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

Provider Outreach & Education
Date: May 9, 2023

Moderator: Sarah Barbian
Time: 6:00 p.m. EST

Introduction

Good evening and welcome to the CGS Administrators DME MAC Jurisdiction B & C "End of the COVID-19 Public Health Emergency (PHE) Ask-the-Contractor Teleconference (ACT)." My name is Sarah Barbian. Also, on the call this evening are subject matter experts from CGS operational departments.

For this ACT call you are welcome to ask questions specific to the end of the COVID-19 PHE. We will also speak specifically to claim instructions regarding the CR modifier and "COVID-19" narrative. We want to keep our focus on this topic, 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 we will post the questions and answers 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 questions and answers to the DME MAC websites for future reference. Hyperlinks for more information on the topics discussed today will also be provided in the transcript.

If you would like to participate in the question-and-answer segment, ensure you have logged into the Cvent platform. You must log in, enter your verification code sent to your cell phone or email address and click "join." After you click "join session," you will be asked to open Zoom Meetings. Click "join" from your browser, enter "your name" and click "join."

The Provider Outreach & Education team has made 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.

Our topic for today's ACT call is End of the Public Health Emergency (PHE).

On February 9th, the Department of Health and Human Services (HHS) announced the Public Health Emergency (PHE) for COVID-19 will end May 11, 2023.

For initial dates of service on or after May 12, 2023, the following waivers will end:

- Certain face-to-face encounters
- Clinical indications for coverage found in respiratory, infusion pump, and therapeutic continuous glucose monitor NCDs or LCDs
- Proof of delivery
- Part B drugs providing more than a 30-day supply.

Suppliers are to discontinue the use of the CR modifier and the "COVID-19" narrative on claims with initial dates of service on or after May 12, 2023.

The DME MACs are instructing suppliers to continue the use of the CR modifier and "COVID-19" narrative for continued rentals and related supplies/accessories for claims that were initially provided during the PHE.

Suppliers should continue to bill the KX, and/or CG modifiers, as applicable, for any DMEPOS item or related supply/accessory dispensed (key word here is dispensed) on dates of service between March 1, 2020, through May 11, 2023.

Suppliers submitting oxygen claims prior to April 1, 2023, may continue to use the KX modifier or may use the N modifiers for dates of service after April 1, 2023.

The DME MACs are instructing suppliers who bill initial oxygen claims or a new 36-month rental period to use the N1, N2 or N3 modifier for dates of service on or after April 1, 2023. These modifiers indicate the coverage criteria in the related LCD has been met and if the beneficiary is in Group 1, Group 2, or Group 3.

In addition to the N-modifiers, suppliers may also use the CR modifier and "COVID-19" narrative for dates of service on or after April 1, 2023, through May 11, 2023. If none of the N modifiers are applicable, suppliers may continue to use the CR modifier and "COVID-19" narrative without appending an N modifier.

As we prepare for accepting your questions, please be sure you locate and click "reactions" at the bottom of your screen. Click "raise" hand" to have your phone unmuted to ask a question. If you no longer wish to ask a question, click "lower hand." 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. We have provided the URL and the QR code for our survey about today's call. You can scan the QR code that is on the present slide to your mobile device. We will also follow-up with an email to all attendees to include the URL and QR code to complete the survey after this evening's call.

We are now ready to take the first question:

Question 1: If a practitioner orders home oxygen for an acute condition, such as respiratory failure after surgery, pneumonia, etc. and that order has a length of need of one year, are we still supposed to obtain continued need/use from the practitioners in the form of an updated order, medical records, or refills for supplies?

Answer 1: If the order has a length of need that has expired, you will need to obtain a new Standard Written Order (SWO).

A new order is necessary to confirm continued medical need. There is no requirement for retesting or re-evaluation of the test results. Information regarding length of need

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will be determined by documentation in the beneficiary's medical record.

For beneficiaries with an acute condition that qualify for oxygen, the supplier is obligated to maintain close communication with the beneficiary and the treating practitioner to determine length of need. Suppliers are reminded that Medicare will only pay for items/services that are reasonable and necessary. Once the acute need is resolved, depending on co-existing chronic conditions, the oxygen may no longer be reasonable and necessary.

CGS Medical Review has published Frequently Asked Questions (FAQs) for oxygen that you may also refer to.

- **JB:** https://www.cgsmedicare.com/jb/help/faqs/current/oxygen.html
- **JC:** https://www.cgsmedicare.com/jc/help/faqs/current/oxygen.html

Question 2: If we dispensed a CPAP machine during the PHE and it was billed with the CR modifier because the sleep study was greater than 12 months due to the Phillips recall along with ResMed, and that CPAP capped out, would we submit CPAP supply claims with the CR modifier during and after the PHE?

Answer 2: Yes, you would continue to use the CR modifier and "COVID-19" claim narrative for CPAP supplies since the base item was initially provided during the PHE under waiver/non-enforcement.

Question 3: If patients started parenteral nutrition during the PHE, would you end parenteral nutrition on May 12, 2023, or would you continue the use of the CR modifier?

Answer 3: If any of the waivers applied during the PHE for an item or service initially obtained during the PHE, you will continue to use the CR modifier and "COVID-19" narrative. For items initially provided for dates of service on or after May 12, 2023, all current coverage criteria apply.

Question 4: When we deliver locally, we need to obtain a beneficiary's signature. At times, patients are away from their house when our drivers deliver the item(s) locally and the patients request that we leave the item(s) on their porch. After the PHE, is there any exception where we do not need a beneficiary's signature, such as a photograph of the package?

Answer 4: In response to the COVID-19 pandemic, CMS waived signature requirements on proof of delivery (POD) documentation, when a beneficiary refused to sign due to COVID-19, not because the beneficiary would not be home. This flexibility will no longer apply for dates of service on or after May 12, 2023. In an audit, reviewers will be looking for the beneficiary's signature after the PHE has ended. After the PHE, for proof of delivery - Method 1 (direct delivery to the beneficiary), you must obtain a beneficiary or their designee's signature.

- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2020/04/cope16792.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2020/04/cope16792.html

Question 5: For a CPAP and CPAP supplies that were provided initially during the PHE, does the CR modifier and "COVID-19" narrative go away at any point such as the five-year reasonable useful lifetime (RUL) or annual medical necessity?

Answer 5: If a CPAP was provided during the PHE, when waivers were in place, medical necessity was considered met. For the RUL, there must be an in-person evaluation by their treating practitioner that documents the beneficiary continues to use and benefit from the PAP device. There is no requirement for a new sleep test or trial period.

For equipment that was initially provided during the PHE and is being replaced for dates of service on or after May 12, 2023, the CR modifier and "COVID-19" claim narrative can continue to be used.

Question 6: Would you continue to use the CR modifier and "COVID-19" claim narrative if you had any other DMEPOS dispensed during the PHE such as you could not obtain a signature for proof of delivery or items that you need to repair?

Answer 6: Yes, you may continue to append the CR modifier and "COVID-19" claim narrative for dates of service on or after May 12, 2023, for continued and capped rentals and related supplies/accessories, initially provided during the PHE under waiver/non-enforcement.

If you could not obtain a signature for proof of delivery for the base equipment during the PHE, you do not have to use the CR modifier and "COVID-19" claim narrative for related supplies that are shipped.

Question 7: The CR modifier is a catastrophic modifier. Would we also use the CR modifier if we must replace someone's equipment because it was destroyed in a hurricane and is it that claim narrative that drives the emergency?

Answer 7: Correct. You would use the CR modifier if a waiver has been declared and you are replacing equipment because it was destroyed during a hurricane or other disaster. In addition to the CR modifier, you would use the applicable claim narrative.

CGS has published Disasters & Public Health Emergencies (PHE) Questions & Answers (Q&As) that you may also refer to.

- **JB:** https://www.cgsmedicare.com/jb/education/qa/disasters.html
- **JC:** https://www.cgsmedicare.com/jc/education/qa/disasters.html

Question 8: Will telehealth still be allowed after the PHE has ended?

Answer 8: Yes, telehealth will continue to be accepted. The Consolidated Appropriations ACT of 2023, extended many telehealth flexibilities through December 31, 2024.

We recommend asking the practitioner who conducted the telehealth if the telehealth is valid and billable/payable to the A/B MAC.

CMS Telehealth Guidance: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page

Frequently Asked Questions: CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency: https://www.cms.gov/files/document/frequently-asked-questions-cms-waivers-flexibilities-and-end-covid-19-public-health-emergency.pdf

Question 9: Where can we find and download FAQs?

Answer 9: Currently, only CMS has published FAQs about the end of the PHE. All links to these FAQs can be found on the Jurisdiction B and Jurisdiction C websites under the COVID-19 tab.

- **JB:** https://www.cgsmedicare.com/jb/covid-19.html

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- **JC:** https://www.cgsmedicare.com/jc/covid-19.html

CGS is working on a list of FAQs to publish on our website as soon as possible.

Question 10: If a beneficiary qualified for CGM during PHE and the CR modifier was used because the insulin regimen was less than 3 times a day, based on new LCD guidelines, will the beneficiary meet the criteria for coverage? Can we drop the CR modifier and bill as a regular claim?

Answer 10: Going forward as of April 16, 2023, the coverage criteria 1-5 has changed. Since your patient now meets the current coverage Glucose Monitor LCD criteria, you can stop using the CR modifier and "COVID-19" claim narrative if you have supporting medical documentation.

Addendum: Since the CGM device was impacted by the PHE, the provider may choose to use the CR modifier and "COVID-19" narrative. However, since the beneficiary meets the existing coverage criteria for the CGM now, adding the CR modifier and "COVID-19 narrative" is not mandatory; it is at the supplier's discretion.

Question 11: Since the new LCD indicates that non-insulin beneficiaries can qualify for CGMs only if they suffer from problematic hyperglycemia, what about non-insulin beneficiaries who qualified during the PHE based on medical necessity? Can they continue to receive CGM supplies?

Answer 11: For patients who received a CGM during the PHE, continue to use CR modifier and "COVID-19" claim narrative after the PHE. If a base item, such as the CGM, was provided during the PHE, related supplies/accessories should be billed w/ CR modifier "COVID-19" claim narrative after the end of the PHE.

Question 12: Since non-insulin patients can continue to receive CGM supplies that were provided during the PHE, do claims continue to be billed with the KX or KS modifier?

Answer 12: For CGMs whose clinical indications were not being enforced during the PHE, continue to bill the appropriate modifiers, include the KS, KX, and/or CG modifier, after the PHE.

For equipment initially provided during the PHE, for dates of service on or after May 12, 2023, continue to use the CR modifier and "COVID-19" claim narrative on accessories and supplies.

Question 13: Since telehealth has been extended to 2024, what will audit contractors be looking for in a telehealth visit such as audio or video telehealth?

Answer 13: Auditors will not be auditing the actual telehealth visit because that visit falls under the authority of the A/B MAC. Auditors will be looking to ensure the beneficiary had a visit with their practitioner that meets applicable requirements as outlined in the Local Coverage Determinations and related Policy Articles.

We recommend asking the practitioner who conducted the telehealth if the telehealth is valid and billable/payable to the A/B MAC.

Question 14: What protocol needs to be followed for insulin treated beneficiaries who started CGM within six months to a year and end up with no insulin as part of their diabetes management and do not suffer from severe hypoglycemia? Do we stop servicing these non-insulin patients as soon as we become aware of it? If so, what information or guidelines do we provide to patients to ensure there is no negligence on our end pertaining to their diabetic care?

Answer 14: If it was during the PHE, when clinical indications were not being enforced, you will continue to append the CR modifier and COVID-19 narrative after the end of the PHE.

For CGM continued coverage, the Glucose Monitors LCD states, "Every six (6) months following the initial prescription of the CGM, the treating practitioner conducts an in-person or Medicare-approved telehealth visit with the beneficiary to document adherence to their CGM regimen and diabetes treatment plan."

There is no requirement for the treating practitioner to reconfirm the initial coverage criteria are met for continued coverage.

If the beneficiary initially obtains a CGM for dates of service on or after May 12, 2023, after the PHE has ended, the enforcements apply, and coverage criteria must be met.

Closing

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

Please continue to visit our calendar of events page for upcoming teleconferences and webinars regarding the Post-PHE education.

Thank you for attending Ask-the-Contractor Teleconference and participating in our live Q&A session. We will post the questions and answers 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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