Jurisdiction B & C Ask-the-Contractor Teleconferences (ACT)

Provider Outreach & Education
Date: February 23, 2023

Moderator: Maurdi Wilson
Time: 1:00 p.m. EST

Introduction

Good afternoon and welcome to the CGS Administrators DME MAC Jurisdiction B & C Oxygen & CMN/DIF Elimination "Ask-the-Contractor Teleconference" (ACT). The DME MAC Provider Outreach and Education team hosts the ACT call once a quarter. My name is Maurdi Wilson. Also on the call this afternoon are subject matter experts from CGS operational departments.

For this ACT call you are welcome to ask questions specific to Oxygen and the CMS Elimination of Certificates of Medical Necessity (CMNs) & DME Information Forms (DIFs). We will also speak specifically to CMN and DIF Instructions for Oxygen CMS 484.3 and External Infusion Pump DIF form 10125. We want to keep our focus on these topics and request that you do not ask unrelated questions.

Please keep in mind that questions regarding a specific claim or beneficiary cannot be discussed due to possible Protected Health Information (PHI) issues, and those questions should be directed to our customer support department.

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 the transcript to the DME MACs websites for your future reference. Hyperlinks for more information on the topics discussed today will also be provided in the l transcript.

If you would like to participate in the question-and-answer segment, please call in on your telephone. You must enter your audio PIN number into your telephone keypad. Your audio PIN is located in the GoToWebinar control panel under the audio drop down right below your access code. Each audio PIN is unique and may not be shared with other attendees. In order for us to unmute your line, your PIN number must be entered.

The Provider Outreach & Education team has put forth every effort to ensure that the information presented today is accurate and up to date; however, it is your responsibility as a DMEPOS supplier to stay informed and compliant with Medicare program guidelines.

We do have a Mega Workshop in Louisville, KY on March 14th. Provider Outreach & Education will lead 13 sessions, including a question-and- answer segment. Registration is still open, so please come join us!

Our topic for today's ACT call is the. . .

Elimination of Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFs) Reminder

CMS has discontinued the use of CMNs and DIFs for dates of service on or after January 1, 2023, which also includes recertification and revised CMNs and DIFs.

The following forms should not be submitted for claims with dates of service on or after January 1, 2023:

CMNs

- CMS-484 – Oxygen
- CMS-846 – Pneumatic Compression Devices
- CMS-847 – Osteogenesis Stimulators
- CMS-848 – Transcutaneous Electrical Nerve Stimulators
- CMS-849 – Seat Lift Mechanisms
- CMS-844 – Section C Continuation Form

DIFs

- CMS-10125 – External Infusion Pumps
- CMS-10126 – Enteral and Parenteral Nutrition

For services on or after January 1, 2023, the Common Electronic Data Interchange (CEDI) will reject electronic claims submitted with a CMN or DIF. For CMS-1500 paper claim forms, the DME MACs will reject and return claims submitted with a CMN or DIF.

Suppliers must continue to submit CMN and DIF information for claims with dates of service before January 1, 2023, if it's required. For more information, reference MLN Matters Article SE22002 https://www.cms.gov/files/document/se22002-elimination-certificates-medical-necessity-durable-medical-equipment-information-forms.pdf.

Stay tuned for additional information and instructions for specific policies. CGS will share all updates on the https://www.cgsmedicare.com website and through our email list.

- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2022/11/cope3354b.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2022/11/cope3354b.html

Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFs) Elimination – Common Questions and Answers

- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2022/11/cope3354b.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2022/11/cope3299.html

In addition to that:

On January 10, 2023, CMS announced 3 new **N modifiers for Oxygen**. The 3 new modifiers for home oxygen use under the national coverage determination (NCD), the DME MAC Oxygen and Oxygen Equipment Local Coverage Determination (LCD), and LCD-related Policy Article (PA) were created to indicate the appropriate treatment regimen and presence of supporting documentation for each Medicare patient oxygen therapy group.

- LCD Group I: modifier N1 (NCD Section B)
- LCD Group II: modifier N2 (NCD Section B)
- LCD Group III: modifier N3 (NCD Section D)

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The new modifiers are effective January 1, 2023, and will be available in the April 2023 HCPCS code release. The DME MACs will be incorporating instructions for the use of the new modifiers, in lieu of the KX modifier in an upcoming revision to the Oxygen and Oxygen Equipment LCD (L33797) and the Oxygen and Oxygen Equipment LCD-related PA (A52514).

Suppliers will be given advanced notice to allow ample time for system changes prior to implementation. Until the Oxygen and Oxygen Equipment LCD and LCD-related PA are revised, suppliers are instructed to continue to follow the current Oxygen and Oxygen Equipment LCD-related PA instructions for the use of the KX modifier.

For more information, please reference the Article - Oxygen and Oxygen Equipment - Policy Article (A52514): https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52514&ContrID=140

As we prepare for accepting your questions, please be sure you have input your audio PIN number so we can unmute your line.

Raise your hand to ask your question, and we will call on you. We want to give everyone a chance to ask a question, so please ask one question at a time, and then rejoin the queue for each additional question.

We value your feedback. In the chat window on your dashboard, you will see the URL for our survey about today's call. You can copy and paste the URL into your browser or scan the QR code that is on this slide to your mobile device.

We are now ready to take your first question:

Question 1: QI need clarification on the Oxygen Policy. The treating practitioner has ordered and evaluated the results of the qualifying blood gas study and to determine need. The patient has been seen by a physician, and he orders the overnight oximetry. We get the results of the oximetry and then a Standard Written Order. Do we need to have something in the physician's medical record to prove that he evaluated the testing?

Answer 1: If you have a good working relationship with your referral sources and are sure that they know to document their records of the oxygen test result and order the oxygen, then you would want to make sure that documentation of the coverage criteria is available in an audit situation.

Question 2: Do we have to show in the physician's medical documentation after the test that there is proof that he evaluated the blood gas study, or is the standard written order acceptable to assume that we know the physician evaluated the test because she ordered the oxygen?

Answer 2: The information in the medical record must justify that all four of the coverage criteria are met.

Question 3: If the patient was seen in the hospital, they had testing within 2 days of discharge and the hospitalist signed the order, we set up the oxygen, and then the patient follows up with a completely different physician, and they want to extend the order for the oxygen longer, is there something in the physicians record that has to say that, yes, he reviewed the initial testing from the middle, then the order?

Answer 3: We would assume if the physician writes an order for oxygen, he has already reviewed the test results. Standard practice of care is that the new physician would obtain and evaluate the test results, and document them in the medical record.

Question 4: Can you re-clarify the date for the O2 rentals that can use the KX modifiers as prior to April first?

Answer 4: You can continue to use the KX modifier for pre-existing setups of oxygen prior to April. For new oxygen set-ups with dates of service on or after April 1, 2023, suppliers must use the N1, N2, or N3 modifier.

Question 5: I have a question about the requirement for Group I & II. Does the provision that oxygen and oxygen equipment in the home setting will improve the beneficiary's condition have to be stated directly in the patient medical record? What exactly is Medicare looking for to satisfy that requirement?

Answer 5: It would have to be in the medical record that they have a qualifying test and that the doctor is ordering it.

Amendment: All the coverage criteria in the LCD must be met and documented:

1. The treating practitioner has ordered and evaluated the results of a qualifying blood gas study performed at the time of need; and,
2. The beneficiary's blood gas study meets the criteria stated below; and,
3. The qualifying blood gas study was performed by a treating practitioner or by a qualified provider or supplier of laboratory services; and,
4. The provision of oxygen and oxygen equipment in the home setting will improve the beneficiary's condition.

Question 6A: I have a question regarding claim denials CO 176 for 2023. Normally, I would have needed a recert CMN. We did not get a recert CMN. myCGS shows the length of need for my initial as 12. When I called customer service, they said, I'd have to send in documentation and go to redetermination to extend my length of need.

- **POE question:** Do you have the KX modifier on your claim?
- **Answer:** Yes

Answer 6A: There is information regarding this issue on the "Claim Payment Alerts " page on the CGS website. Claims for HCPCS that previously required a CMN/DIF may have been denied in error for missing the CMN/DIF for dates of service on and after 01/01/2023. We are in the process of continuing to review and adjusting those claims.

- **JB:** https://www.cgsmedicare.com/jb/claims/payment_alerts.html
- **JC:** https://www.cgsmedicare.com/jc/claims/payment_alerts.html

Question 6B: We did not want to have to take every claim to redeterminations. Could we attach something in the claim narrative?

Answer 6B: CGS is adjusting those claims. For dates of service on or after January 1, 2023 and you have a previous oxygen CMN or DIF on file, when the CMN was only set up for a certain amount of time, it is beneficial to include information in the narrative as you do any other situations where you want to extend the existing information. That narrative information is helpful if you put that narrative information on that claim.

Question 7: Group I Test results… with respect to the continued need after 12 months, I understand another standard written order is all that is required to document continued

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need after 12 months. Does another evaluation need to be performed after 12 months to show continued need?

Answer 7: No. For group 1 a new standard written order every 12 months is acceptable for continued need.*

Note: We have FAQs that provide clarification that an in-person evaluation is not required with the revised Oxygen LCD.

Question 8: My question is about the timeframe for when a patient qualifies for oxygen to where the oxygen is ordered and delivered. I know with the CMN the patient testing had to be within 30 days initial of the CMN. I see January 1 and going forward that requirement is no longer there. Is there a timeframe that Medicare would prefer to see? Would it still be within 30 days of the order or 30 days before the delivery?

Answer 8: There is no specified time. The time of need is when the beneficiary exhibits the symptoms of hypoxia that require oxygen. The testing must be done at that time. The oxygen should be delivered shortly after that prescription is written (short period of time) because oxygen is life sustaining. Because if it is life sustaining, what was happening if they went 6 months without oxygen. Did they really need that oxygen.

The medical records should paint a picture for the reviewer, so we know what is going on. If they got tested and then went into a hospital and they were there for a month and then came out, that is a possible exception. If they are tested and that oxygen's not delivered within a short timeframe, that's your decision, but I am trying to let you know it's life sustaining.

Question 9: In the past, the physician's order has not been considered part of the medical record. The testing is noted on the physician's order has changed in these new policies. What if you have an order showing the testing is not valid?

Answer 9: The order with the testing on there is fine. That is for your benefit. We only require certain elements to be on the order; the testing results itself do need to be in the medical records.

If the testing isn't valid, the beneficiary doesn't meet the coverage criteria.

Question 10 A: Do you have a timeframe when will see the changes with modifiers being posted?

Answer 10 A: The LCD and policy article have been updated with the clarification of these modifiers.

Question10 B: What will happen for oxygen that is set up after April 1?

Answer 10 B: For oxygen claims covered by Medicare prior to April 1, 2023, suppliers may continue to use the KX modifier.

For initial claims for oxygen or new 36-month oxygen rental periods with dates of service on or after April 1, 2023, suppliers must use the N1, N2, or N3 modifier.

Question 11: Can we start entering N modifiers now and use both KX and the N modifier together?

Answer 11: Yes, as the N modifier prior to April 2023 is informational only.

Question 12: If you have a patient who was under a Covid waiver where they didn't have a qualified saturation, is there any instruction about what modifier to use in place of the N modifier, if you don't have a modifier to attach?

Answer 12: We are still in the PHE as of right now. You can still use that CR modifier. We are working with CMS right now to determine how to proceed once the public health emergency ends. Make sure you sign up for our electronic e-mail for the most up-to date notifications.

Question 13: Do we have to get a new SWO every 12 months as long as they have oxygen, or is it just after the first 12 months?

Answer 13: Continued need documentation is within 12 months of the date of service in question. As long as they have the oxygen, confirm that you have continued need documentation. Again, yes, it is every 12 months. It does not have to be an order. It could be a visit with that treating practitioner and just documentation in their records saying that they are still using the oxygen or an order. The route that most suppliers utilize is obtaining a new order to support continued need.

Question 14A: Is there any requirement for placement for the N modifiers. Are they okay in positions 2, 3, or 4?

Answer 14A: I do believe so. Usually your rental modifier, such as RR, then your KX modifier after that, but the N modifier will replace the KX. The pricing modifiers should be right after the HCPCS code and at the end. So, it's going to be the RR and then the N modifier at the end.

Question 14B: Where would the Q modifier go?

Answer 14B: The Q modifiers would go after the N or the KX modifier.

Question 15: Are you currently successfully processing claims that have both N and KX modifiers?

Answer 15: Currently the N modifiers are just informational. However, anything starting April 1, a new set-up, does have to have the N modifier on there.

Question 16A: The SWO, after the first 12 months and thereafter every 12 months, we can use for continued need. Do we also need the medical records along with that, or will one or the other be sufficient?

Answer 16A: One or the other will suffice. A new order will work as continued need for oxygen within the previous 12 months. If you have medical records within 12 months of the date of service going forward, that will work as well.

Question 16B: What if they change doctors within that time frame? Will we need a new order and a new note?

Answer 16B: No. A new order would support that as well.

Question 16C: I have an active recert, basically after 12 months of oxygen. Earlier, you said a SWO is all we need after 12 months. However, a SWO is not part of the medical records. You said either/or. Now I'm confused.

Answer 16C: Our medical directors made the decision for oxygen that a new order would support continued need. Previously a new order for refills was part of the continued need documentation. You can find that in the Standard Documentation Requirements. A new order would be acceptable for refills, but now a new order in general for oxygen is also acceptable to support continued need.

Question 17 A: Will we be supported in an audit situation if we don't have the 12-month documentation in the medical record if we have an SWO from the doctor?

Answer 17 A: Yes. That is correct. Keep in mind that this is for the DME MACS. Most auditing entities should be following the same process or protocol. If, for some reason, you get denied, you always have the right to appeal.

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Question 17 B: Would it be only after the 36th month, after they restart, that we would have to start getting new documentation every 12 months?

Answer 17 B: No. Continued Need documentation is every 12 months. For example, you initially get oxygen today, February 23. You are setting up a new beneficiary for oxygen and they fall into Group 1. They're going to get their oxygen and that's fine. You are going to put the KX modifier on there if all coverage criteria is met. As of February 23 next year, you have to have continued need documentation. A new order would suffice in that situation.

Question 18: If we have a beneficiary who was in hospice treatment, has gotten discharged, and now wants to switch to us for oxygen rather than go back to their previous supplier, what would be required other than documentation that they qualify with testing, a standard written order, and bill dates? If they were before April 1, would we still use the KX and add an additional note?

Answer 18: If they have already had 36 months paid, they went to hospice and they come back out, they can't switch suppliers until that reasonable useful lifetime has been met. The original supplier must continue providing the equipment. If it's less than 36 months, you can go ahead and start servicing them for the remainder of that 36 months.

Question 19A: If we were not privy to the previous testing when they qualified under Medicare, I am assuming we would use testing throughout their care showing qualifying stats and everything else that you would require, then change the date of service coming from skilled care to this, would they be billed with the KX modifier since it would have been prior to the April 1 date?

Answer 19A: Yes, but there must be documentation of that qualifying test performed at the time of need and the physician evaluation of that test.

Question 19B: So, do we have to get the original qualifying test?

Answer 19B: Yes. You want to have that test, or if there is a more recent one and it's qualifying, you may use that as well.

Question 20: What is needed for a new to Fee-for-Service beneficiary that is coming from another payor? Previously, we would have them go into the doctor and get new testing and an evaluation. Now my understanding is that we just need a new SWO, and the physician needs to evaluate the most current qualifying saturation test. Is that correct?

Answer 20: Yes. That is correct.

Question 21: Do we, as the supplier, need something in addition to the SWO from the physician stating that they did review those tests and they do qualify?

Answer 21: No. Suppliers are not required to obtain that documentation up front. However, in an audit situation, you would have to obtain that documentation.

Question 22A: Will our claims be rejected if we put the N modifier on them now?

Answer 22A: No. They will not be rejected. Right now, it's just considered informational, so we are ignoring it. We are processing by the KX modifier.

Question 22B: So, we would keep using the KX modifier, and then after April 1, we'd have to change up our billing and use the N modifiers?

Answer 22B: Continue to use the KX modifier even after April 1. The N modifiers apply to new set-ups April 1 and after. That is when the N modifiers must be used.

Question 23: If we have a patient on gap oxygen and we get a new standard written order to add a portable system in the eighth month, do we just need to prove continued medical need from the new order date?

Answer 23: Yes, since the new order in the 8th month, it's documentation of continued need.

Question 24: My question is about overnight oximetry. A patient has chronic obstructive pulmonary disease (COPD) and the doctor thinks they may also have sleep apnea. They go in for their polysomnogram. The polysomnogram says, "You don't have sleep apnea that meets Medicare's guidelines." Is the oximetry then obtained on that polysomnogram okay for qualification?

Answer 24: Yes, you can use that test result. We do have the top oxygen FAQs that are posted on our webpage. If you go to our webpage on the left-hand navigation, under FAQs, under current FAQs, scroll to the bottom and you will see them. That is one of the FAQs stating as long as they determine they don't have obstructive sleep apnea (OSA) during the polysomnogram, but they do qualify for the oxygen, and they desat during that study, it is acceptable.

Question 25: I will check out the Frequently Asked question because the LCDs as the overnight oximetry does not include oximetry obtained during polysomnogram or other sleep testing for sleep apnea.

Answer 25A: Yes. The FAQs will help clarify.

Question 26: Whenever there is a major change with policy with Medicare, seems the Recovery Audit Contractors (RACs) fall behind on their education of it. I am just wondering what type of education is being performed at the RAC, so we don't have to expend tons of labor educating them.

Answer 26: All the contractors work together. The RAC should be following the same guidelines as the DME MACs. If there is an issue, a global issue that occurs with the RACs, you can let us know. We would look to see if they are processing incorrectly.

Question 27: We have a lady here who does our recert CMNs. I know you say the recerts are not needed after January of this year. What if they need a CPAP supply refill? Do we still need to do a recert CMN on that as well, or does that pertain to oxygen and they don't require a CMM?

Answer 27: That might be your own internal thing that your company uses for a letter of medical necessity. They don't need the CMN for CPAP.

If you are new to billing Medicare, I want to suggest attend our webinars, especially our documentation series. It is helpful to hear questions from other suppliers and to get a better understanding of the requirements.

Question 28A: If we have active oxygen patients that we have active CMNs for and they are not up for their "recert," do we keep billing with the CMN, or for our active oxygen patients, do we need standard written orders going forward?

Answer 28A: Just to clarify... you have a beneficiary that has a CMN on file and as of January, a recert would have been due. Is that what you are saying?

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Question 28B: No. They got oxygen in November, and we have an active CMN with them. Would that CMN still be good for that 12 months, or do we have to go back for all our active oxygen patients?

Answer 28B: A CMN that was for November last year is good up until, assuming it is a group 1, October/November of this year.

Do not submit the CMN with the claim on or after January 1, 2023.

Question 29: The CMNs you listed… one was for seat lift mechanism. We do not need a CMN for seat lift mechanism anymore? Would that be a standard written order as well?

Answer 29: Correct, along with the documentation to support coverage criteria.

Question 30: I think that my question was already asked, but I'll just go ahead and clarify. It is the oxygen overnight oxygen versus the polysomnography pulse ox. The polysomnography pulse ox is okay, as long as the OSA is ruled out. The LCD that makes it sound like it doesn't support for oxygen, but you previously stated that is to just a definition of pulse ox.

Answer 30: Yes, that is just the definition of the pulse ox. You are correct: If during the polysomnogram study OSA was ruled out and they are still desaturating, that would support the oxygen test results.

Clarification: *The LCD states the following that is only a definition of the pulse oximetry. It does not disqualify a polysomnogram test result for oxygen qualification.*

For purposes of this policy:

- "Blood gas study" shall refer to both arterial blood gas (ABG) studies and pulse oximetry
- "Oximetry" shall refer to routine or "spot" pulse oximetry
- "Overnight oximetry" shall refer to stand-alone pulse oximetry continuously recorded overnight. It does not include oximetry results done as part of other overnight testing such as polysomnography or home sleep testing.

There are no questions pending in queue, so we will end today's ACT call.

Closing

Thank you for attending today's Ask-the-Contractor Teleconference and participating in our live Q&A session. We will post the transcript to our website within 30 days and send out an email notification when it is available. We look forward to seeing you at future educational events.

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