Jurisdiction B Ask-the-Contractor Teleconferences (ACT)

Provider Outreach & Education
Date: December 1, 2021

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

Welcome & Introduction

Good afternoon and welcome, everyone, to the Jurisdiction B "Ask the Contractor Teleconference." My name is Kathryn Torro, and I am a member of the Provider Outreach and Education team at CGS Administrators. Our department conducts this teleconference every quarter to give you an opportunity to ask questions of subject matter experts at the DME MAC (Durable Medical Equipment Medicare Administrative Contractor). We have a great team here today ready to address questions, including the entire JB provider education team, medical review clinicians, and other specialists from operational areas. You will need to call customer support if you have issues with a specific claim or beneficiary, since the purpose of this call is to ask questions about Medicare billing, policies, and/or procedures.

We are recording this teleconference so that we can provide a transcript of everything that is asked and answered here today. The transcript will be available on our web site within 30 business days. We will send an email through the electronic mailing list when it is available. Because of the transcript, we are not allowing written questions, since we want to record everything to include in the transcript.

The provider education team puts forth every effort to ensure the information you receive today is accurate and up to date. However, it is ultimately your responsibility as a supplier to stay informed and compliant with Medicare program guidelines. Rules and guidelines change frequently, so be sure to stay up to date by reviewing all the information shared in the electronic mailing list and in the "News" section of the website. https://www.cgsmedicare.com/jb/pubs/news/index.html

Before we open the call for questions, I just need to go over a few housekeeping rules. Even though we are conducting the call using our webinar platform, and you may be accustomed to some of the features available during a webinar, this teleconference does not include a presentation and we cannot accept written questions. All questions must be asked verbally.

You can use either your computer or your telephone for audio. If you are on the telephone, then you must enter the PIN number using your telephone keypad so that we can unmute your phone line in case you have a question. You can find your PIN number in the audio section in your GoToWebinar control panel.

Now, if you have a question, I am going to ask you to please raise your hand and my co-moderator, Maurdi Wilson, will unmute your phone line and call your name. To raise your hand, just click on the hand icon located in the control panel. If you see a red arrow on your hand, this means your hand is raised, and Maurdi will unmute your phone line when it is your turn to speak. The green arrow means your hand is not raised.

To give everyone a chance to ask their question, we will only take one question at a time. Our goal is to address as many questions as possible during our scheduled time.

Just a quick reminder, you may not record this teleconference for any reason or purpose. Just watch for the transcript if you want to refer back to anything.

While we queue the questions, I'll go over a few updates very quickly. We do encourage you to ask follow-up questions about any of these items that we will be discussing today.

COVID-19 Public Health Emergency (PHE)

First, let's start with the COVID-19 Public Health Emergency (PHE). The PHE does continue, and the waiver was renewed on October 15th for another 90 days. We have a dedicated COVID-19 web page which includes many resources for how and when to use the CR modifier. It's really easy to access from the homepage or any page on our website from the left navigation menu. We have not received any further instructions from CMS on what will happen after the PHE ends. Just be sure to include the "COVID-19" narrative on your claim if you are using the CR modifier for any of the COVID-19 waiver or clinical non-enforcement reasons. https://www.cgsmedicare.com/jb/covid-19.html

Targeted Probe and Educate (TPE)

Targeted Probe and Educate, that is the TPE program, has resumed, and claims during the PHE will be selected for review. If you are selected for TPE audit, you will receive a letter with details which includes an email address where you can communicate directly with medical review. We have provided many resources including videos and a dedicated web page in the "Medical Review" section of the website. https://www.cgsmedicare.com/jb/mr/tpe.html

myCGS

myCGS 7.2 was released last month and included a lot of new and exciting changes to the registration process to make it easier and faster to register as not only as a new user, but also for Designated Approvers to manage their users. There is a news article dated November 15, 2021 which gives an overview of the new features. https://www.cgsmedicare.com/jb/pubs/news/2021/11/cope23986.html

Some highlights of the new version include:

- Streamlined registration process for both Designated Approvers and End Users
- We made it simple and easy for Designated Approvers to recertify a large number of users at once
- Recertification every 365 days instead of every 90 days

Originated December 27, 2021 | Revised January 3, 2022

CGS® A CELERIAN GROUP COMPANY

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

- We also fixed a couple of known issues. You can search ADR (Additional Documentation Request) letters by Case ID, and the new TPE letter types have been added to the ADR education summary (https://www.cgsmedicare.com/jb/mycgs/index.html)

K0553

Also, a reminder: the K0553 therapeutic continuous glucose monitors supply allowance code should not be billed with a span date. This HCPCS code is set up to pay for 30 days of supplies, and claims billed with a span date will be denied. These claims should have denied all along, but we started rejecting them as unprocessable on November 15th. We have created a calculator to help you determine subsequent billing dates if you need help. The K0553 billing calculator is located under "Tools & Calculators" on the website. https://www.cgsmedicare.com/jb/pubs/news/2021/10/cope23770.html https://www.cgsmedicare.com/medicare_dynamic/jb/k0553/index.aspx

Tools & Calculators

With that being said, on the CGS website under "Tools & Calculators," there are over 39 online resources available to you 24 hours a day, 7 days a week, which you can access without a login or a password. https://www.cgsmedicare.com/jb/help/tools.html

- The Advanced Modifier Engine (AME) is a popular favorite with suppliers. This tool includes commonly billed HCPCS codes with billing scenarios. Based on the specific HCPCS entered and the billing scenario, the tool recommends modifiers for claim submission. https://www.cgsmedicare.com/medicare_dynamic/jb/advanced_modifier_engine/
- The Claim Denial Resolution tool is a great tool to utilize prior to calling the Provider Contact Center. The tool provides the myCGS message for the claim denial and lists possible causes and resolutions associated with your claim denial. https://www.cgsmedicare.com/medicare_dynamic/jb/claim_denial_resolution_tool/search.aspx
- There is also the CGS Wizard. This tool contains claim details for all processed claims. You would just enter the 14-digit claim control number (CCN), and the tool provides the claim details you need to either resubmit your claim, request a redetermination, or request a reopening. https://www.cgsmedicare.com/medicare_dynamic/jb/mrwizard/denials.aspx

With all the resources and tools available to you, don't forget the myCGS portal on the "Claim Status Summary" screen. There are five claim action buttons where you can request:

- Claim Correction – this would include simple corrections such as place of service, submitted amount, number of services, HCPCS codes with the exception of miscellaneous codes or codes beginning with WW, and modifiers with the exception of liability modifiers KX, GA, GY and GZ
- Redetermination
- Reopenings
- Order a duplicate remittance advice, and
- Check to see if an Additional Documentation Request (ADR) letter was sent regarding a particular claim

https://www.cgsmedicare.com/jb/mycgs/pdf/mycgs_user_manual.pdf

Those are the updates we have this afternoon. Before we open the lines, I want to remind everyone when you did register for the event today, if you entered a comment or question, we have researched this for you. Please raise your hand and ask your question verbally as well.

Maurdi, we are ready for the first question.

Q/A Session

Maurdi: Hi Kathryn, the first question comes from Erin. Erin I am going to unmute your line.

Erin: My question is about diabetic shoes. We were researching them, we always bill them, we are a home medical equipment supply and we have always billed shoes, but we saw something that was posted by Medicare, and unfortunately, I can't find it right now. It says something about you having to be a prosthetist or orthotist to be able to provide shoes.

Kathryn: I can address that question for you, Erin. I know exactly what you are talking about. CMS will post CERT Compliance Tips; I believe you are referring to an MLN Article regarding the CERT findings. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/medicare-provider-compliance-tips/medicare-provider-compliance-tips.html and https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/medicare-provider-compliance-tips/medicare-provider-compliance-tips.html#DiabeticShoes

CMS will refer education to their resources, the Medicare Benefit Policy Manual, Chapter 15, Section 140. It does not mean as a DME supplier you cannot furnish shoes. If you have gone through your accreditation process and enrollment with the National Supplier Clearinghouse (NSC), you may still be the supplier and furnish those shoes. In the LCD (Local Coverage Determination) and Policy Article (PA) and the Supplier Manual it does address this as well, or another qualifying individual. At the bottom of the MLN article, there is sentence, rather little/small where it might go unnoticed. It states for any updates, changes, or further questions regarding PA and the LCD, you can contact the DME MAC. CMS is referring to the Program Integrity Manual outlining criteria for the diabetic shoes.

Erin: We just wanted to make sure, this is what we thought. Measure twice, cut once. Thank you so much.

Kathryn: You are very welcome, that is a great question. Thank you, Erin.

Maurdi: The next question is from Donna. Donna I am unmuting your line.

Donna: Thank you so much. I am calling because we are having a difficult time having claims process when the beneficiary is enrolled in a Medicare Advantage Plan and hospice. They receive items not related to the hospice diagnosis. Most often it is diabetic supplies and according to our understanding of the claims processing manual, we are supposed to bill those claims to Fee-For-Service

Originated December 27, 2021 | Revised January 3, 2022

Medicare, even though the beneficiary is enrolled in a Medicare HMO. Then bill the items with the GW modifier. We continue to receive CO-109 denials with the M418 remark code, indicating we should bill it to the Medicare Advantage Plan. We do send some to Redeterminations, some get paid and some get denied with that instruction from the claims processing manual, and I am just wondering if we can get clarification on that.

Kathryn: Sure, absolutely. In regards to your question, Donna, you should request a copy of the hospice enrollment form and confirm with the beneficiary if they chose to stay with the Medicare Advantage Plan or if they have elected to Traditional Fee-For-Service Medicare, items not related to their hospice stay. The beneficiary does have the option, if they are still paying for their premiums for the Medicare Advantage Plan, if they chose to stay with the Medicare Advantage Plan, the Medicare Advantage Plan, would then cover items unrelated to their hospice stay. Now, all items provided under original Medicare, which is not related to the hospice stay, you would append the GW modifier to applicable codes. We did post an article, November 16, 2020, it was a billing reminder, regarding the GW modifier. https://www.cgsmedicare.com/jb/pubs/news/2020/11/cope19459.html. Please check with the beneficiary to see if they chose to stay with the Medicare Advantage Plan or chose the option for all claims to be processed by Traditional Fee-For-Service Medicare.

Donna: If we check eligibility, would it show then, if the beneficiary had been in an Medicare Advantage Plan, and they are currently under hospice coverage and they decided to opt back into the Fee-For-Service Medicare, they are no longer covered under the Medicare Advantage Plan, would that be updated in myCGS? Do the Medicare Advantage Plans know about that billing instruction, because we have had some discussion with some of the Medicare Advantage Plans, and they are referring to Chapter 11 of the claims processing manual, saying that it is supposed to be paid for Fee-For-Service Medicare.

Kathryn: Yes, the beneficiary does have that option. The beneficiary does receive a booklet from Medicare.gov which states they do have the option of staying in the Medicare Advantage Plan or they can elect Medicare Fee-For-Service, while in hospice. You state you already have submitted claims and they are denying CO-109, and you have already called the provider contact center and submitted some for redeterminations?

Donna: Yes, we have some that we are trying to get paid through regular electronic claims process. But we have submitted some for redetermination as well. We have some beneficiaries that are still showing they are enrolled in a Medicare Advantage Plan.

Kathryn: I know there was new editing regarding the GW modifier that went into effect after November 16, 2020. We have a representative from appeals on the call today. Sam, do have any other input for Donna?

Donna: Do you know where that information is? If we were to submit the claims to the Medicare Advantage Plan, and they wanted something in writing, indicating if the beneficiary were still enrolled in the Medicare Advantage Plan, claims unrelated to the hospice stay, should be paid by the Medicare Advantage Plan?

Kathryn: They do have the option as I stated, but if you already submitted the claims with the GW modifier to CGS, let's look at those claims. I do have your email address, and I can email you after the call. We can find out who your community coach is with claim examples and you are trying to send them to Redeterminations.

Donna: Okay, thank you. Or if we are supposed to be submitting the claims to the Medicare Advantage Plan, we just want to show the Medicare Advantage Plan, where the instruction is, if the beneficiary stays with the Medicare Advantage Plan, while they are enrolled in hospice.

Kathryn: I will be in touch with you, Donna. Someone from the tech team is communicating with me right now. We did implement some edits as of November 2020, for Fee-For-Service Medicare, with instructions on how to process those claims. I will be in touch with you. We will gather some examples and send them over to the tech team to review.

Donna: Okay, perfect, thanks so much.

Sam: Kathryn, this is Sam. I am sorry, I was having a hard time unmuting my line. Do you still have a question you need me to answer?

Kathryn: We are good, thank you, Sam.

Kathryn: Thank you. Maurdi, we are ready for the next question.

Maurdi: Our next question is from Gao; Gao is currently self-muted. Gao click on the phone icon to unmute yourself.

Maurdi: The next question is from Sydney; Sydney the same situation. Sydney click on the phone icon to unmute yourself.

Sydney: I have a question. We have recently been advised by Medicare we are receiving false denials, due to an internal edit we have been receiving on some bulk claims. The denial states the procedure/service is inconsistent with the patient's history, with the denial reason code of CO-261. We have been able from a Tier I and Tier II rep to not get any assistance on this. They are telling us it is an internal edit with Medicare but cannot direct this to any guidelines. We have been researching and we are not able to come to a conclusion on how to handle these claims.

Kathryn: Sydney, can I ask you what you are billing for?

Sydney: For all six claims they are for below the knee prosthesis for right or left side. I believe one of them is for above the knee. Medicare is only paying for the component tree L5970 but denying the base codes and the liners.

Kathryn: Okay, thank you. We have Sienna on the line with us today. It might be you are billing a replacement too soon.

Sydney: Actually, one of the patient's has not received a device since 2016.

Kathryn: Ok, thank you. We do have Sienna on the line, she might be able to address some of your questions. I have another tech person on the line as well, asking for claim examples. I will be in touch with you Sydney regarding claim examples. Sienna, perhaps, might be able to address some of your questions.

Sienna: Hello, this is Sienna. Unfortunately, I do not have a lot more to provide you with than what Kathryn has already said. It sounds like, without seeing the claim, I would not be able to tell you for sure what is going on. The other thing I wanted to mention is to make sure that if the device needs

Originated December 27, 2021 | Revised January 3, 2022

prior authorization, you are obtaining that. Without looking at your claim, I would not be able to offer you any other suggestions. Is there anything I can clarify?

Sydney: No, but I am not sure if this is helpful, but we are receiving the MA130 to resubmit the claim. So, it is not appealable as well. And they do not require authorizations for these codes.

Sienna: I apologize, without being able to see the claim, I would not be able to assist much further other than making sure the components match. Making sure if it is an above the knee prothesis, that they are above the knee components. I do know that we do not cover a below the knee components with an above the knee device (prosthesis).

Kathryn: That's ok Sydney. I am going to ask Maurdi to take down your first and last name. She will send me an email after the call. I will locate your registration information/email address. I will be in touch with you regarding claim examples.

Sydney: Thank you.

Kathryn: Thank you. Thank you for your question.

Maurdi: The next question comes from Gao.

Kathryn: Hello, how are you this afternoon? What is your question today?

Gao: I am doing very well, thank you. I have a question regarding an ABN. We have a claim that is denying CO-151. We tried to send to redetermination with the ABN stating that the Medicare allowable for a DME item, and we can never get them to successfully overturn the decision to a PR denial. The finding was the reason for ABN was not valid and does not pertain to the denial reason.

Kathryn: Is the item you are trying to bill for same/similar to the item the beneficiary already has, or does it have to do with frequency where you are billing so many units per month and the beneficiary would like additional units?

Gao: Correct.

Kathryn: How are you billing the units? Are you billing on two lines? On the first line it meets the policy parameters, and on the second line, is the frequency with the GA modifier?

Gao: Correct, the one with the GA modifier is denying CO-151.

Kathryn: Without seeing your ABN, in that instance on the ABN, what are you stating on the ABN? Are you stating Medicare only allows "X" amount per policy?

Gao: It was for urinary supplies. We put down Medicare allows three units per month; patient wants one additional unit.

Kathryn: With the ABN, the Advance Beneficiary Notice, you must be very clear when Medicare may not pay for an item. Sam is on the line with Appeals, and she will be able to add to this as well. I believe the ABN was forwarded to me. With the ABN you must be very clear to the beneficiary. The allowable for Medicare, per the LCD, only allows "X" amount, stating Medicare will not allow over utilization. I am not sure if this was stated or if the ABN was vague. When it comes to a review, it would be left up to the reviewer and their interpretation if the ABN was clear to the beneficiary. Sam can provide additional information on what happens during the appeals process if the decision is not being overturned to a PR denial.

Sam: Thank you, Kathryn. From an appeals standpoint, as Kathryn has shared, if the reason is not specific, it cannot be vague on the reason why Medicare may deny the item, we will consider the ABN is invalid, since it is not specific in detail. In those instances, we would uphold the denial, we would send a letter explaining the ABN was vague and not specific. For the appeal rights, we would provide information that you could appeal to the next level, which would be reconsiderations.

Gao: So, the reason I gave you is that still too vague?

Sam: Similar to what Kathryn had shared, specifically providing the LCD language. It is hard not to say without looking at the case and the actual ABN that you submitted. If there is a way you can provide an example to us, or if you know your redetermination case number, we can go back and look at the case and provide a response.

Gao: I have already done a reconsideration and they have all denied. I did send an email on Monday to the DME learning on demand email box. I have not received a response to that yet, but I did not attach the case number to that. I can forward that information.

Kathryn: Thank you Gao. I have your information. I will be in touch with you. I am your community coach. We will discuss this; I will call you and we will have a one on one together and discuss how you can document and outline the information from the LCD.

Gao: Thank you very much.

Kathryn: You are very welcome.

Maurdi: The next question comes from Robin. Robin, I am unmuting your line.

Robin: I have a question about wound care, a situation has been coming up. There is a physician who is prescribing a contact layer, the HCPCS code is A6206. The LCD states it should only be changed out one time per week. But the doctor is prescribing, let's say four, for the month. He is telling the patient to cut it into three different pieces and change it three times per week. Technically, they are still only using one unit per week, but the documentation is stating to change every other day or so. I am wondering if this is going to be an issue if we come across an audit, not being changed once a week, but multiple times a week, even though they are using the correct amount.

Kathryn: That is a very good question. We have Tina on the line from Medical Review that would be able to address your question in the event of an audit and if this would be problematic. I am going to ask Tina to unmute her line. Or Carolyn may unmute her line as well.

Carolyn: Hi this is Carolyn; I am sorry about that, I was looking. That is something I am going to have to do a little bit more research on if they can cut it. I don't have that information for you today. If I can get your information or if you can reach out to the JBTPE Inquiries email box, we can get that questioned answered.

Robin: Yes, I will email my question to that email box.

Carolyn: Thank you.

Robin: Thank you.

Kathryn: Thank you.

Originated December 27, 2021 | Revised January 3, 2022

Response from Medical Review:

In response to your inquiry, without looking at the documentation it is difficult to answer this question.

While the cutting of dressings is acceptable in some situations, the reviewers would be looking to see that the dressing is appropriate to the wound size. So, if there are wound shapes, bene dynamics, etc. that would further support why the dressing is being cut, those should be included in the documentation.

This will provide the clinician with a clearer picture during their claim review. It all depends on how well the practitioner documents this information in the medical records.

Surgical Dressing – LCD L33831

DOCUMENTATION REQUIREMENTS

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the treating practitioner's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

Surgical Dressings – Policy Article A54563

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

When the prescribing practitioner is also the supplier, and is permitted to furnish specific items of DMEPOS, a separate order is not required; however, the medical record must still contain all of the required order elements.

For initial wound evaluations, the treating practitioner's medical record, nursing home, or home care nursing records must specify:

- The type of qualifying wound (see above); and,
- Information regarding the location, number, and size of qualifying wounds being treated with a dressing; and,
- Whether the dressing is being used as a primary or secondary dressing or for some noncovered use (e.g., wound cleansing); and,
- Amount of drainage; and,
- The type of dressing (e.g., hydrocolloid wound cover, hydrogel wound filler, etc.); and,
- The size of the dressing (if applicable); and,
- The number/amount to be used at one time; and,
- The frequency of dressing change; and,
- Any other relevant clinical information.

Clinical information, which demonstrates that the reasonable and necessary requirements in the policy regarding the type and quantity of surgical dressings provided, must be present in the beneficiary's medical records. This information must be updated by the treating practitioner (or their designee) on a monthly basis. This evaluation of the beneficiary's wound(s) is required unless there is documentation in the medical record which justifies why an evaluation could not be done within this timeframe and what other monitoring methods were used to evaluate the beneficiary's need for ongoing use of dressings.

The source of that information and date obtained must be documented in the supplier's records. This information must be available upon request.

Maurdi: Thank you, Robin. Kathryn the next question comes from Alisha. Alisha, I am unmuting your line.

Alisha: Sorry, I am a little new at this; this is my first time on teleconference. I have a question referring to PMDs. If a beneficiary has a power wheelchair already and they are asking for a scooter, and they are with an advantage plan and the advantage plan is approving the scooter, but we don't know about same/similar, we don't have a record of knowing where the power wheelchair came from, how do we deal with that?

Kathryn: That's okay, I want to welcome you to the call. Regarding if they already have a power wheelchair and now that want to get a scooter, first of all, you want to look to see how long ago the beneficiary received the power wheelchair. Usually, they must go through certain requirements for a power wheelchair, so do they meet the requirements for a POV (scooter). The second thing to address is you stated the beneficiary has a Medicare Advantage Plan. You would have to contact the Medicare Advantage Plan. I cannot speak for them and their policies and what the requirements are. If you are not billing Fee-For-Service Medicare at CGS, you would have to reach out to the Medicare Advantage Plan, private plan in regards to what their rules are and how often a beneficiary can receive an item and how you find out that information from their plan. As far as eligibility goes, you can always use the myCGS provider portal or the IVR for your beneficiary to confirm eligibility. You could check same/similar to see if they received anything from either Jurisdiction B or Jurisdiction C. It could be a change in medical condition why they are going from a power wheelchair to power operated vehicle (scooter).

Alisha: Okay, thank you. Sorry I just have one more question if I can. When we try to educate the doctors exactly what to include on the SWO's and face-to-face. We are getting a lot of vague stuff when they first submit it. Are we allowed to give them the LCD or direct them to the LCD?

Kathryn: You certainly can direct them to the LCD, and also, we have quite a few "Dear Physician" letters for DMEPOS items. On our website, it will be the left-hand navigation pane under "Medical Review", it is called "Physician's Corner." When you click on that, there is a plethora of "Dear Physician" letters that will outline what is needed and to work with the DMEPOS supplier. https://www.cgsmedicare.com/jb/mr/doc_req.html

We also have documentation checklists that you can give to your referral source, what exactly should be documented in that medical record as well. https://www.cgsmedicare.com/jb/mr/documentation_checklists.html

With the Standard Written Order (SWO) you can let them know the elements of a Standard Written Order. Keep in mind, you as a supplier you can create the Standard Written Order, you just can't sign it. The treating/ordering practitioner would need to sign it.

Alisha: Okay, awesome. Okay, sorry I know people have been holding it to one, but I have one more question. On the SWO, it does say the description is general. Does it have to have the HCPCS code and the general description or does it need the HCPCS code on there? Because most doctors' offices do not know that.

Originated December 27, 2021 | Revised January 3, 2022

Kathryn: That's correct, they don't know it. As a supplier, you can create that. Your answer to that is no. It could be, it's kind of like an either-or thing. It could be just a general description i.e., power wheelchair. It could be a general description and the HCPCS code; it could be a general description, HCPCS code, brand make/model number. Especially for you as the supplier, and you are creating that Standard Written Order, you certainly can put that in there. Now, often times people will just put in a general description for example i.e., hospital bed, instead of semi-electric or manual, they will just put hospital bed. All that is needed is a general description on that Standard Written Order. https://www.cgsmedicare.com/jb/mr/wor.html

Alisha: Awesome, thank you. Is there a way to find out who my community coach is? When I first started here a little bit ago, I tried to get in contact with the one that I was told that was ours, but I did not hear anything back.

Kathryn: What are your states?

Alisha: Illinois.

Kathryn: Okay. When you are on our website, on the left-hand navigation under "Education" there will be a tab that says, "Community Coach." It will give a list of everyone's name associated with the territory. At the very bottom you will see if you have questions to email the Learning on Demand email box. You can email and ask for your community coach to contact you, and that will get forwarded to the correct Provider Outreach & Education consultant. https://www.cgsmedicare.com/jb/education/ccp.html

Alisha: Okay, awesome, thank you.

Kathryn: You are welcome, thank you for attending today.

Alisha: Thank you.

Maurdi: Alisha, I am muting your line. Kathryn, the next question comes from Christine. Christine I am unmuting your line.

Christine: So, I have question concerning immunosuppressants. We have a couple of patients that need liquid because of different conditions, and they cannot swallow capsules. We are having a hard time getting these claims paid, so we compounded them at the pharmacy. It's a general non-sterile compound and we compounded a liquid product for them because it is not commercially available for Tacrolimus. We are having a hard time getting these paid. We keep getting them denied month after month. But I am wondering if it is something Medicare doesn't pay for, or is there something else we need to do.

Kathryn: Yes, I am aware of oral, do you happen to have the code you are trying to bill for?

Christine: J7507

Kathryn: J7507, and you said this was Tacrolimus, correct?

Christine: Tacrolimus, yes.

Kathryn: Off the top of my head, I have to be honest with you, please give me one moment… The code you are billing for is an oral form, pill use. As far as liquid goes, I believe for that drug, it is only going to be covered in a pill form. My suggestion to you is for you to confirm you are using the correct code, you need to contact the PDAC. That is the Pricing Data Analysis Coding Contractor. Are you familiar with them?

Christine: I heard of them, yes. I don't believe I have ever contacted them before, but I have heard of it.

Kathryn: Their website is very user-friendly, you just go to their website at www.dmepdac.com. When you get to their homepage, click on DMECS and then you will be able to type in that code and it will give you a description of when you can use that code. If it is liquid, it will say liquid. It will give the brand, make, model number of that. If it is not giving you the brand, make, model number, or if it doesn't say liquid and it is only displaying in an oral pill form, you are not using the correct code and it is not something that can be billed to the DME MAC.

Christine: Okay, perfect. Thank you.

Kathryn: Okay?

Christine: Okay, thank you.

Kathryn: Thank you for your question.

Maurdi: Kathryn, the next question… Kristen, I need to click on the microphone to the far left to unmute yourself so you may ask your question. Savannah, it looks like the same situation, I need you to click on the microphone to unmute yourself so that you are able to ask your questions. We will wait, give them a few minutes to get situated. Suzanna, I am going to need you to do the same thing: click on that icon to unmute yourself. Okay, looks like Kristen, I am going to unmute your line, thank you for joining us today.

Kristen: Hi, I have a question regarding the wheelchair policy article about home assessments. For power wheelchairs. We recently had a post-payment review and then denied our claim for a hemi wheelchair. So, I submitted to redeterminations and the explanation is stating the documentation submitted does not include an on-site home assessment that verifies the beneficiary has adequate access between rooms, maneuvering space, and surfaces for the operation of the device billed. I read through our home assessment form that we have that our delivery people fill out, and it sounds pretty good to me. It says there are no obstacles, talks about some rooms have carpets, some rooms have linoleum, there is only a small threshold, little bump, that the patient was able to get to the bathroom, to her bedroom, to her kitchen. So, I was wondering is there someplace else, is there an actual form maybe that Medicare has devised that we should be using?

Kathryn: There is not a mandatory template for the home assessment. For the home assessment in the policy article, you are correct it does state there must be a home assessment. There is not anything set in stone. Typically what we see in a home assessment is that the doorways are wide enough for the wheelchair to enter the home, there is enough space between the hallways and the bathroom doorway, etc., for the wheelchair to maneuver. As you stated, if there are lose carpets on the floor, advice is given to the beneficiary to tack the carpets down or if there is furniture in the way, to move any obstacles out of the way. Without actually seeing your post-pay review and seeing why it denied for the home assessment, that would be hard for me to make a judgement. Did you say you are exercising your redetermination rights?

Kristen: Yes, that is the explanation after the redetermination. So, our form says physical lay-out of the home, she wrote down it is a ranch style home, the doorway width she wrote down wide enough for the wheelchair and

Originated December 27, 2021 | Revised January 3, 2022

doorway threshold it says there is a little bump. The surfaces are carpet and linoleum, the patient has a ramp going into the home. It says patient able to move around the house in the wheelchair, to get to kitchen, bedroom, and bathroom areas with ease. No furniture or other obstructions.

Kathryn: Okay, well we certainly have some staff that is on the line today that was part of that post-pay review. I would ask one of the clinicians to unmute their line and provide additional input.

Kristen: Okay.

Tina: Hi, this is Tina. Without looking at the case, I know you are giving us a verbatim explanation of the denial and what you have in your home assessment, could you send that to our inquiries mailbox and we can take a look at the claim and give you a better rationale as to why we denied that or if we did deny in error? I don't want to give an answer over the call, over the phone without looking at the records, but if you would, please if you have any other questions, please feel free to reach out to our inquiry's mailbox. We use that for both post-pay and pre-pay claims and we are willing to reach out and respond to you.

Kristen: Okay, that would be good. Do you have that mailbox address?

Tina: Yes, I do, it is JB.TPE. I am sorry it is jb.tpeminquiries@cgsadmin.com. Maurdi can I send it to you, and you forward it to them?

Maurdi: Yes ma'am. I will put it out there in the chat mailbox. Unless someone else has it on hand.

Kathryn: Thank you Maurdi. Also, if you still have your post-pay review letter, you can always refer to that letter. The email address in your letter as well.

Kristen: Alright thank you so much, goodbye.

Kathryn: Thank you for your question.

Maurdi: Kristen, I am going to mute your line. Tammy and Suzanna, I am going to need you to click on the microphone, on the side, so your phone can be unmuted for you to ask your questions.

Maurdi: Tammy, are you with us? Tammy, if you want to click on the microphone to the left, and Suzanna, I will be able to unmute your phone.

Kathryn: While we are waiting for them to unmute their lines, Maurdi, we can go over one of the questions that came through. One of the questions submitted during registration was "Do we need to send a prescription, a Detailed Written Order (DWO), Standard Written Order (SWO) with the claim?" The answer is "You are not required to submit or transmit the Standard Written Order (SWO) with your claim, only submit or transmit required documents like the Certificate of Medical Necessity (CMN) or Durable Medical Equipment Information Forms (DIFs)." Another question was "Does recertification apply to Enteral Nutrition?" The answer "No, it does not require a recertification according to the Local Coverage Determination (LCD) and Policy Article." I will now check back in with Maurdi to see if they were successfully able to unmute their lines.

Maurdi: At this point, it looks like if you are trying to unmute yourself through your computer, you will not be able to do so. Suzanna are you with us?

Suzanna: Hello, this is my first time, I am so sorry. This is my first time, and I just want to ask about the personal injury. I am actually home health and do personal injury for car accidents. So, I want to know who I can ask those questions to for billing, coding and for appeals. I would like to know who I can address those questions to.

Kathryn: Home health might be under the Part A benefit. Are you supplying Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items to the beneficiary?

Suzanna: Yes, but it is more in personal injury when they have a car accident. So, I do not know CPT codes for personal injury, through the car accident. And I know it's a new thing, I just want to know who can address those questions, or if it is different, so that is kind of my questions.

Kathryn: Yes, you would have to contact the No-Fault or Liability insurance. That is something that needs to be billed to them first. We do not use or deal with CPT codes when you are billing your claims for Durable Medical Equipment. If this has to do with personal injury, whether it is workers' compensation, automobile, no-fault, liability… you will need to contact that insurer. For the DME MAC we do not require CPT coding.

Suzanna: I know that we are doing something new with CMS, which is when they are in a car accident and trying to merge it with Medicare. First to bill it to the insurance card and then after to Medicare, so I don't know if that is something you were not informed of that. I don't know who to call for that.

Kathryn: You would have to make sure the beneficiary's insurance is all reported and coordinated with the coordination of benefits. That is the Benefit Coordination & Recovery Center (BCRC). They do all the coordination of benefits in regard to making sure who pays first and that everything is on file in regard to what type of insurance. When you are on our website, if you were to go to Medicare Secondary Payer (MSP) information, you will see what is MSP, Medicare Secondary Payer. Right below that, when you open the link it will give you contact for the BCRC – Benefit Coordination & Recovery Center. Okay?

- https://www.cgsmedicare.com/jb/msp/overview.html
- https://www.cgsmedicare.com/jb/msp/bcrc.html

Suzanna: Okay, thank you so much.

Kathryn: You are welcome. Thank you for attending.

Maurdi: Thank you Suzanna, I am going to mute your line. It looks like we have a question from Tammy. Tammy, I am going to need you to click on the microphone, over to the left of your screen, to unmute your phone. While we wait for Tammy, Alisha, it looks like you have another question. I am going to unmute your line.

Alisha: I do have one more question. On the CMNs, are those strictly for PMDs or POVs, or are you supposed to be using them on anything that is rental?

Kathryn: Hi, there are only certain items that do require a Certificate of Medical Necessity (CMN). PMDs and POVs do not require a Certificate of Medical Necessity (CMN). Currently at this time it is going to be: TENS Unit (purchase only), Oxygen, Osteogenesis Stimulators, Pneumatic Compression Devices and Seat Lift Mechanisms. So, no you do not need a CMN for Power Mobility Devices (PMDs) or Power Operated Vehicles (POVs).

Originated December 27, 2021 | Revised January 3, 2022

Alisha: So, for the lift chairs, seat lift mechanisms, we do need it?

Kathryn: Yes.

Alisha: Okay, thank you.

Kathryn: You are very welcome. You can find that information on our website as well. If you are at the left hand navigation under Forms/Checklists/Guides, and you click on that tab, if you concentrate to the left side of the page you will see a list of items that do require a CMN. Okay? https://www.cgsmedicare.com/jb/forms/index.html

Alisha: Okay, thank you.

Kathryn: You are welcome, thank you.

Maurdi: Thank you, Alisha. I am going to mute your line. Tammy, it looks like you are still muted. I am going to need you to go over to microphone and click on that so I can unmute your line for you to ask your question. That is all that we have as of right now, Kathryn. It looks like Kristen has another question.

Kristen: Hi, I have a question regarding the recoupments from Medicare for our overpayments. We have been having a lot of issues lately where they are not recouping the full amount of an overpayment. We send in the immediate offset form, but they only recoup part of it, even though there is plenty of money in our check to take back the whole amount. But a couple days later they will take back more money and there will be a zero-amount check, because there is only a small amount of claims paid, and for some reason those remittances do not get transferred for electronic payments. Is there a reason a full amount cannot be taken from a check once they get that immediate offset?

Kathryn: There could be a number of reasons why, and you might have to call the Provider Contact Center (PCC) and then get transferred over to finance. Are you sending in a check for one beneficiary or for more than one beneficiary?

Kristen: For one of our patients, the overpayment was for over $1800.00. That is a very large amount, normally it would not be that much. Back in August they started taking back that payment, and they haven't taken anything back since. There is still $800.00 owed on that, that we owe Medicare. Medicare has not recouped that. The other ones, when we do immediate offset, after we get the overpayment letter, sometimes there is one or two claims, sometimes three, but when I submit that immediate offset, I put it for the full amount that is being requested in the letter. But when they only take back part of it, at a certain point if it is only one claim, that works out okay, but some of the claims they only take back part of the monies.

Kathryn: Do you have multiple locations or just one location?

Kristen: Just one location.

Kathryn: Definitely, my suggestion is a telephone call for sure. That is a lot for someone to figure out. You will need to contact the Provider Contact Center (PCC) and they will escalate that call to overpayment department. They will be able to explain to you what is going on. There could be a number of reasons why the amount is not been taken at once, certainly reach out for a telephone conversation with finance.

Kristen: Alright, thank you so much.

Kathryn: You are welcome, thank you.

Maurdi: Tammy, it looks like you are really wanting to ask a question. Either your computer is not compatible or, if you wish to submit your question to Kathryn, please submit your question to the Learning on Demand email box. Kathryn, at this time it looks like we do not have any other hands raised.

Kathryn: Ok, thank you. I just want to remind everyone of an upcoming event for the myCGS 7.2. CGS will be presenting two webinars. One will be on December 10th and that will be from 2:30 p.m. - 4:00 p.m. ET, and then on December 27th 2:30 p.m. - 4:00 p.m. ET. They are both the same webinars. If you can't save the date for December 10th and December 27th works out better for you, I encourage you to sign up for that. Just go to our left-hand navigation pane, under "Education" then "Calendar of Events," you will see the two dates there for you. If you have any questions in regard to the updates to the myCGS provider portal it will be a live event for you to ask questions. https://www.cgsmedicare.com/medicare_dynamic/wrkshp/dme_coe/dme_coe_b/jb_report.aspx

I am going to give Tammy one more chance at trying to unmute her line. We are at the top of the hour; I am going to check-in with Maurdi to see if we have any more hands raised.

Maurdi: We do not. Tammy, if you are still wanting to ask that question keep in mind you must dial in to ask the question, you cannot ask your question via your computer, that is the other option. As of this moment Kathryn, no ma'am, I do not see any other hands raised.

Kathryn: I want to thank everyone for attending today. The transcript for this call will be posted within 30 days on the Jurisdiction B website. Have a nice afternoon, everyone. https://www.cgsmedicare.com/jb/education/act.html

Originated December 27, 2021 | Revised January 3, 2022