CGS DME MAC

Michigan Home Care & Hospice Association

Denise Winsock, Provider Relations Senior Analyst May 4, 2023

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COVID-19 Public Health Emergency (PHE)

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Transition Forward from the COVID-19 PHE

- Department of Health and Human Services (DHHS) plans to expire the COVID-19 PHE on **May 11, 2023**
  - February 9, 2023, Press Release: Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html
- Continue to use CMS resources
- DME MACs will offer education as CMS provides additional instructions

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COVID-19 PHE – What We Know Now

- Currently operating under Interim Final Rules
- Continue to report the CR modifier and "COVID-19" claim narrative for applicable claims with dates of service prior to May 11, 2023
  - Non-enforcement of clinical indications of coverage in NCDs and LCD for:
    - Respiratory Equipment
    - Infusion Pumps
    - Continuous Glucose Monitors
- Face-to-face and in-person requirements for national and local coverage determinations
- Signature requirements for proof of delivery Method 1
- More than a 1-month supply of immunosuppressive drugs used after an organ transplant, oral anticancer drugs, intravenous immune globulin (IVIG), and enteral nutrition

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Medical Review After the COVID-19 PHE

- **Question:** At the end of the PHE, how will CMS' review contractors conduct medical reviews for claims billed during the PHE based on approved waivers of flexibilities?
- **CMS Answer**: CMS contractors (MACs, RACs, and SMRC) review a very small percentage of Medicare Fee-for-Service claims each year. During the PHE, flexibilities were applied across claim types. For certain DME items, this included the non-enforcement of clinical indications for coverage. Since clinical indications for coverage were not enforced for certain DME items provided during the PHE, once the PHE ends CMS plans to primarily focus reviews on claims with dates of service outside of the PHE, for which clinical indications of coverage are applicable. We note that we may still review these DME items, as well as other items or services rendered during the PHE, if needed to address aberrant billing behaviors or potential fraud. The HHS-Office of the Inspector General may perform reviews as well. All claims will be reviewed using the applicable rules in place at the time for the claim dates of service.
- https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/overview

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CGS DMEPOS COVID-19 Resources

- COVID-19 PHE page
  - Most frequently used resources and CR modifier usage information
  - Resources by Topic
  - JB: https://www.cgsmedicare.com/jb/covid-19.html
  - JC: https://www.cgsmedicare.com/jc/covid-19.html

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Elimination of CMNs and DIFs

- **CMNs and DIFs are no longer required for claims with dates of service on or after January 1, 2023.**
  - For dates of service on or after January 1, 2023, CMS will no longer process claims with a CMN or DIF attached.
    - Don't submit CMN or DIF forms or their electronic claim data elements.
    - Electronic claims received with these forms attached will be rejected by the Common Electronic Data Interchange (CEDI) contractor and returned to the provider or supplier.
    - Paper claims with CMNs or DIFs attached will be returned by the DME MACs.
- **Claims Processing Manual Update - Pub. 100-04**
  - MLN Matters Article SE22002: https://www.cms.gov/files/document/se22002-elimination-certificates-medical-necessity-durable-medical-equipment-information-forms.pdf
  - Change Request 12734: https://www.cms.gov/files/document/r11427CP.pdf

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CMNs & DIF Elimination

- The following forms should not be submitted for claims with dates of service on or after January 1, 2023:
  - CMS-484 – Oxygen
  - CMS-846 – Pneumatic Compression Devices
  - CMS-847 – Osteogenesis Stimulators
  - CMS-848 – Transcutaneous Electrical Nerve Stimulators
  - CMS-849 – Seat Lift Mechanisms
  - CMS-854 – Section C Continuation Form
  - CMS-10125 – External Infusion Pumps
  - CMS-10126 – Enteral and Parenteral Nutrition

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Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)

- In addition to initial justification documentation, for ongoing supplies and rental DME items, there must be information in the medical record to support items continue to remain reasonable and necessary.
  - Any of the following may serve as documentation justifying continued medical need:
    - A recent order/prescription by the treating practitioner **for refills of supplies**
    - **A recent change in an order/prescription by the treating practitioner for repairs**
    - A recent change in the order/prescription
    - A properly completed Certificate of Medical Necessity (CMN) or DME MAC Information Form (DIF) **obtained prior to date of service January 1, 2023**, with an appropriate length of need specified
    - Timely documentation in the medical record showing usage of item
  - Information used to justify continued medical need must be timely for the date of service under review.
    - Timely documentation is a record in the preceding 12 months unless otherwise specified in the applicable policy.
  - https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=55426

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Revised Glucose Monitor Local Coverage Determination Summary

- Final LCD effective for dates of service on or after April 16, 2023
- Removed:
  - 3 or more daily administration of insulin or continuous subcutaneous insulin infusion from continuous glucose monitory (CGM) coverage criterion
  - Treatment regimen requiring frequent adjustment from CGM coverage criteria
- Added initial coverage CGM criterion related to history of problematic hypoglycemia
- Revised to include telehealth visits
- New HCPCS codes and revised narratives for continuous glucose monitors and supplies

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JZ Modifier – Zero Discarded Drug

- Effective for claims with **receipt date on or after July 1, 2023**
  - Claims with dates of service on or after January 1, 2023
  - Single-dose containers when there are no discarded amounts must append the **JZ** modifier
- Continue to report the JW modifier for drug wastage
- Policies affected:
  - External Infusion Pumps
  - Intravenous Immune Globulin (IVIG)
  - Nebulizers
- JW Modifier FAQs https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/JW-Modifier-FAQs.pdf

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Other Policy Updates

- External Infusion Pumps
  - KX modifier applicable for claims submitted for all infusion drugs, pumps and supplies with dates of service on or after January 1, 2023, for claims submitted on or after March 1, 2023
- Open meeting held March 23 and comment period ended March 25
  - KX modifier will be added to
    - Enteral Nutrition
    - Osteogenesis Stimulators
    - Parenteral Nutrition
    - Seat Lift Mechanisms
- Pneumatic Compression Devices – reconsideration on hold pending Greenwald decision

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Oxygen Updates

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Revised Oxygen LCD and Policy Article – Effective January 1, 2023 Summary

- Aligns coverage with Home Use of Oxygen National Coverage Determination (NCD) 240.2 and elimination of CMN
- Removed references to "chronic stable state" (effective 09/27/2021)
- Removed long term oxygen therapy trials criteria
- Revised reasonable and necessary criteria for Groups I and II (effective 09/27/2021)
- Added coverage criteria for Group III (effective 09/27/2021)
  - Includes cluster headaches
- Added Group IV criteria
- Revised testing criteria (effective 09/27/2021)
- Revised documentation requirements
- New modifiers effective 04/01/2023: N1, N2, N3

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Oxygen Coverage Criteria

- Initial coverage of home oxygen therapy and oxygen equipment is reasonable and necessary for Groups I and II if all of the following conditions are met:
  - The treating practitioner has ordered and evaluated the results of a qualifying blood gas study performed at the time of need; and,
  - The beneficiary's blood gas study meets the coverage criteria; and,
  - The qualifying blood gas study was performed by a treating practitioner or by a qualified provider or supplier of laboratory services; and,
  - The provision of oxygen and oxygen equipment in the home setting will improve the beneficiary's condition.
- "Time of Need" is defined as during the patient's illness when the presumption is that the provision of oxygen in the home setting will improve the patient's condition

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Oxygen Group 1 Criteria

- Group I:
  - Room Air at Rest:
    - Arterial PO2 is 55 mm Hg or less or saturation is 88% or less taken at rest (awake) while breathing room air; or
  - During Sleep:
    - An arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken during sleep for a patient who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89%, while awake; or
    - A decrease in arterial PO2 more than 10 mm Hg; or a decrease in arterial oxygen saturation more than 5% from baseline saturation, taken during sleep associated with symptoms of hypoxemia such as impairment of cognitive processes and nocturnal restlessness or insomnia (not all inclusive)
      - In either of these instances during sleep, coverage is provided only for use of oxygen during sleep, and then only one type of unit will be covered. Portable oxygen would not be covered in this situation; or,

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Oxygen Group 1 Criteria

- **Group I continued:**
  - **During Exercise:**
    - An arterial PO2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88%, taken during exercise for a beneficiary who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89%, during the day while at rest.
      - In this instance, portable oxygen and oxygen equipment is only reasonable and necessary while awake and during exercise.

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Oxygen Group II Criteria

- **Group II:**
  - Arterial PO2 is 56 - 59 mm Hg or saturation is 89% and,
  - Any of the following:
1. Dependent edema suggesting congestive heart failure, ***or***
2. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF); ***or***
3. Erythrocythemia with a hematocrit greater than 56 percent

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Oxygen Group III Criteria

- **Group III:**
  - Initial coverage of home oxygen therapy and oxygen equipment is reasonable and necessary for beneficiaries in Group III, if all of the following conditions are met:
    1. Absence of hypoxemia [as evidenced by a blood gas study] defined in Group I and Group II above; **and**,
    2. A medical condition with distinct physiologic, cognitive, and/or functional symptoms documented in high-quality, peer-reviewed literature to be improved by oxygen therapy, such as cluster headaches (not all inclusive).

    NOTE: DME MACs use the same methodologic principles of evidentiary review as those used for NCDs. For details, please see Appendix A of the National Coverage Analysis (NCA) Decision Memo Home Use of Oxygen and Home Oxygen Use to Treat Cluster Headaches CAG-00296R2. NCA - Home Use of Oxygen to Treat Cluster Headache (CAG-00296R) - Proposed Decision Memo (cms.gov)
  - If all the coverage conditions for initial claims for beneficiaries in Groups I, II and III, or documentation requirements for continued payment of subsequent claims are not met, the oxygen therapy and oxygen equipment will be denied as not reasonable and necessary

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Oxygen Group IV Criteria Not Reasonable & Necessary

- **Group IV:**
  - Oxygen therapy and oxygen equipment will also be denied as not reasonable and necessary if any of the following conditions are present:
    - Angina pectoris in the absence of hypoxemia
    - Dyspnea without cor pumonale or evidence of hypoxemia
    - Severe peripheral vascular disease in absence of systemic hypoxemia
      - There is no evidence that increased PO2 will improve the oxygenation of tissues with impaired circulation
    - Terminal illnesses that do not affect the respiratory system

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Continued Oxygen Coverage

- In order to continue payment of oxygen and oxygen equipment claims, there must be evidence in the medical record documenting:
  - **Group I:**
    - No requirement for re-evaluation or retesting
    - Providers should ensure oxygen therapy and oxygen equipment remain reasonable and necessary
  - **Group II and Group III:**
    - A repeat qualifying blood gas test and evaluation of test results by the treating practitioner between the 61st and 90th days after initiation of therapy and,
    - A new SWO by the treating practitioner.

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Oxygen Beneficiaries Entering Medicare

- Beneficiaries on oxygen covered by (Private Insurance, Medicaid or Medicare Advantage Plan) prior to their eligibility/enrollment in Medicare Fee-for-Service (FFS) "**time of need**" for oxygen is established on/after their Medicare FFS eligibility/enrollment date.
  - The beneficiary does not have to obtain a new blood gas study, but the test must be the most recent qualifying study the beneficiary obtained previously and under the guidelines specified in DME MAC policy.
  - While we have allowed an exception to utilize a previously qualifying test, we would expect the treating practitioner to evaluate the results of the qualifying test and write a new SWO upon enrollment in FFS Medicare.
- If they were on oxygen Medicare FFS then went to a Medicare Advantage Plan (MAP), then back to Medicare FFS, they will pick up where they left off with Medicare FFS.

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Medical Record Documentation

- Documentation for initial coverage requires information in the medical record showing:
  - Evidence of qualifying test results at the time of need; and,
  - Evidence of an evaluation of the qualifying test results by a treating practitioner
- In order to provide initial coverage for beneficiaries in Groups I, II and III, there must be evidence in the medical record documenting one of the following A-C criteria:
  - A symptomatic, hypoxemic patient who meets criteria for Group I or II; or,
  - A symptomatic, normoxemic patient with a medical condition that improves with oxygen therapy; or,
  - For beneficiaries with concurrent Obstructive Sleep Apnea (OSA), the qualifying oxygen saturation test is performed following optimal treatment of the OSA as described in the Coverage Indications, Limitations and/or Medical Necessity

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New Oxygen Modifiers

- RR - Monthly rental
- RA - Replacement of DME item, first month rental only
- MS - Maintenance and service

Note: For new initial oxygen claims set-up **April 2023**

- New Oxygen Group Modifiers
  - Group I - **N1**
  - Group II - **N2**
  - Group III - **N3**
    - **Group I example**: E1390RRN1

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Frequently Asked Questions

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Frequently Asked Questions

- **Question:** Is an initial F2F evaluation required?
  - **Answer:** While there's no formal requirement in the NCD or LCD, good medical practice would dictate some type of F2F or telehealth evaluation prior to ordering oxygen.
- **Question:** Will a CMN or DIF dated prior to January 1, 2023, still be sufficient to show continued need/use, once CMNs are eliminated?
  - **Answer:** Yes, a CMN (initial, recert, revised) obtained prior to 1/1/23 will be good for one (1) year from the initial, recertified, or revised date on the CMN.

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Frequently Asked Questions

- **Question:** For a beneficiary that qualifies for oxygen based on Group I criteria but with a length of need less than lifetime, what is required to extend the length of need?
  - **Answer:** A new order is necessary to confirm continued medical need. There is no requirement for retesting or re-evaluation of the test results. Information regarding length of need will be determined by documentation in the beneficiary's medical record. For beneficiaries with an acute condition that qualify for oxygen, the supplier is obligated to maintain close communication with the beneficiary and the treating practitioner to determine length of need. Suppliers are reminded that Medicare will only pay for items/services that are reasonable and necessary. Once the acute need is resolved, depending on co-existing chronic conditions, the oxygen may no longer be reasonable and necessary

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Frequently Asked Questions

- **Question:** For Group III, how is the following documented:
  - Evidence of an evaluation of the qualifying test results. The lab values are often a separate document in a record and ordering MD doesn't document they evaluated the lab result in as many words.
  - Oxygen will improve patient's condition
- **Answer:** A blood gas study is necessary to show the absence of hypoxemia. Additionally, the DME MACs would look for documentation to see if oxygen provided will improve the beneficiary condition. There must be a documented medical condition with distinct physiologic, cognitive, and/or functional symptoms published in high-quality, peer-reviewed literature to be improved by oxygen therapy, such as cluster headaches (not all inclusive). The DME MACs cannot speak for other auditing contractors.

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Frequently Asked Questions

- **Question:** Can a beneficiary qualify for oxygen based on the oxygen SAT results obtained during a polysomnogram if the patient is found not to have OSA during that study or can the titration polysomnogram results only be used for patients that do have OSA?
  - **Answer:** The test result obtained during a diagnostic polysomnogram would be acceptable for beneficiaries in whom OSA has been ruled out. Results from a titration polysomnogram may be acceptable once the OSA has been sufficiently treated to qualify for oxygen, assuming all other requirements outlined in the Oxygen LCD are met.

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Updates to Required Face-to-Face Encounter and Written Order Prior to Delivery (WOPD) List

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New HCPCS Codes
Face-to-Face & Written Order Prior to Delivery (WOPD)

- Effective for dates of service on or after April 17, 2023
  - Includes 10 new items for required Face-to-Face & Written Orders Prior to Delivery

New Statutorily Required DMEPOS Items		
Ankle Foot Orthosis	Knee Orthosis	Lumbar-Sacral Orthosis
L1932	L1843	L0631
L1940	L2005	L0637
L1951	L2036	
L1960		
L1970		

- Update to Required Face-to-Face Encounter and Written Order Prior to Delivery (WOPD) List
  - JB: https://www.cgsmedicare.com/jb/pubs/news/2023/01/cope134093.html
  - JC: https://www.cgsmedicare.com/jc/pubs/news/2023/01/cope134093.html

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Required Face-to-Face & WOPD List

- HCPCS that were effective April 13, 2022:
  - Osteogenesis Stimulator: E0748
  - Back braces: L0648 & L0650
  - Knee braces: L1832, L1833 & L1851
  - Shoulder Elbow Wrist Hand Orthosis: L3960
- 46 PMD codes were already on the Required Face-to-Face Encounter and Written Order Prior to Delivery (WOPD) List

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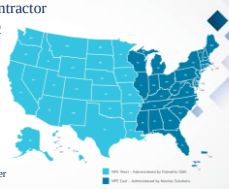
DMEPOS National Provider Enrollment (NPE)

- DMEPOS Change to Enrollment Contractor
  - Became effective November 7, 2022
- What's Changed?
  - 2 new contractors process DMEPOS enrollment applications
    - NPE East: Novitas Solutions https://www.novitas-solutions.com/webcenter/portal/NovitasSolutions
      - DMEPOS activities for suppliers located east of the Mississippi River
    - NPE West: Palmetto GBA https://www.palmettogba.com/palmetto/npewest.nsf
      - DMEPOS activities for suppliers located west of the Mississippi River



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Prior Authorization Updates

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Voluntary Prior Authorization of Power Mobility Accessories (PMD) with a PMD Base

- Voluntary prior authorization for 53 PMD accessories began March 20, 2023, for dates of service on April 6, 2023
  - Submitting a voluntary Prior Authorization Request (PAR) for a PMD accessory is not mandatory and does not create a condition of payment
  - PARs submitted for a PMD accessory must include the related PMD base item
  - If the PAR does not include a required PMD base, the PAR will be rejected
  - If the base item on the PAR is non-affirmed, the accessory will also be non-affirmed
- The following codes can obtain voluntary prior authorization when submitted with PMDs that require prior authorization
  - E0950, E0955, E1002-E1010, E1012, E1029, E1030, E2310-E2313, E2321-E2330, E2351, E2373, E2377, E2601-E2608, E2611-E2616, E2620-E2625, K0020, and K0195

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Voluntary Prior Authorization Required Documentation & Timeframe for Review Decisions

- Documentation required for the voluntary PAR package for PMD accessories:
  - Same documentation required for the prior authorization of PMDs
  - Documentation from the medical record to support medical necessity
- Timeframe for review decisions are the same as for the PMD base:
  - 10 business days
  - Expedited: 2 business days
- Decision remains valid for 6 months following the provisionally affirmed review decision

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Prior Authorization Programs Exclusions

- The following claim types are excluded from any prior authorization program, unless otherwise specified:
  - Veterans Affairs (VA)
  - Indian Health Services (HIS)
  - Medicare Advantage Plans (MAPs)
  - Part A and Part B Demonstrations
  - Claims from Representative Payees (not implemented on a national level)

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Prior Authorization for Orthoses

- Required nationwide October 10, 2022
  - Spinal braces: L0648 & L0650
  - Knee braces: L1832, L1833 & L1851
- Acute situations – ST modifier
  - Prior authorization not required
  - 100% pre-pay clinical review

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Prior Authorization Information

- Other Required Prior Authorization programs:
  - Lower Limb Prostheses
  - Power Mobility Devices (PMDs)
  - Pressure Reducing Support Surfaces
- Dedicated pages on the CGS Website in the Medical Review section
  - JB: https://www.cgsmedicare.com/jb/mr/condition_of_payment_prior_auth.html
  - JC: https://www.cgsmedicare.com/jc/mr/condition_of_payment_prior_auth.html

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Insulin Furnished Through DME

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Insulin Furnished Through DME

- Inflation Reduction Act Section 11407
  - Effective July 1, 2023
  - Medicare Part B deductible is waived for insulin furnished through an item of DME
  - Beneficiary coinsurance for a month's supply of insulin is not to exceed $35
    - To make sure patients aren't charged more than the $35 maximum allowed for the month of July, there are billing instructions you must follow for May and June 2023
  - MLN4443820 - Billing Medicare Part B for Insulin with New Limits on Patient Monthly Coinsurance https://www.cms.gov/files/document/mln4443820-billing-medicare-part-b-insulin-new-limits-patient-monthly-coinsurance.pdf

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Insulin Furnished Through DME

- Modifiers were added to April HCPCS quarterly file update:
  - JK: One-month supply or less of drug/biological
  - JL: Three-month supply of drug/biological
  - Starting in May 2023, if you don't include 1 of these modifiers, DME MAC will return the claim without processing it.

From Date of Service	Modifier	Billing
April 2023	JK, JL	Not required
May 2023	JK	Bill 1-month supply with HCPCS code J1817
June 2023	JK	Bill 1-month supply with HPCPS code J1817
July 2023 and later	JK or JL	Bill 1-month or 3-month supply with HCPCS code J1817

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GW Modifier Usage

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DMEPOS Claims while Beneficiary is in Hospice

- Services unrelated to the terminal illness and related conditions are exceptional and unusual and the hospice should be providing virtually all care needed by the individual who has elected hospice
- A beneficiary receives, as part of the information on Hospice coverage, notification of the individual's (or representative's) right to receive an election statement addendum if there are conditions, items, services, and drugs the hospice has determined to be unrelated to the individual's terminal illness and related conditions and would not be covered by the hospice
- When billing for conditions unrelated to the individual's terminal illness:
  - Append the GW modifier to the claim if the condition is listed on the election statement addendum
  - Addendum must be available upon request https://www.cms.gov/files/document/model-hospice-election-statement-addendum-modified-july-2020.pdf
- Medicare Benefit Policy Manual, Chapter 9, Section 20.2.1.2

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Hospice Addendum Statement

- For Hospice elections beginning on or after October 1, 2020, when the hospice determines there are conditions, items, services, or drugs that are unrelated to the individual's terminal illness and related conditions, the individual (or representative), non-hospice providers furnishing such items, services, or drugs, or Medicare contractors may request a written list as an addendum to the election statement.
- All elements must be present
  - Diagnoses related to the terminal illness and related conditions
  - Diagnoses unrelated to the terminal illness and related conditions
  - Non-covered items, services, and drugs determined by hospice as not related to the terminal illness and related conditions
  - Must be signed by the beneficiary or their representative and a witness

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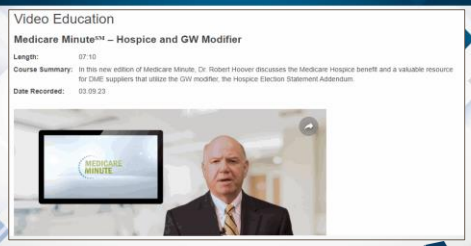
Medicare Minute^{SM} – Hospice and GW Modifier



https://www.cgsmedicare.com/jb/education/video/index.html

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Targeted Probe & Educate (TPE)

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Dr. Sunil Lalla, MD, FACS, CPC
Medical Director Jurisdiction B, DMD

Sunil Lalla, MD, FACS, CPC
Chief Medical Officer, CGS Administrators, LLC
Surgeon
6 years as Contractor Medical Director (5 A/B MAC, 1 DME)

- Dr. Sunil Lalla has been appointed the JB Executive Medical Director to succeed Dr. Stacey Brennan who retired January 2023
  - Dr. Lalla has over 25 years of experience as a clinical surgeon. He is board certified and twice recertified by the American Board of Surgery and is a Fellow of the American College of Surgeons
  - Dr. Lalla also has extensive experience as an A/B Medical Director with another MAC prior to joining CGS Administrators, LLC
  - Dr. Lalla has been in the role of the CGS Research Medical Director for JB and JC since September 2021

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Targeted Probe & Educate (TPE)

- Purpose:
  - Decrease provider burden
  - Reduce appeals
  - Improve medical review processes
- Pre- and post-pay reviews of a specific provider/supplier
- Up to 3 rounds of reviews
- Goal is to reduce claim errors and denials

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Provider Selection

- Based upon internal data analysis of provider billing practices
- Comparative reports of code utilization rates
- Comprehensive Error Rate Testing (CERT) reports
- CMS directives and Office Inspector General (OIG) recommendations
- Referral from a RAC, UPIC, or Government Accountability Office
- Providers based on:
  - Historic high claim denials
  - Outlying billing practices
  - Potential risk of harming the Medicare Trust Fund

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TPE Rounds

Round 1
- Notified via letter
- 20-40 claims reviewed
- Notified of focus topic
- Can receive education during the probe

Round 2
- Follows post-probe education from Round 1
- Did not meet required guidelines
- Claims selected for review – 45 day waiting period
- Can receive education during the probe

Round 3
- Follows post-probe education from Round 2
- Did not meet required guidelines
- Claims selected for review- 45 day waiting period
- Can receive education during the probe

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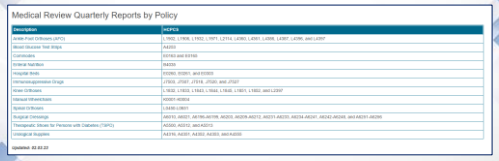
Targeted Probe & Educate (TPE)

- Medical Review Quarterly Reports by Policy


Medical Review Quarterly Reports by Policy

Description	HCPCS
Ankle-Foot Orthoses (AFO)	L1902, L1906, L1922, L1971, L2114, L2861, L2871, L2906, L2907, L2996, and L2997
Blood Glucose Test Strips	A4253
Continuities	E0760 and E0740
Enteral Nutrition	B4034
Hospital Beds	E0260, E0301, and E0303
Intramuscularinjectable Drugs	J1303, J1567, J1816, J1930, and J7507
Knee Orthoses	L1832, L1833, L1843, L1844, L1845, L1851, L1852, and L2397
Manual Wheelchairs	K0001-K0004
Spinal Orthoses	L0450-L0631
Surgical Dressings	A6010, A6021, A6196-A6199, A6203, A6209-A6212, A6231-A6233, A6234-A6241, A6242-A6246, and A6251-A6299
Therapeutic Shoes for Persons with Diabetes (TSPD)	A5500, A5512, and A5513
Urological Supplies	A4316, A4351, A4352, A4353, and A4355

Updated: 02.03.22

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Possible CMS Penalties (42 CFR § 424.535)

- Additional rounds of TPE
- 100% prepayment review
- Extrapolation (PIM Chapter 8)
- Referral to RAC
- Referral for revocation
- Medicare privileges revoked

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Provider Responsibility

- Respond promptly to any letter offering education
- Responsible for sending all requested documents
  - Separate each claim with a coversheet
- Ask questions
  - Interact with TPE education sessions
  - Through email
- Consider who will attend education session(s)
- Can request education at any time

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Tips & Recommendations

- Thoroughly review and follow directions on letter request
  - Obtain the requested documentation
    - Must be legible and signed
    - Do not highlight information
    - Do not combine multiple requests into a single response
    - Only send documentation once per ADR letter
    - Respond within the timeframe specified
    - Respond to proper entity (CERT, UPIC, RAC, etc.)
- Always place the ADR letter as the cover sheet ON TOP of your documentation

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Tips & Recommendations

- Seek clarification
- Have a designated contact person
  - Email and/or direct phone number
  - Avoid providing customer service lines, fax numbers, service operators, etc.
- Verify address in PECOS – notification letters are sent to the "other" address
- Respond to letter offering education

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