Collaborative CGS & Noridian DME MAC ACT Call Transcript

Elimination of CMNs and DIFs

December 8, 2022 – 2:00 p.m. ET/1:00 p.m. CT | Moderator: Kathryn Torro

Introduction

Good afternoon and welcome to the Collaborative DME MAC "Ask-the-Contractor Teleconference." My name is Kathryn Torro, and on the call this afternoon we are joined by subject matter experts from CGS and Noridian Healthcare Solutions operational departments.

For this ACT call, we will be discussing the CMS Elimination of Certificates of Medical Necessity (CMNs) & DME Information Forms (DIFs). We will also speak specifically to CMN and DIF Instructions for Oxygen CMS 484.3 and External Infusion Pump DIF form 10125.

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 the Provider Contact Center (PCC) and speak with customer support for issues with a specific claim.

There is not a presentation for this call; however, we have a few slides listing affected timelines.

This call is being recorded and questions and answers (Q&As) will be posted to the DME MACs websites within 30 business days. Because we are recording, all questions must be asked verbally. As a reminder, you may not record this teleconference for any reason or purpose. We will be posting the ACT transcript and Q&A document to the DME MACs websites for your future reference. Hyperlinks for more information on the topics discussed today will also be provided in the final transcript document.

If you would like to participate in the verbal question-and-answer segment, 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.

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

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

- **JA:** https://med.noridianmedicare.com/web/jadme/policies/dmd-articles/2022/cmn-and-dif-elimination-correct-coding-and-billing
- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2022/11/cope3354b.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2022/11/cope3354b.html
- **JD:** https://med.noridianmedicare.com/web/jddme/policies/dmd-articles/2022/cmn-and-dif-elimination-correct-coding-and-billing

CMS is eliminating all remaining CMNs and DIFs effective for claims with dates of service on or after January 1, 2023, which also includes recertification and revised CMNs and DIFs. 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 CMS-1500 paper claim forms, the DME MACs will reject and return claims submitted with a CMN or DIF to the provider or supplier.

For claims with dates of service prior to January 1, 2023, providers and suppliers must continue to submit a CMN or DIF if one is required, the process will not change. If a CMN or DIF is required, it will need to be submitted with the claim or there must be one on file from a previous claim.

The following forms are being eliminated, which means they are being discontinued, and 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
- CMS-848 – Transcutaneous Electrical Nerve Stimulators
- CMS-849 – Seat Lift Mechanisms
- CMS-844 – Section C Continuation Form

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DIFs

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

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

- **JA:** https://med.noridianmedicare.com/web/jadme/policies/dmd-articles/2022/cms-issues-interim-final-rules-with-comment-cms-1744-ifc-cms-5531-ifc-covid-19-public-health-emergency-revised2
- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2020/06/cope17942.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2020/06/cope17942.html
- **JD:** https://med.noridianmedicare.com/web/jddme/policies/dmd-articles/2022/cms-issues-interim-final-rules-with-comment-cms-1744-ifc-cms-5531-ifc-covid-19-public-health-emergency-revised2

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

Questions & Answers

This concludes our updates.

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 are now ready to take your first question.

QAs:

Question 1: Do we unattach CMNs and DIFs from our claims on/after January 1, 2023?

Answer 1: Yes. You want to make sure your billing software is updated. You will not attach CMNs and DIFs to your clams for dates of service on/after 01/01/2023. This applies to initial, revised, or recertification CMNs and DIFs.

Keep in mind, if the date of service is on or before 12/31/2022 and a CMN or DIF is required for your claim to process correctly, you will attach it to your claim.

Question 2: This an enteral nutrition question. We have a patient who has been using 4 cans of enteral nutrition a day, the MD just increased it to 5 cans a day. This is greater than the 10-day overlap period. Should we include a narrative, this is an increase in calories, or how do we show that? Do we obtain a revised DIF?

Answer 2: Since there is an increase in calories; you will obtain a new order and a revised DIF for current dates of service. You will continue to bill by units of service. We recently published an article on Billing Instructions - Parenteral and Enteral Nutrition.

- **JA:** https://med.noridianmedicare.com/web/jadme/policies/dmd-articles/2022/billing-instructions-parenteral-and-enteral-nutrition
- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2022/11/cope3354a.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2022/11/cope3354a.html
- **JD:** https://med.noridianmedicare.com/web/jddme/policies/dmd-articles/2022/billing-instructions-parenteral-and-enteral-nutrition

Question 3: I have a question regarding insulin pumps. If you were to attach the DIF in error and you get the upfront denial for dates of service after January 1, 2023, can you reopen the claim and delete the DIF and then move forward? Or would you have to appeal at this point?

Answer 3: For dates of service on/after 01/01/2023, the claim will be rejected on the front end by the Common Electronic Data Interchange (CEDI). Your claim will not make it to the DME MAC for processing. You will resubmit the claim without the DIF attached.

If you submit a CMS 1500 paper claim with a CMN or DIF attached for dates of service on or after 01/01/2023, the claim and attachments will be returned to you by the DME MACs (A, B, C, D).

Question 4: Please go back to the Interim Final Rules with Comment (IFC) slide.

Answer 4: CMS article published by all 4 DME MACs regarding the Oxygen CMN 484 and External Infusion Pumps DIF 10125 is not required during the COVID-19 PHE.

- **JA:** https://med.noridianmedicare.com/web/jadme/policies/dmd-articles/2022/cms-issues-interim-final-rules-with-comment-cms-1744-ifc-cms-5531-ifc-covid-19-public-health-emergency-revised2
- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2020/06/cope17942.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2020/06/cope17942.html
- **JD:** https://med.noridianmedicare.com/web/jddme/policies/dmd-articles/2022/cms-issues-interim-final-rules-with-comment-cms-1744-ifc-cms-5531-ifc-covid-19-public-health-emergency-revised2

Question 5: My question is related to the PHE. We have not received the 60-day notice from the Biden Administration, so it is likely going to be extended. January is right around the corner and there are a lot of changes with oxygen and CMNs we need to understand and implement. For example, we have a patient

who started oxygen in December 2022, we have all the qualifying documentation, except for the CMN. We are going to append the CR modifier and the COVID-19 narrative. Once the PHE is over, are we to remove the CR modifier and narrative from our claims? Or do we leave them on the claims?

Answer 5: We have not received instruction from CMS regarding claims affected by the PHE and how to bill after the PHE ends. Stay tuned to our electronic mailing notices. The DME MACs will hold additional educational events when we receive notice from CMS of the PHE end date.

We have a CGS/Noridian Collaborative Oxygen webinar scheduled on December 13, 2022, at 2:00 p.m. ET/1:00 p.m. CT. We will cover the Oxygen local coverage determination (LCD) changes.

Question 6: Can you elaborate on continued need for oxygen after January 1st? Do we need that in the form of office notes, or can that be in the form of a prescription?

Answer 6: Yes, once initial medical need and continued payment requirements specified in the Oxygen LCD and Policy Article are met, a new order would be acceptable to meet continued medical need moving forward for oxygen.

Question 7: For patients on total parenteral nutrition (TPN) that we worked very hard to get their additional lipids covered, how is that going to be affected after the DIF is no longer required? Are we going to have to re-establish medical necessity?

Answer 7: No. You will continue to bill the lipids as you are now except for not submitting a DIF. The medical record must contain medical documentation that justifies the need for the TPN and the prescribed amount of lipids. If the TPN compound changes or the lipids, you will obtain a new order (SWO).

Question 8: My question relates to pneumatic compression devices (PCD). We mainly provide PCDs for lymphedema patients, qualifying with a diagnosis of lymphedema. The PCD CMN does not have a question that could be answered yes for lymphedema, which means the majority of our PCD claims get denied on the initial submission and must be appealed. So, without the CMN being transmitted how are they going to be processed? Do you anticipate most of them getting medical records requests, or would they be paid and subject to random audits later?

Answer 8: PCDs are not diagnosis driven; however, the beneficiary must have one of the conditions in the LCD. The claims will process through the system and may be subject to random audits at some point.

Question 9: We were wondering how you will keep track of rentals without the CMNs/DIFs?

Answer 9: A dummy CMN/DIF will be created in our system. You will be able to check same/similar in the myCGS web portal or the Noridian web portal.

Question 10: Is it true that as of January 1st, we will need to replace a PCD CMN with a new detailed written order?

Answer 10: No. If you have a current PCD CMN on file, you do not need to obtain a new SWO as of January 1st. You only need to obtain a new SWO if the order changes or the length of need on the CMN has expired.

Question 10A: OK. So, the notes are supporting documentation and no other document is needed, correct?

Answer 10A: You need the notes on file in case of an audit and the previous CMN and/or a new SWO if there are changes to the current order.

Question 11: I have a question about external infusion pumps used to administer drugs that are not covered under Medicare Part B. We normally put the HCPCS code on the DIF form and add the ABN GA modifier to the claim. Is the GA modifier the only thing that will exclude payment now? Is Medicare going to look at these and say, you put a GA modifier on the claim but what drug is being billed?

Answer 11: If the beneficiary does not meet the benefit for the item and you are executing an advanced beneficiary notice (ABN), letting them know upfront and adding the GA modifier on your claim, you will submit the HCPCS code and the GA modifier the same as you do today. The only difference is you will not be submitting the DIF.

Question 12: Yes, I was curious if all the required medical documentation is not changing and the DME MACs are creating dummy CMNs/DIFs in the portals, then what is the purpose of eliminating the CMNs and DIFs?

Answer 12: CMS's purpose in eliminating the CMNs and DIFs is to reduce burden on practioners and suppliers. The medical record must contain documentation of medical need for all items ordered; therefore, CMNs and DIFs are redundant.

DME MACs are going to assist the supplier community by creating dummy CMNs in our systems and web portals to track rental periods and provide same/similar information.

Question 13: I'm a little confused about the DIF for parenteral nutrition. We do not have to send it with our claim, but do we have to have a DIF on file for audit?

Answer 13: No, you no longer need to obtain a DIF (initial, revised) for dates of service on/after 1/01/2023. The DIF is a supplier completed form. In addition to the DIF you must obtain medical documentation and a SWO from the treating practioner for billing and/or auditing purposes.

Noridian response: I think one of the things that the previous questioner asked, that is applicable to this one as well, is, "what's the purpose of the elimination?"

Ultimately, it is to reduce paperwork. CMS is very interested in the reduction of the paperwork burden for practitioners and suppliers.

CMNs and DIFs were never a part of the clinical record. The Comprehensive Error Rate Testing (CERT) auditors, as well as other auditing entities, looked toward the medical record. The emphasis now is on the medical record, and the elimination of what is now considered to be unnecessary paperwork.

We are happy to add where we feel there's value. We appreciate CGS hosting the ACT, and you've done a marvelous job with the questions.

Question 14: My question is related to infusion pumps. We are providing the insulin pump and related supplies, but we are not billing the insulin. A reminder recently came out about the insulin had to be billed to DME Part B, but sometimes the beneficiary gets their insulin elsewhere, and it is not always billed in a timely manner. So, you're going to say that needs to be documented in the medical record. Just curious, what are the terms of how that's documented or how that is communicated? The beneficiary does not always get the insulin from the same provider as the pump.

Answer 14: Are you billing the insulin to Part B and the pump to the DME MAC?

Question 14A: We are not billing the insulin because we are not providing it.

Answer 14A: Ok, that does happen, a pharmacy is providing the insulin and a DME supplier is providing the pump and supplies. You need to obtain beneficiary medical records that document the beneficiary is a diabetic, receiving insulin, administered via an insulin pump, regardless of if you are billing for the insulin or just the pump.

Question 15: We have a CMN 484 on file for oxygen. I am telling my billing team to go ahead and let the oxygen claims go without the CMN. However, we are receiving denials for lack of a recert CMN. As long as our medical records support medical need, then we should be able to release those claims, and they shouldn't deny for a recert CMN, is that correct?

Answer 15: During the COVID-19 PHE, you do not need to obtain or submit an oxygen CMN (initial, revised or recert). In this instance you must append the CR modifier to the HCPCS line item, and the COVID-19 claim narrative in the claim NTE note segment.

If you did not submit your claim with the required CR modifier and claim narrative, and you received a denial for lack of an oxygen recert CMN, you can resubmit the claim with the CR modifier and the COVID-19 narrative. If you received a medical necessity denial, you will submit a written reopening via myCGS or Noridian's web portal or via fax to the DME MACs.

- **JA:** https://med.noridianmedicare.com/web/jadme/policies/dmd-articles/2021/use-of-cr-modifier-and-covid-19-narrative-on-specified-claims-due-to-the-covid-19-phe-revised
- **JB:** https://www.cgsmedicare.com/jb/pubs/news/2021/05/cope21892.html
- **JC:** https://www.cgsmedicare.com/jc/pubs/news/2021/05/cope21892.html
- **JD:** https://med.noridianmedicare.com/web/jddme/policies/dmd-articles/2021/use-of-cr-modifier-and-covid-19-narrative-on-specified-claims-due-to-the-covid-19-phe-revised

Question 16: My question is related to the oxygen CMN 484. The first one we would get would be 99. If the second one we got was 99, we wouldn't have to get another CMN for 3 more years. How's that going to work with the CMN 484 being eliminated?

Answer 16: You need to ensure the medical record documents the medical need for the oxygen at the time of service. Instead of a CMN 484, you will obtain a SWO for all new initial oxygen beneficiaries on/after 1/01/2023. If there is a change to an existing oxygen beneficiary's order, you will obtain a new order/SWO.

Keep in mind the beneficiary must meet either Group I, Group II, or Group III coverage criteria under Medicare Fee-for-Service (FFS). Most states consider oxygen a drug and require annual orders. You can obtain an annual order/SWO for your oxygen beneficiaries to meet continued medical need under Medicare FFS. The Standard Documentation Requirements for all DMEPOS (SDR) will be updated to reflect the allowance of annual orders for oxygen for continued medical need. Noridian agrees with this direction.

There is a collaborative (Noridian/CGS) oxygen webinar scheduled for December 13, 2022, 2:00 p.m. ET (1:00 p.m. CT).

Question 17: If we have the recert, and we logged it for 99 months, do we still need to obtain annual orders for oxygen?

Answer 17: This is in line with the previous question. Medicare does not require annual orders for oxygen. However, you can choose to obtain annual orders to meet Medicare FFS continued medical need requirements. Also, you want to pay close attention to your state laws, they may require annual orders for oxygen.

Question 18: My question is related to enteral nutrition. We have a patient who is in a persistent vegetative state. They were admitted to a new facility. There are no swallow tests. How do we know if this is enough documentation indicating they are in a persistent vegetative state and enteral nutrition is required long term?

Answer 18: Enteral nutrition is covered for beneficiaries who require feeding via an enteral access device. There must be documentation that the beneficiary has a permanent, full, or partial non-function or disease of the structures that normally permit food to reach their small intestine or impairs their digestion or absorption. You mentioned the beneficiary was un-responsive and in a persistent vegetative state. There should be documentation that they are in a vegetative state and nutrition cannot be administered orally.

Question 18A: How do we document permanence has been met?

Answer 18A: Permanence is no longer defined in the LCD as a specific length of time, it is based on documentation in the medical record that it is of long and indefinite duration. It does not have to be those words exactly. For example, the practitioner should document how long the beneficiary has been in a persistent vegetative state and that they cannot be fed orally.

Question 19: I have a couple of questions. With the discontinuation of the DIF and CMN requirements, do we need to indicate in a narrative that the patient has met the medical necessity?

Answer 19: No, you do not need to include a narrative. You will follow the same billing guidelines that are currently in place except for submitting a DIF or CMN with your claim. If medical need has been met and the policy (oxygen) requires a KX modifier, you will append the KX modifier to indicate medical necessity has been met.

Question 19A: The statement you mentioned earlier about adding the CR modifier and the COVID-19 narrative. Are we to add this to denied claims?

Answer 19A: Keep in mind, the CR modifier and COVID-19 narrative applies to beneficiary claims affected by the PHE. Enteral nutrition still requires a DIF through 12/31/2022. CMNs & DIFs are still required during 2022. Exception, CMS does not require you to obtain or submit the Oxygen CMN 484 and External Infusion Pump DIF 10125 claims. For those two policies, if you are not submitting the CMN or DIF, you will append the CR modifier and the COVID-19 narrative. The CR modifier and COVID-19 narrative is also applicable to claims missing required proof of delivery (POD) beneficiary or designee signature.

Medical Review response: If you did not submit your claim with the required CR modifier and claim narrative and you received a denial for lack of a CMN or DIF, depending on the denial reason codes and the remark codes, you may be able to resubmit the claim with the CR modifier and the COVID-19 narrative. If you received a medical necessity denial, you will submit a written reopening via myCGS or Noridian's web portal or via fax to the DME MACs.

- **JA:** https://med.noridianmedicare.com/web/jadme/policies/dmd-articles/2021/use-of-cr-modifier-and-covid-19-narrative-on-specified-claims-due-to-the-covid-19-phe-revised
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- **JD:** https://med.noridianmedicare.com/web/jddme/policies/dmd-articles/2021/use-of-cr-modifier-and-covid-19-narrative-on-specified-claims-due-to-the-covid-19-phe-revised

Question 20: I have a few questions. So, with the elimination of the CMNs and DIFs, January 2023, I will only need a signed order to submit my claim?

Answer 20: That is correct. You do not need to submit a CMN or DIF. Nothing has changed as far as obtaining a SWO, your proof of delivery, and medical documentation that justifies medical necessity for the items you are providing to the beneficiary.

Question 20A: The DOS is 1/01/2023. Will we need a recert for the 2023 year?

Answer 20A: No, elimination applies to all initial, revised, and recert CMNs and DIFs. You do not need an initial, recert, or revised CMN or DIF for dates of service 01/01/2023 and after.

Question 20B: What about same/similar information, will we still be able to check same/similar by HCPCS code?

Answer 20B: Yes, nothing has changed or will change with same/similar verification via the IVR or the DME MAC web portals.

Question 21: My question is, does the elimination of the CMN apply to incontinence supplies or PAP supplies?

Answer 21: No, as far as urological supplies, surgical supplies, PAP supplies, they never required a CMN. Some suppliers get what they call a CMN or a letter of medical necessity; however, that is not an Office of Management and Budget (OMB) Medicare CMN which is an approved form that is used for specific items.

We went over the list of OMB CMNs and DIFs that are being eliminated. All remaining CMNs and DIFs are being eliminated effective 1/01/2023.

Keep in mind you must obtain a SWO and medical record documentation for all DMEPOS items you bill to Medicare.

Question 22: You do not require an annual SWO, but my state law requires an annual prescription for oxygen. So, if I obtain my annual SWO, it will suffice for continued medical need. Correct?

Answer 22: Yes, that is correct. The DME MAC Medical Directors (DMDs) will be updating the Standard Documentation Requirements (SDR) for all DMEPOS to reflect the allowance of annual orders to meet continued medical need for oxygen.

Question 23: So, the title of the annual prescription or annual order does not matter. Correct?

Answer 23: Noridian: That is a really, good point and question. The title of the order is of no concern to Medicare. You can call it a CMN or Letter of Medical Necessity (LMN) or Annual Oxygen Order. However, the elements of the order itself are [of concern to Medicare], and so long as your order—whatever you call it—has all those required Medicare SWO elements, then that is what we will be looking for.

Question 24: My question is regarding enteral nutrition and qualifications for patients who are drinking the enteral. They can eat a little bit, but not enough to survive. We've always been told if patients are drinking the enteral formula, then they do not qualify. But in a case where the patient couldn't survive without the enteral, would that be considered qualifying?

Answer 24: If the enteral nutrition is being administered orally, they are drinking it, then they do not qualify, Medicare would not cover it.

Question 24A: What if they have a tube though? They can only drink a little bit, not enough to sustain life, but in addition to the tube feeding. How does that work?

Answer 24A: Minimal oral intake along with tube feedings for full nutritional intake should be acceptable. We call it pleasure feedings. However, they must require tube feedings via syringe, gravity, or pump, to maintain their weight and overall health status.

If they can drink all their nutrition, then they would not qualify. If you want to bill for denial, you will append the BO modifier for oral feedings which is not covered by Medicare.

Question 24B: So, if we are just billing for the enteral nutrition they are receiving through their tube, we would not append the BO modifier. Correct?

Answer 24B: Correct, if they meet all the requirements for enteral nutrition via tube feeding outlined in the LCD and related policy article.

Question 25: I have a question about the 5-year reasonable useful lifetime (RUL) for oxygen concentrator and portable. Do we need a doctors order for replacement?

Answer 25: Yes. Once the 5-year RUL is up, a new SWO is required for replacement equipment.

Question 26: I have a couple of questions. First is regarding recertification: we will still need chart notes for continued need, so how will Medicare know? Do we just obtain the documentation and keep it on file, or how will Medicare know that there is still medical need for the next 12 months?

Answer 26: Yes. You are still required to have continued medical need documentation. You do not need to send the documentation to Medicare, unless requested. A prescription/SWO for oxygen can show continued medical need as well. Keep in mind, to append the KX modifier, you must have the documentation on file.

Question 26A: The reason I am asking is that normally at 12 months, if we do not submit the recert CMN, Medicare denies our claim as CO-176. We already add the KX modifier showing Medicare we have the documentation on file. So is Medicare going to deny our claim after 1/01/2023 for lack of a recert CMN?

Answer 26A: No. Because CO-176 is specific to recertification. CMNs are being eliminated. Since CMNs are being eliminated, we will have updated editing in place in our claims system so future claims will not be looking for a CMN any longer with your claims.

Question 26B: Chronic stable state used to be required in the continuous positive airway pressure (CPAP) with oxygen being bled in. If the requirement is going away, do we still need to have documentation in the sleep study that the patient desaturated to 88% or below for 5 minutes while using the CPAP device to qualify?

Answer 26B: For the beneficiaries who are on a PAP device who also require oxygen therapy, a titration sleep study (PSG) is still required. Chronic stable state was removed. The Oxygen and PAP LCDs now state after optimal PAP pressure settings are reached while on the PAP device and hypoxemia is unmasked to warrant the need for oxygen.

Once the optimal pressure settings have been obtained while using the PAP and they continue to desaturate to 88% or below, then they can be considered for oxygen used concurrently with their PAP device.

Question 27: I know the CMNs are being eliminated. We need the SWO, it would be good up to the 12 months. What happens after the 12 months, or if we are audited? Will they be looking for office visit notes within the 90 days prior to the 12th month rental for oxygen?

Answer 27: A recert CMN 484 for oxygen is no longer required and they will not be looking for a recert. They will be looking for documentation of continued medical need for the oxygen.

Group I oxygen beneficiaries do not require annual re-evaluation or retesting. However, there must be documentation of continued medical need in the medical record or a new oxygen SWO within the most recent 12 months for the date of service in question.

For Group II oxygen beneficiaries, a re-evaluation and re-testing is required between the 61st – 90th day and a new SWO.

For Group III oxygen beneficiaries a re-evaluation between the 61st – 90th day is required and a new SWO.

For continued medical need for oxygen you will need documentation in the medical record (progress note) or a new order (SWO).

Question 28: So, let's say there is a revision, we would normally obtain a revised oxygen CMN. Would we report that in the narrative of the claim line itself?

Answer 28: No. A revised CMN is no longer required; a claim narrative is not required for a revised order. Any revision or change to the order for oxygen would need to be documented in the medical record. Also, a new SWO is required for any changes in the practitioner's order.

Question 29: I had a question about continued medical need for oxygen, and I just want to make sure I'm very clear, because we have had some questions in our office about this. In the standard documentation requirements (SDR), the section regarding continued medical need is very specific on what can be used for documentation to justify continued medical need. I know it was recently updated to add the recent order, for repairs and the CMN elimination statement for dates of service on/after 1/01/2023. For capped rental items like a hospital bed or manual wheelchair, an annual order will not suffice; we are required to obtain medical record documentation within the most recent 12 months to justify continued medical need for capped rental items.

So, we get a chart note, saying that patient continues to need, and use this hospital bed, or wheelchair, whatever the case may be with… Y'all are saying that just a prescription alone is good enough to justify continued medical need for oxygen. Are they going to update the continued medical need section in the standard documentation requirements to show that oxygen was always a special situation while all the items that could have a CMN and or DIF was a special situation? But the other options don't really say just an annual prescription. It's a prescription for a refill of supplies. Like in the case of a PAP device with supplies or diabetic strips or a recent order for repairs. If I'm not doing any repairs, that wouldn't apply. A recent change in order prescription. Let's say liter flow or method of delivery, that wouldn't apply if it was just an annual order. So, the only other option, after date service 1/01/2023, would be timely documentation, which would mean the patient would go back, and the doctor would document continued need. So, if I read continuing medical need, as just an order. A regular standard written order, which I do obtain yearly for oxygen, because I'm in Arkansas, and our pharmacy board requires it, but we were under the impression the patient would also have to go back to be reassessed, and we would have to receive medical record documentation showing usage of the item. The way continued medical need section in the standard documentation requirements is spelled out, it doesn't say just a regular order is good enough to meet that. It reads as if we need a doctor's visit within the last 12 months in the same way that we do for capped rentals.

Answer 29: What you state in the SDR is accurate. Oxygen contents may be indicated on the oxygen order if a stationary gas or liquid system and/or portable system is prescribed.

Question 30: I just had one additional comment to the oxygen continued need and the available options. Just wanted to clarify, that a supplier could get, under that supply exception, a written order for supplies for oxygen, if that order included the equipment and cannula and tubing, which would be supplies for the oxygen. It doesn't require suppliers to bill for those supplies because they are included in the allowance. But if we add those supplies to that SWO, that should satisfy the burden and not require medical chart notes to satisfy continued medical need. Would you agree with that?

Answer 30: There seems to be a bit of confusion on this topic. We (DME MACS) are taking this back to the DME MAC Medical Directors (DMDs) for clarification.

DME MAC Update: *Since Oxygen is considered a drug in most states and requires an annual prescription, would an annual prescription meet the continued need requirement?*

DMDs Response: *Yes; once initial medical need and continued payment requirements specified in the Oxygen LCD and Policy Article are met, a new order would be acceptable to meet continued medical need moving forward.*

The Standard Documentation Requirements for All DMEPOS (SDR) will be updated to reflect this annual oxygen order allowance.

Oxygen administration supplies are not separately billable or payable and should not be indicated on the order.

Question 31: My question is regarding enteral. I know that the LCD, is changing but I do not see webinars or training in place for that new LCD that begins January 1st. Is there something planned?

Answer 31: There is not any education planned at this time. The enteral nutrition coverage is not changing, only the elimination of the DIF. The language was removed, which specified when a DIF is needed and when it isn't, but the coverage criteria itself is not changed.

We will look at providing enteral education soon.

Question 32: My question is related to billing span dates. Say we bill enteral December 15th – January 14th, will we need a DIF for our claims to be paid, or will they reject?

Answer 32: Yes, because the from date on your claim is prior to 1/01/2023, the DIF is still in effect for dates of service (DOS) on/prior to 12/31/2022. Your initial date is December 15, 2022 (from date) you will need to attach a DIF if it is the initial claim for the enteral or a revised DIF if one is needed.

Question 32A: So, all 30 days would pay on that claim?

Answer 32A: Yes, it should pay if you billed correctly and the patient meets all the coverage criteria and you submitted the DIF, if December 15th is the initial date of service.

Question 33: My question is related to test of permanence. Does the type of G-tube placement play a role in showing the test of permanence? For example, if it's a G-tube through the nose, that's usually for a short-term treatment. But you know if the G-tube is surgically inserted, it's usually considered for a long-term.

The LCD and the policy article does not say, by administration, what is considered permanent and what is not considered permanent when it's through the nose, a gastric tube, or etc.

Answer 33: The language of permanence was eliminated from the Enteral LCD. Like Judie stated earlier, indications in the medical documentation must warrant that it's likely to last a longer period.

DMD Response: That is an interesting question. We have never really looked at the choice of the tube. As you pointed out, whether it would be through the nose or a G-tube, to differentiate in terms of looking at the medical record during medical review. We prefer to look at the beneficiary's medical condition or clinical state and what is going on with them and why they need the enteral feeding. So, it would be a piece of information, obviously, that we would have, but I can't say that we would decide only based on that. We would need to see clinical information and a diagnosis.

Question 33A: That's why I'm talking about the test, to show that it's not just a temporary need.

Answer 33A: **DMD Response:** I'd rather have the surgeon, or the gastroenterologist have a statement in the medical record, or in his or her progress notes that say, we're going to do this for a long time, or we're going to give it a try.

I think you're all having a very difficult time because you want us to tell you how many months.

Question 33B: No, but it seems that if they are nasal tube feeding, it is something that would be short-term, and they only use G-tube if it's going to be a for a prolonged period.

Answer 33B: **DMD Response:** Well, we'll leave it to the ordering physician because they may say that they want to use a G-tube and not actually end cap it off and not use it, and allow the patient to eat, because that has been done in the past. So, I would say don't risk a medical review and only have that information. Be sure to get all the clinical documentation should you have reason for your claim to be reviewed by our medical staff.

Question 34: My question is related to a revised DIF for TPN. We submitted a revised DIF for 10/04/2022 with the incorrect initial date of 06/04/2022 instead of the correct initial date of 6/04/2021. Our claim was denied because of an incorrect initial date. Will you pay off the DIF revised date with an incorrect initial date?

Answer 34: Are you advising me you already have a payable DIF on file, or is the DIF in a denied status?

Question 34A: We have an initial DIF in a payable status, but we are trying to get the revised DIF with the incorrect initial date approved. Do we have to put in the correct initial date? We submitted through an appeal. will you still consider full payment on that?

Answer 34A: Since it's prior to January 1, 2023, if you needed a revised DIF for TPN parenteral nutrition and the initial date was entered incorrectly, you are correct you are going to have to take that to appeal. You cannot hold your claims and wait until the elimination of the DIF and CMNs, then try to submit those claims going forward, because, remember, the DIF elimination is for dates of service on/after January 1, 2023.

So, if you have a DIF or CMN on file with the DME MACs and it's already in a denied status, then come January 1, 2023, with the elimination, if you were to submit claims for anything that has a denied CMN or DIF on file, those future claims will deny.

So, it all depends on why your DIF is denying and it sounds like you said you took it to an appeal. You need that initial date updated before you can receive payment. Because those dates of service are prior to January 1, 2023.

Question 34B: Oh, I see, so in that case although we put the incorrect initial date on the DIF, will you focus on the revised date we put on the DIF instead of the initial date on the revised DIF for payment?

Answer 34B: Well for TPN and enteral, it's not like oxygen where it's looking for the initial, recert or revised. Typically, you're sending a revision, because the length of need was only good for X number of months, or there was a change in the order.

If lifetime was not indicated, then you would need to make sure, when you submit your appeals, you state, exactly what was going on with your initial DIF and what's going on with your revised DIF. You state your case.

Question 35: Right now, we file our claims electronically and the CMN is attached to the claim. After January, our billing system is saying that they are copying that CMN over to a generic form called a CMN, but a prescription. Does that need to be attached to the claim electronically?

Answer 35: No, it does not.

Closing

This was a great call! Thank you to everyone for attending, and all the great questions, you asked today!

There are no questions pending in que, so we will end today's ACT call. I want to thank not only the supplier community for attending today's Collaborative DME MAC Ask-the-Contractor Teleconference, but also everyone here at CGS and Noridian Healthcare Solutions participating in our live Q&A session. We will post the transcript to the DME MACs websites within 30 business days and send out an email notification when it is available. Again, I want to thank everyone that attended today, and we look forward to seeing you at future educational events.

