Provider Outreach & Education
Date: May 11, 2022
Moderator: Belinda Yandell
Time: 2:00 p.m. EST

Introduction

Good afternoon and welcome to CGS Administrators DME MAC "Ask the Contractor Teleconference." The ACT call is hosted once a quarter by the DME MAC Provider Outreach and Education team. My name is Belinda Yandell, 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 questions on the new Face-to-Face, Written Order Prior to Delivery and Prior Authorization requirements. 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 here due to possible PHI issues and those questions should be directed to our Customer Support department.

There is not a presentation for this call, though we will have four slides listing affected HCPCS codes, timelines and modifiers. This call is being recorded and questions and answers 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 question and answer (Q&A) document to the website for your future reference. Hyperlinks for more information on our topics today will be provided in the Q&A document.

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.

I'd like to take a moment before we begin to let you know that CGS is once more hosting in-person workshops. Our JC Charlotte, NC mega workshop on May 10 was very well-attended and we hope that our upcoming JB mega workshop on May 24 in Louisville, KY will be just as successful. The Provider Outreach and Education staff is happy to once again provide education in a ''face-to-face encounter."

We value your feedback. In the chat window on your dashboard, you will see the URL for our survey about today's call. The slide currently on the screen is the QR code, along with that same URL. You can use the QR code through your phone, or enter the URL in your browser window. Tell us what you liked about the call, or if you think there is something we could improve. We need your feedback to make our educational events the best they can be.

Before opening the call to your questions, let's go over the new F2F, WOPD and Prior Authorization requirements.

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

As anticipated for some time, CMS has updated the Required Face-to-Face Encounter and Written Order Prior to Delivery list, often referred to simply as the "Required List." Some items (such as Power Mobility Devices (or PMDs)) have statutorily imposed requirements. For items that do not have statutory requirements, a face-to-face encounter and written order prior to delivery is required only if the item is placed on the Required List. This does not change any existing Local Coverage Determination (or LCD) face-to-face requirements. 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 now seven non-Power Mobility Devices that require a face-to-face encounter and written order prior to delivery: six orthoses and one osteogenesis stimulator.

Five of the orthoses added to the Required face-to-face encounter and written order prior to delivery requirements also fall under the Prior Authorization Program, as we will discuss in just a moment. Those orthoses are two lumbar sacral orthoses, the L0648 and L0650, and three knee orthoses, the L1832, L1833, and L1851.

Two additional HCPCS now requiring face-to-face encounter and written order prior to delivery requirements that are NOT part of Prior Authorization are the E0748 Osteogenesis Stimulator and the L3960 Shoulder-Elbow-Wrist-Hand Orthosis. These two items must also meet the face-to-face encounter and written order prior to delivery requirements as of April 13, 2022. These F2F requirements for orthotics do not fall under the relaxed standards for COVID-19.

Face-to-Face Encounters

For all items requiring a face-to-face encounter, a practitioner visit is required within six months preceding the order. This six-month timing requirement does not replace other CMS policies.

A face-to-face encounter means an in-person or valid telehealth encounter between the treating practitioner and the beneficiary. Treating practitioner means a physician, as defined in Section 1861(r)(1) of the Social Security Act (the Act), or physician

Originated June 3, 2022
© 2022 Copyright, CGS Administrators, LLC.

CGS
A CELERIAN GROUP COMPANY
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

assistant, nurse practitioner, or clinical nurse specialist, as Section 1861(aa)(5) of the Act defines those terms. The face-to-face encounter must support payment for the item(s) ordered/prescribed and be documented in the pertinent portion of the medical record (for example: history, physical examination, diagnostic tests, summary of findings, progress notes, treatment plans or other sources of information that may be appropriate). The supporting documentation must include subjective and objective beneficiary specific information used for diagnosing, treating, or managing a clinical condition for which the DMEPOS is ordered.

This face-to-face requirement also includes examinations conducted via the CMS-approved use of telehealth examinations, which must meet the requirements of 42 CFR §§ 410.78 and 414.65 for purposes of DMEPOS coverage.

Written Order Prior to Delivery List

Items that appear on the Required List are also subject to the requirement for a Written Order Prior to Delivery. A written order prior to delivery is simply a completed Standard Written Order (or SWO) with only two additional requirements. The first is that the written order prior to delivery is communicated to the supplier before delivery of the item, meaning that the date of the WOPD must be on or before the date of delivery. The second is that it must be completed within six months after the required F2F encounter. All the other requirements for SWOs are the same.

For items other than power mobility devices on the Required List, the treating practitioner that conducted the face-to-face encounter does not need to be the prescriber for the DMEPOS item. However, the prescriber must verify that a qualifying face-to-face encounter was conducted within six months prior to date of order and have documentation of that encounter. For power mobility devices, only the treating practitioner can complete the WOPD of the item pursuant to 1834(a)(1)(E)(iv). More information and a complete list of items on the Required face-to-face encounter and written order prior to delivery list is found on the CMS website. You can find additional resources on the https://www.cgsmedicare.com website and in the Standard Documentation Requirements. We also have a new tool, the Written Order Prior to Delivery Look-Up Tool, to show you whether a code is included on the required F2F encounter and WOPD list. You'll find it under the "Tools and Calculators" section on the left-hand side of the Web page.

Prior Authorization

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

Power Mobility Devices

In the Power Mobility Devices or PMDs category, six 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. I do want to mention that Group 2 Power operated vehicles or POVs (K0806, K0807, K0808) are denied as not reasonable and necessary and will not be affirmed on prior authorization. Therefore, if a Group 2 POV is provided it will be denied as not reasonable and necessary. Suppliers should obtain an Advance Beneficiary Notice of Non-Coverage, which will be reviewed for validity.

Orthoses Timeline for Prior Authorization Implementation

In the Orthoses category, five additional HCPCS codes for knee and lumbar sacral orthoses were also added to the Required Prior Authorization list: L0648, L0650, L1832, L1833, and L1851. Implementation of this requirement will be completed in three phases.

Phase One began April 13, 2022, in New York, Illinois, Florida, and California.

Phase Two begins July 12, 2022, in Maryland, Pennsylvania, New Jersey, Michigan, Ohio, Kentucky, Texas, North Carolina, Georgia, Missouri, Arizona, and Washington.

Phase Three begins October 10, 2022, in all remaining states and territories not included in Phase 1 or Phase 2.

Our website has helpful Prior Authorization information including a look-up tool which allows you to enter any HCPCS code to determine whether or not the code is subject to Prior Authorization. You'll find it under the "Tools and Calculators" section on the left-hand side of the Web page.

Prior Authorization Exceptions for Orthotics in Acute Situations

Standard Prior Authorization decisions are communicated to the submitter in writing within 5 business days, while expedited decisions are within 2 days. Exceptions to the Prior Authorization requirements are being made for acute situations, when the beneficiary's health or life is jeopardized without the use of the orthotic device even within the expedited prior authorization review timeframe of two days. Examples of such situations would be when a beneficiary suffers an acute injury to the knee or spine. Certain providers and suppliers may choose to forego submitting a prior authorization request, provide the item, and bill the claim with the ST modifier. The ST modifier indicates that the claim is related to trauma or injury. The ST modifier should only be used in acute Prior Authorization exceptions.

Be aware that all claims for orthoses subject to prior authorization and billed with modifier ST will be subject to 100% prepayment medical review by the MAC. Documentation supporting the trauma or injury should be as thorough and detailed as possible.

We've had multiple questions regarding whether or not these items can be submitted for Prior Authorization before surgery. Prior authorization should not be requested prior to the start of medical necessity, and medical necessity does not begin until after surgery. CMS has updated the Operational Guide for DMEPOS Prior Authorization and the DMEPOS Prior Authorization Frequently-Asked-Questions to provide guidance about acute situations. Both of these are located on the https://www.cms.gov website.

Originated June 3, 20222
© 2022 Copyright, CGS Administrators, LLC.

Prior Authorization and Competitive Bidding: KV, J4, and J5 Modifiers

Prior Authorization of the specified orthotics also impacts exceptions to the Competitive Bidding Program for certain practitioners. Physicians and non-physician practitioners, physical therapists and occupational therapists enrolled as DMEPOS suppliers may furnish certain off-the-shelf back and knee braces to their own patients without being a Competitive Bidding Program contract supplier. This exception only applies if the practitioner is prescribing and furnishing the orthotic on the same day as the professional service being rendered in accordance with the rules associated with the limited exception to the Physician Self-Referral or Stark Laws.

Claims billed to the DME MACs for these items must have the same date of service as the professional office visit or physical/occupational therapy service billed to the Part B MAC.

To be paid for these off-the-shelf back and knee braces as a non-contract supplier, physicians and other treating practitioners should use the modifier KV. Physical therapists and occupational therapists should use the modifier J5 when billing their claims. Hospital-based suppliers should use the J4 modifier. These modifiers convey that the DMEPOS item is needed immediately.

Claims for L0648, L0650, L1833, and L1851 billed with modifier KV, J5 or J4 will not be subject to prior authorization requirements. Claims submitted with the KV, J5, or J4 modifiers for HCPCS L0648, L0650, L1833, and L1851 will be subject to prepayment review.

Just to be clear, the KV, J4 and J5 are only to be used by physicians and non-physician practitioners, physical therapists and occupational therapists for beneficiaries residing in Competitive Bid areas, and only when provided on the same day as the office visit.

Please keep in mind that the ST modifier should not be used together with the KV, J5, or J4 modifiers.

Briefly, here are a few other important reminders regarding Prior Authorization. For the purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by orthotists and prosthetists shall be considered part of the individual's medical record. In the event the orthotist or prosthetist documentation does not support the documentation created by the eligible professional, the DME MAC may deny payment.

The beneficiary and supplier addresses listed in the Prior Authorization Request will not be used by the DME MACs when sending review decision letters. Supplier letters will be mailed to the address on file with the National Supplier Clearinghouse, while beneficiary letters will be sent to the address on file with the Social Security Administration.

Submitters may send Prior Authorization Requests by mail, fax, electronic submission of medical documentation (esMD), or myCGS, which is the fastest and easiest way to submit a request.

For both initial and resubmitted requests, decision letters will be sent with the Unique Tracking Number (or UTN) within 5 business days. For expedited requests, based on the DME MAC determination where delays in a review and a response could jeopardize the life or health of the beneficiary, Medical Review will attempt to review and communicate a decision within 2 business days.

Prior Authorization for orthoses remains valid for sixty (60) calendar days following the provisional affirmation review decision. The supplier has up to 60 days to furnish the orthoses or they will have to submit a new Prior Authorization Request.

You will find additional information on the https://www.cgsmedicare.com website under Medical Review Prior Authorization.

Education Updates

CGS continues working to improve our educational resources for suppliers. Our popular Encore webinars continue to be available for download at your convenience when you can't attend a regularly scheduled webinar. Be aware that we are now simply calling these recorded webinars and making them available on a more user-friendly platform. You will be directed to the new platform automatically, but you will notice that now you can browse through the available videos and see more information about their contents, without having to register first.

We are also excited about two new education formats.

The first is our "To the Point" recordings. 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. It also looks at inpatient stays and hospice as it applies to DMEPOS items. "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. Please see our Events Calendar on https://www.cgsmedicare.com for upcoming presentations.

CGS has a large library of Online Education Courses, and we hope you will take advantage of these convenient offerings. These courses average about 30 minutes and cover both general topics such as upgrades and ABNs, as well as specific policies such as ostomy supplies and ventilators. The online education courses include a ten-part series called "Welcome to Medicare" that takes you step-by-step through the entire 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 to it later. It's another way we strive to provide information that will help your company thrive.

CGS Medicare App is newly refreshed with new features and functionality. The DME Menu offers access to LCDs/Policy Articles; results from the CGS Wizard; DMEPOS

Originated June 3, 20222
© 2022 Copyright, CGS Administrators, LLC.

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 the App Store and Google Play Store. Search "CGS Medicare."

You will also find many other resources in the Tools and Calculators section of our website. As I mentioned earlier, we have two tools that will help you specifically on today's topics: the Face-to-Face and Written Order Prior to Delivery Look-Up tool, and the Prior Authorization Look-Up tool.

We have revised the documentation checklists for Osteogenesis Stimulator, Power Operated Vehicles, Knee and Spinal Orthoses to address the recent changes and there are numerous other helpful checklists available on the Form, Checklists, and Guides section of the website.

CGS Connect™

Last but certainly not least, I'd like to remind you about CGS Connect™. 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, but 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, located under the Medical Review tab in the left-hand navigation menu.

Questions & Answers

This concludes our updates. Before we open the lines for your calls, the slide with the survey QR and URL are on the screen again. We would really appreciate your opinion.

We will take just a moment to prepare for accepting your questions. Please be sure you have input your PIN 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, so please ask one question at a time, and then rejoin the queue for each additional question.

Question 1: Is the face-to-face requirement for effective date on dates of service before April 13, moving forward, or is it for claims that are being billed after that day, moving forward?

Answer 1: The policy goes into effect on that April 13th. So, the requirements are for any dates of service on or after April 13, 2022.

Question 2: For patients who have a trauma injury and require surgery, should we use the ST modifier since we cannot do a prior authorization?

Answer 2: The ST modifier is specific to an emergent need. If the beneficiary needs it immediately following the surgery, due to trauma or injury, you would append the ST modifier.

There must be documentation to substantiate that the beneficiary needs to be in the brace immediately following the surgery. You should also verify that the brace is not included in any Part A billing, allowing the brace to be separately payable to the DME MAC.

Question 2A: Can you request a prior authorization after the brace is issued?

Answer 2A: You cannot request a prior authorization after the brace is already issued; prior authorization is not retroactive. You can use the ST modifier, but we need documentation to show the beneficiary needed to be in the brace right after surgery.

Claims submitted with the ST modifier are subject to 100% prepayment review. Documentation must meet the requirements per the Local Coverage Determination (LCD), written order prior to delivery, as well as your face-to-face encounter. We also will be looking for documentation that that beneficiary needed to be in the brace immediately after surgery.

Question 4: I have some questions regarding the L3000 custom-fabricated orthotic. Are you saying that we would have to do a face-to-face and send the documentation before the brace is made for the patient?

Answer 4: The L3000 is for a custom-fabricated orthotic. Custom-fabricated orthotics are not part of the Prior Authorization codes. Codes that currently require or will require Prior Authorization in the near future are L0648, L0650, L1832, L1833, L1851. Neither does the custom-fabricated orthotic require a Written Order Prior to Delivery and Face-to-Face Encounter as of April 13, 2022. Refer to the appropriate LCD and Policy Article for those requirements. The Required List for face-to-face and written order prior to delivery is only for the prefabricated, off-the-shelf. It can be custom-fitted but that is not the same as custom-fabricated.

Question 5: Can the op-reports from surgery be used for the face-to-face requirement?

Answer 5: The face-to-face must occur within six months of the written order prior to delivery. The written order prior to delivery must be completed within six months after the required face-to-face encounter. There is specific information in the Standard Documentation Requirements for All Claims Submitted to the DME MAC Policy Article A55426 (https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=55426).

The face-to-face encounter must support the item ordered or prescribed. There must be documentation in the medical record such as history, physical examination tests, etc. that documents subjective and objective beneficiary information used for diagnosing, treating, or managing a clinical condition for which that specific item is ordered. If that face-to-face encounter meets those requirements in the Standard Documentation Policy Article, then it would meet the requirements.

Question 6: If the patient went to an urgent care, would those notes be okay, or do they still have to follow up with their physician?

Answer 6: Medical records can come from different treating practitioners, facilities, etc. If there was a face-to-face encounter with a physician, and if that physician can order DMEPOS items, as well as document medical records, then that would be acceptable.

For power mobility devices, the treating practitioner must conduct the face-to-face evaluation and complete the

Originated June 3, 20222
© 2022 Copyright, CGS Administrators, LLC.

written order prior to delivery. For items other than power mobility devices, the face-to-face evaluation does not have to be completed by the same practitioner who writes the written order prior to delivery.

Question 7: If it was an emergent request and we get our expedited decision, what would be the turnaround for prior authorization? Is it two days and would it be by letter?

Answer 7: For prior authorizations, there's the standard prior authorization, which they have five days to get back to you for orthotics. They will send the response by letter.

If there's a reason that the beneficiary's health and well-being require the use of an orthotic device as soon as possible, you can request an expedited review. The Prior Authorization department will get it back to you within two business days via call or fax.

Now, there is also the ST modifier which bypasses prior authorization. If it's a situation where the beneficiary's health, well-being, or life might be endangered by not having the orthoses immediately, you can bypass prior authorization by appending the ST modifier. However, when you use the ST modifier, those claims will be on a 100% prepayment audit. This is to ensure the need was emergent.

Question 8: Does the face-to-face examination need to be on file with the supplier prior to billing? Or is that something that we can obtain if requested from Medicare?

Answer 8: There is no requirement that you have a copy of that face-to-face, but it is required that it occurred. If you choose to wait until the claim is audited, if that face-to-face didn't occur, your claim will be denied. Although not required, we strongly suggest that you obtain your medical record documentation upfront to protect yourself in the event of an audit.

Question 9: We noticed that Medicare updated their electronic signature requirements recently, saying that it has to be easily identifiable as electronic instead of typed. We noticed that on Noridian's website, they have provided an electronic orders signature process form for facilities to validate electronic signatures. Is CGS going to come out with their own form?

Answer 9: I'm not familiar with the Noridian form to which you are referring. Most of the electronic signatures we see now are good at indicating that they are electronic signatures rather than just information. If the electronic signature is very different from what everyone is using or not immediately recognizable, we may ask you to provide a protocol from your software provider. The protocol is something that explains how the software records and validates a signature.

Question 9A: For CGS, if a signature was to come into question, could we complete the form used by Noridian and submit to CGS to indicate it was an acceptable signature?

Answer 9A: As we are not familiar with Noridian's form, we would continue to request the protocol from your provider if needed.

Question 10: Would it be sufficient to say in the surgical pre-op note that the brace will be needed immediately after surgery for X, Y, Z? Would that meet the documentation requirements? I'm assuming, in that post op note, reiterating the need for the brace immediately after surgery and applying the ST modifier if the patient is residing outside of a competitive bid area and providing the KV modifier would be acceptable?

Answer 10: Let's clarify these modifiers because they are used for two different situations. The ST modifier is used for urgent situations like the one you have described; the beneficiary has suffered trauma or injury and requires the brace immediately after the surgery, so you use the ST modifier to bypass Prior Authorization, aware that your claim will be reviewed pre-payment.

The KV modifier is only used if you are a doctor's office providing one of these braces to your own patient who resides in a competitive bid area based on their zip code and doing so on the same day as an office visit.

You would never use ST and KV on the same claim.

Question 10A: In the surgery notes or the office report and providing the documentation from the written order, the face-to-face encounter at the pre-op and the written order prior to delivery, does that suffice in being able to dispense that brace immediately after surgery?

Answer 10A: To be clear, even if it's after surgery, and even if the surgery was scheduled, a beneficiary needs to be in the brace immediately after the surgery. You also should verify that the brace isn't included in any other Part A billing, or any other billing. In that scenario, the ST modifier can be appended. We're looking for information to identify that the beneficiary needed to be in the brace immediately following the surgery.

If there was no surgery and the beneficiary had a fracture for the last few months and you're trying to utilize the ST modifier, but they already have a preexisting condition, then the ST modifier would not apply in that scenario.

If it's a stress fracture, and you're wanting the L1851, you would submit for prior authorization, wait the two days or the five days for it to come back and then dispense it with the Unique Tracking Number (UTN).

If it was a brand-new fracture, and the beneficiary needed to be in the brace, you could do the ST modifier, again, dependent on the medical records and the particular condition. If it was an ongoing condition, then you would follow the standard prior authorization process.

Question 11: How can we check which patients are going to be subject to competitive bidding? When we're in the CGS portal, the only thing it tells us is which jurisdiction they are in. It doesn't tell us their current zip code.

Answer 11: Part of your intake process is to verify that the information the beneficiary gives you is correct. Sometimes the best way is to ask them what address is on file for them with Social Security; in other words, ask "Where is your social security check mailed to?" That information will determine whether a beneficiary is in a competitive bidding area and what modifiers are appropriate.

Remember that competitive bid has nothing to do with where you are located, but where the beneficiary resides.

The myCGS Web portal provides beneficiary specific competitive bid information in the beneficiary eligibility tab.

Originated June 3, 20222
© 2022 Copyright, CGS Administrators, LLC.

The CBA zip, CBA number, effective date and expiration date is provided if the zip code entered is in a Competitive Bidding Area (CBA).

Question 12: The WOPD requirement is that it needs to be communicated to the supplier before delivery of the item. Does that mean we have to have it in-house, and a timestamp as received prior to us delivering the item to the patient?

Answer 12: A timestamp is not required but you do need the WOPD in hand before delivery of the item.

Question 13: Could you explain what the prepay review process is when using the ST modifier?

Answer 13: When you submit the claim with the ST modifier, you will receive an additional documentation request letter (ADR). The ADR letter will list the required documents needed to support the medical necessity for your claim, and you have 45 days to respond. The Medical Review department has a total of 30 days to process those prepayment reviews. You can submit your responses and check the status of reviews in the myCGS Web portal. The review decision will also be mailed once completed.

Conclusion

There are no questions pending in queue, so we will end today's ACT call. I will post the question-and-answer summary from today's call to our website within 30 days. We will send out an electronic email notification when it is available.

Thank you again for attending, and we look forward to seeing you at future educational events.

Originated June 3, 20222
© 2022 Copyright, CGS Administrators, LLC.