Provider Outreach & Education
Date: February 17, 2022

Moderator: Belinda Yandell
Time: 2:00 p.m. EST

Introduction

Good afternoon. My name is Belinda Yandell with Provider Outreach and Education. Welcome to CGS Administrators DME MAC Jurisdiction C General "Ask-the-Contractor Teleconference."

The ACT call is hosted once a quarter by the DME MAC Provider Outreach and Education team, and on the call this afternoon we are joined by subject matter experts from CGS operational departments.

For this ACT call, you are welcome to ask general questions on any Medicare-related topic. Please keep in mind that questions regarding a specific claim or beneficiary cannot be discussed here due to possible PHI issues, and those questions should be directed to our customer support department.

Please note that there is not a presentation for this call. This call is being recorded and a complete transcript will be posted to our website within 30 business days. Because we are recording, all questions must be asked verbally. As a reminder, you may not record this teleconference for any reason. We will be posting a transcript for your future reference. Hyperlinks for more information on our topics today will be provided in the transcript.

If you would like to participate in the question-and-answer segment, you must call in on your telephone and be sure to enter your audio PIN. Your audio PIN is located in the GoToWebinar navigation pane, right below your access code. Note that each audio PIN is unique and may not be shared with other attendees. In order for us to unmute your line, your PIN must be entered.

Please note that while the Provider Outreach & Education team has put forth every effort to ensure that the information presented today is up to date and accurate, it is your responsibility as a DMEPOS supplier to stay abreast and compliant with any changes within the Medicare program.

Before opening the call to your questions, let's go over the latest updates and reminders.

COVID-19 Public Health Emergency (PHE)

The ongoing COVID-19 Public Health Emergency (PHE) determination was renewed on January 16, 2022, by the Secretary of Health and Human Services. All current waivers and flexibilities remain in effect until further notice and we have no instructions from CMS on what will happen after the PHE ends. Just be sure to include the "COVID-19" narrative on your claim if you are using the CR modifier for any of the COVID-19 waiver or clinical non-enforcement reasons.

Complete information is available in our comprehensive COVID-19 Resources page (https://www.cgsmedicare.com/jc/covid-19.html) located on the https://www.cgsmedicare.com web pages, by clicking on COVID-19 under the left-hand navigation menu.

New Customer Service Options When Calling

Your feedback is vital to how we upgrade and improve our services. Most recently, we've updated our Customer Support call menu in response to your requests and suggestions. In addition to the existing options of eligibility, claim information, and prior authorization, we have added 3 new options: myCGS, general questions with a national provider identifier (NPI), and other inquiries. You can find all the information you need on the Calling Customer Support Guide (https://cgsmedicare.com/pdf/dme/jc_cti_user_guide.pdf). You will find this resource on the CGS website, under the Customer Support tab of the left-hand navigation menu.

CGS added the "myCGS" option as a direct result of survey feedback, as suppliers requested a faster way for callers to access myCGS-specific customer support agents. We hope you enjoy this new feature, and as always, please complete surveys whenever possible to share your feedback.

Redetermination Requests Reminder

We want to remind you about an element of the appeals process regarding billing agencies. Redetermination requests must be submitted by someone who is considered a party to the appeal.

Suppliers who retain a billing agency to handle their appeals need to submit a properly executed appointment of representative. Suppliers can use the Form CMS-1696 Appointment of Representative (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1696.pdf) or submit a statement containing all of the required elements. You will find this form on the Appeals tab of the CGS website left-hand navigation menu.

Chapter 13 of the Supplier Manual (https://www.cgsmedicare.com/jc/pubs/pdf/chpt13.pdf) has more information about parties to an appeal and the appointment of representative.

Prior Authorization

CMS has added several new HCPCS codes to the Required Prior Authorization list.

In the Power Mobility Devices or PMDs category, 6 additional codes were selected for required prior authorization to begin nationwide on April 13, 2022. Those codes are K0800, K0801, K0802, K0806, K0807, and K0808.

In the Orthoses category, 5 additional HCPCS codes were also added to the Required Prior Authorization list: L0648, L0650, L1832, L1833, and L1851.

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Implementation of this requirement will be completed in 3 phases. Phase 1 begins April 13, 2022, in New York, Illinois, Florida, and California. Phase 2 begins July 12, 2022, in Maryland, Pennsylvania, New Jersey Michigan, Ohio, Kentucky, Texas, North Carolina, Georgia, Missouri, Arizona, and Washington. Phase 3 begins in October 2022 in all remaining states and territories not included in Phase 1 or Phase 2.

CMS has also published the updated Prior Authorization information and Required List (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items) on the CMS website.

We will be publishing additional prior authorization resources to the website prior to implementation.

Required Face-to-Face Encounter and Written Order Prior to Delivery List

As anticipated for some time, we now have an update to the Required Face-to-Face (F2F) Encounter and Written Order Prior to Delivery (WOPD) list. Some items (such as PMDs) have statutorily imposed requirements. For items that do not have statutory requirements, a F2F encounter and written order is required only if the item is selected from the master list and placed on the required F2F encounter and WOPD. Items selected for the list will be published in the federal register with no less than a 60-day notice period.

Effective April 13, 2022, there are seven non-PMD items that require a F2F encounter and WOPD: 6 orthoses and 1 osteogenesis stimulator. Forty-six PMDs are on the list as dictated by statute. Therefore, as of April 13, 2022, a total of 53 items requires both a F2F encounter and WOPD.

Six of the orthoses added to the required F2F encounter and WOPD requirements also fall under the prior authorization program discussed previously: L0648 Lumbar Sacral Orthosis, L0650 Lumbar Sacral Orthosis, L1832 Knee Orthosis, L1833 Knee Orthosis, and the L1851 Knee Orthosis.

Two additional HCPCS now requiring F2F Encounters and WOPD requirements that are NOT part of prior authorization—which, as we discussed above, are being implemented in phases—are the E0748 Osteogenesis Stimulator and the L3960 Shoulder-Elbow-Wrist-Hand Orthosis. These 2 items must meet the F2F and WOPD requirements as of April 13, 2022.

More information and a complete list of items on the Required F2F encounter and WOPD list is found on the CMS website MLN Matters SE20007 (https://www.cms.gov/files/document/se20007.pdf). We will be adding additional F2F and WOPD resources to our website prior to implementation.

A Reminder on Medical Record Documentation

For Medicare to cover any DMEPOS item, the patient's medical record must include enough documentation to justify the need for the type and quantity of items ordered, plus the frequency of use (or replacement if applicable).

The medical record should include the patient's diagnosis, condition duration, clinical course (worsening or improving), prognosis, nature and extent of functional limits, other therapeutic interventions and results, and any experience with related items.

The medical record may include records from hospitals, nursing facilities, home health agencies, and other health care professionals. CGS offers the documentation requirements 3-part series twice a month to ensure suppliers are aware of these requirements.

You will also find more information in the Medicare Program Integrity Manual, Chapter 5, section 5.9 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033).

Sequestration Fee Update

The sequestration has been suspended until March 31, 2022; however, the 1% payment adjustment will occur from April 1 through June 30 of this year. The additional 2% payment adjustment will begin July 1, 2022.

Accreditation Edits

We wanted everyone to be aware of the accreditation edits CMS has put into place. Starting January 3, if you aren't properly accredited, you will receive notification on your remittance advice (RA) indicating the ANSI adjustment reason code CO-185 which states, "The rendering provider is not eligible to perform the service billed." Also, the reason/remark codes are N790-provider/supplier not accredited for product/service and N369 reads, "Alert: Although this claim has been processed, it is deficient according to state legislation/regulation."

Be sure to contact an approved organization to get accredited. If you believe this message is incorrect, review your enrollment to ensure your accreditation information is up to date. Contact the National Supplier Clearinghouse for help changing your enrollment record. If your record is correct, ask your approved organization to check their records.

More information on the accreditation edits can be found on the DMEPOS Accreditation Fact Sheet (https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/dmepos_basics_factsheet_icn905710.pdf) available at CMS.gov.

Medical Review

CGS has recently added functionality to myCGS to assist suppliers with medical review audits and tracking of targeted probe and educate (TPE) cases. These functionalities now include the ability to directly submit your additional documentation request (ADR) responses to TPE reviews. You can also now view each ADR letter that was mailed to you as part of the TPE probe along with the letters showing notification and results. Finally, myCGS also allows you to view the summary from the post-probe educational call.

myCGS is the fasted and easiest way to respond to the different aspects of TPE reviews, and we hope that you will take advantage of these new capabilities.

myCGS Updates

CGS continues to improve our web portal, myCGS. In addition to a new layout making our User Manual even easier to use, we've made some important changes to the registration and recertification process. myCGS 7.2 has

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the new ability for Designated Approvers (DAs) to register and self-recertify for myCGS without involvement from an Authorized Official. Instead of using an Authorized Official, DAs need to enter the check number and dollar amount of a recent check sent to their company by CGS DME MAC Jurisdiction B or C.

For details about the registration and recertification process, refer to the myCGS Registration and Account Management Guide (https://www.cgsmedicare.com/jc/mycgs/pdf/mycgs_registrationguide.pdf).

Education Updates

CGS continues working to improve our educational resources for suppliers. In addition to adding new webinars to our robust schedule, we are now offering our popular 3-part series on Documentation Requirements twice a month. Additionally, we've begun scheduling one set of webinars in the morning, and the other in the afternoon. Our hope is that these additional options will make it more convenient than ever to attend when your schedule permits.

Our Encore Events are recordings of our most popular webinars. You can download these at your convenience when you can't attend a regularly scheduled webinar. It's also handy if you attended the webinar and would now like to share it with other staff.

We are also excited to introduce two new education formats:

The first is our "To the Point" recordings (https://www.cgsmedicare.com/jc/education/point/index.html). As the name implies, these are brief segments of 10 minutes or less with key learning takeaways on specific Medicare subjects. Our first recording is "Consolidated Billing," which explains how it relates to residents in a skilled nursing facility, capped rental DME items, and the home health prospective payment system (PPS). It also looks at inpatient stays and hospice as it applies to DMEPOS items. "To the Point" recordings will rotate every few months, and also offers resources for further education available. "To the Point" can be found under the Education tab on the left-hand navigation panel of https://www.cgsmedicare.com.

The second educational innovation is the new pilot program "Listen & Learn," a pre-recorded webinar that gives listeners the opportunity to submit written questions. Participants will receive responses via email shortly after the session, usually within a few business days. The first of these "Listen & Learn" events is on Knee Orthoses, scheduled for presentation twice on February 14 at 12 pm EST and 4 pm EST. External Breast Prostheses will follow on February 21 in the same time slots. Please see our Events Calendar (https://www.cgsmedicare.com/medicare_dynamic/wrkshp/DME_COE/dme_coe_c/jc_Report.aspx) on https://www.cgsmedicare.com to register.

If you'd like a more detailed look at a topic like Consolidated Billing, we continue to offer our Online Education Courses (https://www.cgsmedicare.com/jc/education/online_education.html). These courses average about 30 minutes and cover both general topics such as upgrades and advance beneficiary notices (ABNs), as well as specific policies such as ostomy supplies and ventilators. The online education courses include a 10-part series on "Welcome to Medicare," that takes you step-by-step through the Medicare process. These are great training tools for new staff as well as opportunities for veteran suppliers to update their knowledge or learn about a new policy. Best of all, these online education courses are available whenever you find it most convenient; you can even pause the course and come back later. It's another way we strive to provide information that will help your company thrive.

The CGS Medicare App℠ (https://www.cgsmedicare.com/pdf/cgs_medicare_app_guide.pdf) is newly refreshed with new features and functionality. DME Menu offers access to Local Coverage Determinations (LCDs)/Policy Articles, results from the CGS Wizard, DMEPOS Fee Schedules, the MBI Name to Number Converter, Dear Physician Letters, Drug/Pharmacy Fees, Contact Information, Tools & Calculators, and much more. It is available in App Store and Google Play Store; just search "CGS Medicare."

You will also find many other resources in the Tools and Calculators section of our website. For example, you can utilize the Claim Denial Resolution Tool (https://www.cgsmedicare.com/medicare_dynamic/jc/claim_denial_resolution_tool/search.aspx) which is a great next-step resource for suppliers who have received a claim denial. Simply enter the ANSI denial code from your RA, and the tool will provide the myCGS message for the claim denied and list possible causes and resolutions without your having to call Customer Support.

We also have a new Knee Orthoses Documentation Checklist along with all of our helpful checklists available on the Forms, Checklists, and Guides (https://www.cgsmedicare.com/jc/forms/index.html) section of the website.

Last but certainly not least, I'd like to remind you about CGS Connect™ (https://www.cgsmedicare.com/jc/mr/cgsconnect.html). This is a voluntary program that offers 16 policies in which you can request a review by one of our Medical Review clinicians who will evaluate your pre-claim documentation. In all cases, you will be provided with documented, detailed feedback regarding your submission. I want to stress that this is NOT a prior authorization of your claim or a claim review for denial or approval, but rather an educational service for valuable feedback.

We strongly urge you to take advantage of this beneficial program. You will find more information on the https://www.cgsmedicare.com website.

Questions & Answers

This concludes our updates and we will take just a moment to prepare for accepting your questions. You need to be sure you have input your PIN to make sure we can unmute your line. Raise your hand to ask your question, and we will call on you. Keep in mind that we want to give everyone a chance, so please ask one question at a time, and then rejoin the queue to ask a second question.

Question 1: Why are we seeing different allowed amounts for the same code? For example, we have seen three different allowed amounts for the same standard walker HCPCS within the same 2021 date range.

Answer: Fee schedule amounts for items where contracts were not awarded in Round 2021 of the Competitive Bidding Program (CBP) in competitive bidding areas (CBAs) and former CBAs are found in the "Former CBA Fee Schedule" files accessed from the CMS Fee Schedule page (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule). The files are

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located within the appropriate ZIP file for the latest quarterly update for your date of service.

Question 2: Are we allowed, as an exempted physician supplier, to provide orthoses within the 48-hour window prior to discharge from a skill nursing facility (SNF), and bill those directly to CGS? These beneficiaries reside in a competitive bid area.

Answer: There are a several parts to your question.

If the beneficiary resides in a competitive bid area, then that orthosis is a competitive bid item. If you are providing the service as part of your professional service, the date of service must be billed as the same date of service as your office visit.

If the date of service is not the same date as your office visit, the exception does not apply, because that exception is based on the orthosis being provided as part of your professional service in your office. And if it is not billed on the same date of service as your office visit, then the beneficiary would need to go to a contract supplier.

If these patients are receiving these orthoses immediately after surgery, this would be part of the surgery and considered incident to that billing. That item would need to be billed to the Part A of Medicare; it cannot be billed to DME.

Question 3: When an order is signed by either a physician assistant (PA) or nurse practitioner (np), do our medical chart notes have to be done by that exact same PA or NP who signed the script?

Answer: It doesn't have to be the same person unless it's something that has a specific requirement (such as WOPDs for PMDs) where you have to have a F2F encounter with a particular practitioner. The medical record is not limited to the treating practitioner's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc.

Question 4: Does the signer on the chart notes have to be Provider Enrollment, Chain, and Ownership System (PECOS) registered?

Answer: The ordering physician does, and whoever writes the order is the one that you should submit on the claim.

Question 5: Can a hospital case manager, who is also a registered nurse, document the criteria for a wheelchair?

Answer: We're looking for medical records from physicians and treating practitioners who would actually do the diagnosis, or the person that's actively treating them, instead of just a nurse.

Question 6: Do the LCDs for home oxygen have any updates on the revision according to the national coverage determination (NCD) changes?

Answer: We don't have any final LCD revision. Those are still in progress.

Question 7: I have two NPI numbers: one as a group for Medicaid, and another as an LLC for Medicare. Which do I put on claims when Medicare is secondary?

Answer: Do you have a number that's linked correctly to your provider transaction access number (PTAN), your National Supplier Clearinghouse number? That's the one that you would want to use to bill to the DME MACs. We cannot confirm any Medicaid claims here.

Question 8: Many of our physicians only provide one diagnosis for ostomy supplies; typically, it's only a Z code status. Is the diagnosis status code allowed to be the only one billed?

Answer: You would use the codes listed in the ostomy policy article (https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52487&ContrID=140).

Question 9: If I have a patient who has a F2F prior to a continuous positive airway pressure (CPAP), how specific do the symptoms need to be? If it doesn't say anything about snoring, daytime sleepiness, or gasping at night, but the doctor states that the patient has heart issues and would like to rule out obstructive sleep apnea (OSA), is that sufficient?

Answer: The treating practitioner's documentation needs to "paint a picture" of what signs and symptoms are leading him/her to suspect OSA and subsequently order a polysomnogram (PSG). Typically, this documents the signs and symptoms outlined in the Policy Specific Documentation section of the LCD-related Policy Article (A52467) (https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52467&ver=48); however, there may be other conditions such as heart failure and other cardiopulmonary conditions that also raise the level of suspicion for OSA. The supplier may find it helpful to also consult the A/B MAC for conditions under which a PSG or home sleep test (HST) are covered, L6593 (https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=36593&ver=31&keywordtype=starts&keyword=Polysom&bc=0).

Question 10: If we're a non-participating provider, what guidance can you give me regarding the appropriateness of charging a nominal delivery fee?

Answer: Generally, those fees are included in the fee schedule allowance. Look at Chapter 20 of the Medicare Claims Processing Manual (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf) for the rules that apply to making reimbursement for exceptional cases.

Question 11: In our nursing facilities, the doctor will write the order. However, all of the documentation is coming from the physical therapist or the nurses. Is that acceptable as far as documentation?

Answer: Medicare allows for a wide range of different medical documentation. It's best to give us the most information you can; nursing notes along with typical visit notes would help.

Question 12: In enteral nutrition, do all the items that are on our standard written order and the quantities prescribed have to be verbatim in our clinical notes?

Answer: The medical records should be consistent with your order. It doesn't have to be verbatim as long as there is documentation in the medical record to substantiate the quantity that's being dispensed. If the beneficiary is receiving enteral nutrition per day, then there should be documentation to substantiate that there was enteral nutrition, but the medical record doesn't have to list every single item, such as the catheters, the bags, etc.

Question 13: Are the LCD criteria for continuous glucose monitors still waived for diabetic patients during the PHE as long as the item as reasonable and necessary?

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Answer: Clinical indications for CGMs are still being non-enforced at this time.

Question 14: The L codes: L0648, L0650, L1832, L1833, and L1851, fall under the competitive bid program and are now requiring prior authorization. How can physician suppliers fulfill the requirement to be fit on the same date of service for competitive bid items, and also fulfill the prior authorization requirements before fitting, which could take, according to the website, up to 10 days?

Answer: MLN Fact Sheet DMEPOS Competitive Bidding Program: Physicians and Other Treating Practitioners, Physical Therapists, and Occupational Therapists (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Physicians_Other_Pract_Factsheet_ICN900926.pdf) states that on the claim billed to the DME MAC, the competitive bid item must have the same date of service as the professional service office visit, or physical therapy/occupational therapy service that's billed to the AB MAC. It is specific to an office visit.

Question 15: Have there been any updates or any further guidance regarding oxygen CMNs being discontinued?

Answer: We're still waiting for that consideration.

Question 16: A power rehab wheelchair F2F was done through a telehealth because of COVID. Is that valid?

Answer: As long as it's considered a valid telehealth, it would be considered part of that F2F; however, this is a prior authorization item, so you can submit all of your documentation and you'll find out if it is considered for coverage prior to providing the item.

Conclusion

If we have no further questions, we will conclude this call. I want to thank everyone who joined us today. We will have a transcript of this within 30 days and we'll send out an electronic mailing list notification as soon as it is available.

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