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Recorded Webinar: Urological Supplies

Contract	DME MAC Jurisdictions B & C
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Today's webinar will provide an overview of the Urological Supplies policy. It is designed to familiarize you with the basic coverage criteria and documentation needed. As a supplier, be sure to review the Supplier manual, the LCD and Policy Article as well as the Standard Doc Requirements for All claims Submitted to DMEMACs just so that you get the full understanding of what is needed.

Just a couple of things from the disclaimer. The information was current at the time of the webinar so make sure to check the website and Electronic Email messages for updates. And the last thing, I want to remind attendees that you may not record this presentation for any reason. However, CGS may record webinars for educational purposes.

We will begin by talking about the various coverage criteria, starting with indwelling, specialty and foley catheters, insertion trays, drainage systems, and irrigation. We'll take some time to talk about intermittent catheterization and the specific requirements, before moving on to external catheters. I'll go over some important things to keep in mind when you are billing for this policy group and about the documentation needed for proper claims submission. Finally, I'll go over the resources available to help you with billing and understanding of the requirements.

Urinary catheters and external urinary collection devices are covered under Medicare's Prosthetic Device benefit to drain or collect urine from a beneficiary who has permanent urinary incontinence or permanent urinary retention. We will look at what is meant by permanent on the next slide.

In this policy, permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected in the beneficiary within three months. This doesn't mean that there's no possibility that the beneficiary's condition may improve at some point in the future; just not in the next three months. If the medical record, including the judgment of the treating practitioner, indicates the condition is of long and indefinite duration (ordinarily at least three months), the test of permanence is considered met.

Temporary is considered anything lasting less than three months, and catheters and related supplies are not covered for a "temporary" condition. But when the catheter is covered, then the related supplies necessary are also covered.

What if the beneficiary has chronic urinary tract infections or some other bladder condition? The issue of permanence is still required. Simply having chronic UTIs or some other condition is not covered if there is no permanent incontinence or retention.

If supplies are provided in the doctor's office, even there, the test of permanence is still required. Keep in mind, temporary conditions again are not covered under DME. When the condition is defined as temporary and the supplies are provided in the doctor's office, those supplies are considered items provided as part of the physician's service or incident to the physician's service

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and therefore billed and payable by the Part B MAC. If the doctor's office provides the supplies, and the test of permanence is met, then you can bill the DME MAC. You must use the place of service as the beneficiary's home and not the physician's office.

These are the major categories of urological supplies and the related codes that we will be talking about going forward. The coverage criteria has some additional elements based on the specific type of catheter and or method of catheterization. Let's start with indwelling catheters.

For indwelling catheters, no more than one per a month is covered for routine catheter maintenance.

Medicare **will** cover catheter changes in certain "non-routine" circumstances such as:

1. Catheter is accidentally removed or pulled out
2. The catheter malfunctions (e.g., balloon does not stay inflated, hole in catheter)
3. Catheter is obstructed by encrustation, mucous plug, or blood clot
4. If the beneficiary has a history of recurrent obstructions or urinary tract infections **and** the record shows that these occurrences have been prevented in the past by changing the catheter more than once a month, then Medicare will allow for additional supplies. But like all cases of overutilization – use in excess of what Medicare covers in normal circumstances – must be backed up in the medical record.

If you are providing more than one indwelling catheter within a month, be sure you have documentation of one these situations in the medical records.

What we mean by specialty indwelling catheters, we are talking about the coude tip A4340 or silicone catheters A4344, A4312, A4315). These are covered if the beneficiary's medical records justify the basic criteria, which is, does the beneficiary have permanent incontinence or urinary retention and is the particular catheter necessary for a specific medical reason? An example of this would be when the beneficiary needs the silicone because he or she cannot tolerate latex.

Remember, the coude tip catheter (A4340) is rarely medically necessary for female beneficiaries, because the curved tip is normally prescribed for patients with enlarged prostates that makes it difficult for a straight catheter to pass. But in all cases, medical records must support any claims for this HCPCS code. Foley catheters such as the three-way indwelling catheter A4346 – alone or with components such as the irrigation trays (A4313 or A4316) are covered only if continuous catheter irrigation is reasonable and necessary, and we'll discuss the requirements for that in a moment.

Looking at the catheter insertion trays. One insertion tray is covered per episode of an indwelling catheter insertion. If more than one is provided, it will be denied as not reasonable and necessary. Medicare will cover one intermittent catheter with insertion supplies A4353 per episode. The beneficiary must meet special coverage criteria for the A4353. We will discuss in a minute, but first let's talk about drainage collection.

Here we see a list of HCPCs codes for collection systems covered by Medicare, and the number per month that Medicare considers normal maximum usage.

Medicare will cover additional supplies, as long as the need is medically supported by a history of obstruction or chronic, recurrent UTIs, and it is well documented in the medical record.

If there is a catheter change (using A4314-A4316, A4354, all of which contain a bag) and then there's an additional drainage bag (A4357) change within a month, you should look at the combined utilization for **all** those codes A4314-A4316, A4354, and A4357 when you're trying to figure out if the beneficiary has exceeded that "normal" maximum usage, and therefore whether or not you need to submit additional documentation with the claim. For example, if one unit of A4314 and one unit of A4357 are provided, this would be considered as two drainage bags, which is the usual maximum quantity of drainage bags needed for routine changes. So, it still falls within normal usage, and you don't need to submit any additional documentation. There's no overutilization to justify.

A couple of special points to remember about drainage collection supplies. First, leg bags are covered only if the beneficiary is ambulatory, or chair or wheelchair bound. If the beneficiary is bedridden, the leg bag will be denied as not reasonable and necessary. Beneficiaries that do need a leg bag, can have either a vinyl leg bag (A4358) or a latex leg bag (A5112), but they cannot have both. The use of both is not reasonable and necessary.

Now, there are drainage bags containing absorbent material such as gel matrix or other material, which are intended to be disposed of on a daily basis, but their medical necessity has not been established. Claims for this type of bag will be denied as not reasonable and necessary. Next up irrigation.

There are two types of irrigation, intermittent and continuous. Supplies for the intermittent irrigation of an indwelling catheter are either an irrigation tray, which is the A4320, or the irrigation syringe the A4322, along with sterile saline or water the A4217. Now these are covered when they are used on an as needed or nonroutine basis when there is acute obstruction of the catheter. If it is provided as routine intermittent irrigation of the catheter, it will be denied is not reasonable and necessary. Routine irrigation to prevent possible Complications is not covered. So just so everyone understands, routine irrigations are defined as those that are performed at predetermined intervals. Covered supplies for continuous bladder irrigation include a three-way folly catheter, irrigation tubing set and sterile saline and water are water. More than one irrigation tubing set per day for continuous catheter irrigation, will be denied as not reasonable and necessary. When intermittent irrigation has been tried and hasn't solved the acute obstruction. Then it's time to consider changing to continuous irrigation. But if there's no history of obstruction, meaning it is used primarily as preventative and there's no medical records to support the obstruction, it will not be covered. Continuous irrigation is a temporary measure. Continuous irrigation being performed for more than two weeks it is rarely reasonable and necessary.

In this situation, you can appeal but be sure the beneficiary's medical records support that greater than two week usage. Your documentation needs to specifically address why they irrigation is needed and paying particular attention to the need for continuous as opposed to intermittent. You want to ensure that the rate of solution administration and duration of need is documented. As the supplier, documentation must be available upon request. Now for a moment, look at the section at the bottom of the slide. It has information regarding how Medicare will process claims for irrigation solutions containing antibiotics and chemotherapy agents. These will be denied as non-covered. Also, irrigating solutions such as acetic acid or hydrogen peroxide, which are used for the treatment of our prevention of urinary obstruction will be denied as not reasonable and necessary. The applicable HCPCS codes are listed on the slide for your reference.

A quick recap of the information from the previous slide. For intermittent irrigation of indwelling catheters, those that are non-routine with an acute obstruction will be covered. But if it is routine, it will not. And for continuous irrigation of indwelling catheters, there must be documentation. The beneficiary's medical record showing a history of obstruction and intermittent irrigation is not sufficient. In other words, intermittent irrigation has been tried and proven ineffective. In this situation, it would be covered. But if it is primarily for preventative measures, it will be denied as not reasonable and necessary. And continuous irrigation is again, a temporary measure and if it's used for more than two weeks, that is rarely reasonable and necessary. So, in order for Medicare to consider it for coverage, documentation to support the need is required.

Intermittent catheterization is covered when basic coverage criteria are met along with a second criteria for intermittent, that is the beneficiary, or the caregiver can perform the procedure. And for each episode of covered catheterization, Medicare will cover one catheter (A4351 or A4352), an individual packet of a lubricant, the A4332, or one sterile intermittent catheter kit, the A4353. If additional coverage criteria are met and we'll cover that on the next slide.

So, intermittent catheterization using a sterile intermittent catheter kit, again, that's A4353 is covered when the beneficiary requires catheterization, and the beneficiary meets one of the five criteria that's listed here:

- The beneficiary resides in a nursing facility,
- The beneficiary is immunosuppressed. For example, now keep in mind these are not all inclusive:
    - On a regimen of immunosuppressive drugs post-transplant on cancer, chemotherapy,
    - Has AIDS,
    - Has drug-induced state such as chronic oral corticosteroid use. You will notice in the LCD that these criteria are followed by, again, not all inclusive, meaning these are not the only ones, just the most common. And so, one of the questions that's come up a lot about spinal cord injuries and I just want to point out that beneficiaries with a T3 or higher are considered immunosuppressed and qualifies under this criterion,
- The beneficiary has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization.

- The beneficiary is a spinal cord injured female with neurogenic bladder who is pregnant and that's for the duration of the pregnancy.
- And the beneficiary has had distinct recurring urinary tract infections while on a program of sterile intermittent catheterization. That is twice within the 12-month period prior to the initiation of sterile intermittent catheter kits.

Once again, we are looking at coverage criteria number five for the sterile intermittent catheter kit. The beneficiary has had at least two UTIs within 12 months while using the A4351 or the A4352 as the clean technique. Now, a beneficiary would be considered to have a urinary tract infection if they have a urine culture with greater than 10,000 colony farming units of a urinary pathogen and concurrent presence of one or more of the following signs or symptoms or findings you see on the slide. I'm not going to read through all of these but things like a fever, muscle spasm, change in urination such as frequency, urgency, or incontinence just to name a few.

Now, this chart shows the usual maximum quantity for intermittent catheterization supplies. As a supplier, you should keep in mind that anytime you're using the coude catheter, there must be documentation in the medical record that justifies the medical necessity for using that particular catheter. Again, use of the coude in female beneficiaries is rarely reasonable and necessary.

If documentation is requested and does not substantiate the medical necessity for that specialty catheter listed here at the bottom of the slide, payment for those codes, the A4340, 4344 and A4312 or the A4315, will be denied as not reasonable and necessary.

Now, I also want to point out that while Medicare will cover up to 200 intermittent catheters per month, that is the maximum number allowed. Ordering 200 per day for every patient is inappropriate. Most patients self-catheterize less than six times per day. Orders must be based on what the individual patient needs and not just the maximum quantity allowed.

Now external catheters and urinary collection devices are covered for those beneficiaries who have who have permanent urinary incontinence as an alternative to indwelling catheters. But keep in mind that Medicare will not pay for both an external and indwelling. So, if there's an order for someone using an indwelling catheter, the external one will be denied as not reasonable and necessary.

The utilization of male external catheters, the A4349, generally should not exceed 35 per month. If the beneficiary needs more than that, you will need documentation of medical necessity in the beneficiary's medical record. Specialty type male external catheters, the A4326, such as those that inflate or that include a face plate or extended wear catheter systems are covered only when documentation substantiate the medical necessity for that type of catheter. If documentation does not justify the medical need, claims will be denied as not reasonable and necessary. For female external urinary collection devices, more than one meatal cup per week or more than one pouch per day will be denied as not reasonable and necessary.

Now this chart covers the miscellaneous supplies often used with catheters. We have in the first column the name of the item, the next one has the HCPCS code for the item, and the codes that the item can be used with along with the usual allowances. So, I'm not going to read through the items. They're just here for you to reference, if needed. You can also find this information in the LCD.

Keep in mind, that the urethral inserts, the A4336, are covered for adult females with stress incontinence, (the applicable diagnoses are found in the policy article) and when basic coverage criteria are met, and the caregiver can perform the procedure. They are not indicated for women with the following conditions:

- Bladder or other UTIs,
- With a history of urethral structure, bladder augmentation, pelvic radiation, or other conditions where urethral catheterization is not clinically advisable.
- Those who are immunocompromised,
- Unable to tolerate antibiotic therapy,
- On anti-coagulants and,
- With overflow incontinence or neurogenic bladder.

So, I hope most of you are familiar with the inFlow™ pump. Unlike standard catheters that passively drain urine, the inFlow™ device actively provides a forceful, virtually complete evacuation of urine on demand. It is considered reasonable and necessary as an alternative to intermittent catheterization for beneficiaries with Permanent Urinary Retention (PUR) due to

Impaired Detrusor Contractility or (IDC). One inFlow™ device may be covered no more than once every 29 days. Claims for inFlow™ devices build more than once every 29 days will be denied not reasonable and necessary.

Sorry, I think I jumped ahead a little bit here. Okay. There's been a lot of shuffling with the HCPCS codes for inFlow™. The date of service determines which HCPCS codes to use. We have a breakdown of the codes to use for dates or service April 1, 2021, through March 31, 2023, and the appropriate codes for dates of service on or after April 1, 2023. So, here are the codes, the dates and the applicable codes that correspond to those dates.

Continue coverage of the inFlow™ device beyond the first three months of therapy requires that no sooner than the 31st day but no later than the 91st day after initiating therapy, the treating practitioner must conduct a clinical re-evaluation and document that the beneficiary continues to use and is benefiting from the inFlow™ device. Documentation of use and clinical benefit is demonstrated by:

- In-person encounter by the treating practitioner with documentation that urinary symptoms are improved; and,
- The treating practitioner verifies the beneficiary's adherence to use of the inFlow™ device.

If the above criteria I just mentioned, has not been met, continued coverage of the inFlow™ device and related accessories will be denied as not reasonable and necessary. Now, if the practitioner's re-evaluation does not occur until after the 91st day, but the evaluation demonstrates that the beneficiary is benefiting from the inFlow™ device as defined in criteria one and two, that I just mentioned, continued coverage of the inFlow™ device will commence with the date of that re-evaluation. If there is discontinuation of usage of the inFlow™ device at any time, as the supplier, you are expected to ascertain this and stop billing for the equipment and related supplies and accessories.

The PureWick Urine Collection System™ is coded K1006: suction pump, home model, portable or stationary, electric, any type, for use with external urine management system. There are five components with this system:

1. A urine suction pump
2. A urine collection canister
3. Tubing from collection canister to the suction pump
4. Tubing from the collection canister to the external catheter and
5. External urine collection device.

Note: The K1006 is individually considered. If it is denied, a redetermination can be requested. There is a joint DME MAC publication effective for dates or service on or after October 1, 2020, the HCPCS code for use when billing the urine suction pump is again, the K1006. Effective for dates of service on or after September 23, 2021, through March 31, 2023. The HCPCS codes for use when billing the accessories would be the A9999, which is miscellaneous DME supply or accessory, not otherwise specified. Now, when multiple accessories are provided, for example, the urine collection canister, the collection tubing, the pump tubing, and the external collection device, you must code the accessories as separate line items. In this scenario, the A9999, would appear on multiple claim lines. Remember, that anytime you're billing using a miscellaneous code like the A9999, you must enter:

- A description of the item,
- The manufacturer's name,
- Product name/model number,
- Supplier's price list and,
- The HCPCS code of the related item in loop 2300 or 2400 of electronic claims and item 19 or for paper claims.

For dates of service on or after April 1, 2023, the A9999 is replaced by:

- The A6590, that is the external urinary catheters, disposable, with wicking material, for use with suction pump, per month.
- The A7001, is the canister, non-disposable, used with suction pump each.
- A7002, tubing used with suction pump, each.

You will find more information in the DME MAC Joint Publication article at the links at the bottom of the slide. These items again, will be considered on an individual basis.

For the next few slides, I'm going to talk about some billing tips for this particular policy.

The AU modifier is used to indicate items that are furnished in conjunction with a urological, ostomy, or tracheostomy supplies. For this policy, codes A4217, A4450, and A4452 are the only 3 codes for which the AU modifier may be used. For these codes, if the AU modifier is not appended, the claim will reject for missing information.

The KX, GG, and GZ modifiers:

Remember to use the KX when all the coverage criteria have been met. This means both the statutory benefit criteria and the applicable reasonable and necessary medical criteria that's listed in the LCD and policy article all of those have been met.

If that information has not been met, you should just expect a denial and that's when the GA or GZ modifier would be appropriate. You would enter the GA modifier on the claim line if you have obtained a properly executed ABN or advanced beneficiary notice of non-coverage or the GZ modifier if they have not obtained an ABN.

If an item is statutorily excluded or does not fit the definition of any Medicare benefit, that's when you would use the GY modifier. Claim lines billed without the KX, GA, GY or GZ modifier, will be rejected as missing information.

Certain incontinence management items, things like diapers, disposable under pads, drainage bag holders, adhesive remover, etc., are not covered because they are not prosthetic devices, nor are they required for effective use of a prosthetic device.

You can find this chart in the policy article for your urological supplies. It is very useful for keeping up with which HCPCS codes to use. Any time a code exists that includes multiple products, that's the code you should be using and not the individual codes.

Payment for items in column one includes payments for the items listed in column two. So, when you're billing multiple items at the same time, use the code and column one instead of billing the separate column two codes or the claim will be denied as unbundling.

For claims not requiring date spans, and urological supplies do not, there needs to be a narrative note for anything greater than one month supply. So, if you are billing 60 or 90 days, you need to be sure to put a note in the narrative on the claim form or in the note section of electronic claims. Now, we've been seeing quite a few denials for missing this information and it's something that can easily be avoided. So, make sure that you're indicating the number of days that you're billing if it's more than a one-month supply.

Let's take a look at the documentation requirements for urological supplies.

All items billed to Medicare require a prescription from the treating practitioner as a condition of payment. For each item billed, you must have a signed order or prescription from that treating practitioner. You must keep the order on file and make it available upon request. The standard written order must be communicated to the supplier prior to claims submission. The order must contain the elements listed on the slide and they include:

- The beneficiaries name or Medicare beneficiary identifier or MBI
- The order date. This date should ideally reflect the date the order was first communicated to the supplier by the treating practitioner.
- General description of the item,
- The quantity to be dispensed if applicable.
- The treating practitioner's name or their national provider identifier or NPI and,
- The treating practitioner's signature.

Quantity to be dispensed is defined as the total number of units that the practitioner is ordering per refill. Usually, it is the number of units the beneficiary will need per month or per 90 days. The frequency of use refers to the daily usage.

Now, it is normally provided in terms of time intervals. For example, every four hours or four times daily, or the daily utilization number such as four per day. Frequency of use of catheters is usually for a day and the most you can bill is 90 days.

The standard written order only specifies quantity. However, the quantity on the standard written order should reflect the number of times the beneficiary catharizes per day. When a reviewer looks at your claim, they're going to check to see if the frequency of use in the records matches the number of units being billed.

While frequency is not a required element on the standard written order, suppliers are allowed to add elements to help with clarity. The number of times the beneficiary catharizes should be clearly documented in the medical record.

Remember, the medical records are those notes from the practitioner, hospital notes, home health agency, etc. The standard written order alone is not enough for Medicare payment purposes. The information on the order must be cooperated in the contemporaneous medical record.

When do you need an order or a new order? The only time a new prescription is needed for Medicare is when there is a change in the item.

- For initial purchases or rentals
- If there is a change in the order
- When an item is replaced and this is referring to DME and not a refill of supplies,
- When there is a change in the supplier.
- On a regular basis, if the documentation section of a particular medical policy requires it. It is not required for urological supplies. Now, I will say this, if your particular state requires a new order yearly, then that is what you would need to get.

Be sure the medical records verify that the beneficiary meets the criteria. For reasonable and necessary. Documentation should show that the beneficiary has a permanent urinary incontinence or retention that is not expected to be medically or surgically corrected within three months. The physician must have signed the medical records and the written order, and their signature must meet CMS signature Requirements.

For the coude catheter, the A4352, the medical records must document the medical need for this type. An example would be the inability to use a straight tip catheter but to also document why or what prevents the beneficiary from using the straight tip. If the documentation does not substantiate medical necessity, then the claim will be denied as not reasonable and necessary.

Also, be sure if you are billing for sterile intermittent catheter kits, the A4353, that the medical record documents one of the five criteria that's listed in the LCD. We discuss those a few slides back, but again, make sure that the records document at least one of those five.

The medical records can include physician office records, hospital, nursing home, home health documents, and records from other health care professionals. Supplier produced records and attestation letters are not part of the medical record for Medicare payment purposes.

When it comes to medical need, urological supplies are an exception to the requirement. Ongoing need for urological supplies is assumed to drain or collect urine from the beneficiary who has permanent urinary incontinence or permanent urinary retention. There is no requirement for further documentation of continued medical need as long as the beneficiary continues to meet the prosthetic benefit, which means devices that replace all or part of an internal body organ or replace all or part of a permanently inoperative or malfunctioning internal body organ.

So, here are the refill requests requirements as with most DME items, contact of some kind with the beneficiary is required. You can't just ship supplies on a routine schedule even if the beneficiary asks you to do so. There are three different scenarios to be considered when talking about refill requirements.

When the beneficiary or their authorized representative comes into the retail store, that meets the need for the beneficiary to request a refill. So, if they come in and ask for it, then that meets the request for that refill. The fact that they walk through the door is the request. Documentation can either be a sign delivery slip or an itemized sales receipt. I would suggest that if you use the same delivery slip for in-store pickup as you do for deliveries, make sure that there's some way to comment or indicate that it was an in-store pickup versus a delivery.

Now as a supplier, you can determine how those refills are handled. For all written refill requests, as well as telephone contact, you need to ensure that you document how many of each item the beneficiary still has on hand. This is something that gets frequently overlooked.

Now, you want to watch for the date of contact and the date of delivery as well. Whether the beneficiary contacts you or you contact the beneficiary, that contact cannot be any sooner than 14 days prior to the shipping or delivery. And that the shipping or delivery date cannot occur any sooner than 10 days prior to the date when the beneficiary completely exhausts their supply.

So, this is this is an example of a valid refill request. The supplies are clearly detailed it shows the number of supplies on hand and it's noted that the beneficiary is requesting a refill of specific supplies.

Documentation requirements for delivery differs depending on how they are delivered.

Direct delivery is when you deliver the items to the beneficiary yourself. You send out an employee to make home deliveries for direct delivery the date of delivery is your date of service. The required elements are listed here:

- We have the beneficiaries name,
- The delivery address,
- The date delivered,
- The quantity delivered,
- Sufficiently detailed description to identify the items being delivered. With that, you can use the narrative description, a brand name, model number, HCPCS code, or the long narrative are the HCPCS code description.
- The beneficiary or the beneficiary or designee's signature. So, either the beneficiary or their designee has to sign.

When a shipping service is being used, you need a clear paper trail from your warehouse or store to the shipper and then to the beneficiary. Usually, this is through the identification number on both the delivery services, tracking slip and on the shipping invoice. In the case of a shipping service, the shipping date is the date that the item left your warehouse or store, and it is the date of service.

Now, the shipping date may be defined as the date the shipping label is created, or the date that the item is retrieved for delivery, however there should not be a significant variation between the creation of the label and the time the item is shipped out. The long description of the HCPCS code is sufficient to identify items being delivered.

The delivery requirements are the same when you deliver to a skilled nursing facility. It depends on whether you use direct delivery or a shipping service but with a couple of additional requirements. You must have documentation showing that the facility received the items specifically for use for that beneficiary and that the quantity delivered and used must match the quantity you billed.

Now, this slide is an at-a-glance chart of the delivery requirements according to each method of delivery. So, these are the requirements, whether it is direct, whether you're using a shipping or mail order or if you're shipping and using a mail order return postage-paid invoice. These are the requirements you need to make sure that they are documented in your records for that delivery.

Now, we're going to move on and talk a bit about the Comprehensive Error Rate Testing or CERT program. CERT was first developed by CMS back in 1996 to measure Medicare's fee-for-service improper payment rate. This was for the purpose of reducing costs that are associated with either improperly completed and improperly paid Medicare claims. Now, the CERT contractor randomly audits claims from both Jurisdictions B and C. At that time, they also received the supplier's address in the system so that they may request the records for review.

CERT will send up to four letters to the supplier requesting the records, and that's one about every 15 or 20 days or so. They also follow up with a phone call to the supplier to offer assistance with the request or to answer questions. Failure to respond to a CERT request for documentation may result in an error. That is why it is so important that suppliers keep their information up to date with the National Provider Enrollment or NPE (East or West) because the address on file is where the additional documentation requests will be sent. I'll talk more about the National Provide Enrollment in resources.

Here's the contact information for CERT. I've included the phone, fax, email, and Web address. The email address listed on this slide should be used when contacting the CERT call center or when you need an ADR reprinted and sent to a different address.

For details on how to submit documentation, timeline, sample letters, and FAQs, visit the CERT provider website.

Please note that the CERT contractor under a different name, effective March 21, 2023. The new name is Empower AI. Here are the ways that a supplier can respond to a request from CERT. The options are mail, fax, esMD, encrypted cd, and encrypted email.

Now, here's an example of the CERT letter and envelope that it comes in. Everyone in your organization that comes into contact with the mail should be familiar with these documents. Remember, there is a timeframe for responding to requests from CERT.

Here I have a few tips to help prepare you for any audit or to prepare for claims submission. Our tips are you want to:

- Implement a thorough intake procedure.
- Ensure that all documentation requirements are met.
- Reply to all CERT documentation requests to avoid recoupment.
- Submit documentation to the CERT Documentation Contractor within the requested timeframe.
- Use the bar code sheet as the cover letter to all documentation submissions.
- Appeal a CERT denial:
    - After you receive the overpayment demand letter
    - You would submit the redetermination request to the appropriate DME MAC and not to the CERT contractor.

So, here are important resources for additional information on this policy.

The resources available to you. First, there's the documentation checklist that tells you exactly what documentation you would need. We have links to the CGS Wizard Tool, and this is a self-service tool that provides exactly the same information available from our customer service representatives. And the CGS Wizard is always available to provide you with everything you need to understand why the claim denial occurred and what you need to do next.

The best and most complete information on your claim is access through the myCGS web portal. You can find out why your claim was denied, you can check eligibility, same or similar, MSP status. It is the single most valuable tool we offer.

And as always, your best resource for questions relating to individual policies are the Local Coverage Determinations and the Policy Articles. If you want to confirm that the beneficiary meets the coverage criteria, the CGS Connect is also available.

The CGS Connect is our unique concierge level service for Jurisdictions B and C suppliers that are seeking professional review and evaluation of pre-claim documentation before submitting an initial claim to Medicare. Now, this voluntary program provides suppliers with a higher level of assurance that supporting documentation meets the necessity required to process the claim for payment consideration.

Suppliers should periodically check the CGS Connect page on the CGS website as codes are added and removed. This is a chart that shows which policies and the HCPCS codes that are applicable for the CGS Connect program.

Here are some common resources for Jurisdiction B. We have links to the IVR, customer service, telephone reopenings. These are, again some of the more frequently used services.

We have the same resources for Jurisdiction C. Keep in mind that the phone number and addresses are different than those of Jurisdiction B. You should be using the appropriate contact depending on which jurisdiction your claims are being submitted to.

Here are some additional contractors that you may need to reach out to periodically. We have the Price, Data analysis, and Coding or PDAC. That is your contact for questions regarding coding. If you have a product and you're not sure of the HCPCS code, you can contact PDAC for assistance

to verify that you are using the correct code. Just remember, a HCPCS code does not indicate payment or coverage for the item, it is simply an identifier for billing.

You should contact CEDI or the Common Electronic Data Interchange Contractor for electronic claim submission issues. Whenever you are new to submitting claims to Medicare, you can contact CEDI for instructions and information how to get started submitting claims electronically or information on front-end edits. If your claims are denying, they can help you with that as well.

The National Provider Enrollment or NPE contractors are responsible for provider enrollment and the issuance of PTAN or your Provider Transaction Access Number. NPE East is Novitas Solution, which handles enrollment for suppliers east of the Mississippi River and NPE West is Palmetto GBA, which process enrollments for suppliers west of the Mississippi.

We have information on how to save time, money, and resources by using the myCGS web portal. You can submit reopenings and redeterminations through the portal as well as checking the status of those that you have already submitted. We have a user and registration guide to get you started.

The electronic mailing list is the best way to stay up to-date on DME news for Jurisdictions B and C. You can sign up to receive these electronic mailing messages on the CGS Medicare website or by using the link on the screen. You would just enter your first and last name, your email address, the phone number, the complete address and company information and which Medicare specialty or Medicare contract lists that you're interested in. Please note that you must select at least one or more of the options. Click sign up and you're done.

This brings us to the end of the presentation portion of the webinar.