CGS DME MAC

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Agenda

- DME News & Policy Updates
- myCGS Updates
- Comprehensive Error Rate Testing Data
- Targeted Probe & Educate
- Resources

DME NEWS & POLICY UPDATES

Claims Affected by the COVID-19 Waivers and the CR Modifier

- Continue using the CR modifier and COVID-19 narrative when billing for any DMEPOS item (ongoing rentals) and related supplies/accessories if:
  - Base item was initially provided during the Public Health Emergency (PHE) (dates of service on March 1, 2020 – May 11, 2023) and
  - Excluded from enforcement of clinical indications of coverage in Interim Final Rules CMS-1744-IFC and CMS-5531-IFC.
- How to Submit Claims:
  - Add CR modifier and any other applicable modifiers
  - Add claim narrative: COVID-19
    - Electronic Claims: NTE 2400
    - Paper Claims (CMS-1500 Claim Form): Item 19
- When an item initially provided under waiver is replaced due to the 5-year Reasonable Useful Lifetime (RUL), the beneficiary doesn't need to requalify for the item. However, replacement rules must be followed, and suppliers should continue to use the CR modifier.
- JB: https://www.cgsmedicare.com/jb/pubs/news/2025/04/cope175580.html

Billing Instructions: When the Billed Amount Exceeds $99,999.99

- Bill claims for services over $99,999.99 on separate claims:
  - Claim 1
    - Bill service with an acceptable dollar amount (9999999). Don't use dollar signs, decimals, dashes, commas for dollar amounts.
    - Add claim narrative: "Claim 1 of 2; Dollar amount exceeds charge line amount."
  - Claim 2
    - Enter the charge as the remaining dollar amount from the total split.
    - Add claim narrative: "Claim 2 of 2; Remaining dollar amount from Claim 1 amount exceeds charge line amount."
- You must add a claim narrative with reason why the claim is split. Without a narrative, the claim will deny as a duplicate.
  - JB: https://www.cgsmedicare.com/jb/pubs/news/2025/01/cope169968.html

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Accreditation Claim Message

- **CO-185 N790-N369** - The rendering provider is not eligible to perform the service billed. Provider/supplier not accredited for product/service. Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.
- Supplier Action:
  - Check the remittance advice (RA)
  - If this message is on the RA, confirm you are accredited to provide the item billed
  - If you are not accredited for the item, contact your accrediting organization or the National Provider Enrollment (NPE) contractor
    - NPE East: Novitas Solutions: https://www.novitas-solutions.com/webcenter/portal/DMEPOS
      - 1.866.520.5193
    - NPE West: Palmetto GBA: https://www.palmettogba.com/palmetto/npewest.nsf
      - 1.866.238.9652

New HCPCS Codes – Wheelchair Accessories – Coding and Billing

- CMS revised E1028, which now reads "wheelchair accessory, manual swingaway, retractable or removable mounting hardware, other," into three new HCPCS codes for dates of service on or after April 1, 2025:
  - **E1032** - …hardware used with joystick or other drive control interface
  - **E1033** - …hardware for headrest, cushioned, any type
  - **E1034** - …hardware for lateral trunk or hip support, any type
- These items are in the capped rental category
- If an item began renting under E1028, suppliers should continue billing that code
- The three codes should be used for new items dispensed on or after April 1, 2025
- JB: https://www.cgsmedicare.com/jb/pubs/news/2025/03/cope173566a.html

New HCPCS Codes – Wheelchair Transportation/Transit Securement Systems – Correct Coding

- CMS created two (2) new HCPCS codes for wheelchair transportation/transit securement systems effective for dates of service on and after April 1, 2025:
  - **E1022** – "Wheelchair transportation securement system, any type includes all components and accessories"
    - Describes all components and accessories needed to secure the wheelchair to a vehicle for transportation
  - **E1023** – "Wheelchair transit securement system, includes all components and accessories"
    - Describes all components and accessories needed to secure the beneficiary into a wheelchair during vehicle transit
- CMS determined there was a need to simplify the claims processing needed for HCPCS Level II code K0108 for wheelchair tiedowns and occupant restraint systems.
  - JB: https://www.cgsmedicare.com/jb/pubs/news/2025/04/cope175265.html

Nebulizers, External Infusion Pumps and Related Drugs

- Administration of the drug via nebulizer or infusion pump must be reasonable and necessary
- Coverage details for newly approved drugs will not initially be available in the LCDs until a reconsideration is completed and evaluated by the DME MACs
- Claims for drugs will be processed on a claim-by-claim basis
- Drugs with no HCPCS code may be billed using J7699 (inhalation medication via a nebulizer) or J7799 (medication administered by an external infusion pump) and must include:
  - Name of drug
  - Manufacturer name
  - Dosage strength
- JB: https://www.cgsmedicare.com/jb/pubs/news/2025/01/cope170400a.html

Capecitabine: Oral Anti-cancer Drug (J8520 & J8521) Billing Instructions

- Dates of Service on or after January 1, 2025:
  - Bill these drugs with the NDC instead of a HCPCS code.
    - This is consistent with billing other drugs under the Oral Anti-Cancer LCD.
- Dates of service October 1– December 31, 2024
  - Bill these drugs with HCPCS code J8999 (Prescription drug, oral, chemotherapeutic, NOS)
  - Claim narrative field: Drug name (Capecitabine or Xeloda), Dosage, and National Drug Code (NCD)
- JB: https://cgsmedicare.com/jb/pubs/news/2024/08/cope161884.html

PrEP Fee Amount and New Supply Code for 2025

- Starting September 30, 2024, CMS covers pre-exposure prophylaxis (PrEP) using antiretroviral drugs approved by the FDA to prevent HIV in individuals at increased risk for contracting HIV.
  - Effective January 1, 2025, the new supply fee HCPCS **Q0521** will replace all existing supply fee HCPCS codes Q0516 - Q0520.
  - JB: https://www.cgsmedicare.com/jb/pubs/news/2024/10/cope164791.html

Continuous Glucose Monitors: Replacement Supplies

- Dates of service on and after February 18, 2025
  - For replacement supplies (A4238, A4239), the medical necessity for the Medicare paid beneficiary-owned CGM is assumed to be established.
    - There must be documentation every 6 months of an in-person or Medicare-approved telehealth visit with the beneficiary to document
      - Beneficiary's adherence to their CBM regimen and diabetes treatment
      - Support that the supplies remain medically necessary and are essential for the effective use of the CGM
    - Glucose Monitor Local Coverage Determination (L33822): https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33822&ContrID=140)
    - Policy article A52464: https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52464&ContrID=140)

Immunosuppressive Drug Supply Allowance

- Dates of service on or after January 1, 2025:
  - Suppliers can dispense and bill up to a **90-day supply** of immunosuppressive drugs.
  - Claim Narrative field: 3-months or 90 days
  - CGS will automatically adjust claims with dates of service on or after January 1, 2025, that denied in error for billing a 90 day-supply.
- Dates of service before January 1, 2025:
  - Suppliers can dispense and bill no more than a **30-day supply** of immunosuppressive drugs.
  - JB: https://www.cgsmedicare.com/jb/pubs/news/2025/02/cope172911.html

Ostomy Supplies

- Ostomy Supplies Policy Article - Revision Effective Date: 01/01/2022
  - Added: “Ostomy supplies are covered for a beneficiary who has a permanent impairment requiring an ostomy. A permanent ostomy is defined as a condition that is not expected to be medically or surgically corrected in that beneficiary. Permanence is a condition that is of a long and indefinite duration. This does not require a determination that there is no possibility that the beneficiary's condition may improve sometime in the future. If the medical record, including the judgment of the treating practitioner, indicates the condition is of long and indefinite duration, the test of permanence is considered met. Ostomy supplies will be denied as non-covered in situations in which it is expected that the condition will be temporary.” as clarification
    - JB: https://cgsmedicare.com/jb/pubs/news/2025/03/cope174576.html

Lymphedema Compression Treatment Items – Correct Coding and Billing - Revised

- This Correct Coding and Billing publication is effective for claims with dates of service on or after January 1, 2024.
  - Revised to update the long descriptions for HCPCS codes A6549, A6583, A6585, A6586, A6587, and A6588 effective for dates of service on or after April 1, 2025
  - Revised to add HCPCS codes A6515, A6516, A6517, A6518, A6519, and A6611, effective for dates of service on or after April 1, 2025
    - JB: https://www.cgsmedicare.com/jb/pubs/news/2023/12/cope147943.html

Lymphedema Compression Treatment Replacement (1)

- A quantity of three (3) daytime garments or wraps per body area are allowed once every six (6) months.
- A quantity of two (2) nighttime garments per body area are allowed once every two (2) years (24 months).
- Replacement of the garments can only be made in accordance with the frequency limitations of once every six (6) months for daytime garments or wraps and once every two (2) years for nighttime garments.
- Claims for gradient compression garments or wraps billed in excess of the frequency limitations outlined above will be denied as not reasonable and necessary unless replacements are needed in cases of loss, theft, or irreparable damage.

Lymphedema Compression Treatment Replacement (2)

- Payment is made for replacement of an entire new set of daytime and/or nighttime garments and the six month and/or two-year replacement frequency begins anew at the time the replacement items are furnished.
- A new Standard Written Order (SWO) and the RA modifier are necessary for the replacement of garments due to loss, theft, or irreparable damage.
- If there is a change in the medical necessity a new Standard Written Order (SWO) and documentation of the change in condition that justifies a new garment or wrap.
- In addition, payment can be made for a new set of garments or wraps if determined to be reasonable and necessary due to a change in the beneficiary's medical or physical condition that warrants a new size or type of garment or wrap.

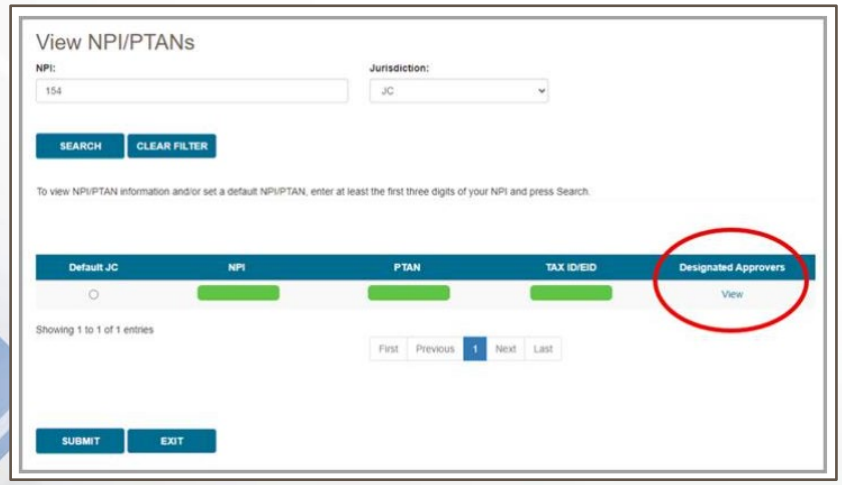
Urological Supplies

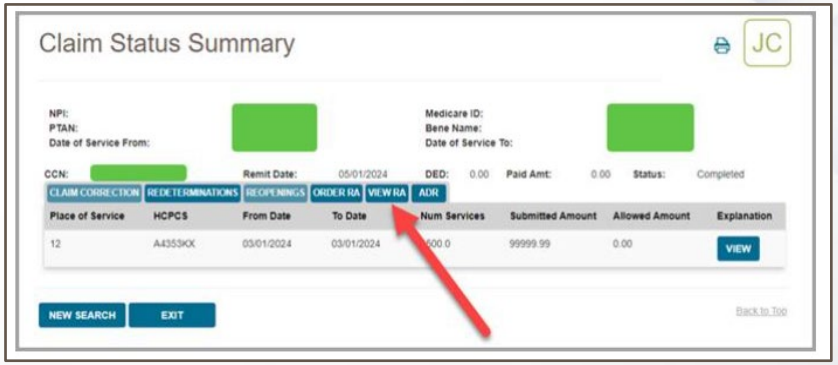
- Urological Supplies Policy Article - Revised Effective Date: 04/01/2023
  - Removed: “Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected in that beneficiary within 3 months” and “(ordinarily at least 3 months)” as clarification
    - JB: https://cgsmedicare.com/jb/pubs/news/2025/03/cope174576.html

MYCGS UPDATES

myCGS 8.8 New Features

- This update provides the option to view a list of all your Designated Approvers (DAs) and provides easier access to the Remittance Advice (RA)





https://www.cgsmedicare.com/jc/pubs/news/2024/07/cope160426.html

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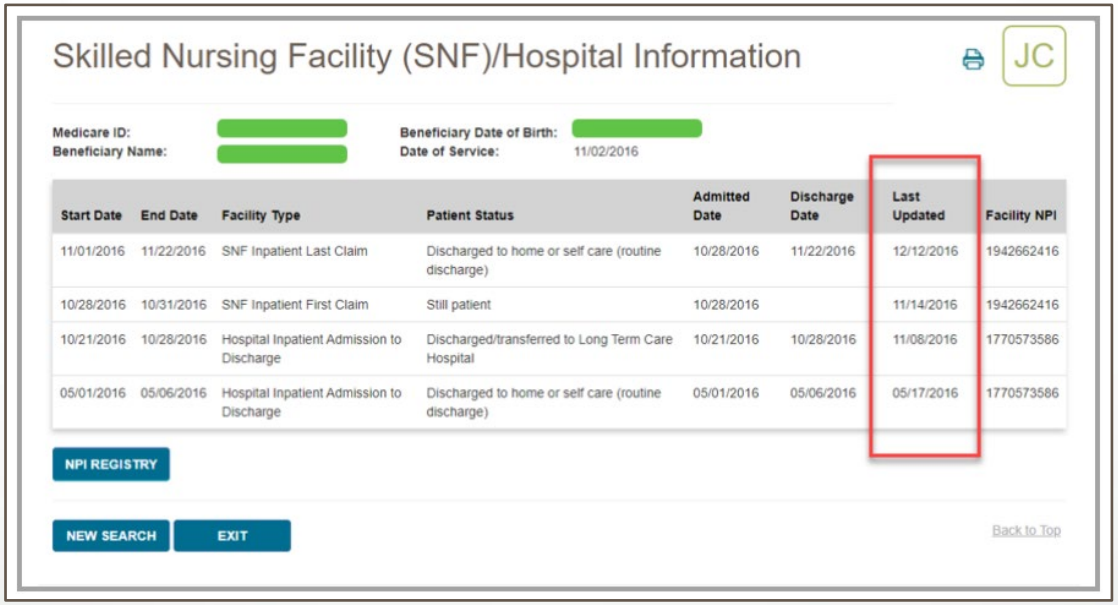
myCGS 8.9 New Features

- The SNF/Hospital Information screen now includes a new "Last Updated" field. This field shows the date the SNF/Hospital record was last updated in the Common Working Files (CWF).



Skilled Nursing Facility (SNF)/Hospital Information

JC

Medicare ID: [redacted]
Beneficiary Name: [redacted]
Beneficiary Date of Birth: [redacted]
Date of Service: 11/02/2016

Start Date	End Date	Facility Type	Patient Status	Admitted Date	Discharge Date	Last Updated	Facility NPI
11/01/2016	11/22/2016	SNF Inpatient Last Claim	Discharged to home or self care (routine discharge)	10/28/2016	11/22/2016	12/12/2016	1942662416
10/28/2016	10/31/2016	SNF Inpatient First Claim	Still patient	10/28/2016		11/14/2016	1942662416
10/21/2016	10/28/2016	Hospital Inpatient Admission to Discharge	Discharged/transferred to Long Term Care Hospital	10/21/2016	10/28/2016	11/08/2016	1770573586
05/01/2016	05/06/2016	Hospital Inpatient Admission to Discharge	Discharged to home or self care (routine discharge)	05/01/2016	05/06/2016	05/17/2016	1770573586

NPI REGISTRY

NEW SEARCH EXIT

Back to Top

https://www.cgsmedicare.com/jc/pubs/news/2024/07/cope160426.html

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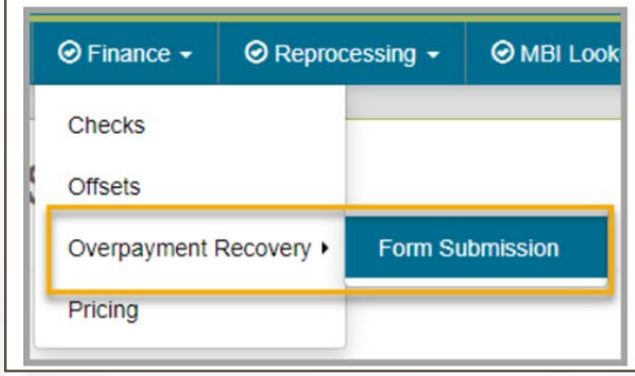
myCGS 9.0 New Features

- Access to Overpayment Recovery Request and Offset Request Forms

To submit an Overpayment Recovery request in myCGS, navigate to the Finance menu and select **Overpayment Recovery – Form Submission**.



https://www.cgsmedicare.com/jc/pubs/news/2024/07/cope160426.html

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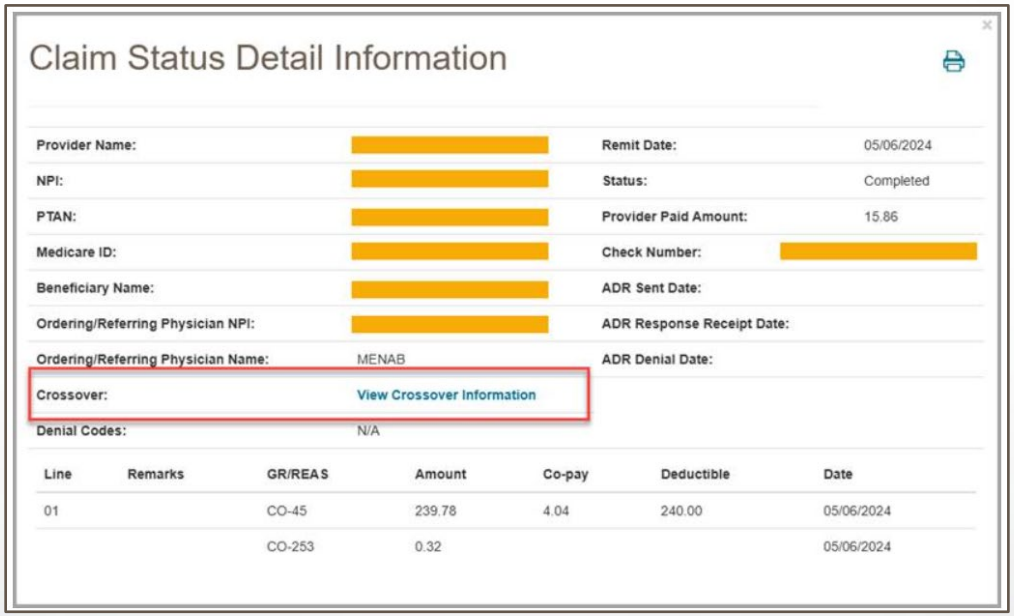
myCGS 9.2

- New Features/Enhancements
  - Updated Prior Authorization Smart Submission (PASS) to allow up to seven (7) calendar days to process the request.
  - Remove the “Time to Process Request” table from PASS.

myCGS 9.3(1)

- Coordination of Benefits Agreement (COBA) Crossover information added to myCGS
  - Available on the Claim Status Detail Information screen



https://www.cgsmedicare.com/jc/pubs/news/2024/07/cope160426.html

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myCGS 9.3(2)

- Coordination of Benefits Agreement (COBA) Crossover information added to myCGS
  - After pressing the link, a Crossover Details popup will appear:

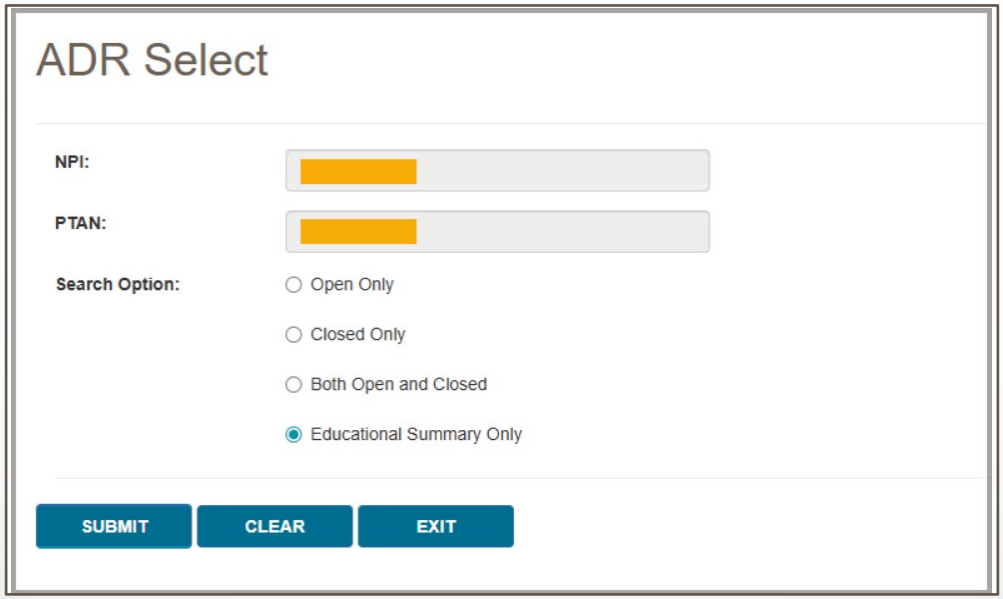
https://www.cgsmedicare.com/jc/pubs/news/2024/07/cope160426.html

myCGS 9.3

- Other enhancements with myCGS 9.3:
  - Check number associated with a completed claim is now on the Claim Detail Information screen (right hand side of the screen)
  - Designated Approvers (DAs) will receive an email when a new DA registers under the same Tax ID number
  - Same/Similar now gives an error message with a higher HCPCS in the "From" field
    - Example: a search of K0001 and K0009, the K0001 must be in the "From" field
  - When submitting an Additional Documentation Response (ADR) response, the submitter can see a list containing of file names of documents submitted
    - File names also displayed on the ADR OnBase Coversheet

myCGS 9.4(1)

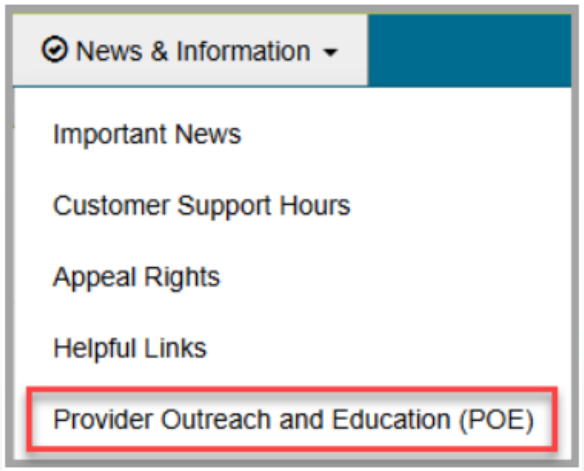
- The ADR Select screen (within Claims menu) allows you to view your Educational Summary without searching for specific ADR cases



https://www.cgsmedicare.com/jc/pubs/news/2024/07/cope160426.html

myCGS 9.4(2)

- A new screen has been added to the News and Information menu for POE
- Click to see a listing of current workshops and events



https://www.cgsmedicare.com/jc/pubs/news/2024/07/cope160426.html

myCGS Contact Information

- Use this email contact for questions related to the myCGS web portal
  - Do not include PHI or PII in your emails
  - Do not send multiple emails regarding the same issue/problem
    - JB: cgs.dme.jb.mycgsfeedback@cgsadmin.com

COMPREHENSIVE ERROR RATE TESTING (CERT)

2024 CERT Annual Report

- 2024 Improper Payment Rates and Projected Improper Payment
  - https://www.cms.gov/files/document/2024-medicare-fee-service-supplemental-improper-payment-data.pdf

FFS Type	Improper Payment Rate	Projected Improper Payment Amount
Overall	7.7%	$31.7B
DMEPOS	**21.4%**	**$1.9B**
Part A (excluding Hospital Inpatient Prospective Payment System (IPPS)	7.6%	$14.2B
Part A (Hospital IPPS)	3.9%	$4.1B
Part A (Hospital IPPS)	10.3%	$11.5B

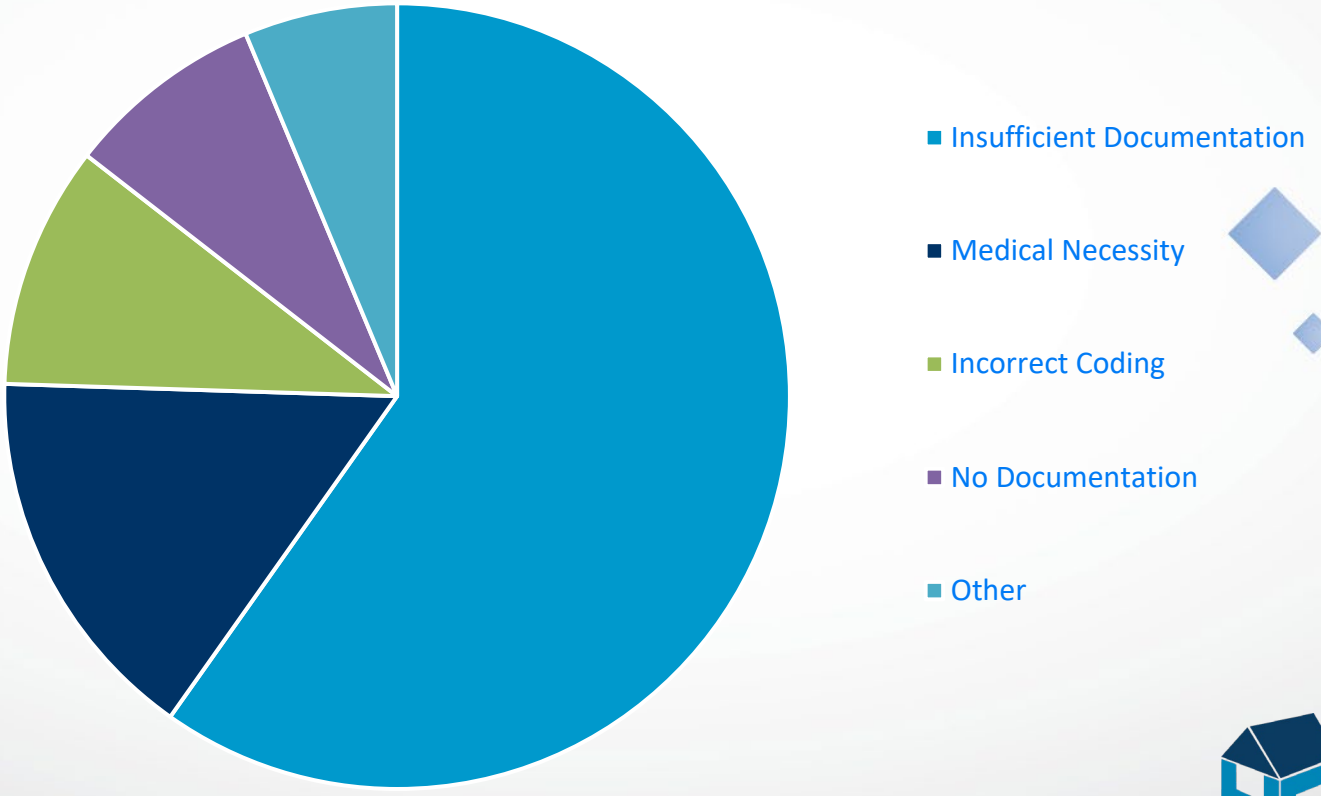
Michigan FFS Projected Improper Payment: DMEPOS Only

	Claims Reviewed	Projected Improper Payments	Improper Payment Rate
All States	11,000	$1.9B	21.4
Michigan	**303**	**$81.3M**	**32.8%**

Highest Improper Payments by Service Type

Policy Group	Projected Improper Payments	Error Rate
Glucose Monitor	$278,458,137	25.2%
Urological Supplies	$257,761,158	45.2%
Surgical Dressings	$176,907,941	57.6%
CPAP	$146,106,081	12.5%
Wheelchairs Options/Accessories	$105,842,955	35.4%
Lower Limb Orthoses	$91,221,893	35.2%
Infusion Pumps & Related Drugs	$89,453,268	14.1%
Parenteral Nutrition	$81,850,376	33.0%
Oxygen Supplies/Equipment	$81,010,316	11.3%

2024 CERT Annual Report – Error Categories

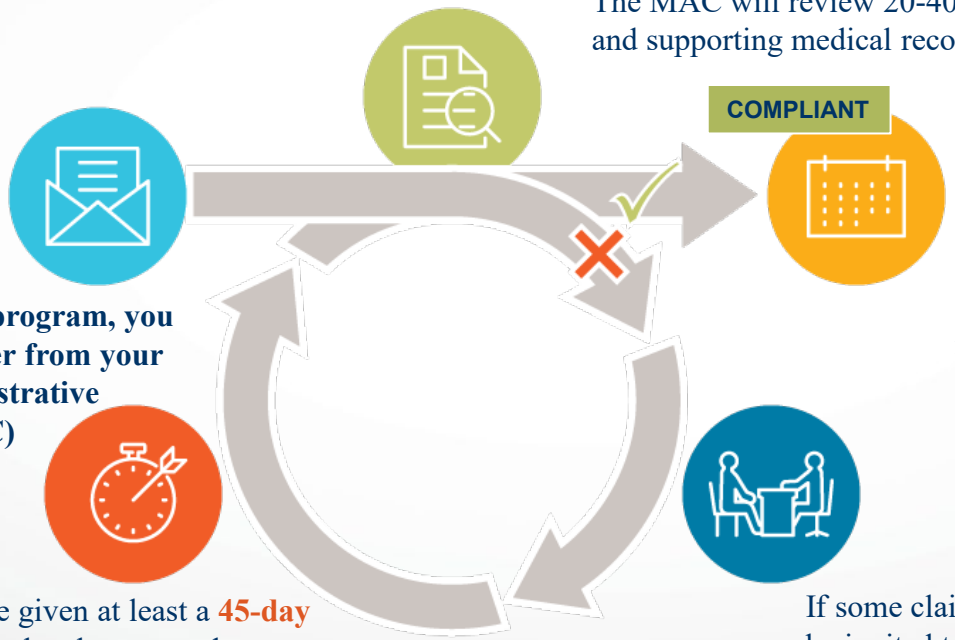


TARGETED PROBE & EDUCATE (TPE)

Targeted Probe & Educate

- TPE goal is to improve claims payment error rate
- Reduce volume of appeals
- Existing data analysis determines suppliers to review
- High claim error rates or unusual billing practices
- Claims with greatest financial risk to Medicare
- Initial TPE review consists of 10 claims
- Review of 20-40 claims, if errors are found in the initial 10
- One-on-one education to address errors
- Up to three rounds of probe reviews
- JB: https://www.cgsmedicare.com/jb/mr/tpe.html

How Does TPE Work



The MAC will review 20-40 of your claims and supporting medical records

If chosen for the program, you will receive a letter from your Medicare Administrative Contractor (MAC)

If compliant, you will not be reviewed again for at least **1 year** on the selected topic

You will be given at least a **45-day** period to make changes and improve

If some claims are denied, you will be invited to a one-on-one education session

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TPE Quarterly Reports

- Supplier results for all TPE reviews completed October – December 2024:
  - 10 Claim Pilot – 33% Successfully Passed
  - Round 1 – 89% Successfully Achieved Exclusion
  - Round 2 – 56% Successfully Achieved Exclusion
  - Round 3 – 72% Successfully Achieved Exclusion

Policy Results: October – December 2024

Description	Error Rate
Ankle-Foot Orthosis (AFO)	34.61%
Commodes	35.56%
Continuous Positive Airway Pressure (CPAP) & Supplies	17.78%
Enteral Nutrition	18.87%
Glucose Monitors & Supplies	27.57%
Hospital Beds	21.25%
Immunosuppressive Drugs	11.02%
Knee Orthoses	58.44%

Description	Error Rate
Manual Wheelchairs	32.05%
Nebulizers	41.33%
Oxygen and Oxygen Equipment	20.68%
Spinal Orthoses	37.37%
Surgical Dressings	58.87%
Therapeutic Shoes/Inserts for Diabetics	44.48%
Urological Supplies	37.50%

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

- 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
- Utilize checklists
  - https://www.cgsmedicare.com/jb/mr/documentation_checklists.html

What Questions Do You Have?

THANK YOU FOR ATTENDING!

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The End

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