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

Provider Outreach & Education
Date: May 12, 2023

Moderator: Kathryn Torro
Time: 10:30 a.m. EST

Introduction

Good morning and welcome to the CGS Administrators, LLC (CGS) DME MAC Jurisdiction B & C "End of the COVID-19 Public Health Emergency Ask-the-Contractor Teleconference." My name is Kathryn Torro. Also, on the call this morning we are joined by 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 Public Health Emergency (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 about 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 questions and answers (Q&As) will be posted to the DME MACs websites 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 ACT transcript and Q&A document to the DME MACs websites for your future reference. Hyperlinks for more information on the topics discussed today will also be provided in the final transcript document.

If you would like to participate in the verbal 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 made every effort to ensure that the information presented today is accurate and up to date; however, it is ultimately 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 and 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 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 our 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 a URL and a QR code for our survey about today's call. You can scan the QR code with a smart device. We will also follow-up with an email to all attendees to include the URL and QR code to complete the survey after today's call.

We are now ready to take the first question:

Question 1: For CPAP/Bi-PAP therapy, during the Public Health Emergency (PHE), beneficiaries were allowed to have a telehealth visit with their doctor, then they would go for a sleep study to qualify for CPAP therapy. Telehealth visits have been extended to the end of 2024. However, on different webinars, VGM is advising telehealth would not be acceptable for PAP patients to qualify at the end of the PHE, because it is one of the few policies that specifically states "in-person" visit is required as opposed to a "face-to-face" visit. Please clarify if Medicare is still going to allow a "telehealth visit," documenting signs/symptoms and recommending a sleep study to qualify for a PAP device after the PHE ends?

Answer 1: Yes, the flexibilities for telehealth visits are being continued through December 31, 2024. Medicare has always allowed CMS approved telehealth visits. Telehealth visits will continue to be allowed after December 31, 2024, when flexibilities end. It is in the best interest of the supplier

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to confirm with the treating/prescribing practitioner the telehealth visit is an approved telehealth visit and meets CMS guidelines.

Question 2: We deliver immune and nebulizer drugs/supplies. For proof of delivery, will we need to get the beneficiary's signature as well as proof of delivery?

Regarding audits, if we have the proof of delivery but not the beneficiary's signature, would this pass an audit?

POE asked clarifying question: Are you referring to dates of service on or after May 12, 2023, where the PHE has ended, and this is for initial dates of service for the supplies, but the base was dispensed during the PHE?

Supplier response: We have never obtained a signature from the beneficiary when supplies are delivered via Fed Ex, UPS, USPS, prior to COVID-19 and during COVID-19. At the end of the pandemic, going forward, would we need the signature?

Answer 2: During the Public Health Emergency (PHE), an in-person delivery, whether the item was delivered storefront or from a company owned vehicle, when the beneficiary refused to sign the proof of delivery (POD), suppliers were instructed to document on the POD the beneficiary refused to sign the POD due to COVID-19. Suppliers were allowed to bill claims with the CR modifier and "COVID-19" narrative. These instructions applied to only Method I POD.

It did not apply to Method II POD, where a shipping service was used. Method II does not require a signature for POD. The requirement for Method II is to show evidence the item(s) were delivered. For example: item(s) left by the garage, porch, picture taken with a smart device and text to the beneficiary, etc. The only time a signature is needed for Method II is when a supplier uses a mail order return post-paid delivery invoice.

Question 3: For in-person visits, it was stated from the first caller's question, we could use a telehealth visit. If the policy itself states a face-to-face or an in-person visit is required, can we use a telehealth visit through December 31, 2024? Is there any notification we need to put on the claim that this was part of a telehealth visit?

Answer 3: The telehealth visit should address the visit from either the treating practitioner or the prescribing practitioner and not the supplier.

Yes, the flexibilities for telehealth visits are being continued through December 31, 2024. Medicare has always allowed CMS approved telehealth visits. Telehealth visits will continue to be allowed after December 31, 2024, when flexibilities end. It is in the best interest of the supplier to confirm with the treating/prescribing practitioner the telehealth visit is an approved telehealth visit and meets CMS guidelines. As a supplier, you would not append anything on your claim line or add any additional information in the claim narrative. This information should be documented in the beneficiary's medical record.

Question 3A: Does the telehealth visit have to be video and audio to replace an in-person or face-to-face visit?

Answer 3A: Please make sure the telehealth visit meets all requirements and guidelines outlined by CMS for approved telehealth visits. Jurisdiction B and Jurisdiction C websites have links on the COVID-19 webpages, which address CMS telehealth guidance and updated Questions & Answers (QAs) on COVID 19.

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

Question 4: We have a claim for oxygen where we billed with the CR modifier and "COVID-19" narrative. The oxygen has now capped. Since all rental claims were paid with the CR modifier and "COVID-19" narrative during the PHE for the oxygen, would the maintenance and service claim also need the CR modifier?

Answer 4: Just like any other service for accessories and supplies, where the base was provided during the PHE and under an approved waiver, then yes, you would apply the MS, KX modifiers in addition to the CR modifier and "COVID-19" narrative.

Question 5: For insulin infusion pump supplies, is there a standard amount Medicare will allow? I have looked and cannot find this information on HCPCS code A4224.

Answer 5: HCPCS code A4224 is a weekly supply. (Supplies for maintenance of insulin infusion catheter, per week) The information is in the Local Coverage Determination (LCD) for External Infusion Pumps. It is covered for the period of continued use of the infusion pump. They are also covered for the weeks in between covered infusion pump use, not to exceed 4 weeks per episode.

External Infusion Pump LCD: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33794&ContrID=140

Question 6: If a beneficiary qualified for a CGM during the PHE based on physician medical necessity, where clinical indications were not being enforced, but they do not meet the current coverage criteria, can we continue to append the CR modifier and the "COVID-19" narrative for CGM supplies?

Answer 6: Yes, that is correct.

Question 7: When the base unit was covered under the PHE, would we bill supplies with the CR modifier after the PHE ends? Are there safeguards in place to avoid any erroneous denials, or is this something we need to monitor and closely watch to ensure the claims are processed correctly?

Answer 7: If the base item was provided during the PHE, the base item is on file under claim history for a beneficiary. For any supplies/accessories billed after the end of the PHE, you are allowed to continue to append the CR modifier and "COVID-19" narrative and claims will process correctly.

Question 7A: If we take over services from another supplier, is there a way we can confirm through the myCGS portal the base item was billed using the CR modifier and "COVID-19" narrative? This way we can acknowledge moving forward and bill with the CR modifier and "COVID-19" narrative on supplies.

Answer 7A: During the COVID-19 PHE, although clinical indications were not being enforced, this did not give treating/prescribing practitioners leniency on medical documentation.

Many beneficiaries met clinical indications and medical records documented such, where there was not a need for the CR modifier or "COVID-19" narrative.

There is not information in the myCGS portal showing this item was provided/delivered under the COVID-19 PHE waiver. However, in the myCGS portal, you can confirm the beneficiary received a particular item under same/similar equipment and claim history. It is best you obtain all information from the transferring supplier to confirm if the item was provided during COVID-19 PHE and under an approved waiver.

Question 8: If we discovered, moving forward, we neglected to append the CR modifier and "COVID-19" narrative, will we still

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be able to do reopenings or redeterminations to get that corrected?

Answer 8: Clarification: Yes, you can correct your claims if you wish, although if claims for supplies were initially paid without the CR modifier and "COVID-19" narrative there is no need to reopen these claims. When the base item was initially provided during the COVID-19 PHE under waiver/non-enforcement, you can append the CR modifier and "COVID-19" narrative on future claims.

As a reminder, the time limit to reopen a claim is one year from the date on the Medicare Remittance Advice. Through written reopenings, you can request to have the CR modifier and "COVID-19" claim narrative appended to the claim. Telephone reopenings does not handle these types of requests.

Question 8A: When the base item was provided during the COVID-19 PHE, we only appended the CR modifier and "COVID-19" narrative because we did not obtain a signature from the beneficiary. After the PHE, when drop shipping supplies, do we have to append the CR modifier and COVID-19?

Answer 8A: No, you do not have to append the CR modifier and "COVID-19" narrative when shipping supplies (POD Method II). The base item paid with the CR modifier and "COVID-19" narrative.

Question 9: I would like clarification on an article from CGS, when the PHE ended, we were no longer going to be allowed to append the CR modifier. I am looking at the April 28, 2023, claim billing instructions and it is saying that the CR modifier and the "COVID-19" narrative should be entered into the line claim note. My understanding is the claim should be submitted with RR, KJ, KX, not the CR. The CR modifier and the "COVID-19" narrative would go in the claim note NTE 2400 loop, is this correct?

Answer 9: In addition to continued rentals, accessories/supplies, CMS has clarified, when the base item was provided during the COVID-19 PHE under an approved waiver, suppliers are to continue to append the CR modifier and just "COVID-19" in the claim narrative. The narrative could be entered in either the NTE 2400 loop or NTE 2300 loop.

For the example you provided, on the claim line, you would append modifiers: RR, KJ, KX, CR. In the claim narrative, only enter "COVID-19." The only time you would append the CR modifier in the claim narrative is when you have more than four modifiers and modifier overflow. In that situation, you would bill the following modifiers: RR, KJ, KX, 99. In the claim narrative, add the modifier overflow (i.e., CG, CR) and "COVID-19."

Claim Submission Instruction Post-PHE – Continued Use of Modifier CR and COVID-19 Narrative

- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2023/04/cope138167.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2023/04/cope138167.html

Question 10: Clarification for PAP supplies. If we use the CR modifier for the first 3-month rentals, prior to billing the 4th month, beneficiary has a telehealth visit for continued need, instruction is to continue to append the CR modifier out to the 13th month rental.

Once the equipment has capped, if the beneficiary comes to the store or we ship supplies, would we have to continue to use the CR modifier for the supplies?

Answer 10: Yes, continue to append the CR modifier and "COVID-19" narrative since clinical indications were not being enforced at initial issue of the PAP device.

Question 10A: When providing supplies to beneficiaries where they switched suppliers, how are we to know when to append the CR modifier and "COVID-19" narrative? Would we have to obtain all the clinical information and decide ourselves if the CR modifier and "COVID-19" narrative should have been used?

Answer 10A: It is in the best interest of the supplier to ensure you have access to the beneficiary's medical records to determine if the items were provided during the COVID-19 PHE and under an approved waiver for continued use/continued need.

Question 11: Are telehealth visits still going to be allowed (specifically for PAP policy) as the policy states that an in-person visit is required?

Answer 11: Yes, the flexibilities for telehealth visits are being continued through December 31, 2024. Medicare has always allowed CMS approved telehealth visits. Telehealth visits will continue to be allowed after December 31, 2024, when flexibilities end. Please ensure the treating/prescribing practitioner has a valid telehealth visit, it is an approved telehealth visit, and meets CMS guidelines.

Question 11A: That could be used for the initial visit, ongoing visit, 30–60-day visit, etc.?

Answer 11A: Yes, that is correct.

Closing

There are no questions pending in queue, so we will end today's ACT call. Please continue to visit the calendar of events page for upcoming the post-PHE education teleconference and webinars.

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

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