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

Provider Outreach & Education
Date: November 17, 2022

Moderator: Kathryn Torro
Time: 2:00 p.m. EST

Introduction

Good afternoon and welcome to CGS Administrators, LLC DME MAC Jurisdiction B & C General "Ask- the-Contractor Teleconference." The ACT call is hosted once a quarter by the DME MAC Provider Outreach and Education team. My name is Kathryn Torro, 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 general questions on any Medicare related topic. Please keep in mind that questions regarding a specific claim or beneficiary cannot be discussed due to possible Protected Health Information (PHI) issues, and those questions should be directed to our customer support department.

Please note that there is not a presentation for this call. This call is being recorded and a complete transcript will be posted to our website within 30 business days. Because we are recording, all questions must be asked verbally. As a reminder, you may not record this teleconference for any reason. We will be posting a transcript for your future reference. Hyperlinks for more information on our topics today will be provided in the transcript.

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 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 will be hosting a CGS IMPACT Conference. This is a collaborative conference with DME, Home Health & Hospice (HH&H) and Medicare Part A/B. We hope you will make plans to attend this 2-day conference, which will be held in Nashville, TN on February 27 and 28, 2023, at the Music City Conference Center. Go to https://web.cvent.com/event/aea8fd49-497d-4dbc-97da-8166d8e32c3b/regProcessStep1 to complete registration.

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 the URL. You can use the QR code via a smart device or enter the URL in your browser window. Take a moment to complete the survey, 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 education events the best that they can be.

Before opening the call for your questions, let's go over the latest updates and reminders.

COVID-19 Public Health Emergency (PHE)

The ongoing COVID-19 Public Health Emergency (PHE) determination was renewed on October 13, 2022, by the Secretary of Health and Human Services through January 11, 2023. All current waivers and flexibilities remain in effect until further notice. Currently, we do not have any information or instructions from CMS on what will happen after the PHE ends. If you have claims affected by the PHE, follow the proper claim instructions, include the "COVID-19" narrative and the CR modifier on your claim for any of the COVID-19 waiver or clinical non-enforcement reasons. Complete information is available in our comprehensive COVID-19 resource page located on the https://www.cgsmedicare.com web pages, by clicking on COVID-19 under the left-hand navigation menu.

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

Medicare Fee-for-Service Compliance Programs

CMS has recently released information regarding how review contractors will conduct medical reviews for claims billed during the PHE based on approved waivers or flexibilities, CMS contractors (MACs, RACs, and SMRC) review a very small percentage of Medicare Fee-for-Service claims each year. During the PHE, flexibilities were applied across claim types. For certain DME items, this included the non-enforcement of clinical indications for coverage. Since clinical indications for coverage were not enforced for certain items provided during the PHE, once the PHE ends, CMS plans to primarily focus reviews on claims with dates of service outside of the PHE, for which clinical indications of coverage are applicable.

We note that we may still review these DME items, as well as other items or services rendered during the PHE, if needed to address aberrant billing behaviors or potential fraud. All claims will be reviewed using the applicable rules in place at the time for the claim dates of service.

Resource: https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/overview

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

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

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

CMNs

- CMS-484 – Oxygen
- CMS-846 – Pneumatic Compression Devices
- CMS-847 – Osteogenesis Stimulators

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- CMS-848 – Transcutaneous Electrical Nerve Stimulators
- CMS-849 – Seat Lift Mechanisms
- CMS-844 – Section C Continuation Form

DIFs

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

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

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

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

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

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

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

Orthoses Prior Authorization Resources

In the Orthoses category, five additional HCPCS codes were added to the Required Prior Authorization list: L0648, L0650, L1832, L1833, and L1851. Implementation of this requirement has been completed in three phases. Phase 1 began on April 13, 2022, in New York, Illinois, Florida, and California. Phase 2 began on July 12, 2022, in Maryland, Pennsylvania, New Jersey, Michigan, Ohio, Kentucky, Texas, North Carolina, Georgia, Missouri, Arizona, and Washington. Phase 3 began on October 10, 2022, in all remaining states and territories not included in Phase 1 or Phase 2.

Medicare requires as a condition of payment, that all HCPCS codes which appear on the Required Prior Authorization List must be submitted for prior authorization before delivery and claim submission. There are numerous resources to assist suppliers: You can refer to the Prior Authorization Process for DMEPOS Operation Guide https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/Operational-Guide-for-DMEPOS-PA-current.pdf for complete information and instructions.

CGS has created additional resources including "What Suppliers Need to Know" and the "Prior Authorization Lookup Tool," where you can enter any HCPCS code and quickly determine if a prior authorization is required.

Orthoses Prior Authorization – What Suppliers Need to Know

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

Prior Authorization Look Up Tool

- **JB:** https://www.cgsmedicare.com/medicare_dynamic/jb/pa/pa.aspx
- **JC:** https://www.cgsmedicare.com/medicare_dynamic/jc/pa/pa.aspx

The fastest, easiest way to submit prior authorization requests is through the DME myCGS web portal (https://mycgsportal.com/mycgs/).

- If you are not yet registered for myCGS, you can get started with the myCGS Registration and Account Management Guide (https://www.cgsmedicare.com/mycgs/regguide/dme/index.html).
- If you are already registered for myCGS, you can review the "Prior Authorization" section in the myCGS User Manual (https://www.cgsmedicare.com/mycgs/manual/dme/index.html).

Aside from the myCGS web portal, you can submit a Prior Authorization request via mailing address, fax, and esMD using the Prior Authorization (PA) Request Coversheet. As a reminder, place the Prior Authorization Request Coversheet first before all other documentation.

Additional information is available on the Medical Review page, located on the https://www.cgsmedicare.com website and by clicking on Prior Authorization, under the left-hand navigation menu.

- **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

DMEPOS National Provider Enrollment (NPE) – Change to DMEPOS Enrollment Contractor

CMS has awarded 2 new contractors that will process Medicare applications for DMEPOS suppliers to make sure they meet all supplier standards and enrollment requirements. This new process replaced the current National Supplier Clearinghouse (NSC) effective November 7, 2022.

NPE East has been awarded to Novitas Solutions and will be responsible for DMEPOS activities for suppliers located east of the Mississippi River (https://www.novitas-solutions.com/webcenter/portal/DMEPOS).

NPE West has been awarded to Palmetto, GBA and will be responsible for DMEPOS activities for suppliers located west of the Mississippi River (https://www.palmettogba.com/palmetto/npewest.nsf).

- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2022/11/cope3059.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2022/11/cope3059.html

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CGS Connect™ – Medical Review Education Program

I'd like to remind you about the CGS Connect™ which is part of medical review education program. CGS Connect™ offers a broad range of benefits, including:

- Reducing claim denials related to documentation errors
- Reducing appeals
- Receiving one-on-one education on correct required documentation submissions

This is a voluntary program that offers 17 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 encourage you to take advantage of this beneficial program. You will find more information on the https://www.cgsmedicare.com web pages, located under the Medical Review tab, select "Education Programs" in the left-hand navigation menu.

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

Documentation Checklists

Documentation Checklists are an excellent tool that will help you navigate required documentation, standard written orders, delivery documentation, medical record documentation, claim submission, reminders, and additional resources. CGS has developed over 36 Documentation Checklists to assist suppliers, to access the full list of Documentation Checklists on the https://www.cgsmedicare.com website, select the "Forms/Checklists/Guides" tab in the left-hand navigation menu.

- **JB:** https://www.cgsmedicare.com/jb/forms/index.html
- **JC:** https://www.cgsmedicare.com/jc/forms/index.html

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. There are multiple charts and guides you can use as desk references. "Dear Physician Letters" to assist you in educating physicians, practitioners, and referral sources. Multiple documentation checklists to assist in obtaining necessary medical record documentation. Also, CGS offers online education courses, videos, and recorded webinars to assist you and your staff. The CGS Medicare App provides information access at your fingertips wherever you may be. 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# 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 will first address one written question.

Question 1: Can a wheelchair Group 1 seat and back support surface, HCPCS code E2601, E2602, E2611, and E2612 be included when a prescriber orders a manual wheelchair? Specifically, can the provider check a box on the Standard Written Order (SWO), for a K0001, K0003, K0006, and K0007 manual wheelchair along with the wheelchair description that states with a seat cushion E2601 or E2602 and back cushion E2611 or E2612?

Answer 1: Yes. A general use seat cushion, E2601 or E2602, and a general use wheelchair back cushion, E2611 or E2612, will be considered for coverage for a beneficiary who has a manual wheelchair, or perhaps a power wheelchair with a sling solid seat back, which meets Medicare coverage criteria. If the beneficiary does not have a covered wheelchair, then the cushion will be denied as not reasonable and necessary. If the beneficiary has a power operated vehicle (POV) or a power wheelchair (PMD) with a captain's chair seat, then the cushion will be denied as not reasonable and necessary. CGS cautions you to be very careful of check off lists on the SWO, as this might be considered a blanket order. The rules for blanket written order: "If more than one accessory or supply is ordered, and the contractor is not able to ascertain what has been provided, you could experience claim denials. As a reminder, make sure the beneficiary not only meets the criteria for the manual wheelchair, but also any accessories or supplies".

We are now ready to take the first verbal question.

Question 1: Question regarding signature requirements, location of the signature, and this is specific to Therapeutic Shoes for Persons with Diabetes. On the medical records, on the first page of the documentation, all the information is needed for Therapeutic Shoes, this was done by a nurse practitioner (NP), working incident to an MD. The foot evaluation on the first page, the doctor included a statement "agrees with the diabetic management and foot evaluation." There is no signature on that first page; the doctor is signing it at the end of the medical record, with the NP electronically. Does this suffice to meet signature requirement?

Answer 1: CGS Medical Directors, Dr. Brennan and Dr. Lalla advised this should be sufficient, but without seeing an example the answer may be misleading. Kathryn Torro advised attendee to email her the JB TPE audit letter number. The medical directors will review the audit and documentation.

Question 2: Does CGS have a specific guideline on how long they can process a claim?

Answer 2: If the claim is a clean claim, meaning it does not stop for any type of review, audit, manually pricing, etc., electronic claims can take 14 days to process, and paper claims can take 29 days to process.

Question 3: Claim not processing correctly for HCPCS code K1018. Receiving denials for incorrect modifier use. CO-108 denial, rent purchase guidelines have not been met.

Answer 3: Send the claim control number (CCN) with no PHI to Kathryn Torro.

CGS Update: "HCPCS Codes K1018 and K1019 – Correct Coding – Revised" December 1, 2022

- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2022/01/cope24779a.html

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- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2022/01/cope24779a.html

Question 4: We provide E-coded capped rental items, which are not separately payable when patients are in a Skilled Nursing Facility (SNF) and not separately billable. Patients are requesting if they can pay themselves out of pocket for the item(s).

Answer 4: If the beneficiary resides in a Medicare Part A stay, the SNF/facility is responsible for their care, and you must seek reimbursement (purchase order (PO)) from the facility for the product since the facility is responsible. For services and supplies furnished to a SNF resident covered under the Part A benefit, SNFs are not able to unbundle services to an outside provider of service or supplies that can then submit a separate bill directly to the Medicare contractor. Instead, the SNF must furnish the service or supplies either directly or under an arrangement with an outside provider. The SNF, rather than the provider of the service or supplies, bills Medicare.

Supplier's response: The patients are not in a Part A covered stay. Can the patient pay for their device directly? If we can bill the patient directly, should we execute an Advance Beneficiary Notice of Non-coverage (ABN)? If we execute an ABN and the patient opts for us to generate a claim, what modifier(s) and place of service would we use?

CGS response: The DME benefit is only meant for items a beneficiary is using in his or her home. For a beneficiary in a Part A stay, an SNF is not defined as a beneficiary's home. Medicare does not make a separate payment for DME when a beneficiary is in a SNF. The SNF is expected to provide all medically necessary DMEPOS during a beneficiary's covered Part A stay. You must always verify the beneficiary stay with the SNF and seek reimbursement from the SNF when required. However, if the beneficiary is no longer under a covered Part A stay and the facility is not willing to provide the service for a beneficiary who remains in the skilled facility, then you can conduct a private transaction between you/supplier and the beneficiary for services not payable in a skilled facility. An ABN Form CMS-R-131 should be obtained in this instance whether the beneficiary wants a claim filed to Medicare Part B or chooses not to file a claim. To find out the licensure of a facility, most states have a state facility licensure listing. Also, you can call the facility and request to speak to the director of nursing who should be able to verify the facility licensure for any of the following:

- **Skilled care:** Place of Service 31, 32
- **Custodial Care:** Place of Service 33
- **Assisted Living:** Place of Service 13
- **Group Home:** Place of Service 14

Keep in mind, if the facility offers multiple types of beds, then their licensure must reflect the different licensed beds. If they only hold licensure for skilled care, then all beds are considered skilled by licensure.

You can reference the DMEPOS Place of Service (POS) codes where DMEPOS claims are payable and published in the CGS Supplier Manual, Chapter 6, Section 11.

- **JB:** https://www.cgsmedicare.com/jb/pubs/pdf/chpt6.pdf
- **JC:** https://www.cgsmedicare.com/jc/pubs/pdf/chpt6.pdf

Also, CGS has an excellent Consolidated Billing Tool to assist suppliers in determining if a DMEPOS item is payable in a SNF Part A stay, after a Part A stay, and items not payable in a SNF.

- **JB:** https://www.cgsmedicare.com/medicare_dynamic/jb/consbill/consbill/index.aspx
- **JC:** https://www.cgsmedicare.com/medicare_dynamic/jc/consbill/consbill/index.aspx

Question 5: HCPCS code L1852, prefabricated knee orthosis, knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint. On the documentation checklist for Knee Orthosis, it states for L1852, the beneficiary has to have had a recent injury or a surgical procedure of the knee, and the medical records must support the beneficiary is ambulatory. Why would this be on the documentation checklist if the beneficiary has osteoarthritis (OA)?

Answer 5: In the Knee Orthosis policy article, it states there must have been a recent injury or surgery, or the beneficiary must have joint laxity. If the beneficiary does not meet those criteria, then the item is not covered by Medicare.

Supplier's response: I understand what you are saying, but a hinged, unloader knee brace is for OA. There is a single hinge and then a dual hinge, these are specifically for OA and have been approved in PDAC letters for L1852 and L1845, custom fitted.

CGS response: The coverage criteria, as previously discussed, the L1852 and L1845, are covered if the beneficiary has a recent injury, surgical procedure, or if the beneficiary is ambulatory and has a knee instability. It is the only coverage criteria for L1852. If you disagree with the Local Coverage Determination (LCD) for Knee Orthosis, you can submit a policy reconsideration. This information is available on the LCD web page on the CGS website.

- JB: https://www.cgsmedicare.com/jb/coverage/reconsideration.html
- JC: https://www.cgsmedicare.com/jc/coverage/reconsideration.html

Supplier's response: I would like clarification from a medical director if osteoarthritis would be considered a knee injury.

Dr. Sunil Lalla, JB Chief Medical Director, response: Osteoarthritis is not considered a recent knee injury, and agree with the answers provided today.

Question 6: If Medicare is secondary to Blue Cross, and if a patient needs an air mattress, would the prior authorization still be required?

Answer 6: Coverage and payment rules are the same for Medicare secondary payer (MSP) as they are for Medicare primary payer. If the beneficiary has Medicare secondary, you will submit the prior authorization request, if it is a Group II Support Surface that requires a prior authorization. Submit the prior authorization request; submit your claim to the primary insurer. If the primary payer denies the claim, submit the claim with the prior authorization unique tracking number (UTN) to Medicare as the secondary payer with all other information.

Question 7: For continuous positive airway pressure (CPAP) and BiPAP. I heard in 2023, that Detailed Written Orders (DWOs) are not going to be needed, is this correct?

Answer 7: Standard Written Orders (SWOs) are required for all items billed to Medicare. There seems to be some confusion around DWOs with CMNs and DIFs. CMNs and DIFs are being eliminated for dates of service on or after January 1, 2023. Those CMNs and DIFs are from the Office of Management and Budget approved forms for specific items such as oxygen, seat lift mechanism, etc. Every item will still require an SWO

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or a Written Order Prior to Delivery (WOPD) if it is on the WOPD list, and you must have documentation to substantiate the need for the DMEPOS item. None of the documentation requirements are changing, only formal CMNs and DIFs are going away.

Supplier's response: Does the order still have to have the quantity and the frequency of items?

CGS response: The Standing Documentation Requirements for All Claims Submitted to DME MACs (Policy Article A55246) https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=55426 states the following must be on an SWO:

- Beneficiary's name or Medicare Beneficiary Identifier (MBI)
- Order Date
- General description of the item
- Quantity to be dispensed, if applicable
- Treating Practitioner Name or NPI
- Treating Practitioner's signature

You may also add the frequency to the order, although it is no longer a requirement of a SWO effective January 1, 2020. The frequency must be documented in the beneficiary's medical record.

Question 8: We recently went through a TPE audit and found the information to be very helpful. I do have a follow-up question to that, and this goes back to signature requirements. We came out of the TPE with a very good understanding that for example "authorized by" is an acceptable form of an electronic signature. The prescribing physician's office has come back to us and said that "authorizing provider" for their protocol actually means "authorized by." They were able to put together a document/workflow process that shows that to be the case. We did send this example back to TPE to get clarification. The response was "if it shows on the SWO from the treating physician, and EPIC is listed as a system used, then Medicare would accept that as being an acceptable for of signature." I just want to make sure I have the right understanding, and is this correct? Does every order have to say it is generated by EPIC, and we must have some sort of documentation on file in case we go through an audit?

Answer 8: As far as what is acceptable for an electronic signature, CMS does not provide a list of approved electronic signature but does provide examples of acceptable e-signatures and what they may look like. For example: "Electronically signed by"; "Signed by"; "Authenticated by"; etc. Each software vendor will be looked at independently, as far as what their guidelines and software is set up to receive electronic health care records and e-signature requirements. Not all physician's offices use EPIC, it would be in your best interest to have a copy of the software program guide and any documents/manuals in the event of any Medicare audit.

Supplier's response: Will the SWO have to list "EPIC" on the order as well?

CGS response: No, this would only be applicable to signature requirements on orders or medical documentation, when questioned during an audit. You would be able to provide what system the ordering/treating practitioner uses for e-signatures.

Question 9: Medically unlikely edit (MUE) question. We are a home care pharmacy, and we have claims denying, citing the units billed have exceeded the published MUE value of the drug. The HCPCS code is J2260, has a published MUE value of 4 per day. Based on the usual adult maintenance dose for congestive heart failure and the current MUE guidelines, the low end of this adult maintenance dose would equate to an 81-pound adult and the upper end would equate to a 40-pound adult. How do we inquire or how do we dispute what we think is an unreasonable MUE value?

Answer 9: MUEs are determined by CMS. CMS determines if the MUE values will be published or non-published. The DME MACs must follow the guidelines set in place by CMS. If a beneficiary needs to exceed the MUE value, you have appeal rights and submit a redetermination with all documentation to support the need for additional units of service.

CGS response: There is information on the CMS website and frequently asked questions (FAQs) regarding MUEs and how to request a change in the MUE value for a HCPCS/CPT code. https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare/medicare-ncci-faq-library

Question 10: Requesting clarification regarding "frequency on orders." It was our understanding that frequency can be on the order or in the medical record. If it is on the order, frequency information would not be needed in the medical record.

Answer 10: Effective for claims with dates of service on or after January 1, 2020, the elements outlined in the SWO, the frequency no longer needs to be on the order; however, frequency and quantity must be documented in the medical record. Even if the frequency is on the order, the frequency must also be supported by the medical record as well. An SWO is not a medical documentation. For anything listed on the SWO, there must be medical documentation to support the need for the item(s) being billed. You can add additional elements such as frequency of use on the SWO if you choose. This information is outlined in the Standard Documentation Requirements for All Claims Submitted to DME MACS (A5426) https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=55426

Question 11: SWO clarification. With unit dose, nebulizer, and the medication, we do have to put quantity to be dispensed, so we would need the frequency of use to determine the quantity being ordered and dispensed. They usually go hand in hand. So, you are telling me even though the SWO says we need it, I don't have to have it, it has to be in the medical record?

Answer 11: To clarify, the quantity is a required element on the SWO. Frequency of use is not required to be indicated on the SWO; however, both quantity and frequency of use is required to be documented in the medical record. In situations where drugs are being billed, in your situation, nebulizers, yes, often you will receive an order not only for the quantity but also for the frequency, but again all this information must also be in the medical record. Frequency cannot just be on the SWO. If your claim was ever chosen for a review, the medical documentation would need to corroborate what is listed on the SWO. A SWO is not a medical documentation. It is not a requirement for Medicare purposes to have the frequency on the order, but you are correct, the frequency is often times seen, because drugs are being filled at pharmacies.

Supplier's response: Thank you, I will need to make sure other departments are aware of this and reviewing the medical documentation.

CGS response: Thank you. Also, CGS offers a dedicated page on the www.cgsmedicare.com website specific to Standard Written Orders. On the left-hand navigation page, under

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"Medical Review" select "Resources" and then select "Standard Written Order (SWO) Resources."

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

Question 12: If a patient receives an orthotic from a non-CBA contractor, we generate an ABN, do we also have to get a non-affirmative UTN for patient responsibility?

Answer 12: If the beneficiary resides in a competitive bidding area (CBA) and it is a competitive bid item, under most circumstances they would need to get the item from a contract supplier, but they want to go to a non-contract supplier. In that scenario, you can execute an ABN, you would not need to obtain prior authorization, but the DME MACs may check the ABN for its validity upon claim submission.

Supplier's response: During the prior authorization process, we receive an affirmative UTN, we check same/similar on file in the myCGS portal, but when we send in the claim, we do receive a same/similar denial. What is the proper way to handle this?

CGS response: Are you checking same/similar prior to providing the item to the beneficiary and after you receive your affirmed prior authorization?

Supplier's response: We are checking twice, prior to dispensing and prior to claim submission.

CGS response: It depends on the item you are providing. If the item you are providing is for the same purpose, the other item provided very well may deny. You can request a redetermination if there was a change in medical need. If it is the same exact item, you could refer back to the beneficiary to verify if they received a same or like item for a different condition.

Resource: Same or Similar Denials for Orthoses and the Appeals Process

- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2020/08/cope18619.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2020/08/cope18619.html

Conclusion

There are no questions pending in que, so we will end today's ACT call. I want to thank you for attending today's Ask-the-Contractor Teleconference and participating in our live Q&A session. We will post the transcript to our website within 30 business days and send out an email notification when it is available. Thank you again for attending, and we look forward to seeing you at future educational events.

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