Recorded Webinar: Documentation Requirements 3

Contract	DME MAC Jurisdictions B & C
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Welcome to Documentation Requirements Part 3. This is the third in our 3-part series on documentation requirements. We will be looking at refills, delivery, and Advanced Beneficiary Notices of Non-Coverage, we call that ABNs for short.

This is our disclaimer slide, it's in all our presentations. It's a reminder that the information presented today was current and accurate at the time it was created. As we all know, Medicare changes very, very frequently so make sure you are up to date by vising our website and signing up for our electronic email list which we will discuss under resources. Attendees may not record this presentation for any reason. However, CGS may record webinars for future educational purposes.

This is our agenda for today. First, we will look at the requirements for continued use and need. Then we will look at documentation for refill requirements and proof of delivery. We will review the guidelines for Advanced Beneficiary Notices of Non-Coverage. Again, that's ABNs for short; we have a lot of acronyms in Medicare. We have information about the end of the COVID-19 Public Health Emergency that has officially ended. We have some real documentation examples of documentation that we received here at CGS. And then we will have some helpful resources and we'll have time for a live verbal question and answer session.

Continued use and need documentation. This information we are going to review can be located in the Standard Documentation Requirements for All Claims Submitted to the DMEMACs policy article. So, I highly recommend that you go out and review that SDR article if you've not done that or if you just need a reminder.

First, we have initial need documentation. Medical need must established with that first order. And that's accomplished with medical records supporting that the items are reasonable and necessary. When we refer to medical records, that will include doctor's notes, practitioner notes. It also can include supporting documentation such as hospital and home health notes, records from other professionals such as lab results, those involved in patient care, etc. Just keep in mind that documentation that you as the supplier created, even if the practitioner signs it, it's not considered part of the medical record. Medical records should document the beneficiary's condition with things like the diagnosis, prognosis, the beneficiary's past experience with any related item, etc. And those medical records must be created just prior to, or at the time of, the creation of that first initial prescription; that first order.

In addition to initial documentation, for ongoing supplies and rental Durable Medical Equipment, DME, items, the medical record also needs to show that the item continues to be reasonable and necessary. Does the beneficiary still have a valid need for the item? For instance, if someone had surgery, they would not need surgical dressings after that wound has healed.

Any of the items listed on this slide could be documentation for continued need. It could be a recent order by the treating practitioner for refills of supplies. It could be a change in that order or a prescription by the treating practitioner for repairs, or it could be a change in the order. It also could be a Certificate of Medical Necessity (CMN) or DIF; that's a DME MAC Information Form, and that would be for services prior to January 1, 2023, because CMNs and DIFs have been eliminated as of January 1st. And regardless of which you have for continue medical need, it needs to be timely. And when we say timely documentation in the medical records showing usage of the items, it can also be in the medical record, but any of these must be timely and timely is defined in the last preceding 12 months, from the date service in question.

Along with continued need, you also need continued use documentation. Continued use is pretty much what it says. It means, does the beneficiary, are they still using that item or items? For instance, they may need an item such as a positive airway pressure device but are they actually using that device? You as the supplier are responsible for monitoring utilization of DMEPOS- that is Durable, Medical Equipment, Prosthetics, Orthotics and Supplies; DMEPOS rental items and supplies. For those items that are purchased or capped rental items that have been converted to a purchase, you don't have to monitor that. That's because since the beneficiary owns that item, we don't need that continued use documentation, but we do need continued use documentation for ongoing utilization, for those items being rented or for supplies used for every single month. If the beneficiary isn't using those items or supplies, you should stop billing Medicare. To show continued use, it could be the beneficiary medical records or supplier records. An example of that would be a refill request, or you can ask the beneficiary if they are still using the wheelchair or supplies, and you can document that. Also just remember that oftentimes, when continued need documentation met, continued use documentation is met as well. And just like continued need, continued use is timely documentation within the last 12 months from that date service in question.

I briefly mentioned the elimination of CMNs and DIFs and hopefully most of you are familiar with it. But CMS has eliminated CMNs and DIFs for dates of service on or after January 1, 2023. You can see the list of the remaining CMNs and DIFs that have been eliminated. So, what this means for you, is that if you submit a claim with the CMN or DIF and your date service is on or after January 1, 2023, the Common Electronic Data Interchange, CEDI, will reject the claim, meaning it won't ever get to Medicare. And you'll have to resubmit that claim again.

And when it comes to continue need, if you've obtained the CMN or DIF before January 1, 2023, that will suffice for 12 months, for that continued need.

And when I say that CMNs and DIFS have been eliminated, that includes revised, so if you have a beneficiary who obtains, let's say, an initial DIF or CMN before January 1, 2023, and you think oh, it's time for their revised or recert CMN, that's not the case anymore. If it's after January 1, 2023, don't submit anything as far as the CMN or DIF, even if it's a recert or revised, we don't require those anymore. Your claim will be rejected.

Next, I'm going to talk about refills. This is another requirement, and that's for supplies. It wouldn't be for wheelchairs. It'd be something like CPAP tubing, mask, it could be enteral nutrition supplies, etc. The supplier is responsible for refill documentation, not the practitioner, it's the supplier. In an audit, items delivered without a valid refill request will be denied as not reasonable and necessary, holding the supplier responsible. You want to make sure you do have a valid refill request which will go over in detail. Also, just to let you know that one of the basic principles of refills is that you must contact the beneficiary prior to dispensing the item; you can't automatically ship no matter how much the beneficiary wants you tp. Medicare won't allow that because it's to ensure that the refill item remains reasonable and necessary. Their existing supplies, they're about ready to exhaust, they don't have very many left. And confirm that there's not been any changes or modifications to the order because things can change for a beneficiary.

So, let's look closer at the refill requirements. When a beneficiary comes into your store and requests a refill, this is all you need.

You would either need the signed delivery slip, or it could be a copy of the itemized sales receipt, and that's going to be a sufficient enough if they're coming to your store in person. Just as a reminder, because there's different requirements depending on the type of delivery versus pickup. Make sure if it's pickup, it's clear the beneficiary picked it up in your store in case of an audit so it's clear the auditor, the beneficiary picked it up in the store, and this is all the auditors would be looking for.

Next are items that are delivered. You'll need more documentation than what you would if the beneficiary would come into your store. The refill request can be a written document from the beneficiary, a letter, an email, or it could be a written record of a phone conversation between that supplier and beneficiary. That refill request must occur and must be documented prior to

shipping that item. You cannot do it after the fact, and that's why it states in the orange color, "a retrospective attestation statement by the supplier or beneficiary is not sufficient." It has to be before shipment and again, it cannot be automatically shipped.

For the supply items and accessories that are refills to that original order, there's other rules that do apply. Again, suppliers must contact the beneficiary prior to dispensing, no automatic shipment on predetermined basis is allowed with Medicare. The supplier can contact the beneficiary, but they can't contact the beneficiary sooner than 14 calendar days prior to delivering or shipping that item. And when it comes to delivery, that supplier must deliver the items no sooner than 10 calendar days prior to the end of that usage of the current product.

This slide shows what must be documented for those items delivered for a refill request with the beneficiary. it needs to have the beneficiary's name, or it could be the authorized representative if they're the ones who requested that refill. It needs a description of each item that's being requested, and the day that the refill request was made. It also either needs quantity of consumable supplies remaining or functional condition of non-consumable supply items, and I know that can sound confusing, so we have some slides that we're going to look at closer, the difference between consumable supplies and non-consumable supplies.

Consumable supplies are supplies that get used up. I think about consumable as I'm eating something, so I'm eating and it's getting used up. That's how I remember it; there's some examples on the slide. Surgical dressings, urological supplies, diabetic test strips; things that get used up. For these things that get used up, the suppliers should assess the quantity that beneficiary still has, and document that amount remaining will almost be exhausted on or about that anticipated end of usage from the previous delivery. So basically, ask how many the beneficiary still has on hand and document that quantity. Determine when they will be completely out. Many claims are missing this information. It's a very common reason for denial. So, make sure you document how many of the items are remaining.

Next, we have non-consumable supplies. Those are more durable in nature, but they can require periodic replacement. There are examples again. Here we have the positive airway pressure supplies, nebulizer supplies, and Respiratory Assist Device (RAD) supplies. Even though Medicare may say, oh, these can be replaced once a month or once every 6 months, whatever it may be, that doesn't mean we will automatically pay for them to be replaced. Medicare will only replace these when it is no longer functioning. So, if you're replacing one of these items, you need to document the reason for replacement. Why isn't it working anymore?

Worn is not enough. We need more information. Medicare is going to only replace something, again, when it comes to non-consumable supplies when it's no longer functional.

For example, if there's a hole in the tubing, that would justify placement on the refill request, maybe the PAP or RAD mask is no longer sealing appropriately, it cannot be cleaned appropriately according to manufacturer's recommendations due to mold for instance, those are some valid reasons for replacement, that functional condition and non-consumable supplies.

This is a handy chart that shows all the documentation methods of delivery and the documentation requirements. We just talked about these. I won't read these off all to you because there's a lot more that we need to go over during this webinar. But this is a great reference should you need it. Also, if you don't know what a refill request looks like, we do have a suggested refill request form. You don't have to use this form. You can, though, use this form. You can make your own form, but it's a helpful form that want to look at and to make sure if you do have a refill request, it meets all the needs listed here. And then the suggested refill request form.

When it comes to claim narratives for 90-day supplies, most DMEPOS items, those are accessories and supplies, can be provided on a recurring basis.

This can be dispensed with a 3-month supply. I say most, because you want to check the refill requirements section; it's in each individual Local Coverage Determination, because some items can only be provided as a one-month supply and example of that is enteral nutrition, it is only one month. When you provide more than a month supply, you need to add a claim narrative to indicate how much you're billing. If you don't, that claim could deny for frequency without that claim narrative. So, it's important to add that claim narrative. It would go in the NTE segment if you're doing an electronic claim and, you would add that narrative of how many months you are billing. So, examples here: If you're billing a 3-month supply of PAP accessories, indicate 90-day supply or 3 months' supply. We also have the link on the slide. We have a lot of references, so you are able to refer to them later. It's a claims narratives chart. It's a very helpful chart. It lists situations in which claim narratives are needed.

There's more than one. This is one of them. It also lists what type of narrative needs to be entered in the claim, depending on that scenario.

Now that we've discussed refill requirements, we are going talk about proof of delivery. Proof of delivery is a supplier standard. You do need proof of delivery for any item for DMEPOS Medicare.

There are 3 methods of delivery that you see listed here. We'll talk about these each more in-depth on the next few slides. No matter which method is used, the delivery documentation must prove that the items delivered are the very same items being billed, and the beneficiary actually received those items. Just keep in mind that suppliers, employees, or anyone with a financial interest in that delivery cannot sign and accept an item on behalf of the beneficiary.

First, we have method one, that's direct delivery to the beneficiary.

This occurs when the beneficiary comes to your store to pick up the item, or you deliver the item via a personal vehicle, a company vehicle. It must include everything you see here: the beneficiary's name, the delivery address, the quantity delivered, a description of the items being delivered, and the description does have some variance. It could be a narrative description, such as lightweight wheelchair, base.

It could be the HCPCS codes, such as K0003 is a lightweight wheelchair base, just an example. It could be the long description of the HCPCS code, or even can be the brand name, model number. It should be evident what you're delivering and needs the date the item was delivered and the beneficiary or their designee's signature. This is the only method that actual requires the beneficiary or their designee to sign. When it comes to billing, the date of service is the date the beneficiary receives the item. As it says on your slide, the date of service equals the date of delivery. Also just be careful about the beneficiary signature. If they date their signature and put the wrong date, because that wrong date will become your date of delivery. You may not want to have a blank for that beneficiary to date, if you already have the date delivered, or if you do have a blank for the beneficiary to date it, just make sure they put the correct date.

Next, we have Method 2: shipping. That's using a delivery service postal, UPS, Fed Ex, etc. It must include everything you see here. Beneficiary's, name, delivery, address, description of the item being delivered, the quantity being delivered, date delivered, and evidence of delivery. When we say evidence of delivery, what does that mean when it comes to shipping? You have to have evidence, obviously. So, an example would be a detailed supplier's invoice, and then the tracking and slip, let's say, from FedEx. Your record must be linked to the delivery service records, such as maybe you have that tracking number on both the supplier's invoice and the tracking slip. Sometimes we get questions about this because it can seem confusing. We do have some examples we'll look at in a little bit later towards the end of the webinar. You can also use a return postage paid delivery invoice from the beneficiary, but it has to have all the information shown here. When it comes to date of service for shipping, there are options. It can be the shipping date and the date the delivery service label is created, the date the item is retrieved by the shipping service for delivery, or it could be the date. the beneficiary actually received the item.

Lastly, is Method 3- delivery to skilled nursing facility. We call that SNF for short. When the beneficiary is inpatient in the skilled nursing facility, whether you deliver it yourself or use a delivery service, you must have proof of information listed on this screen that the items were delivered, and documentation showing the items were accepted by that nursing facility for the usage of that beneficiary. When it comes to date of service, it will depend on which method you use; Method 1 or Method 2.

If you submit a claim for a DME item and you may have experienced this before with a date that falls within an inpatient stay, the claim most likely will deny for an inpatient stay. Because Part A is responsible for everything that beneficiary needs when they're inpatient in the skilled nursing facility or hospital. However, there are situations when you can deliver to the facility, but certain rules apply, and this slide goes over those rules here. A supplier can deliver a durable medical equipment item, prosthetics, or orthotics, it can never be supplies to a beneficiary who was inpatient for the purpose of fitting or training the beneficiary on how to use that item properly. Or maybe it's needed immediately, when the beneficiary discharges. Again, just keep in mind, this doesn't apply to supplies. You can't deliver supplies early in the circumstance. You can deliver one of these items, but not supplies. again, up to 2 days prior to the beneficiaries expected discharge date. As a supplier, you must ensure the beneficiary takes that item home with them or the supplier can pick up the item at the facility on the date of discharge. If the beneficiary forgets the item, and you have to go back to the facility to get it, you cannot charge a beneficiary any extra delivery fee. You can never charge delivery fees for Medicare. Just keep in mind that this is only for fitting and training purposes because that skilled nursing facility should supply all the beneficiary needs under Part A benefits. This is an important point because some items should be provided by

the facility. If that facility or the supplier tries to substitute one for the other, it can be considered fraud. And if you're unsure of whether you can bill a DME item when the beneficiary is inpatient, in hospice, or home health, we do have a consolidated billing tool on the website under our tools and calculators. Basically, just enter the Healthcare Common Procedure Coding System, the HCPCS code, and it'll tell you when and how and who it can be billed to.

This is an image of what we just discussed to help you understand better.

So, on June 1, you've delivered a hospital bed to the beneficiary's home.

Two days later, which should be June 3rd, the beneficiary discharged from the hospital. And when you go to bill the date of service, the date of service on the claim should be June 3rd. If it was, let's say June 1st when the beneficiary was inpatient, that claim would deny. Also, you want to be aware that discharge dates can change just because their anticipated to be discharged within 2 days, you really want to stay in touch with that beneficiary or hospital to make sure it's the case that they actually discharge within 2 days, because if they don't, let's say it's supposed to be 2 days and their length of stay was extended for 4 days, you would have to redeliver that item, because it can only be 2 days prior to that beneficiary discharging.

Also, for proof of delivery, when a beneficiary receives a DMEPOS item from another payer, such as a Medicare Advantage Plan, or maybe another primary and that beneficiary becomes eligible for traditional Medicare, that first Medicare claim is considered a new initial claim. Medicare doesn't automatically continue coverage for any item obtained from another payer when a beneficiary transitions to Medicare coverage. In order for Medicare to consider payment, the beneficiary must meet all Medicare coverage, coding. and documentation requirements for that item in effect on that date of service of that initial Medicare claim. A proof of delivery is required even for those items that the beneficiary already has provided by another insurer before they become Medicare eligible. If this is the case, a statement that is signed and dated by the beneficiary or their designee, that you, as a supplier, you've examined that item meets the proof of delivery requirements. And, you also have to have a supplier attestation statement that the item actually meets Medicare requirements. It's in the beneficiary's possession, and you've confirmed it's in good working order.

Now that we've talked about refill requirements, proof of delivery, you have a valid refill request, you have your proof of delivery, you have continued use in need. We are now going to discuss Advanced beneficiary notices of Non-Coverage or ABNs.

First, I'm going to talk about what an ABN is. It's an advanced beneficiary notice of nonpayment. It lets the beneficiary know before you provide an item or service that Medicare is probably won't pay for that item or service that Medicare is probably won't pay for that item or service, and the beneficiary may be held liable for that item by providing an ABN. The beneficiary can decide whether or not they can afford to, or willing to pay out of pocket for that item. If you fail to provide a valid ABN, you will be held liable as a supplier for the item or service, and you cannot bill and collect payment from the beneficiary if this is the case, if it's not a valid ABN, and then you would have to refund any amounts that you've collected from that beneficiary. ABNs are not required for statutorily excluded items or services such as personal comfort items, convenience items, cosmetic surgery, things like that.

When you provide an ABN in this way, it's considered voluntary. CMS would prefer that you provide an ABN in this way for statutorily excluded items and services. You don't have to, and since it is voluntary, it's just basically a courtesy in this case to the beneficiary, letting them know of impending financial obligation. And since it's voluntary, the beneficiaries shouldn't be asked to choose an option box or sign. And then it's a notice, it's just basically a courtesy to that beneficiary just letting them know. But again, that is for statutory excluded items and services. And if you're sitting here thinking what statutory excluded items or services, if you're in the policy article of each item, of most Medicare items, if you're in that policy article, it will tell you what is statutory excluded, that's where you'll find that non-covered statutory, excluded language. And that's when you are not mandated to get an ABN. It will hold the beneficiary responsible if you bill for a statutory excluded item or service for the Medicare.

In order for the beneficiary to be responsible for payment, you must obtain an ABN for the reasons on this slide. If you don't obtain a valid ABN for these reasons, this supplier will be held financially responsible. So first, we have our not reasonable and necessary denials.

You can find this language in the Local Coverage Determination itself.

If you're looking in the LCD, you're looking at the criteria, it will basically say, if this criterion is not met, the item will deny as not reasonable and necessary. That's your key to know that

suppliers will be held liable if the item is not reasonable and necessary unless you obtained a valid ABN. Second, suppliers are not allowed to make unsolicited marketing telephone contacts to beneficiaries. It's a violation actually of the Social Security Act. So, if you do, hopefully, no one does here, but if you do, you must obtain a valid ABN. Then we have advanced determination and Medicare coverage ADMC request. These are voluntary. It's a program that allows suppliers to request prior approval of certain items. Right now, the items for ADMC requests are only certain wheelchairs. But if you do submit an ADMC request, and that is denied, you need a valid ABN, or you'll be held financially responsible. If you have a beneficiary that's in a competitive bidding area, and they come to you, and you do not have a competitive bid, you're not contracted, you should advise that beneficiary to go to a contracted supplier. Because that claim will automatically deny holding the supplier responsible. But if that beneficiary refuses to go to a contract supplier, you should obtain a valid ABN. This should be unusual. Typically, they will want not to be held responsible by going to a contracted supplier. And lastly, you need a valid ABN if you have not met supplier number requirements; you don't qualify as a supplier under Medicare enrollment, you don't have a valid Provider Transaction Access Number. Then you would need a valid ABN.

Routine ABNs are prohibited. Routine ABNs are provided to beneficiaries when there's not a specific, identifiable reason that Medicare may not pay. So, for instance, you cannot put on the ABN, I don't know if Medicare is not going to pay so sign this ABN, that is completely unacceptable. You must have a good reason as why you don't think Medicare won't pay for a particular item. If you don't, we consider that a blanket or generic ABN. You also cannot provide that sort of blanket or generic ABN; it cannot be routine. Statements on the ABN as to why Medicare won't pay must be specific to that beneficiary, and it should be in language a beneficiary understands; make sure they understand why Medicare most likely won't pay. Make sure that ABN is complete. Make sure you fill it out correctly, because if not, it'll become an invalid ABN and you'll be held financially responsible. ABNS can be provided routinely in exceptional circumstances. You can see those listed here. Medicare does not usually pay for this many treatments or services. Medicare usually does not pay for this service, or the treatment is experimental. Medicare does not pay for this many services within a period of time. Or Medicare does not pay for such extensive treatment. Those are acceptable reasons to obtain a routine ABN.

These are the ABN requirements. You cannot make up your own ABN form. You have to use this CMS approved form. Currently, CMS has 2 forms out. It's the same form, basically, the only thing that changes are the expiration date. Currently you can use either of these forms. However, once, you can see the expiration date, June 30, 2023. You must stop using the one that expires on June 30, obviously on June 30, and use the one that will expire on 1/31/26. Again, the ABN must be provided to the beneficiary before providing them with that item. It must be very specific as to why Medicare won't pay. You can't say I don't know why Medicare won't pay. That's not acceptable. The beneficiary must sign and date that ABN. Suppliers should clearly identify the item or service that Medicare most likely won't cover. It also should give a clear estimate of the non-covered item or service, and that estimate should be within $100 or 25% of the actual cost, whichever is greater. Regardless, if you billed an assigned or non-assigned claims, ABN notices still apply. We also have a link to the Medicare Processing Manual, which is Chapter 30, Section 5. This is a great link. If you have questions about ABNs or you have questions later, please go out and read this information about ABNs as it applies to Durable Medical Equipment, or DMEPOS. It has a lot of great information, a lot of very detailed information.

Next, we are going to look at some instructions for ABNs. If you are not a participating supplier; and a participating or non-participating suppliers, that's an option that you sign up for when you register for Medicare. It can be changed on a yearly basis. But if you're a non-participating supplier, you do have the option to bill claims on an assigned or non-assigned basis, with exception of Medicare covered drugs and biologicals. And again, to bill a non-assigned claim, you have to be non-participating. If you're participating, this is not an option for you. If you bill a claim as non-assigned claim and issue an ABN prior to, you will need to follow certain instructions. You will have to cross out this sentence, draw a single line through. And as you can see in Box H, it says, "this supplier does accept payment from Medicare for the items listed on the table." So, if the beneficiary checks option 1, they are responsible for paying any charges directly to the supplier. But if Medicare pays, then the beneficiary will be paid the Medicare approved amount for that item and that may be less than what they paid you, the supplier. You must add statement H to the additional information here.

There are also special guidelines that apply if you have a beneficiary who's a qualified Medicare beneficiary, they're duly eligible, we call these QMB beneficiaries. It means a beneficiary is enrolled in both Medicare and Medicaid. The program helps pay for part A or part B or both program premiums deductibles, coinsurance, and co-payments. If it's a QMB beneficiary, you cannot bill the beneficiary any Medicare deductibles, coinsurance, or copayment amounts, even if Medicare does not pay.

This is not a CGS rule, it's actually a federal prohibition and special instructions do apply when you issue an ABN to that QMB beneficiary. Because they cannot be asked to pay upfront, you do have to cross out, "you may be asked to be paid now, but I also and I understand that if Medicare doesn't pay, I am responsible for payment," because that beneficiary is not responsible for payment, because they are a QMB beneficiary. If Medicare denies a claim where an ABN is provided to a beneficiary, that claim could be crossed over to Medicaid, or submitted by the provider to Medicaid for adjudication. But again, you cannot charge the beneficiary.

When it comes to ABNs, we're going to now talk about how long they are effective for. They're effective indefinitely. As long as there have been no changes from anything that you see listed here. If the beneficiary's care has changed from what was described on that original ABN, you do need to get a new ABN. If that beneficiary's health status has changed, and it requires a change in the subsequent treatment for the non-covered item or condition, you need a new ABN. Also, if the Medicare coverage guidelines for items or services have changed, there's been updated changes to the policy, you need a new ABN, if that's affected.

And these are the guidelines for how to deliver an ABN. ABNs should be provided in person, if possible, in a perfect world. But we all know this is not a perfect world. Sometimes it's not always possible to be in person. Sometimes you just deliver those items. So, it's not in person. CMS has allowed other delivery methods when it isn't in person, it can be by telephone, mail, secure mail, or internet email. If it's by telephone, you must verify in the beneficiary's records that you had that telephone contact. And then you would follow up immediately with a hand-delivered, mailed, emailed, or faxed ABN notice. And then the beneficiary would sign and keep that ABN and send a copy of that signed ABN to the notifier. In some cases, the beneficiary may not return that signed copy. So, what happens if they don't return that signed copy? You need to make multiple attempts. It shouldn't just be one attempt; it should be multiple attempts to obtain the signature and then put in the beneficiary's records so you can show that you did try to get the beneficiary to sign. In this case, you can either decide not to provide that item if it doesn't harm that beneficiary, or if you do provide that item, make sure that you do document all those attempts, that you tried to obtain that beneficiary's signature. Also, all methods of delivery require that you adhere to HIPPA.

Another reason to use ABNs is when you are talking about upgrades. Usually that happens when the beneficiary wants something that's a bit more deluxe or more convenient than what Medicare will cover for that particular condition. Upgrades come into play when an item provided, and it goes beyond what's reasonable and necessary. according to Medicare coverage. Upgraded items can be issued at the request of the treating practitioner, the beneficiary can request it, or maybe it's provided as a supplier convenience. Just make sure you bill it correctly, because Medicare does not automatically pay at the least costly alternative. You must build a claim correctly to receive that payment for the lower-level item. Because a lot of this can seem confusing, we have examples of upgrades as well to show you, and it'll make a little bit more sense to you if you are unfamiliar with upgrades.

When ABNs are involved, some specific modifiers come into play that you need to be aware of. If you have an ABN, you "got" an ABN, you would use a GA modifier, you have a valid ABN on file. I remember it is "GA," "you got an ABN." If you don't have a valid ABN on file, it is the GZ modifier. GZ- you got "zero", you got "none." Basically, this is how I remember it. But this means you do not have a valid ABN, and you expect that item to deny as not reasonable or necessary. The GY modifier- you use that one if an item or services is statutory excluded, it doesn't meet the definition of any Medicare benefits. The GK modifier, that goes on the reasonable and necessary item, and you'll never see a GK modifier, unless it's associated with an upgrade with the GA or GZ modifier. And lastly, we have the GL modifier. I think about this to remember as beneficiary "got lucky." That is how I remember this modifier. They basically get an upgraded item at no cost to them. Let's look at some examples so all of this fits in together better for you.

In this situation, the beneficiary wanted the upgrade or the practitioner ordered the upgrade, and the supplier has decided to charge the beneficiary for that difference. A valid ABN was obtained. You would bill your claim in a certain way. So let's say the beneficiary only qualifies for the reasonable and necessary item, the E0260, which is a semi-electric hospital bed. The upgraded item is E0265, which Medicare does not pay for the E0265 because it's a fully electric hospital bed. So, the beneficiary wants a E0265, but only qualifies for the E0260, this how you bill your claim. On claim line one is the E0265, that's the item that you've actually provided to that beneficiary. The GA modifier would be appended along with all applicable modifiers. And then on the second line, is your reasonable and necessary item, the one the beneficiary qualifies for. This is where you'll see the GK modifier. In this circumstance, the beneficiary would be held viable for the difference between that, that would be $50. Again, you must bill this in a certain way with a GA and GK modifier if you have a valid ABN or you won't receive the payment for that difference; you cannot charge a beneficiary for that.

This is exactly pretty much just what we looked at except in this instance, you do not have a valid ABN but the beneficiary requests an upgrade. In this case, you are not going to charge the beneficiary the difference because you did not get that valid ABN. Line one is E0265 with the GZ modifier, you don't have an ABN. Then, on your second claim line, is the not reasonable and necessary item- or excuse me, the reasonable and necessary item, the E0260, the one that the beneficiary actually qualifies for. You would append the GK modifier. And again, you can't bill the beneficiary the difference between these two items, because you don't have a valid ABN, and that's why it's considered a free upgrade.

This is supplier convenience, or the practitioner ordered a free upgrade.

This does actually happen. I was talking to a supplier yesterday where this came into play. Many suppliers maybe only cover or may only certain wheelchairs. In this circumstance, the supplier only has a K0003 wheelchair, which is an upgraded wheelchair, but the beneficiary only qualifies for the K1, the K0001. So, in this situation, you provide the beneficiary with the K0003 because maybe that's all you carry, even though they only qualify for the K0001, and it is free of charge for that beneficiary. This is how you would bill a claim. On claim line one, that would be the item the beneficiary qualifies for, the reasonable and necessary, and use the GL modifier. In the note segment electronically, it'd be NTE segment 2300 or 2400. If you're doing paper claims still, it's item number 19. Specify the make and model of the item that's actually provided with the description of why this is an upgrade. As you can see, the description is a free upgrade.

And our last example of upgrades when it comes to ABNs. This is an overutilization upgrade with an ABN. The practitioner orders glucose testing twice a day for a non-insulin treated beneficiary, but documentation only supports testing one per day. And this is how to bill your claim. On line 1, you will bill the test strips, the amount the practitioner ordered, and you obtain a valid ABN with the GA modifier. Make sure that they are aware their practitioner ordered testing two times a day but only qualifies for one time per day. Make sure they want this upgrade. And then you have the second line item, that is the line item that is reasonable and necessary, which you have documentation for, showing it's reasonable and necessary what the beneficiary qualifies for. You would append the GK modifier. When it comes to claim processing, the line with the GA modifier will be denied as not reasonable and necessary with a patient responsibility, PR denial. And then the claim with the GK modifier, the reasonable and necessary item will just process through like normal.

Next, we're going to talk about the Public Health Emergency for COVID-19 that has now ended. The PHE ended on May 11, 2023, for COVID-19. For initial dates of service for items the beneficiary obtains for the first time, you would stop using the CR modifier and COVID-19 narrative for dates of service- initial dates of service- after May 12, 2023. You can still utilize the CR modifier and COVID-19 claim narrative if you have rental items, supplies, and accessories for items that were provided initially under the waiver or non-enforcement. We also have links to our COVID-19 CGS page for Jurisdiction B and C; it has a lot of information about the COVID-19 Public Health Emergency as well as the end of the PHE. So if you have any questions, you can also go out to these links.

This is more information about the instructions for use of the CR modifier and COVID-19 claim narrative. So, you would apply the CR modifier and COVID-19 claim narrative if your data service fell during the Public Health Emergency: March 1, 2020, to May 11, 2023, and that item was provided under a waiver or flexibility listed in an MLN Matters. That MLN Matters is listed below. Or you could continue to use the CR modifier and COVID-19 claim narrative for claims with date to service on or after May 12th, 2023, for those continued rentals, supplies, or accessories; for items that you provided during the PHE under waiver or non-enforcement. But if the beneficiary comes to you, let's say on May 12 or after, and they're obtaining an item for the very first time, you cannot use this CR modifier and COVID-19 claim narrative. This is only applicable during the Public Health Emergency and for those continued rentals. Maybe you have a wheelchair that was provided during the Public Health Emergency, and it's still being rented or maybe you have a base equipment that was paid under a waiver or flexibility during the PHE and the supplies and accessories you're now billing for. Then you can continue to use the CR modifier and Covid 19 narrative. Also, when you're using that CR modifier, make sure you append all other applicable modifiers, and that would include the KX or CG modifier or for oxygen, it could be the KX or N1, N2, or N3 modifiers.

During the Public Health Emergency, CMS waived requirements for Method One proof of delivery. That's the only method that requires a beneficiary or their designee's signature. If a beneficiary or designee signature could not be obtained during the Public Health Emergency, suppliers were instructed to document the date of delivery and that a signature cannot be obtained because of COVID-19 and then they would apply the CR modifier and COVID-19 claim narrative. If this

was the case, that you didn't get the beneficiary or designee's signature during the Public Health Emergency for that item, this means you already have a proof of delivery. You don't have to obtain a new proof of delivery for those items that were provided prior to May 12, 2023. Now for dates of service on or after May 12, 2023, this is no longer an exception. Signature and proof of delivery requirements have been reinstated so if you're using Method one, which would probably about earlier, you must obtain the beneficiary, or their designee's signature. Of course, we have a links on this for more information.

Oops, I apologize. I got a little ahead of myself. There we go. Also, during the PHE, CMS allowed beneficiaries to obtain immune suppressive drugs after organ transplant, anti-cancer drugs, IVIG, which is Intravenous Immune Globulin, and Enteral Nutrition for more than a 30-day supply. Normally, those are only limited to a 30 days' supply, but if the practitioner it, beneficiaries could obtain more than a 30-day supply during the PHE. Since the PHE has ended, for dates of service after May 12,2023, this has stopped. So the DME MACs will only pay for that 30-day supply of those items listed here. The LCD will stipulate for all of these items that it's only a 30-day supply, and that has resumed since the Public Health Emergency has now ended.

When it comes to CMNs and DIFs, during the Public Health Emergency, you did not have to obtain an oxygen CMN or External Infusion Pump- IEP- DIF regardless of the beneficiary's diagnosis or etiology. If this was the case, suppliers were instructed to use the appropriate modifiers, including KX or CG modifier when applicable and of course, CR modifier and COVID19 claim narrative and the oxygen or EIP Dif if those were not submitted during the PHE. Don't submit a CMN or DIF of any sort for dates of service on or after January 1, 2023, because we no longer accept CMNs or DIFs. This is just to make you aware of what you could do regarding a CMN or DIF or oxygen or EIPs during the PHE.

Before we get into resources and our questions and answers, we have some great documentation examples that I have come up with, we're going to review quickly.

Recently, I've got a lot of questions about Method 2, proof of delivery so I have a couple examples we are going to review now. This is a valid, prof of delivery for a shipping service. We have the supplier's invoice that has the beneficiary's name, delivery address, a description of the item, the quantity dispensed or shipped. We have redacted all private health information. And then we have the UPS tracking slip that has the delivery address, date shipped, and date delivered. And remember I said early, these two must be linked. The way these were linked was that the supplier got that tracking number pm their invoice and is automatically on the UPS proof of delivery. These are linked together by that same tracking number.

This is the second example of a valid proof of delivery. This is a supplier shipping invoice and the UPS tracking slip. In this case, these two are linked together by the patient ID and tracking number are both listed on here. You don't have to have both, but this supplier did. You could just use one or the other, but that shows you how to link these together.

Next, we have an example of an invalid refill request. You can see it's for CPAP supplies, and those are non-consumable supplies which means you do need to document the functional condition. As you can see, one of the reasons for replacement is worn; that's not acceptable. You can only replace the supplies when they're no longer functioning, not just because the policy says oh, you can replace these every so many months. And worn is not good enough, it needs to explain why it's no longer functional. Why isn't it functioning for that beneficiary? This is just a little closer up. That "worn" is unacceptable. The others are, but not worn, because it does not give us enough description of what it is not working.

This is an example of an invalid ABN. We call this a generic or blanket ABN. There are several errors going on here. First, we have column B, there's a lot of items listed here. But did the beneficiary actually request all these items? If not, the supplier needs to be clear about what items the beneficiary requested, that the practitioner ordered.

Next, the reason Medicare may not pay states, Medicare will only cover new supplies at either 90 days or 180 days. We have no one of knowing when supplies were received last from your previous supplier. You need to know when the beneficiary last obtained supplies. You can do this, using the myCGS web portal, for instance. This is not a valid reason. You can verify same or similar. And then you have F. This is a really large estimate, it is about $5 vs$300. That's a huge estimate; you have to be more accurate in the estimate. The cost should be either within $100 or 25% of the actual cost, whichever is greater. It shouldn't have this big of range like this is listed here, this is not accurate. As you can see, this is a very invalid ABN.

This happens more than you would expect, but the beneficiary authorized must choose one of these options: 1, 2, or 3 or their or authorized representative. In this circumstance, the beneficiary

did sign the ABN, but they did not select an option, so it became invalid. The supplier was held viable because this was an invalid ABN. They were held liable for the CPAP supplies in this circumstance.

Now that we've looked at these examples, we do have resources that we're going to quickly review. This is a list of our most commonly used Jurisdiction B resources. It makes a nice desk reference if you need to refer to it. We have more than just these contacts, but these are the most commonly used.

And then, of course, we have the same for Jurisdiction C. Just keep in mind that CGS is the contractor for both Jurisdiction B and C. And because these are different jurisdictions, the phone numbers, contact information, fax and mailing address do vary. Sometimes we do get wrong, incorrect requests for the incorrect jurisdiction. So just make sure you're aware, and you're sending it to the correct area, depending on the jurisdiction that claim was filed with.

These are some helpful resources. First, we have the Standard Documentation Requirements for All Claims Submitted to the DME MACs. The information that we discussed today we discussed today can be found in this local coverage article; most of the information. We have medical review resources. We have a lot of medical review resources out there. If you've never been out there, I suggest you go and check them out. We have documentation checklists for a lot of policies, Dear Physician Letters, and more. And then we have our news and publications; that is our news and publications. It has our news and that's also where you can find the Durable Medical Equipment supplier manual for Jurisdictions B and C.

If you don't know which modifiers to use, I strongly recommend using AME, the Advance Modifier Engine besides looking in the Local Coverage Determination. Basically, you enter a HCPCS code and the scenario and based on the HCPCS code and scenario that you've chosen, AME will tell you which modifiers to use and what order. If you don't know which modifiers to use or your claim denied, maybe because you use the wrong modifier. Check that LCD and also verify on AME. We have the COVID-19 web page and a link for ABNs. This is a link for the CMS website. And if you go out there, it will have options to download the ABN forms in English and Spanish. There's a large version and a smaller version, as far as printable sizes. We also have an ABN tool. It's a real, helpful tool. If you're unsure what to put on the ABN, you can use the instructions found on this link or you can go out to the tool. Basically, you hover over an area and the tool informs you what you need to put in each box on the ABN.

These are just some other contractor resources you may need to be aware of. We have PDAC, Pricing Data Analysis and Coding. If you have an item, maybe you don't know the HCPCS code, you can go out to their website or contact PDAC. CEDI, that's the common Electronic Data Interchange. They help with free, low-cost software support, support for electronic claim formats. And if you have a claim rejection report, you will contact CEDI. Lastly, we have National Provider Enrollment, NPE East and West. They're responsible for enrolling in Medicare. They issue the PTAN. If you have any questions about enrollment, maybe there's changes to enrollment, your address has changed, you can contact the National Provider Enrollment. If you're east of the Mississippi River, if your location is, it'd be Novitas Solutions. If you're west of the Mississippi River, it'll be Palmetto GBA.

Then we have our electronic mailing list. I highly recommend you sign up for this. It doesn't take any time to sign up, and it helps you stay up to date on news or any changes that are happening, we communicate it through the mailing list.

Also, our educational opportunities will be communicated through the mailing list as well. You can sign up on our website on the top, right hand side, or by the link shown here. When you sign up, you just enter your email, first and last name phone number, address, and company. And you must also select one or more contract email lists. For instance, when I signed up; I am signed up, I select both Jurisdiction B and C. Durable medical equipment, prosthetics, orthotics, and supplies as the contract because I'm involved with both contracts. And then click sign up and you'll start receiving those emails.

We also have a lot of workshops out there. We are coming to Indianapolis, Indiana, on June 21 for a comprehensive workshop. If you would like to come, please use the links on this slide. We also have more workshops, I believe Milwaukee is coming up in July, and we even have more than that. If you go to our education tab on our website under in person events, you will see all of the in-person events that we have to offer. We'd love to see you in person so please sign up if we're near your area this year, please sign up.