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

Provider Outreach & Education
Date: July 20, 2022

Moderator: Teresa Camfield
Time: 2:00 p.m. EST

Introduction

Good afternoon and welcome to the Jurisdiction B & C "Ask the Contractor Teleconference." The ACT call is hosted once a quarter by the DME MAC Provider Outreach & Education team. My name is Teresa Camfield, and on the call this afternoon we are joined by subject matter experts from CGS operational departments.

For this ACT call, we will be discussing the following Medicare Updates: CMS Elimination of Certificates of Medical Necessity (CMNs) & DME Information Forms (DIFs) and the CMS Interim Final Rules with Comment (IFC) (CMS-1744-IFC & CMS-5531-IFC) COVID-19 Public Health Emergency- Revised. We will speak specifically to the CMN and DIF Instructions for Oxygen CMS 484.3 and External Infusion Pumps DIF form 10125. We will also speak about Orthoses Prior-Authorization - Phase 2 Implementation, Sequestration Changes 2% Payment Adjustment, and myCGS 7.3 enhancements and Internet Explorer (IE) 11 retirement in relation to myCGS as well as CGS online resources.

You are welcome to ask questions related to any of today's topics; however, we request that you refrain from asking unrelated questions. Also, please keep in mind that questions regarding a specific claim or beneficiary cannot be discussed due to possible Protected Health Information (PHI) issues. You will need to call our Customer Support department for issues with a specific claim.

There is not a presentation for this call; however we will have a few slides listing affected HCPCS codes and timelines.

This call is being recorded and the questions and answers (Q&A) 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 or purpose. We will be posting the ACT transcript and Q&A document to the CGS 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 question-and-answer segment, it is best if you call in on your telephone. You must enter your audio PIN # into your telephone keypad. Your audio PIN is located in the GoToWebinar control panel under the audio drop-down, 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.

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 ultimately your responsibility as a DMEPOS supplier to stay informed and compliant with Medicare program guidelines.

I'd like to take a moment before we begin to let you know that CGS Provider Outreach & Education (POE) is hosting addtional in-person workshops. We hope you will make plans to attend our upcoming Mega Workshop in Nashville, TN, on August 18, 2022. The POE staff is happy to once again provide face-to-face education.

We value your feedback. In the chat window on your dashboard, you will see the URL link for our survey about today's call. The slide currently on the screen is the QR code, along with the same URL link. You can use the QR code via your smart device (phone, tablet, watch), or enter the URL link in your browser window. This provides you an opportuinity to tell us what you liked about today's call, or if you think there is something we could improve upon. Your feedback is important and helps us make our educational events the best they can be!

Before we open the call for your questions, let's go over the Medicare Updates. We will begin with CMS Elimination of Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFs).

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

CMS published the initial notice via their MLN Connects newsletter on Thursday, May 5, 2022, with a revision on June 1, 2022, due to the revised implementation date for CR 12734 and to change the link to reference MLN SE 22002.

- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2022/05/cope25989.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2022/05/cope25989.html

CMS is eliminating all remaining CMNs and DIFs effective for claims with dates of service on or after January 1, 2023. CMS has published MLN Matters Article SE22002 and Change Request, CR 12734 explaining the planned change.

For claims with dates of service on or after January 1, 2023, providers and suppliers no longer need to submit CMNs or DIFs with claims.

Due to electronic filing requirements, claims received with these forms attached will be rejected and returned by the Common Electronic Data Interchange (CEDI) to the provider or supplier.

For claims with dates of service prior to January 1, 2023, processes will not change, and if the CMN or DIF is required, it will still need to be submitted with the claim or must be on file from a previous claim.

The current forms that shall be eliminated are as follows:

CMNs	
484	Oxygen
846	Pneumatic Compression Devices
847	Osteogenesis Stimulators
848	Transcutaneous Electrical Nerve Stimulators (Purchase Only)

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CMNs	
849	Seat Lift Mechanisms
854	Section C Continuation Form

and

DIFs	
10125	External Infusion Pumps
10126	Enteral and Parenteral Nutrition

Please ensure your DME software and clearinghouse vendors have been notified of this upcoming change. CGS will share future CMN & DIF information through our electronic mail listing and on the JB & JC websites.

Let's move on to...

CMS Interim Final Rules with Comment (CMS-1744-IFC & CMS-5531-IFC) – COVID-19 Public Health Emergency – Revised

- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2020/06/cope17942.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2020/06/cope17942.html

The June 03, 2022, IFC revision speaks to CMN Instructions for Oxygen (Form CMS 484.3) and DIF instructions for External Infusion Pumps (Form 10125).

CMS has determined that requirements for a CMN 484 for oxygen claims and DIF 10125 for External Infusion Pump (EIP) claims will not be enforced during the COVID-19 PHE.

Therefore, there is no requirement to submit a CMN or DIF during the PHE for oxygen or EIPs.

- These CMNs or DIFs are not required regardless of the diagnosis or etiology necessitating the use of the CMN-related or DIF-related DME.
- You will continue to use the appropriate modifiers, including the KX and/or CG modifier where applicable.

If CMNs or DIFs are not submitted, suppliers must append the CR modifier and COVID-19 claim narrative for any oxygen or EIP claims submitted during the COVID PHE.

- Keep in mind, use of the CR modifier and COVID-19 narrative simply reflects that the claim was submitted during the COVID PHE.

Orthoses Timeline for Prior Authorization Implementation

In the Orthoses category, 5(5) HCPCS codes for knee and lumbar sacral orthoses were added to the Required Prior Authorization list effective April 13, 2022.

Those HCPCS codes are L0648, L0650, L1832, L1833, and L1851. Implementation of the prior-auth requirement will be completed in 3 phases.

1. **Phase One** began April 13, 2022, in New York, Illinois, Florida, and California.
2. **Phase Two** began July 12, 2022, in Maryland, Pennsylvania, New Jersey, Michigan, Ohio, Kentucky, Texas, North Carolina, Georgia, Missouri, Arizona, and Washington.
3. **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 navigation pane of the CGS website.

- **JB:** https://www.cgsmedicare.com/jb/mr/condition_of_payment_prior_auth.html
- **JC:** https://www.cgsmedicare.com/jc/mr/condition_of_payment_prior_auth.html

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. https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/Operational-Guide-for-DMEPOS-PA-current.pdf

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

Prior Authorization for orthoses remains valid for 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.

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

- **JB:** https://www.cgsmedicare.com/jb/mr/condition_of_payment_prior_auth.html
- **JC:** https://www.cgsmedicare.com/jc/mr/condition_of_payment_prior_auth.html

Sequestration Changes 2% Payment Adjustment

- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2022/01/cope24619a.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2022/01/cope24619a.html

The Protecting Medicare and American Farmers from Sequester Cuts Act impacts payments for all Medicare Fee-for-Service (FFS) claims. During the Public Health Emergency (PHE) multiple Congressional Acts suspended the 2% sequestration payment adjustment applied to all Medicare Fee-for-Service claims from May 1, 2020, through March 31, 2022.

Therefore, there was no payment adjustment through March 31, 2022.

A 1% payment adjustment was implemented April 1 – June 30, 2022.

The 2% payment adjustment began on July 1, 2022.

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myCGS 7.3 Web Portal Updates

- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2022/07/cope26465.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2022/07/cope26465.html

myCGS 7.3 released on July 5, introducing major enhancements to the Same/Similar functions available in the portal.

- The new version of myCGS is highlighted by a brand new Same/Similar" screen, which combines the previous functionality of the CMN Status, Claim History, and Diabetic Supplies & Shoes screens into one easy-to-use search.
- The new Same/Similar screen gives users a wide array of options for performing same/similar searches. You can search by individual HCPCS codes, partial codes, a range of codes, or by product category (without entering any specific HCPCS code).
- The Same/Similar screen can provide data for both Jurisdiction B and Jurisdiction C in one search, eliminating the need to switch back and forth.
- The Same/Similar screen adds additional details about beneficiary equipment history (like denied CMNs) and improves the printing ability of same/similar results.

A new user role, called a **Same/Similar User**, is available for suppliers who bill Jurisdictions A and/or D (but not B or C).

- This new role allows for JA/JD suppliers to use myCGS for Same/Similar inquiries, even if they don't submit claims to CGS JB or JC.
- Existing JA/JD-only myCGS users need to re-register for myCGS using the new Same/Similar User role with the release of myCGS 7.3.

The new Same/Similar search screen gives you the options of which jurisdiction(s) you want to search, what type of equipment you want to search for (based on either product categories or HCPCS codes), and whether you want to include denied CMNs in your search.

After performing the search, myCGS will display a list of the claim history of the equipment and CMNs related to the search.

JB and JC suppliers should consider checking Same/Similar for JA & JD via Noridian's web portal as well.

myCGS Will No Longer Support Internet Explorer Beginning 8/15/2022

- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2022/06/cope26253.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2022/06/cope26253.html

Microsoft discontinued support of the Internet Explorer (IE) browser (including IE 11) on June 15, 2022. As a result, myCGS will also discontinue support of IE.

Beginning August 15, 2022, you will no longer be able to use IE to log into myCGS. If you attempt to log in to myCGS using any version of IE on August 15 or after, your login attempt will be blocked.

If you are an IE user, you must switch to a different browser before August 15. The following internet browsers will continue to work with myCGS:

- MS Edge (preferred)
- Safari
- Firefox
- Google Chrome

Keep in mind, we are allowing access to myCGS through IE until August 15; however, IE's official support ended on June 15. If you continue using IE, you may experience technical issues with both the https://www.cgsmedicare.com website and DME myCGS web portal (even before August 15). We strongly recommend that you change your browser as soon as possible to avoid any possible issues.

CGS Online Resources

https://www.cgsmedicare.com

Last but certainly not least, I'd like to remind you about CGS wide array of web-based resources. CGS offers over 30 tools and calculators to assist with claim submission, claim resolution, and related appeals. CGS offers multiple charts and guides you can use as desk references. There are "Dear Physician Letters" to assist you in educating physicians, practitioners, and referral sources and also multiple documentation checklists to assist in obtaining necessary medical record documentation. CGS also offers online education courses, videos, and recorded webinars to assist in educating you and your team members. The CGS Medicare App, available for mobile phone or tablet users, provides information access at your fingertips wherever you may be!

To save you time and money, we encourage you to take advantage of all CGS online resources. These resources are available 24/7 at your convenience, with the exception of regular maintenance and service outage periods. You will find more information about all CGS resources on the https://www.cgsmedicare.com website, located under the left-hand navigation menu.

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 really appreciate your opinion.

We will take just a moment to 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 questions, so please ask one question at a time, and then rejoin the queue to ask each additional question.

We are now ready to take our first question.

Questions & Answers

Question 1: My question is related to myCGS. Were you saying we could look up information for Jurisdiction D in myCGS?

Answer 1: No. What I said was suppliers who reside in JA & JD, can now gain access to myCGS for Jurisdictions B & C to check Same/Similar information.

Question 1A: Okay. We are in Oklahoma, and we have clients along the Kansas border in Jurisdiction D, and we haven't ever gotten onto the portal for JD, and I thought you said we could use myCGS to lookup JD? I was getting really excited!

Answer 1A: No. You will have to register for JA & JD online web portal access to look up beneficiary information for JA & JD.

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Question 2: The general CGS Same/Similar Lookup tool groups upper extremity HCPCS codes as "similar" with any and all upper extremity HCPC codes.

With the myCGS upgrade to version 7.3, I do not see a grouping for "Upper Extremity" (UE) as a product category. If CGS groups upper extremity in the lookup tool, why is there no group within the patient specific myCGS MBI search? I have reviewed all UE claims submitted to all 4 jurisdictions within Q2 2022. We received no denials for upper extremity same/similar in Noridian JA/JD regions, only for same HCPCS code. CGS regions show similar with L3809, L3908, and L3924 but not necessarily against other upper extremity products for the shoulder or elbow (example: L3660, L3761, L3984).

The denials definitely do not match the patient specific myCGS search and will not flag as similar because there is no product category; however, they also do not match the general lookup tool.

Answer 2: The CGS Same/Similar Tool on the JB/JC website is sorted by like or similar HCPCS codes.

The myCGS web portal Same/Similar functions by HCPCS code or by Product Category. However, the product categories in myCGS are based on Medicare policies that have a Local Coverage Determination (LCD). There is not a published LCD for upper extremity products; therefore, there is not an upper extremity product category in myCGS.

Question 3: I have a couple of questions. My first one is regarding myCGS. I have a problem looking up when the patient is deceased and then the inpatient and outpatient skilled nursing facility (SNF) date doesn't seem to be updated. Do you see that being fixed?

Answer 3: There was an update to the date of death system completed on 07/22/2022, this issue should be resolved now.

However, If you are unable to verify date of death in myCGS; you can call the Provider Contact Center (PCC) for assistance.

Question 3A: Then, on the myCGS 7.3 same/similar, I'm having issues where it's not pulling everything the way it should. Are they still working on that?

Answer 3A: They are working on some fixes, since the most recent myCGS update of 7.3.1. You can also check myCGS status on our website at https://www.cgsmedicare.com. There is a myCGS status button at that top right corner on our website, and you can click that button to see the status. Information about any issues with the myCGS web portal will be listed. Also, stay tuned to CGS electronic mailing for updates as well.

myCGS Same/Similar Status: https://r20.rs6.net/tn.jsp?f=001aiwfJm9_3qjJBheloC5SqN2dqWO6GyB06JkJ4oUydmg2CV9zWmHmHywSZ-8_t1dfWFV883evF57QvHn8B0SvdocxiENWjWV7E8YfIBk1ZoI4k-CqZFSnHMmP7-XzOdAtcrvB033X3A9lhdppeOdLTvzxDTdnVQQlwIBo1ESj6S9us4g07jbuyqFCWOOpRQ-MU1DbnOO42H0=&c=kJNxSBisxwU9gOPysXmc9raDSPO90Z-pqPz5SkYPSLgOxcDbGFqcug==&ch=NdRp7NqB2NlxhF-606xpqRwytZAQQz5Rgmwp2__5BLr5jWSyOgvdEQ==

We are currently experiencing some intermittent issues with the Same/Similar screen in myCGS. If you experience a Same/Similar issue in myCGS, the IVR's Same/Similar search is working correctly. Call the IVR to obtain any needed Same/Similar information (https://r20.rs6.net/tn.jsp?f=001aiwfJm9_3qjJBheloC5SqN2dqWO6GyB06JkJ4oUydmg2CV9zWmHmH7tEj-31Quv5KpNvramX02wuegzJeBCmfAA8wVwDzdi7P7Q_a_PxSEGFPL8smt4_T039QHfVvIjyHDxMRv--b98N5ySOknz4CjqJZaJutstweiMYoNgH4mc=&c=kJNxSBisxwU9gOPysXmc9raDSPO90Z-pqPz5SkYPSLgOxcDbGFqcug==&ch=NdRp7NqB2NlxhF-606xpqRwytZAQQz5Rgmwp2__5BLr5jWSyOgvdEQ==). There is one exception, same/similar for Orthoses (L) HCPCS is not available via the IVR.

Please note that we have made several changes to improve the response of Same/Similar inquiries, but we are aware that some users are still experiencing issues. We are working to resolve them as quickly as we can.

Question 3B: I have one other question on a continuous positive airway pressure (CPAP) when they don't meet the compliance period, within 90 days. And it's basically going to be a start over, where they have to have a new facility based titration and be seen by the doctor, so if they kept their equipment until they can get all this stuff done, when we do have him restart, he needs to meet compliant use first. Then go back and have a re-evaluation for the compliance, and then the date of the face-to-face will be our fourth rental month.

i. But my question is, do we need a new RX and a new delivery ticket for when we start billing that fourth month going forward?

ii. Do I need to have them sign a new delivery ticket as well? Or our initial delivery ticket is sufficient, correct?

iii. What month does our billing restart?

Answer 3B: A new CPAP trial period requires the beneficiary to have a new practitioner face-to-face (F2F) exam, a new facility-based sleep study, and a new standard written order (SWO).

If the equipment was not picked up between the two PAP trial periods, you are required to inspect the equipment and attest the CPAP is functioning properly for Medicare billing, or you can obtain a new delivery ticket.

Billing cannot resume until after the second trial period. The beneficiary must meet compliant use and complete the F2F re-evaluation. Billing will resume with the 4th rental month. The maximum reimbursement is 13 months, rent to purchase.

Question 4: I have a patient that's changing providers, the previous provider billed 2 months, and they submitted the initial CMN 484. So, do I need a new or revised CMN, and start over with our billing, or can I submit it with the CR modifier?

Answer 4: Based on the revised "Interim Final Rules with Comment" (IFC) you are not required to obtain CMNs for oxygen during the PHE.

- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2020/06/cope17942.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2020/06/cope17942.html

However, you must have an SWO. To fulfill this requirement, you can obtain copies of the previous suppliers CMN 484 and/or SWO and begin your billing forward. If you cannot obtain copies of the previous suppliers CMN and/or SWO, then you must obtain a completed SWO prior to billing Medicare.

Keep in mind if you do not have a copy of the previous supplier's CMN and you only have an SWO, you are required to append the CR modifier to the oxygen claim lines and COVID-19 in the claim narrative.

Question 4A: My next question goes back to the myCGS issues that are going on. The older system had Claim History

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tab that you could pull from. In the new version, I understand that's everything under Same/Similar. I am trying to check for A codes for PAP supplies. We printed the claim history for 4/26/22 out of the old system, and it showed this patient had gotten supplies on 12/01/21.

In the new, Same/Similar, no matter whether I put in a range or whether I put in a specific date—and I already know they have received supplies for the previous date 12/01/21—the new system will not verify it. It gives no claims found.

CGS response: Even when you select the product category?

Attendee Response: I've tried that, too. I did that a few minutes ago, before, my question came up, to see if I can get it to work that way. So, I can't get it to work code specific, or with a range, or with a product category to show PAP supplies on this patient that I know received supplies in September and December 2021. My concern is, she may have gotten more supplies since then, but I'm really uncomfortable since even the September and December supplies they got don't show in myCGS. What are the recommendations?

Answer 4A: Instructions we have been given is for you to log out of myCGS and clear all your previous searches on your computer. After you have cleared out your browser, then log back in to myCGS and re-run your search. If that does not work, then reach out to us via the CGS.JBJC.LEARNINGONDEMAND@cgsadmin.com, and we will submit your issues to the CGS Tech Team.

myCGS Same/Similar Status: https://r20.rs6.net/tn.jsp?f=001aiwfJm9_3qjJBheloC5SqN2dqWO6GyB06JkJ4oUydmg2CV9zWmHmHywSZ-8_t1dfWFV883evF57QvHn8B0SvdocxiENWjWV7E8YfIBk1ZoI4k-CqZFSnHMmP7-XzOdAtcrvB033X3A9IhdppeOdLTvzxDTdnVQQIwIBo1ESj6S9us4g07jbuyqFCWOOpRQ-MU1DbnOO42H0=&c=kJNxSBisxwU9gOPysXmc9raDSPO90Z-pqPz5SkYPSLgOxcDbGFqcug==&ch=NdRp7NqB2NlxhF-606xpqRwytZAQQz5Rgmwp2__5BLr5jWSyOgvdEQ==

We are currently experiencing some intermittent issues with the Same/Similar screen in myCGS. If you experience a Same/Similar issue in myCGS, the IVR's Same/Similar search is working correctly. Call the IVR to obtain any needed Same/Similar information (https://r20.rs6.net/tn.jsp?f=001aiwfJm9_3qjJBheloC5SqN2dqWO6GyB06JkJ4oUydmg2CV9zWmHmH7tEj-31Quv5KpNvramX02wuegzJeBCmfAA8wVwDzdi7P7Q_a_PxSEGFPL8smt4_T039QHfVvIjyHDxMRv--b98N5ySOknz4CjqJZaJutstweiMYoNgH4mc=&c=kJNxSBisxwU9gOPysXmc9raDSPO90Z-pqPz5SkYPSLgOxcDbGFqcug==&ch=NdRp7NqB2NlxhF-606xpqRwytZAQQz5Rgmwp2__5BLr5jWSyOgvdEQ==). There is one exception, same/similar for Orthoses (L) HCPCS is not available via the IVR.

Please note that we have made several changes to improve the response of Same/Similar inquiries, but we are aware that some users are still experiencing issues. We are working to resolve them as quickly as we can.

Question 5: I do have a question. I didn't catch the part about the CR Modifier for oxygen. Could she repeat that, and then I do have a question about the CR Modifier.

Answer 5: During the PHE, based on the revised IFC, suppliers are not required to obtain the oxygen CMN, no matter the reason, during the PHE.

You are still required to obtain your SWO. Medical necessity documentation must be documented in the medical record. You will continue to use the KX modifier.

If you obtained a SWO and the medical record documents medical need, you would append the CR Modifier to all line items for oxygen and the COVID-19 claim narrative in the 2300 or 2400 segment of your electronic claim. For paper claims you will enter the narrative in block 19 of the CMS 1500 claim form.

Question 5A: If the beneficiary did not obtain the F2F or the testing or etc., and the practitioner documents they need oxygen, and he/she orders it, we should append the CR modifier and the COVID-19 narrative?

Answer 5A: Yes. The respiratory national coverage determinations (NCDs) and LCDs are not being enforced during the PHE. If the requirements of the oxygen NCD or LCD have not been fulfilled and/or you did not obtain a CMN and/or obtain a signed delivery ticket for delivery "direct to the beneficiary," then you will append the CR modifier and the COVID-19 claim narrative.

Question 5B: Okay. What if it is not respiratory or COVID related, and they got a walker and they do not want to sign the delivery ticket? I know we can indicate COVID-19, but do we also put the CR modifier on the claim?

Answer 5B: During the PHE if the beneficiary refuses to sign a "direct to beneficiary" delivery ticket, you will append the CR modifier and COVID-19 claim narrative.

Keep in mind, DMEPOS Quality Care Standards remain in effect during the COVID-19 PHE. Waiver of signature allowance does not apply to items that are custom, custom-fitted, or require fitting at the time of delivery.

Also, for items shipped, the CR modifier and COVID-19 claim narrative do not apply as signatures are not required for items shipped.

Question 6: Hello. With the elimination of the CMNs, will Medicare differentiate between what claims are paid versus what gets denied? Because, as of right now, we're billing and submitting questions on the CMN. And I noticed that most of the time, that's what they're basing their denial versus payment on. So, do you think they maybe going to like a pre-auth or something?

Answer 6: That's a good question. At this time, the Oxygen LCD has not been revised from the NCD changes that removed chronic stable state and group 3 criteria. Other than the IFC changes published on June 3, 2022, we have not received any additional updates from CMS. The DME MAC Medical Directors (DMDs) are working with CMS to revise the Oxygen LCD and related policy article. We have not received any information about documentation changes for dates of service on/after 01/01/2023.

Keep in mind, if the order changes, such as changing from 8 hours nocturnal use to continuous use, the liter flow changes, adding portable O2, then a new SWO would be required. You can add additional elements to your SWO. Just remember the required SWO elements must also be present.

So, the only information we have at this time is the CMNs and DIFs are going away effective 01/01/2023. This was a proactive notice from CMS to allow DMEPOS suppliers and DME software vendors time to prepare their systems for this change and be ready for January 1, 2023.

Question 7: I just wanted to check with you guys to see if a CPAP renting with BlueCross, or any commercial plan, as primary and Medicare as secondary. Sometimes, those secondary claims do not get to you guys. Some claims are not submitted to you during the first month or two because

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of the deductible, and that sort of thing. We were just wondering—will the full 13 months need to be billed to Medicare in order for any repairs to be billed, or for it to be considered patient owned?

Answer 7: Yes, the rules are the same for Medicare, whether Medicare is primary or Medicare secondary payer (MSP). You will need to submit your MSP claims for the full 13 months.

Question 7B: So, what if BlueCross has completed their payments?

Answer 7B: You should submit your secondary claims to Medicare to complete the rent to purchase with Medicare.

Supplier response: Yes ma'am, okay, that's what we wanted to be sure about. We've run into some things recently and wanted to check on that. We will be sure to bill all 13 months. Thank you so much!

Question 8: Hi. So, I was wondering, I know the Oxygen NCD has been updated as far as the tried and failed and the chronic stable state. Do you have a timeline to when the LCDs are going to be updated to reflect that?

Answer 8: At this time, we do not have an ETA timeline on the revised Oxygen LCD. The DME DMDs are working with CMS on the oxygen changes. So, stay tuned to our electronic mailing list for any updates! We will notify you as soon as we know.

Question 9: Quick question for you all, when it comes to the prior authorization. Some of those codes are actually under competitive bidding in my area. So, I guess I'm trying to make sure we get this correct. So, we have a patient who needs a back brace L0650 that is not urgent, so we can get authorization. They come back after the authorization is obtained. Will they still need the office visit billed on the same day they pick up the brace, or are they able to come in and get the brace without billing for an office visit?

Answer 9: So, the item is being provided by a physician's office, exclusion of competitive bidding?

Supplier response: Yes.

Answer 9: Okay, so in that scenario, the office visit does need to be billed on the same date of service as the orthotic device is provided. And in that scenario, you would also utilize the KV, as in "Victor," modifier.

We have some very helpful prior authorization documents that suppliers need to know that talks about the KV modifier and the scenarios in which you can provide those items under exclusion, from competitive bidding as an exception to prior authorization. You can find those documents on the CGS website at https://www.cgsmedicare.com. Access the left-hand blue navigation panel and select Prior Authorization. You can also access the information under the Medical Review tab, then Prior Authorization.

Question 9B: Okay, just one more like this in the same vein, it's not a new question. So just to make sure I'm clear, we will need to schedule a new appointment for the patient coming back in to get the orthotic device?

Answer 9B: There does have to be an office visit billed the same date they pick up the orthotic. So, that would all happen on the same date to fit into those stark laws. You do not have to get prior authorization if the item is being provided by a physician during an office visit. Just append the KV modifier in that scenario.

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

Question 10: I have a question about the CPAP recall, and the Respironics recall and the shortage with ResMed. If we're seeing patients that aren't getting delivered in a timely manner because of the manufacture shortage of the actual machines, and their sleep study might have been right at a year ago.

We've got current prescriptions from the doctor, so is there going to be an issue with us doing that, or are patients expected to have a new sleep study? Is Medicare going to pay for a new sleep study?

Answer 10: Okay. Let's talk about the delay the device first. In that instance, if. If there is a delay, you need to make sure the information is documented as to why there was a delay in dispensing the device. We have PAP FAQs that address this question on our website under PAP FAQs.

- **JB:** https://www.cgsmedicare.com/jb/help/faqs/current/pap_suppliers.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2009/0909/cope10618b.html

Supplier response: Yeah, that is the one I am looking at.

CGS response: Yes, it's FAQ number 9; it states, "While a few months delay in dispensing a CPAP would be understandable, over a year would be hard to justify."

Supplier response: But even in our jurisdiction council meetings with Dr. Hoover, everybody knows the PAPs have been hard to get since the recall, and they still are.

And we have patients that, you know… I have one now that their sleep study was like July first of last year and then they're F2F as part of that. The doctors are writing in the charts, because of the recall, they do not have their machine yet or because of the shortage.

We are getting a current prescription, but we're wondering because this question and answer that says over a year would be hard to justify.

This is a worldwide Respironics recall, and rather than all other CPAP shortages because of that, I just wondered how that was being audited if it was being audited at right now. Because it does say this was reviewed all, 6/30/22, but it doesn't really change it.

And most of our doctors are noting that they're still seeing patients, or their updated prescriptions, when we know we have machine. I just wondered if that question's going to change. Thank you.

CGS response: At this point, this question has been answered a few times during the JB & JC Council meetings, and at this time the answer has not changed.

Supplier response: Is it better to use the CR modifier and go that route?

CGS response: Keep in mind the recall and lack of access is not a PHE exception. If the beneficiary is affected by the PHE, the LCD is not currently being enforced, then you can use the CR modifier and COVID-19 narrative. The lack of access issue is also in the FAQs.

It's very possible that if he/she still does not have a PAP device the beneficiary's condition may have changed in that length of time. That is why the FAQ is cited in that manner, because it's

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been over 12 months. You're looking at 13 months or longer at this point.

If you were able to give them the device that was ordered within 12 months and the delay is documented and you have a current order, I think that could be justified. The Standard Documentation Requirements for All Claims Submitted to DME MACs (SDR) specifically states documentation within the most recent 12 months. So that's another requirement to consider.

Supplier response: So, do you think Part B Medicare is paying for repeat sleep studies?

CGS response: I cannot speak to Part B Medicare (local carrier) paying for repeat sleep studies. That is a question for them.

Question 11: Are you seeing an uptick in CGS Connect™ requests for PAP devices for beneficiaries like this, with sleep studies a year ago, that some PAPs are becoming available? And, we actually are using machines that do not have modem capability because computer chips have not been available. Which makes compliance hard to obtain because patients have to bring in their scan disc for download. I just didn't know if you were seeing any of these kinds of things through CGS Connect™?

Answer 11: No, we haven't seen an uptick in CGS Connect™ requests for PAP devices in the scenarios you have presented. No, we have not seen any increases.

Question 12: We recently had an oxygen claim that was denied that had been submitted to CGS Connect™, and the medical necessity was approved by CGS Connect™. I know it's not like a true prior authorization, but how would we handle that?

Answer 12: Medical Review, "We always say CGS Connect™ is not a guarantee for payment." We do our best based upon the information given to us at the time to provide you a decision of affirmation or non-affirmation.

However, if you see a pattern of approvals that result in denials, please reach out to us at CGS.DMEConnect.Inquires@cgsadmin.com so we can research it, because our goal is consistency among all our reviewers. Without looking at the particular case, I can't speak to it, but please reach out if you see patterns or trends and we're more than happy to look at it.

As I mentioned earlier, CGS Connect™ is not a guarantee for payment, it's based upon the information that the reviewer sees, that it would be affirmed.

Supplier response: Okay. And in all honesty, our group of nurses, you know, had reviewed the information, and we actually felt like it was not appropriate for coverage. But we sent it through at the doctor's request. So, in all honesty, we agreed, but we just weren't sure once it went through that process, and there was still a denial.

CGS response: We greatly appreciate you providing that feedback, and this is something that will help us to be better as well.

Question 13: We had a situation where a gentleman needed a repair on his CPAP, and then he actually had to come in for a second time, and it was approximately six months later. Is there a certain frequency at which repairs will be covered? Like, does it matter?

Answer 13: There is not a certain frequency for repairs, once the equipment has reached the 13th month to purchase and is beneficiary owned. If the equipment or part is no longer covered under warranty and requires repair or replacement, then you would provide the service and bill accordingly.

Question 13A: Also, if there's a repair that's needed and say it's about three months or so prior to the end of the 5- year reasonable useful lifetime (RUL), if we bill that repair at that time, we will need to wait at least 6 months. Is that right, or longer, in order to restart them? If they get a new machine after that? Is that correct?

CGS response: So, you are saying the beneficiary needed a repair and it was 3 months before their 5-year RUL and that you have been instructed that you have to wait 6 months after that for Medicare to pay for additional repairs or replacement?

Supplier response: No ma'am. Someone mentioned that, but I just didn't know if there was a particular timeframe after a repair is billed. Like do we have to wait a certain timeframe after the repair in order to replace the equipment once the patient has met their 5-year RUL.

Answer 13A: No, you do not. Once the beneficiary has met the 5 year RUL, then the beneficiary can choose to obtain new equipment at that time.

Question 14: The last thing—we had a patient that used their oxygen about 11 months. And then they turned it in. And then it was a couple years later where the doctor re-ordered it for the same exact diagnosis. It was greater than 60 days break- in-need, but it was still less than 5 years, as far as the RUL goes. I believe, in that case, for CMS purposes, would we stay on that initial CMN period at that point, or would we go ahead and do a recertification CMN?

Answer 14: Following the current oxygen LCD guidelines (not related to the PHE allowances) you would obtain a recert CMN. Keep in mind, the beneficiary requested the equipment to be picked up. The oxygen was not discharged by their treating physician/practitioner. Therefore, there was not a break-in-need, there was a break-in-billing. In this instance a new rental period will not begin; your rental will continue where it left off at the 12th month rental forward. The only time a new rental period can begin is if there was a change in medical need or a true documented break-in-need. Pay close attention to the oxygen order for any changes in liter flow, administration, etc.

Question 15: My question is on respiratory assist and complex sleep apnea and central sleep apnea. The LCD actually talks about how the physician can choose which device that he thinks is appropriate, whether it's an E0470 or E0471. He does not have to document anything special, whatever he puts in the record should be ok. Right?

Answer 15: The medical record should document the qualifying diagnoses, qualifying testing, and the severity of the beneficiary's condition that warrants the type of equipment ordered, an E0470 or E0471.

Question 15A: Right, and consideration for other comorbidities. I know like, complex or central sleep apnea that should be measuring at 50% above obstructive apneas, when they're conducting the titration portion on the actual continuous positive airway pressure device (CPAP) or bi-level respiratory assist device (BIPAP).

It has to be 50%, not during the initial diagnostic portion of the sleep study. I think that's the hardest thing for my team to get, they're looking at the initial sleep study. But it has to be calculated during the titration, with treatment of the obstructive sleep apnea (OSA). Right?

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Answer 15A: Yes. For a diagnosis of complex sleep apnea (CompSA), during the titration portion of the sleep study and after the obstructive apnea events have been effectively treated with an obstructive apnea hypopnea index (AHI) of less than 5 per hr. The sum total of central apneas and central hypopneas is greater than 50% of the total apneas and hypopneas. With a central apnea-central hypopnea index (CAHI) of greater than or equal to 5 per hour.

For a diagnosis of central sleep apnea (CSA), the sum total of central apneas and central hypopneas is greater than 50% of the total apneas and hypopneas with an AHI greater than or equal to 5 per hour.

Question 16: A patient who has a BlueCross, state plan primary, and Medicare Part B secondary, they need a wheelchair, and it is specifically for their work. It is not only for use in the home; the doctor is ordering it primarily because this person is still employed, and they have a primary commercial plan. BlueCross will pay for the wheelchair for that reason. Medicare is secondary, and the patient has not met their deductible. Is Medicare going to pay the deductible and co-insurance, and also would they pay for the wheelchair at all with it not being for use in the home?

Answer 16: Medicare coverage and billing rules are the same for Medicare primary or Medicare secondary payer (MSP). For Medicare to cover the wheelchair, it must be required for primary use inside the home. In this instance, it would be in your best interest to obtain an Advanced Beneficiary Notice (ABN). Your ABN has to indicate specifically why you believe Medicare is likely to deny coverage for the wheelchair. In this instance you would need to indicate the wheelchair was prescribed for primary use outside the home, for work purposes, etc.

Question 16A: Right. In that situation, can we just opt not to bill Medicare as a secondary?

Answer 16A: No. You cannot opt out of billing, but the beneficiary can opt out on the Advanced Beneficiary Notice (ABN) option 2, that they choose not to bill Medicare. Keep in mind, they can always come back to you later and say, I've changed my mind, I want you to bill, so you want to make sure that you follow Medicare guidelines in ABN completion rules and billing with the GA modifier and/or billing with the GY modifier for non-covered items or services.

Question 16B: Right, okay, so then if we do bill, we would, not put the KX modifier on the claim?

Answer 16B: Article - Manual Wheelchair Bases - Policy Article (A52497) (https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52497&ContrID=140)

If the manual wheelchair is only for use outside the home, it will be denied as noncovered, no benefit, as the DME benefit requires use within the home for coverage eligibility.

If the wheelchair is only to be used for mobility outside the home, the GY modifier must be added to the code.

Article - Power Mobility Devices - Policy Article (A52498) (https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52498&ContrID=140)

If any POV or PWC is only for use outside the home, it will be denied as noncovered.

If the power mobility device or push-rim activated power assist device that is provided is only needed for mobility outside the home, the GY modifier must be added to the codes for the item and all accessories.

Question 17: I have a question I need clarification on related to the SWO. Say for a wheelchair, it used to be a written order prior to delivery, but since it's been replaced with a single written order. So, that means we can get a verbal order, or a supplier generated order, you know talking to the physician, but we cannot dispense the wheelchair until we get all the elements on the single written order. Is that how that works?

Answer 17: Medicare is no longer looking for you to send us, nor are we reviewing for your verbal orders, faxed dispensing orders, or scripts. You are required to have a completed SWO prior to you submitting a claim to Medicare. Keep in mind, the completed SWO is a condition of payment rule in the Standard Documentation Requirements for all DMEPOS.

Question 17A: Okay, so the doctor s called our office and said, "Hey, this patient needs a lightweight wheelchair." So, we. We have a verbal order who we spoke to. We can provide it, but we can't bill it until we get this single written order signed off on, with all the elements that are supposed to be on the detailed order.

Answer 17A: Yes, for manual wheelchairs, you can dispense from a verbal order. The practitioner called, you've accepted their verbal order, you can dispense the manual wheelchair. You cannot bill until you receive the completed and signed SWO.

Keep in mind, your order date is the date you received the verbal order, which is the date they contacted you to dispense the wheelchair and will be the order date you indicate on your SWO.

Question 17B: Okay, right. That would have to be signed by the practitioner. That's ordering that wheelchair.

Answer 17B: Yes, for manual wheelchairs you are allowed to complete the SWO and send it for practitioner review and signature.

Question 18: I have one more question for the A7005, which is a non-disposable nebulizer administration kit,1 every 6 months, because it has the frequency. 1 for 6 months before we can release that to bill on our SWO? It actually needs to say the frequency, correct?

Answer 18: The quantity must be listed on the SWO. Frequency must be documented in the medical record. Your SWO must include at a minimum all the required standard written order (SWO) elements. However, you can add additional elements if you want, such as the frequency of use or change, length of need, etc.

A good place to document ongoing supply orders, item, quantity, and frequency of use, (A7005 1, Q-6 months) etc., is in the medication listing in the medical record. There is an excellent Dear Physician Letter on documentation of continued use.

- **JB:** https://www.cgsmedicare.com/jb/mr/pdf/dear_physician_durablemedicalequipment.pdf
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2016/1216/cope1301.pdf

Question 18A: That's a recommendation from the DME MAC medical directors, and for the medication list to be valid does it have to be signed off by the doctor as well?

Answer 18A: The medication listing is usually part of the progress note itself. It is part of the note that is signed by the practitioner.

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Question 19: Someone touched on this earlier, but I would like further clarification on a beneficiary entering Medicare FFS. I know there is not like a standard form that you have, but we wanted some clarification around what exactly is required in the equipment attestation. The supplier manual says that we have to examine the equipment. What are you expecting within the equipment exam? What are we attesting too? Does it have to be somebody with credentials that performs the assessment? Or can it be performed by delivery personnel?

Answer 19: There is not a Medicare requirement for the assessor to be certified. It is your business decision as to who in your company will perform equipment assessment and attestations for beneficiaries entering Medicare. The equipment assessment has to indicate the equipment is in good working condition and functioning as expected, and it's expected to last. Once they become Medicare eligible, you will receive a new Medicare rental period. In that scenario, the equipment starts a new 5-year RUL.

Question 19A: Yes, I understand the purpose of the policy. My staff is reading too much into the requirement. So, I need to tell them, all they want is a statement saying it is in good working condition, that the person can actually use what they have. Like, my people are saying, somebody from engineering needs to do this. So, what do I need?

Answer 19A: You need to assess and confirm the equipment is in good working condition and it is functioning properly, and the equipment meets Medicare requirements for the item being billed. Proof of delivery (POD) is required for all items, even those in the beneficiary's possession provided by another insurer prior to Medicare eligibility. To meet the proof of delivery (POD) requirements for a beneficiary transitioning to Medicare, you the supplier, must have on record, the beneficiary signed and dated supplier statement that indicates you have examined the item, and your attestation that it meets Medicare requirements. Keep in mind you are receiving a new rental period, and this is the first month of the new Medicare 5-year RUL. The attestation suffices for proof of delivery unless you deliver different/new equipment and obtain a new delivery ticket. See reference SE19003 https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019-Transmittals-Items/SE19003

Question 19B: Is the equipment assessment able to be conducted virtually?

Answer 19B: The supplier manual states the equipment assessment has to be performed and attested to; it does not say it has to be conducted in person. However, please reference the COVID-19 PHE webpage on the CGS website at https://www.cgsmedicare.com for PHE waivers and non-enforcement related to in-person visits.

Question 20: This is a clarification request related to oxygen used with a PAP device. We know Medicare does not accept as needed orders (PRN) for oxygen while the patient is sleeping. We want clarification for a beneficiary moving from private insurance to Medicare who requires oxygen with a PAP device. We want the answer under normal circumstances aside from the PHE non-enforcement. We understand the PAP LCD allows a prior sleep study.

Answer 20: Keep in mind during the COVID-19 PHE, respiratory LCDs are not being enforced.

However, for a beneficiary who is entering Medicare and has a PAP and requires oxygen, under the current LCD, Medicare will require the beneficiary to have a new F2F exam and a new qualifying test via a titration sleep study that shows their oxygen levels desaturate while they are using the PAP device at prescribed optimal settings. The titration must show that they require oxygen in addition to using the PAP device on optimal settings. The F2F and titration sleep study must occur after their Medicare eligibility date and within 30 days prior to the initial CMN date/order date.

Also, for oxygen, keep in mind, unless they are moving from a Medicare Advantage Plan to Medicare FFS new testing is required to qualify for oxygen when moving from a prior payer.

If the beneficiary does not meet the LCD requirements, during the PHE non-enforcement then you will need to append the CR modifier and the COVID-19 NTE note to your claims.

Question 21: My question is related to the Master List of items for face-to-face (F2F) and written order prior to delivery (WOPD). We have had a lot of confusion with some recent changes. The Master List has a lot of codes on it that we were under the understanding they still require the WOPD, for example a hospital bed. The new Required List that came out April 13, 2022, are the only items that require the F2F and WOPD. I just found out that the hospital bed is no longer on the list. The Master List has items that could be subject to F2F/WOPD requirements in the future; is that correct?

Answer 21: Yes, there are two separate lists, the Master List of potential DMEPOS that may require a F2F & WOPD in the future, and there is the Required List. The Required List is the one you want to refer to; it lists the current DMEPOS items requiring a F2F and WOPD.

You also want to keep in mind some of the LCDs and Policy Articles may have F2F requirements in addition to the F2F required list. The Required List does not affect the policy requirements; they are still in effect.

Question 21A: Yes, we understand that. Our main concern is the detailed written order prior to delivery, which we do require a F2F before we provide medical equipment for medical necessity. It is usually within the past 30 days to within 6 months. Our biggest concern is the written order, which is more detailed, if they order a hospital bed, can we dispense the semi-electric hospital bed? However, we cannot bill until we receive that standard written order back that has more specific detail, is that correct?

Answer 21A: Yes, that is correct. Only items that require a WOPD currently are the items on the Required List. You are thinking about the old Affordable Care ACT (ACA) guidelines which went away in 2019. The only items that require a WOPD are the items in the WOPD Look-Up Tool or the items on the Required List.

Question 21B: Okay, unfortunately we missed that memo about the ACA requirements ending in 2019. We have still been requiring that. It wasn't until just a few weeks ago when we saw full face mask was on the Master List and it hadn't been in the past, we were trying to figure out what happened. I reached out to someone at CGS, and that's when it came to light to us. We didn't realize ACA had ended in 2019.

Answer 21B: Yes, the ACA requirements ended 12/31/2019. The implementation of the Standard Written Order was effective 01/01/2020.

Question 22: My question is related to beneficiaries entering Medicare. We have a patient who has an enteral pump that they have owned for several years. We are only delivering supplies and enteral formula. Do we need to examine the pump and provide attestation about the pump in order to bill the

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formula and supplies, or just append the claim narrative that the beneficiary owns the pump?

Answer 22: You just need to append the claim narrative that the beneficiary owns the pump, the HCPCS code, and the approximate date of purchase.

Question 22A: So, we do not need anything on file that states we examined the pump?

Answer 22A: No, not if you are not billing for the pump. You just need the claim narrative.

Conclusion

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

Thank you again for attending today's ACT call. Thank you to all the CGS subject matter experts (SMEs) who assisted us today. We look forward to seeing you at future educational events.

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