need it in writing.

Last part of question...do we tell a person 'no, we can't ship it to you but we don't make enough to cover the shipping charges?' You will have to come to the office to pick it up.

These questions are coming from new employees. I want to make sure we are on the right track so we do the right thing.

**CGS:** Regarding the first part of the question, that is information that has been brought to my attention from the supplier community. If they bill cushions and a mask on same day of service, it will be denied. You can always file a claim and see if it works or not.

**Michael:** If we bill for the mask and the cushion, the MAC doesn't know if we actually gave them the mask that comes with the cushion and a second cushion or not. I'm trying to make sure we do it the way it is expected to be done.

**CGS:** I don't know if there is an edit in place in the system or not. That is where it is going to hit.

**Michael:** The second part of my question is if the patient only wants part of the supplies?

**CGS:** All supplies are considered non-consumable. That means you replace them when the functionality is no longer there. For these items, ask the questions of the beneficiary. Are there cracks in the tubing? Is it dirty, etc.?

The third part was “can you tell beneficiaries you won’t ship it to them?” That would be a business decision on your end on how to handle it. If the beneficiary contacts Medicare, Medicare will side with them. It kind of goes back to the second part of the question that CPAP supplies are considered non-consumable. They should only be replaced when their current usefulness has ended. Just keep that in mind.

**John:** One of the products we provide is external fusion pumps to infuse the new hemoglobin that was added to the LCD. As of this morning, we have 4 different sets of instructions on how to bill that drug. How do we bill units and such?

Sometimes we get paid in vials; sometimes in milliliters; sometimes in grams. Information in the LCD says bill for 200 milliliters. Your counterpart over at Meridian said to bill for 100 milliliters. I recently launched an appeal and they said bill in milliliters. I don’t know what we are doing there.

**CGS:** It should be billed per 100 milligrams. The LCD was updated about a month ago to clarify it. It does still get the J7799 code.

**John:** That is new information to me and I appreciate it.

**Stephanie:** I have a quick question about the Cures Act adjustment. Is there anywhere that fee schedules are published?

**CGS:** The fees from last January?

**Stephanie:** Yes, from the adjustment.

**CGS:** Go to the fee schedule section of our website. Go to the January 2016 fee schedule. That is the one to use.

**Janet:** We ran into an issue with an oxygen referral from a physician where the patient has been abandoned by the company where they were getting their oxygen. It closed and apparently they did not send out notices to their beneficiaries. In this situation, the publication in Medicare states that you do have to have a copy of the notice that was sent to the beneficiary or a letter from the old supplier. If we get a signed statement from the customer that they did not receive any kind of notice from that supplier, would that suffice?

**CGS:** Yes, that should suffice. When you file that first claim, make sure you append the RA Modifier as well as have something in that NTE segment narrative that the beneficiary was abandoned and that the company closed.

For everyone else on the phone, the article Janet referenced is in the News Archive section of our website. It was published on December 19, 2013. That is the Oxygen Abandonment article.

**Kathy:** My question is two-part. The first part is about oxygen concentrator rentals and portable oxygen concentrator rentals. We have been hit hard over the last two years with the reimbursement reductions and the cuts. We are looking for ways to save money on our end and still provide quality service for our patients. We have many patients that are requesting a portable concentrator. We have to explain to them that Medicare will pay for one or the other is extremely difficult. How do these providers like Inogen advertise on television that Medicare will pay for a portable concentrator? They may pay but it is under what circumstances.

The beneficiaries think they can have their E1390 concentrator in the home and a portable concentrator outside the home.

**CGS:** Are you talking about the E1392 (portable)? (Yes.) There should be something in the policy article that talked about the E1392. I am looking for it.

**Kathy:** Even if they would, the reimbursement for the portable is so low that it would not be cost effective as a provider and the beneficiary is tied to that machine for 5 years. We all know they only last about a year.

**CGS:** Also keep in mind that you are going to provide what the physician orders. If the physician orders tanks (E0431), and if the beneficiary wants something else, they should go back to the physician and tell them it is not meeting their needs.

**Kathy:** Right and they do. The physicians want their patients to be happy and they write the orders specifically for a home oxygen concentrator and for a portable one.

**CGS:** I don’t see it. It might have been taken out of the LCD. I am not finding it right now.

**Kathy:** If we bill for both, one will be denied. Right?

**CGS:** According to the article, you should be able to bill for both the E1390 and E1392.

There is nothing that says they can’t be billed together. The portable one (E1392) is considered a ‘convenience’ item and that may be why it is declined.

**Kathy:** Private insurance turns them down more so than Medicare. I don’t think we have ever billed Medicare.

How do the Inogen’s of the world get away with that? They ship a whole unit to the patient when they ship out the portable concentrator. How do we as a small company compete with that?

**CGS:** Regardless of the size of the suppliers, everyone has to follow the Medicare guidelines.

**Kathy:** OK. Next question. We provide our customers will ultra-fill systems so they are able to fill their own. We would like an
opinion letter from Medicare on whether or not we are able to fill those tanks for the patient prior to their discharge from the hospital and provide that tank to them to go home. Right now, the pharmacy boards are preventing us from doing so. They say Medicare doesn’t allow it and you have to buy refills from a supplier which costs a fortune.

If it goes home with the patient, we have to pick it up and get it refilled and then the patient can fill their own tank once they are at home. Does that make sense?

Note added after the call: The supplier never followed up with an email concerning the question above.

Kathy: An opinion from Medicare would go a long way with state pharmacy boards to help us with that.

Alan: We recently had a situation where we received an oxygen referral from a physician and we ran a same or similar and showed nothing on file for E1390 or E0431. We delivered the equipment and got everything set up and we filed a claim. The claim was denied as same or similar.

We ran another same or similar request and at that point, a CMN showed up from 2014 from another company. It showed no payments made and no data found. The patient couldn’t remember about where he got the oxygen. We called the other company to request some documentation and we have had no response.

How do you get a new, initial CMN order?

CGS: Send that same or similar denial to Redeterminations and explain what you just told me. That you checked and found nothing but now there is an old CMN from 2014 but no paperwork with it. Explain it is a new setup and rental and you have a new face-to-face encounter as well as a new CMN. Ask them to load it in the system and get it processed.

Alan: Do I need to use an RA Modifier?

CGS: No, you have already filed a claim and it is not really an RA. You billed it correctly. Since you already filed a claim, you need to follow the appeals process on this one.

Alan: OK. Thanks.

Amy: My question is about overpayments. I need to appeal an overpayment that was due to a SMRC audit. When I appeal the overpayment, do I need to send the entire file if they denied it just because the delivery ticket was missing? Can I appeal it with just the delivery ticket with the SMRC Audit denied or the whole thing from the initial submission?

CGS: You should do your Redetermination based on the denial. You should just send in the delivery ticket.

I would request a couple of things from you: when you complete that Redetermination request form, make sure you check the box indicating that it is an overpayment.

Amy: There is an option for SMRC and I did see the letter that showed the specific denial reason from the SRMC.

CGS: We also have a separate fax line for overpayment appeals. Go to our Supplier Manual, Chapter 13 for Appeals and it will give you the appropriate fax number for Overpayment Redeterminations.

Amy: I did see that fax number on the overpayment letter is different than the Redetermination fax number. I called Customer Service and talked to a couple of reps and they said send it to the regular fax number. They didn’t know what this number is that I am reading in the overpayment letter.

CGS: Make sure you send it to the overpayment fax number for Jurisdiction C is 1.615.664.5907.

Amy: That is even different than what is listed on the letter. It is very confusing.

CGS: Let me know if you have any issues with that.

Maria: I was wondering about competitive bidding. I know the next round has been suspended. Does that mean that we will continue until we hear different…just continue with the round that started last July?

CGS: That would be my assumption, but please remember that CGS is not the CBIC contractor. Have you checked with your CBIC rep or checked their website – http://www.dmecompetitivebid.com?

Maria: Yes, and there is no other information on there either. Just wondering if you had any other updates?

CGS: I haven’t heard from CBIC since our last council meeting. He indicated there was no word from CMS at that time. That is outside our realm of knowledge.

Rachelle: I have a question on E0118. I am getting calls from the customer telling me that Medicare says it is a covered item but I sent in a claim and it was rejected.

CGS: Let me go to the Canes and crutches LCD and see what is out there. It is classified as a crutch substitute. It is not listed in the coverage criteria.

There is a crutch substitute article on the website dated February 18, 2010.

Clarification added: The article states: Section 1862 of the Social Security Act requires that an item or service must be “reasonable and necessary” before payment may be made. A reasonable and necessary determination is largely based on a review of the published clinical literature that is relevant to the item under consideration. When there is no published policy for an item, contractors may still make individual determinations when reviewing claims.

Medical literature supporting coverage of these items can be submitted to the medical director.

Rachelle: The CMS services is telling the members that it is a covered item.

CGS: Refer them to that article on the News Archive section of our website.

Note added after the call: The URL for the article noted above is https://cgsmedicare.com/jc/pubs/news/2010/0210/cope11657.html.

Alexis: I have a question regarding the Overpayment Recovery Request Form. We have some claims that were rebilled for the denial of GA Modifier. The claims were paid. We are faxing in the Recovery Request forms. What is the best way to get our PR denial without having to submit an appeal?

CGS: You will have to go to Redeterminations on that because of the GA modifier.
Alexis: But we billed our claim correctly with the GA Modifier and once it came in, we are giving it back to you. Is there any way to get those looked at so that we can get our original PR denial? I don’t feel we should have to do the appeal when we are doing it correctly.

CGS: Just the presence of a GA on a claim does not guarantee a PR denial. Appeals would be the avenue for them to review that and to change that from a CO to a PR denial.

Alexis: Is there anything being put in place to have the system updated for those so that any claims with GA get reviewed?

CGS: Not to my knowledge.

Janet: Is there a physician letter that discusses qualifications for O2 and other therapeutics? What we run into frequently is having it diagnosed as hypoxemia alone and no discussion of other therapeutics or bronchodilators or anything like that. They get upset when we tell them that it doesn’t meet criteria. Is there a physician letter that we can send to clinicians when we run into this?

CGS: You might take a look at the article called Background on Medicare’s Oxygen Coverage. That was based on a video that Dr. Hoover had. It is under “Oxygen Resources” on the website, there is not a specific physician letter about what else has been tried or ruled out.

Note added after the call. The URL for this article is https://www.cgsmedicare.com/jc/mr/pdf/oxygen_coverage.pdf.

CGS: There is an article called, “Physicians are you Ordering Oxygen for your Patients?” that briefly discusses documentation that shows alternative treatments have been made. That is on the Physicians Corner section.

Note added after the call. The URL for this article is https://www.cgsmedicare.com/jc/pubs/news/2015/0715/cope29792.html.

Rachelle: I was wondering about the educational piece. I know there is some new information about the diabetic insulin pumps. In general, I was wondering where I could go or is there a 24-hour pod or webcast to see the update?

CGS: Are you talking about infusion or continuous glucose monitors?

Rachelle: Glucose monitors.

CGS: They have been added to the LCD and there are also a number of articles on our website in News – a number for this calendar year. You could do a search for ‘continuous glucose monitors” or “CGM.” We have also scheduled a Glucose Monitors and Diabetic Testing Supplies webinar for November 8.

Rachelle: My concern is that I am not always able to sit at the webinar because I am with customers. Is there a recording of it so I could go back to it at anytime?

CGS: There is a Medicare Minute on CGM by Dr. Hoover. That is also available in our Physician’s Corner under Medical Review.

Becky: Where do I find the articles you referred to? Specifically, the one about oxygen abandonment.

CGS: Go to our website under News and Publications (left side Jurisdiction C home page).

One of the choices is “News Archives.” Click on 2013 and it will take you to it.

Lisa: I have a question about the chronic stable state. We are trying to qualify patients for oxygen.

We understood that if they are on steroids, they do not qualify for oxygen. Is that correct?

CGS: It will depend on the medical record. It’s possible that steroid use would alleviate that chronic stable state. I would suggest that if you can at all, using CGS Connect™ and getting that educational feedback from the clinicians here at CGS. They can take a look at those medical records and verify if they feel like Medicare requirements have been met.

Lisa: I am at a loss. If they come for oxygen, they need it that day. If they are on steroids, there is a chance you are not going to get paid for it. You might tell the doctor they are SATing at 81% but we can’t deliver oxygen. It puts us in a bad light with clinicians.

CGS: Keep in mind that there are other criteria besides the SAT percentage that must be met. It also depends on what those steroids are for. If the steroids are for some acute condition associated with COPD or something like that, then it is possible in a review by clinicians, they may not feel it is necessary. If the steroids are for something else, then it shouldn’t play a role. It needs to be based on that medical record. Unfortunately, I can’t give you an all-inclusive “yes” or “no” answer because it will be based on that individual beneficiary and their medical condition.

Lisa: So, they will look at it and make a decision on whether we provide it or not?

CGS: Correct. If they are demanding it that day, then you won’t be able to use CGS Connect™. If it is not something that is absolutely pressing, you can let them know you have an avenue to get some educational feedback from clinicians at CGS after looking at the medical records.

Note added after the call: Here is the URL for the CGS Connect™ Web page: https://www.cgsmedicare.com/jc/mr/cgsconnect.html.

Lisa: OK, I have one more question. We have a lot of our patients that are qualified through Home Health. Does that documentation need to be included in the doctor’s records or that will be brought on the office visit that they were qualified through Home Health? I’m not clear on how that should be.

CGS: When you say ‘qualified through Home Health’, do you mean the SAT test?

Lisa: Yes.

CGS: You still need the medical record from the encounter with the physician to meet the LCD guidelines. The Home Health nurse could conduct the qualifying test during the visit. However, the beneficiary must still have that medical record.

Lisa: Does it need to be included with the doctor’s record or just in addition to the records?

CGS: It could be in addition to, but both of those events need to take place within 30 days of the initial date on the CMN.

Lisa: Thank you.
Heather: This has to do with supplying oxygen to a patient that has OSA. I know you have to meet the coverage criteria in the oxygen LCD as well as the one for OSA for CPAP device. I am running into issues where I am getting denials stating that the oxygen is not covered because there is no lung disease listed in the medical records. I am confused because in the oxygen policy, it clearly states that the patient either has lung disease or hypoxia-related symptoms. Can you tell me exactly why >illegible< at night isn’t related to the hypoxia-related symptoms? Does that make sense?

CGS: Yes. Go to the NCD, the National Coverage Determination, CMS Internet Only Manual (IOM) 100-3, Chapter 1, Section 240.2. The indications for hypoxia-related symptoms are not OSA. OSA is a mechanical condition and not a lung condition. A condition that might be approved with oxygen therapy could be congestive heart failure, as an example.

The information regarding the beneficiary in the LCD outlines the steps taken to get a qualifying SAT result. Then we have to go back to the rest of the oxygen coverage criteria that talks about the lung condition and what else has been tried and ruled out. Does that make sense?

Heather: It does. I still can’t quite grasp it. I focused on the hypoxia portion of the oxygen LCD. So you are going to have some type of lung disease that affects your pulmonary system. Right?

CGS: Exactly. Using congestive heart failure as an example, how has that condition progressed so far that the beneficiary now requires oxygen. Have they been on blood thinners, diuretics, etc.? Paint a picture of where they are now and that oxygen is the absolute necessary step after that.

Heather: OK. I think I understand. Thanks.

Nicky: I have quite a few patients that have been telling me they are getting calls from mail order houses about CPAP. They wonder how they got their information. (The callers) know they are on CPAP, that they have Medicare. When the patient asks the company how they got the information, they state that they work with Medicare. Is that true and how is it possible?

CGS: I can tell you that CS is not giving out any information. It is not coming from DME MACs. It sounds like a marketing statement to try and get their business.

Nicky: Since they knew the patient was Medicare and on CPAP, I wondered how they would know that information. I didn’t think it was true because it is a HIPAA violation but thought I would ask.

CGS: It is not coming from the DME MAC because we hold the beneficiaries’ information very, very close and do not provide it to anyone unless parameters are met. An example is when you call the Provider Contact Center and must provide information in order to ask the claim-specific question.

Sarah: I am calling about the Serial Claims Initiative. I have an audit for a December 2015 date of service that was denied. We never could get it in a favorable status. I finally had to take that date off and bill at a later date. It was for a CPAP. I got a favorable on that. We gave the patient supplies for a later date of service. When I called, they said my CME would never be in a payable status because we never got that initial date of service paid.

CGS: If the device is in a denied status, all supplies will be denied as well. Is the device in a denied status?

Sarah: I got a later date of service for the device paid.

CGS: Is that before you provided the supply claim?

Sarah: Yes.

CGS: We are running some reports on the Serial Claims Initiative but you are welcome to contact Reopenings to see if they can adjust that claim for you as well. Without seeing that history, I would be hesitant to say how that should be taken care of because I don’t really know.

Sarah: We gave the patient a CPAP in January and never got paid, but we got March favorable. Will all my dates after that be paid or will I have to fight every date of service?

CGS: If March was favorable then any dates of service after that should be favorable because they have to get that device in a payable status in order to pay the claim. If January or February were denied for the same reason that March initially did, then that could be part of the Serial Claims Initiative and they could go back and pay those as well.

Sarah: When I called Customer Service, they said if my initial date of service was never found favorable, my DME would never be in a payable status. I thought that was the whole point of the Serial Claims Initiative.

CGS: Not hearing that phone conversation, I would disagree with it because maybe you billed the K1 monthly service and did not have all the documentation you needed. You billed KH and medical review denied it. It might have been dependent on how you asked that question as well.

Diane: I have one question on EO471. The continued coverage on the first three months of therapy, it says the patient has to see the doctor no sooner than 61 days after the initial use of the device. Would that be for a 30-day compliance or a 60-day compliance?

CGS: I don’t understand your question. I am sorry.

Diane: On EO471, for them to get re-evaluated after the first 3 months, it says they can’t see the doctor until after 61 days after they receive the device. To show that they are compliant, will that be for a 60-day compliance or for 30 days like a CPAP? Because you have to wait until 61 to see the doctor.

CGS: I am still trying to wrap my mind around what you are asking. Are you asking if there is a 30-day compliance like there is for a CPAP or 60 days?

Diane: Exactly. Because you can’t see the doctor any sooner than 61 days.

CGS: The LCD doesn’t outline it as such. The LCD states that for continued coverage care for EO471 beyond the first three months of therapy, no sooner than 61 days, there must be documentation in the medical record on the progress of the beneficiary and usage of the device at that time. Failure of the beneficiary to be consistent on using the device for an average of 4 hours in a 24-hour period by the time of the re-evaluation would represent non-compliant utilization.

Diane: Right, so would that be for a 60-day span or 30?

CGS: It is not based specifically on 30 or 60. Are they using an average of 4 hours per day overall? Maybe it is 61 if they get in to see the doctor on day 61. Maybe it is 81 if they don’t get in until day 81.
Diane: So whatever length of time it is between when they got it and when they get the doctor, it has to be compliant within that time?

CGS: Correct.

CGS: This concludes this Jurisdiction C General ACT call. Thank you for your participation this afternoon. Once we get the transcript uploaded to our website, we will alert via a ListServ announcement.