Recorded Webinar: AFO-KAFO

Contract	DME MAC Jurisdictions B & C
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Date Recorded:	10.03.2023

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Good morning and welcome to the AFO/KAFO webinar this morning. I am a Senior Provider Outreach and Education Representative with CGS Jurisdiction B. On the line assisting me today, I have Sarah Barbian, who is also a Senior Provider Outreach and Education Representative, and she's with Jurisdiction C. This is our disclaimer slide. Medicare does change frequently, and this is just a reminder that the information presented today was current and accurate at the time it was created. However, it is ultimately the responsibility of the supplier to stay up to date on Medicare rules and regulations. A great way to keep yourself informed of Medicare Updates is by reviewing the Local Coverage Determinations (the LCDs) as well as the Policy Articles and the CGS Electronic Mailing List. We do encourage you to sign up for our Electronic Mailing List as well. That will be at https://www.cgsmedicare.com/. And just as a reminder, supplier recording of any portion of this presentation is not allowed. However, CGS may record presentations for quality and future education purposes and, again, this webinar is being recorded.

Once again, welcome to the Ankle Foot and Knee Ankle Foot Orthoses webinar.

This is our agenda today. As you can see, we have a lot to cover, so we're going to go ahead and move on with that.

The first thing we're going to talk about is the definitions of the orthoses.

Orthotic devices are rigid or semi-rigid devices used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured body part.

So there is a difference between what you would consider a prefabricated orthosis and just an, um, which is off the shelf, and a custom fabricated orthosis. But, when you're looking at these, um, both the off the shelf and the custom fit items are considered prefabricated braces for the, um, for Medicare coding purposes. And those are manufactured in quantity without a specific beneficiary in mind. Of course, you have the difference between when they get one off the shelf and then if it's, um, if it has to be custom fit. That's a different code, but still considered prefabricated.

And then your custom fabricated orthosis. Those are individually made for a specific beneficiary, and that, they start with the basic material, but it involves more than trimming, bending, or making other modifications to a substantially prefabricated item.

On this next slide we have a, um, we have a chart here. And, again, both the off the shelf, or the "OTS" and custom fit items are considered prefabricated braces for Medicare coding purposes. And the correct coding of the AFO and KAFO items is dependent upon whether there's a need for minimal self-adjustment during the final fitting at the time of delivery. Now, if a custom fit code is billed when minimal self-adjustment was provided at final delivery or if you bill an off the shelf code

when more than minimal self-adjustments were made at final delivery, then those claims would be denied as incorrect coding.

A custom fabricated orthosis is one which is individually made for a specific beneficiary starting with the basic materials including, but not limited to: plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item. Custom-fabricated additions are appropriate only for custom-fabricated base orthotics and those should not be billed with prefabricated base orthotics.

Now this is a chart that's available on our website. It's going to give you a lot of information about the difference between what an off the shelf orthotic is, custom fit, and then custom fabricated. I'm sure that this will be a big help, especially if you have new employees or other new billers who might need to have this information. We have the links available here on our slide, but you can always access this information by going to our website and going to the left-hand side navigation bar, and there you'll see a, a bar, for the, um, guides and charts page and forms, and you'd look for this on the guides and charts page.

So Ankle-foot orthoses (AFO) and knee-ankle foot orthoses (KAFO) are covered under the Medicare Braces Benefit. For coverage under this benefit, the orthosis must be a rigid or semi-rigid device, which is used for the purpose of supporting a weak or deformed body member. Now we're going to move on to the next slide.

So here we're talking about the AFOs for non-ambulation. We have the L4396 and the L4397. That's the static or dynamic positioning ankle-foot orthosis. Now that's covered if either all of criteria 1 – 4 or criterion 5 is met. So that is the plantar flexion contracture of the ankle, and that's a, you'll be able to see that in the group one diagnosis codes. Those will be listed in the Policy Article; Reasonable expectation of ability to correct the contracture; Contracture interference with functional abilities; and it's used as a component of a therapy program; or the beneficiary has plantar fasciitis and, again, that's going to be listed in your group one diagnosis codes that are listed in the policy article.

A static/dynamic Ankle-Foot Orthosis, which is the L4396 and L4397 that we're talking about, and replacement interface – that would be the L4392 – are denied as noncovered (no Medicare benefit) when they are used solely for the prevention or treatment of a heel pressure ulcer because for these indications, they are not used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body (i.e., it does not meet the definition of a brace).

So here we have again, um, on the AFO for non-ambulation, that Medicare does not reimburse for a foot drop splint, recumbent positioning device, and that would be the L4398, or that replacement interface, the L4394. So those will be denied as not reasonable and necessary in a beneficiary that has a foot drop, who is non-ambulatory because there are more appropriate treatment modalities. And, yeah, it's denied as noncovered – no Medicare benefit – when they are used solely for the prevention or treatment of a pressure ulcer because, once again, it does not meet the definition of a brace in that case.

So here we have AFO that are covered for ambulatory beneficiaries with weakness or deformity of foot and ankle. It's covered for beneficiaries who require stabilization for medical reasons and have potential to benefit functionally. The L4631 is covered for Group 2 diagnosis codes, and here we have those diagnosis codes listed here but, again, they will be listed in the policy article. Now the Knee-ankle-foot orthoses (KAFO) are covered for ambulatory beneficiaries for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. If the basic coverage criteria for an AFO or KAFO are not met, orthosis will be denied as not reasonable and necessary.

For a custom-fabricated orthosis, there must be documentation in the supplier's records to support the medical necessity of that type of device rather than a prefabricated orthosis and this information does need to be available upon request.

When providing these items suppliers must: Provide the product that is specified by the treating practitioner; Be sure that the treating practitioner's medical record justifies the need for the type of product (for example, prefabricated versus custom fabricated); and only bill for the HCPCS code that accurately reflects both the type of the orthosis and the appropriate level of fitting. You need to have detailed documentation in the supplier's record that justifies the code that's selected.

The L Code Additions listed on this slide, will be nie, will be denied as not reasonable and necessary if either: the base code, the base orthosis is reasonable and neces, is NOT reasonable and necessary, excuse me; or the specific addition is not reasonable and necessary. So here we have those codes, um, that are the AFO, KFOs that will be um, excuse me, the AFO, KF, no. I cannot pronounce today, excuse me. AFO and KAFO addition codes that would be denied as not reasonable and necessary if either the base orthosis is not reasonable and necessary, or the specific addition is not reasonable and necessary.

These are miscellaneous codes that do not fall into definition of any other codes. There's the L2999 that is covered under the brace benefit. It is used to assist knee joint extension in the absence of any coexisting joint contracture, and it's used to assist ankle joint plantarflexion or dorsiflexion. Now the remaining two are covered under the DME benefit and not the O&P, only, and they're only used to treat contractures. We have the E1810, that's a custom fit code, and the E1815. That's also a custom fit code. Again, they're covered under the DME benefit and not the O&P benefit.

Concentric adjustable torsion style mechanisms used to assist knee joint extension are coded as the L2999 and are covered, again, for beneficiaries, excuse me, who require knee extension assist in the absence of any co-existing joint contracture. Now the concentric adjustable torsion style mechanisms used to assist ankle joint plantarflexion or dorsiflexion are coded, again, as the L2999 and are covered for beneficiaries who require ankle plantar, or dorsiflexion assist in the absence of any co-existing joint contracture. The concentric adjustable torsion style mechanisms used for the treatment of contractures, regardless of any co-existing conditions, are coded as E1810 and/or E1815 and are covered, again, under the Durable Medical Equipment benefit (refer to the CODING GUIDELINES section in the LCD-related Policy Article).

Claims for devices incorporating concentric adjustable torsion style mechanisms used for the treatment of any joint contracture and coded L2999 will be denied as incorrect coding.

Here we have some information about some shoes and foot orthotics. The foot orthotics are shoe inserts. They do not extend above the ankle. For beneficiaries without diabetes, coverage may be considered if the shoe is an integral part of the brace. Shoes that are incorporated into a brace must be billed by the same supplier that is billing for the brace. So you would refer to the Orthopedic Footwear policy for information about that. And then for the multiple density foot orthotics used in the management of diabetic foot problems, coverage is limited to beneficiaries who are diagnosed with diabetes and a qualifying foot condition. And for that one, you would need to refer to the Therapeutic Shoes for Persons with Diabetes Policy. Now we do have separate webinars on these and they are generally given once a quarter. So just look at our calendar of events, and um, you can go into Cvent and sign up for those.

Elastic or other fabric support garments, such as a belt, a strap, a sleeve, a garment, or any covering, any type, um, with or without stays or panels do not meet the statutory definition of a brace because they are not rigid or semi-rigid devices. Those are denied as noncovered, which means there is no Medicare benefit, and they must be coded as the A4467. And then we have the

orthoses used solely for the prevention or treatment of a pressure ulcer denied as noncovered, and we talked about those a little earlier too, and those are no Medicare benefit because for these indications they are not used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body. So it does not meet the definition of a brace. We have the, LC, um we have the Local Coverage Determination and the Policy Article noted here.

Payment for orthoses that are included in the payment to a hospital or skilled nursing facility, um, if the orthosis is provided to the beneficiary prior to the inpatient hospital admission or the Part A covered SNF stay; and the medical necessity for the orthosis began during the hospital or SNF stay; or if it's provided to the beneficiary during that inpatient hospital stay and prior to the date of discharge; and that the beneficiary uses the item for medically necessary inpatient treatment or rehabilitation. So in these cases, you would not submit a claim to the DME MAC.

We'll look at that a little bit more. So if it's delivered to the beneficiary in a hospital or part A covered SNF stay, it is eligible for coverage by the DME MAC if it's medically necessary for the beneficiary after discharge from the hospital or that part A covered SNF stay; and then you would need to remember that you may provide that orthosis to the beneficiary within 2 days prior to discharge but that you must actually, um, have the date of service be the date of the discharge. If the orthosis is needed for inpatient treatment or rehabilitation, then the DME would not be responsible for that. That would be part of the part A responsibility but, if it's not needed for inpatient treatment or rehabilitation – it's just left in the room for the beneficiary to take home –

that would be billable to the DME MAC. Once again, you want to bill the date of service as the date of discharge and then the place of service is going to be the beneficiary's home.

The listed items are required to justify Medicare payment. That would be the Standard Written Order, any medical record information, correct coding, proof of delivery, and – in this case – a Written Order Prior to Delivery, if that is applicable. So we do have a documentation checklist available it is on our website, here at this link but you also will be able to find that on the um, guides and charts page, as well as looking at the Medical Review portion of our website. It'll be available there in Physician's Corner.

There is an exception to the Standard Written Order. The separate Standard Written order is not required when that prescribing practitioner is also the supplier and is permitted to furnish specific items of DMEPOS and to fulfill the role of the supplier in accordance with any applicable laws and policies. Now, in this case, a separate order is not required but the medical record must still contain all of the required order elements.

Now the medical records should paint a picture of the beneficiary's medical need for the items or services, um, what the beneficiary can or cannot do, are there any functional limitations, and why previous treatments tried or considered were ruled out. Why won't they suffice. You do want to keep in mind that any supplier produced records such as equipment checklists, SWOs, or verbal orders are not considered part of the medical record for Medicare payment purposes.

For the Orthotist's records, those are considered part of the medical record and they would be considered in the context of that documentation that's made by the treating practitioner and the other healthcare practitioners to provide additional details that the item is reasonable and necessary. Now those records are expected to corroborate and provide details consistent with the practitioner's records and this will help to establish the medical necessity, but it will not be, um, the medical necessity and subsequent payment will not be provided solely based on the orthotist's documentation. Once again, that information must be consistent with the practitioner's records.

Supplier prepared statements and practitioner attestations by themselves, once again, don't provide sufficient documentation or medical necessity. So even if those are signed by the ordering practitioner, you do need to make sure that you have medical records to back up those statements and the attestations because those documents are not considered part of the medical record.

For the proof of delivery, we must be able to link the proof of delivery documents to the invoice when the item can be shipped. So when you're looking at method 1, that's basically direct to the beneficiary. So the beneficiary walks into your location, or you are delivering it directly to the beneficiary in their home or in the hospital. Well, method 3 the hospital, excuse me. The beneficiary's name and the delivery address are needed and description of that item that's being delivered. So you can either have the narrative description saying it's an ankle foot orthosis or you can just have the HCPCS code, or you could have the long description of the HCPCS code, or you can just include the brand name and model number. You'll need to have how many were delivered, your date that was delivered and either the beneficiary or the representative signature. So if the item is custom fit or custom fabricated, this is the only method of delivery that can be used.

If you're sending a prefabricated orthosis, you may use method 2 or method 3, and as you see, as far as method 2, that information is pretty much the same except that you will need to have that delivery services package ID number. Um, again, we must be able to link those POD Documents to the invoice when the item can be shipped. And. And method 3 documentation delivery, um, demonstrating the delivery of the item to the facility and you'll need to have documentation from the nursing facility that they've received that. That it was received by the benefit, for, excuse me, for use by the beneficiary, and that the quantity delivered and used by the beneficiary must justify the quantity that's billed.

For the purpose of the delivery methods noted, the designee is defined as any person who can sign and accept delivery of DMEPOS on behalf of the beneficiary and no one having a financial interest in the item can sign that proof of delivery.

For all of the items that require a face-to-face encounter the practitioner visit is required within 6 months preceding the order. Now that does not replace any requirements that are in other CMS policies. The encounter is to gather information that's associated with the condition and the demi post item that's ordered.

That face-to-face encounter must be documented in the medical record and that supporting documentation does need to include any subjective and objective beneficiary specific information that's associated with diagnosing, treating, or managing, the clinical condition for the DMEPOS item ordered.

If the encounter is performed via Telehealth, the requirements for telehealth services and payment for telehealth services must be met and we have some links on the slide in order to help you find that information.

So here we have, um, some information on the things that would do require the Written Order Prior to Delivery. We have some items that have been selected beyond the power mobility devices which require that face to face encounter, Written Order Prior to Delivery, and that was effective on April 17 of 2023. There are 46 PMDs that are on this list, and it's dictated by statute. You can find that list here at the link that we've provided here on this slide.

We have a really good tool that is available on our website. You can go to the tools, and you can go to the online tools page. And this one is the Written Order Prior to Delivery Code Lookup Tool. So you enter the HCPCS code, and the results will tell you if the item is included on the required face to face, um, encounter and Written Order Prior to Delivery list.

So in this example, the first code is that L1833 and you can see that the item is on the list requiring a face to face and Written Order Prior to Delivery.

In the second example, we have the L1831, and you can see that the item is not on the Written Order Prior to Delivery and the face-to-face list.

And we're gonna move on to billing and modifiers.

Here's that L2999 we talked about a little bit earlier. That is the lower extremity orthosis that's not otherwise specified. So, when you're looking at this code and when you're billing this code, you would only use that when there are no other codes or definitions that apply and you do need to include information like the manufacturers name, the product name and model name and model number, the medical necessity for the item, and if the item is custom fabricated and the complete and clear description of that item including what makes it unique, and a breakdown of the charges because we need to be able to verify what item is to identify, what the item is to identify the reimbursement amount. So we do have some information available on that. There's an article available and you can find that here at the links on this slide.

So the KX, GA and GZ modifiers, with those, suppliers do need to add the K modifier to the AFO, KAFO base and addition codes only if all of the coverage criteria in the coverage indications, limitations in our medical necessity section in the related LCD have been met and evidence of such is retained in the supplier's files and available to the DME Mac upon request. If all of the criteria in the coverage indications limitations in medical necessity section of the related LCD have not been that then the GA or GZ modifier must be added to that code. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if you have obtained a properly executed ABN, which is the advanced beneficiary notice of non-coverage, or if you have not, then you would need to append the GZ modifier. Any claim lines that are billed without a KX, GA or GZ modifier will be rejected as missing information.

When you were looking at a brace, if it is, um, for, if it's not like a back brace for instance. So if you have one that's for right side or for left side, you do need to have that modifier, the RT or the LT modifier there. Um, if you are billing bilateral, then you need to make sure that those are on separate lines.

For repairs, a new order is not needed but the treating practitioner must document that the item being repaired continues to be reasonable and necessary. Either the treating practitioner or the supplier must document that the repair itself is reasonable and necessary and the supplier must maintain detailed records describing the need for and nature of all of the repairs including a detailed explanation of the justification for any component or part replaced, as well as the labor and time to restore the item to its functionality.

When you are billing a specific HCPS code, the labor is included in the allowance. So HCPCS L4205, that's the repair of orthotic device labor component, and that's per 15 minutes. The claim does need to include an explanation of what's being repaired. It may only be billed for time involved with the actual repair of an orthosis or for medically necessary adjustments made more than 90 days after delivery. Cannot bill separately when replacing an orthotic component that is coded with a specific L code. The L4205 can only be billed with the L4210. Now HCPCS L4210 is the repair of orthotic device or the repair of, or replacement of, minor parts and that claim must include a description of each item that's billed, um, any minor parts that do not have a HCPCS code need to be described, and it does need to include those repair labor fees. As you can see, all at all codes for those season repairs of work policies built with the same date of service must be submitted on that same claim.

Here we have shoe transfers, um, and those are involving shoes that are on a covered brace, and again, those are covered under the orthopedic footwear policy. These include payment for all actions related to transferring a brace from one shoe to the other. So if the beneficiary does bring their own shoe, then the only billable code would be for the transfer. And once again, um, there should be an orthopedic shoe webinar coming up. You'll just need to look at our schedule, our calendar events on the education site of our website.

Any identical or similar items may replace, be replaced, in cases of loss or repairable damage. That does need to be a specific incident and you'll need to report the RA modifier on the claim. Reasonable useful lifetime for AFO KAFO is 5 years. You'll need a new order from the treating practitioner to reaffirm the medical necessity for the replacement item and you must maintain documentation for the reason for replacement.

Now next I'm gonna talk about looking for same or similar equipment in myCGS. Same or similar being, has the beneficiary been in possession of the same or similar equipment previously? And we do also have the same or similar tool that can be used.

Now this is our same and similar tool. It's located on our website under the tools and calculators page, and you just enter your HCPCS code, and the results are going to display any HCPCS code, and it's gonna display the reception, the description, but any HCPCS code that may cause the HCPCS code that's entered to deny as same and similar. That tool is available, again, on our Tools and Calculators page or you can get directly to it by using the links on this side.

Let's move on to the myCGS web portal for same or similar. We'll be discussing this over the next few slides. You can use the same and similar search request screen to verify same and similar information. Your NPI and PTAN will automatically populate. You need to enter the beneficiary's name and date of birth. And one of the newer features you can search, you can search within just your jurisdiction or select both JB and JC. Just keep in mind that selecting only one jurisdiction takes less processing time and it's quicker. Sometimes you could search both, um, both jurisdictions and it might time out. So if that does happen, select one jurisdiction and then select the other. Now you can search by product category or healthcare common procedure coding system, commonly known as the HCPCS code.

Now here we have those screens showing you the product category and you can pick a subcategory if it's applicable. Now, if you selected the HCPCS, you could do a single, a partial or a range of codes. And you can look at the myCGS user manual for more information about that. That information, that link is available right here. It is an actual web page so it's very interactive and easy to use.

When you're looking at the advanced beneficiary notice of non-coverage and you're talking about possibly using that for same or similar equipment, there must be a specific identical, excuse me, identifiable reason to believe that Medicare may not pay for that certain DME item. So you do need to make sure that you obtain all of the possible information from the beneficiaries in order to determine whether they've had same or similar equipment in the past or in the last 5 years, and make sure that you ask them some very specific questions when you're providing that item to the Medicare beneficiary.

So if you're looking in there is actually no indication that same or similar equipment has been previously obtained, you would not have a reason to provide an ABN.

If the beneficiary or the beneficiary's authorized representative is unable to respond fully on the issue of same or similar equipment, then you may issue an ABN. You'll need to refer to chapter 3, section 13 of the DME Supplier Manual for more information about that and we have provided the link for both the JB and the JC Supplier Manuals on this slide.

Now, if you get a same or similar denial and you're wanting to appeal that, um, you may submit a redetermination. If the replacement orthosis is provided due to a change in the medical condition, then you do need to submit some information. You need to submit that standard written order and proof of delivery and there needs to be some medical record documentation in there to show that change of medical or physiological condition.

Now if the item has been lost, stolen, or irreparably damaged, um, you'll need to have the information about the specific incident. Was it due to a natural disaster? Was it stolen? Um, was there a fire? If there was a fire or flood, it was stolen, or anything like that, you're going to, as far as the fire or, excuse me, the, it being stolen or broken somehow, you'll need to have some information in there like a police report for it being stolen, maybe a fire marshals report or something for fire, or some information like that. You do need to include the following

documentation with that Redetermination request such as the documentation, again, of that loss or irreparable damage and you'll need a new standard written order to reaffirm the medical necessity of the item.

The medical record should paint a picture of the beneficiary's medical need for the items or services, what the beneficiary can or cannot do, any functional limitations, and why previous treatments tried or considered, or ruled out, will not suffice. You want to keep in mind, again, that supplier produced records such as equipment checklists, those standard written orders, or the verbal orders are not considered part of the medical record for Medicare payment purposes.

If there's a change, excuse me. If there's a change in the beneficiary's medical condition, why does the previous brace not suffice, and why, specifically, is that new brace needed? There is a chart available um, on our charts page, our checklist and charts page anyway. Replacement Orthotics for Change in Condition During to the Reasonable Useful Lifetime Checklist. So that is available. Excuse me. It's a checklist, not a chart.

Now we get into CERT. CERT is the comprehensive error rate testing.

So the 2022 improper payment rates and projected and proper payment report. It's available at the link that we've provided here on this slide and we're looking at this, you can see we're looking at reporting period July first of 2020 through June thirtieth of 2021. Um, the overall was 31.46 billion dollars and for DMEPOS in particular that projected and proper payment amount was 2.19 billion dollars with an improper payment rate of 25.24%.

The common errors for a lower limb orthosis for CERT are that the base item on the claim is denied and therefore the related addition to the base and accessory, or accessory, is denied; there is missing or inadequate documentation to support coverage criteria; the, there was no description of the modification to the orthotic at the time of fitting; maybe there was no proof of delivery and that was why it denied; there is no order available; or there's no attestation for an unsigned piece of documentation; and then finally, that the documentation does not support medical necessity for the item billed.

Some of the things that you can do in order to avoid getting an error are to implement a thorough intake procedure and ensure that all of your documentation requirements are met. Once again, we do have those documentation checklists available for you. You'll need to reply to all of the CERT documentation requests to avoid recoupment of payments and submit the documentation to the CERT documentation contractor within the time that's requested and that's going to be available in that letter that gets sent to you. Use the bar code sheet as a cover letter to all documentation submissions and you may submit that documentation via paper or CD-ROM but if you do submit it. With the CD-ROM, it does need to be in the TIF or the PDF format.

You'll also need to make sure that all of your records are legible. And then as far as appeal rights, you're going to file those appeals with CGS, not with the CERT contractor and this is done through those normal channels, starting with the redeterminations requests. You will need to use the overpayment appeals process when applicable, meaning if they've already started the recoupment process, you're going to need to use that overpayment appeals process.

Excuse me.

The CERT contractor is Empower AI Incorporated. That's the CERT documentation center and the CERT resources and contacts. We have the customer service number here and their fax number as well as their email and their website available here.

There are 5 ways to respond to requests from the CERT contractor. You can send it by fax and just remember if you are sending something by fax, make sure that you don't have anything highlighted in colors like yellow, orange or pink or anything like that because those highlights come through as dark spots and the information that you're actually trying to highlight for them to be seen, for them to see, is concealed. You can mail that information to the CERT documentation center at the address provided here. You can also, um, submit it esMD through the link that's provided on the slide. You can do an encrypted CD and, again, that must be in the TIF or PDF format and then you can also send that as an encrypted email. The attachment, again, must be in that TIF or the PDF format.

We've reached the end of the education part. We'd like to go over some resources that we've got available for you here at CGS.

This is available under our medical review page, and we do have that quarterly status report linked right here but again, you can get to that by just going to the medical review page. So, um, some of the errors that are available are that, or that we've seen anyway, are that the medical records do not confirm that the coverage criteria have been met for orthotic not using during ambulation and, um, at the moment we have a 27.94% for JB and 20.94% for JC. The HCPCS procedure code on the claim is not correct for the items billed, um, and all of these will be available again on this chart.

The documentation does not include verification that the equipment was lost, stolen, or irreparably damaged in a specific incident, and for information about that, you would need to refer to the Medicare Claims Processing Manual 100 -4, section, Chapter 20, Section 50 and that's available on the CMS website.

Another program we have is a CGS Connect program and AFO/KAFO are included in that. Now to confirm that your documentation meets coverage criteria prior to claim submission, you can use the CGS Connect program. It's a voluntary program and it provides you with a higher level of assurance that your supporting documentation meets the necessary requirements to process your claim for payment consideration. A reduction in claim denials is related, um, related to documentation errors has been noted and there's also been, because of this program, a reduced need to appeal claim payment decisions. This program does include one on one education on the correct way to submit required documentation and CGS Connect does allow subsequent submissions for review requests after you've had the opportunity to make improvements. But those subsequent submissions must be received within 30 days of that initial request.

Here we have listed the, um, some of the documents that we have been speaking about and some of the tools and everything that we've been speaking about, as well as the links to those resources.

As you know, CGS does have both Jurisdiction B and Jurisdiction C. They are separate contracts.

So, Jurisdiction B and Jurisdiction C are run separately. Although we do sometimes offer education the same. These are the Jurisdiction B resources and make sure that if you are looking for information on a Jurisdiction B beneficiary or claim that you use the correct information here. So we've got the telephone numbers and addresses for the different jurisdiction B resources available on this slide and on the next slide, we will have the Jurisdiction C resources.

You can always get to this information, of course, by going to our website. Going over to the left-hand navigation bar and you will see a bar listed for contacts. That information will be listed there.

Now this slide displays some additional contractors that you may need to contact. We have the Pricing Data Analysis and Coding contractor or the PDAC and that's your contact for questions about coding. So if you have an item but you don't know the HCPCS code, you can locate the HCPCS code for that item by going to the PDAC website. Now it is important to note that just because an item has a HCPCS code does not mean that it is covered under Medicare guidelines.

The NPE contractor, National Provider Enrollment, are responsible for provider enrollment and issuance of the PTAN or the Provider Transaction Access Number. If you have any questions about enrollment or updates to your PTAN, please contact that National Provider Enrollment contractor.

Now you should contact CEDI or the Common Electronic Data Interchange contractor for electronic claim or submission, excuse me for electronic claim submission inquiries. They assist with the free low-cost software support for, um, also for electronic claim formats and support for claim and rejection reports. And we do have a full list of resources, once again, under the contractors tab on the JB and JC Websites.

So this is some information on the Electronic Mailing List. If you have not signed up for our Electronic Mailing List, we do encourage you to do so today. It only takes a few minutes at most. You will receive emails about any updates and changes and suppliers do find these very helpful in keeping up with all of the changes. You can sign up for the Electronic Mailing List on the link provided to you on this slide or sign up by visiting the Jurisdiction B or C website and the link is located on the top right-hand side. You can, it'll just say, "Join Electronic Mailing List" and it's also available in the information section at the bottom of the website. We do encourage that if you bill both Jurisdiction B and Jurisdiction C to sign up for both of those lists because at times there may be something that's happening in Jurisdiction B that's not happening in Jurisdiction C, and you would not get that information if you're only signed up for Jurisdiction C.

So this is some information on our myCGS web portal. It will save you some time and money and it will save you some resources. You may submit redetermination and reopening requests through the myCGS portal, and you can get started, excuse me. You can get started by using the myCGS Registration Guide or looking at the myCGS user guide if you are already registered for that. Once again, both of these are actually web pages so they're very easy to use and they're very interactive.

We're pleased to announce that on March 28, 2023, the Centers for Medicare and Medicaid Services, or CMS, announced CGS Administrators LLC as the Jurisdiction B DME MAC for 7 more years! The first part of the, um, the contract actually, started on April 1 of 2023 and goes through August 31 of 2030. CGS was the previous contract holder, which will result in a seamless transaction, I'm sorry, transition for DMEPOS suppliers, and there are no anticipated interruptions in processing, changes in contact numbers, and addresses, supplier cash flow - those payment floor drops, transition related dark days, enrollment changes, etc. So if you need to look at that fact sheet, we do have that listed here on this slide.

Effective on August 21 of 2023, CMS 588 - that electric, excuse me, electronic funds transfer authorization agreement needs to be sent, must be sent, to the applicable National Provider Enrollment Contractor for the supplier's physical location. That bank information must be applicable for all 4 jurisdictions. The forms that are received by the DME MACS anywhere from August 21 through November 19, 2023, will be forwarded to the NPE Contractor. However, on or after November 20, 2023, the forms will be rejected and returned to the supplier. So make sure, and we hope, that by November 20, 2023, you're sending those forms to the correct NPE contractor. If you have any inquiries that are related to the EFT, including any questions about EFT correspondence that's sent by the DME MAC for the NPE contractors, the status of your EFT requests, or any changes in the EFT information, you must contact your appropriate NPE contractor for those. There is the CMS 588 form available at the link that we provided here on this slide.

As, Medicare is kind of catching up with the rest of the world we are transitioning from paper checks. That is supported by 42 Code of Federal Regulations. Suppliers must, suppliers enrolling in the Medicare program must agree to receive Medicare payment via the electronic funds transfer either at the time of your enrollment, when you revalidate, if there's any change of Medicare contractors, and the submission of an enrollment change request. You would need to submit this CMS 588 form to receive Medicare payment via electronic funds transfer and your enrollment contractors will notify you when you must transition from paper checks to EFT. And here we have listed the links on the slide for the NPE East and the NPE West Contractors as well as a link to the information from CFR 424.510.

And we've reached the end of our webinar today and we're going to prepare for questions. But just before we get prepared for those questions.