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A CMS Contracted Agent

Medicare

Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Council Meeting Minutes	
Date:	May 7, 2009
Time:	1:00 p.m. – 4:00 p.m. ET
Location:	Castleton Park Conference Center 6415 Castleway West Drive Indianapolis, IN 46250
Materials Provided:	2009 First Quarter Top 10 Supplier Telephone Inquiries 2009 First Quarter Top 10 Supplier Written Inquiries 2009 First Quarter Top 10 Supplier Claim Submission Errors 2009 First Quarter Jurisdiction B Appeals Update 2009 First Quarter Jurisdiction B Claims Update 2009 First Quarter Jurisdiction B Correspondence Update 2009 First Quarter Jurisdiction B Customer Care Update 2009 Jurisdiction B DME MAC May 09 Council Q & A Clarification of Stamped Dates and Signatures Listserv Repair and Replacement of Durable Medical Equipment – RA, RB Modifier Listserv MLN Matters Article MM6139 – New Provider Authentication Requirements MLN Matters Article MM6392 – Surety Bonds Spring Seminar A.M. and P.M. Handouts

1. Introductions – All
   - **Martin Furman will now be our CMS representative, replacing Mary Beth Jason. Martin was unable to attend today's meeting, but expects to be at future meetings. Representatives from CMS did not attend today's meeting.**

2. Common Electronic Data Interchange Update - Sarah Leonetti, Sally Hopkins
   - **CEDI enrollment – CEDI is currently processing applications with a receipt date of May 4, 2009. The**

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average turn around time is 5-days. On May 1, 2009 CEDI made enhancements to the online forms, in order to help the CEDI enrollment department become more efficient. Suppliers will still be required to print the forms, sign and return them to CEDI enrollment.

- **CEDI Help Desk – Peak call volume times occur between 10:00 a.m. and 2:00 p.m. Suppliers are encouraged to send an e-mail or call during non-peak times to prevent long wait times.**
- **Claim Control Number (CCN) assignments are now completed by CEDI, as of March 20, 2009. DME MAC Level II reports will now only show accepted claims and CMN rejections. These reports will no longer list rejected claims. The CCN assigned by CEDI will be on the GenResponse Report and also listed on the DME MAC Level II report. If submitter has an error or reject on a claim, it will be listed on the GenResponse report, and the supplier will need to correct and resubmit.**
- **GenResponse report length and format: No changes to be made at this time. Currently CMS is working on changes for Version 5010, so as a result, focus to 5010 changes are given priority. Other changes are also being made, including NCPDP editing and translation. CMS is considering standardizing the electronic front-end reports**
- **David Krupla indicated that if suppliers are having problems with the GenResponse report due to size or error messages not being grouped together they can contact him and he will try to assist. David can be contacted via the CEDI HelpDesk or by e-mailing the EDI Help Desk. In the subject line indicate: "David Krupla GenResponse Report Issues." You will need to provide David with your submitter ID so that he can research.**

3. DME MAC Medical Policy Update - Dr. Adrian Oleck

- **CERT error rate has been increasing significantly over the last few months.**
- **Office of Inspector General (OIG) has taken a look at how CERT was reviewing claims and determined that the CERT contractors were not applying policies appropriated which has now resulted in the CERT contractors being very meticulous.**
  - **Some issues identified include: Documentation of continuing need for item – looking for documentation from physician's records. Looking for *recent* documentation (within 6 months of the date of service on the claim.) Dr. Oleck suggested suppliers may benefit by getting more documentation up front.**
- **CMS is asking the RACs to begin focusing on DMEPOS claims due to the increased CERT error rate.**
- **Oxygen concentrator supplies—looking for some doc to support that beneficiary is still using the equipment. NGS recently published an article about "beneficiary requested refills" – this may address the issue of continuing need for the item. Council indicated that CERT is asking for proof of delivery, but have not been specifically asking for delivery tickets on content refills, therefore suppliers have not been sending that information.**
- **CERT findings are consistent with National Government Services Medical Review findings.**
- **From a Medical Review standpoint, National Government Services will continue to look at test strips, power mobility devices, surgical dressings (antimicrobial and gauze dressings), nebulizers,**

Negative Pressure Wound Therapy Pump and supplies, therapeutic shoes.

- **Currently the Medical Directors are working on revisions to policies now in draft including: heating pads, TENS device, appliances for obstructive sleep apnea. No new policies or major policy changes set to come out any time in the near future.**
- **The medical directors are working with Joel Kaiser from CMS on an article regarding oxygen travel issues. The DME MACs will be posting that article soon. The medical directors are also working on a revision to the oxygen policy, which will include recertification changes.**
- **Suppliers have issues with being held accountable for MD documentation – or lack of. MDs do not often chart information in beneficiary's medical records.**
- **A council member suggested publishing documentation requirements in medical journals, or other publications that might be utilized by order physicians and other referral agencies.**
- **A council member indicated that the supplier community is beginning to hear concerns from beneficiaries regarding their ability to afford physician's visits required for Medicare coverage (i.e., PAP). In today's economic times the first cutbacks that people make involve healthcare, they do not go to the doctor unless absolutely necessary.**
- **The RAC will only get to keep money resulting from overpayments if the decision is sustained all the way through the appeals process. (Good News)**

4. Action Items - POE Department

- ABN Option #2 - Stacie McMichel

  The beneficiary initially selects Option #2, which indicates they want the DMEPOS item, but they do not want the supplier to bill Medicare. Council would like to know if the beneficiary changes his/her mind, is the supplier required to submit the claim and if so, how long does the beneficiary have to change their mind? Question was sent to CMS and is pending a response.

  - **This issue was sent to CMS on April 28, 2009 and is currently on CMS's desk to be reviewed, but a response has not yet been received. We will let members know CMS's response upon receipt of the information. (OPEN)**

- Modifier Requirements and Processing Guidelines - Charity Bright

  With the addition of the KE modifier and claims now requiring more than 5 modifiers more often, Council requested that we provide a refresher on modifier order for claim submission. Suppliers should always append the pricing modifiers (NU/RR/UE/KE) in the first position following the HCPCS code. If the item requires the NU, RR, or UE modifier and the KE modifier, the NU, RR or UE modifier should be placed in the first position following the HCPCS code followed by the KE modifier in the second position. If the item also requires a capped rental modifier (KH, KI, KJ, KR,

MS, BR, BP or BU), it would be placed in the third position following the HCPCS code followed by any subsequent informational modifiers (RT, LT, RA, RB, GA, etc.)

- **Question as to where the KX should be placed? No requirement, but would place KX on the claim line rather than in NTE segment. Council requested that this information be sent out in a listserv article or published somewhere on the National Government Services Web site. (OPEN) (ACTION ITEM)**

- IVR Option/Same and Similar Implementation - Charity Bright

  The implementation of the same/similar option was delayed due to the amount of time required to obtain the information and deliver it to the customer being longer than expected. Therefore, enhancements were made to the option in order to provide the most efficient tool possible. Currently those enhancements are being tested. A listserv announcement will be sent out when the same/similar option is available.

  - **This will be implemented on May 11, 2009, but will be available Friday, May 8, 2009. This option will be available for base codes only not accessories or nutrients. You can obtain information related to accessories and nutrients from the CMN option. Council requested this action item be left open to make sure that everything goes as planned with implementation. (OPEN)**

- CSI/Same and Similar - Tamara Hall

  Update will be provided at the meeting.

  - **CMN status through Claim Status Inquiry (CSI) is scheduled for release in October 2009. This option will work differently than IVR option. Suppliers should be reminded this option will only search Jurisdiction B records not CWF. Once implemented we will request CMS add the same/similar option. (OPEN)**

- CERT Audits - Charity Bright

  Council members indicated that the CERT contractor is asking for medical documentation that the medical policy does not require to support payment of the item being reviewed. The number of CERT errors have significantly increased recently across all 4 of the jurisdictions. These errors involve lack of supporting medical documentation in the patients medical record or conflicting information in the patients medical record. Dr. Oleck indicated at the last meeting that the Medical Directors have seen some general changes and they are requesting a meeting with Dr. Perez. **(CLOSED)**

- Wheelchair Batteries - Stacie McMichel

  Council indicated that when more than one wheelchair battery (E2363) is billed, the claims are paid incorrectly and only allow fee schedule allowance for one unit. This code involves an MUE and is

set to allow a maximum of (2) units of service. Claims submitted with more than (2) units of service will be denied. After research, it was determined that an issue in the claims payment system was causing claims to pay incorrectly. This issue has been corrected and claims for batteries (E2363) should now be allowing correctly.

- **Approximately 8,700 claims dating back to January 2005. Council requested that this action remain open until all claims are adjusted for payment. (OPEN)**

Oxygen PR Denials - Charity Bright

Council members requested information on how to submit oxygen claims for denial when the patient refuses to have required testing i.e., ABG, Saturation levels. Claims will reject if a CMN is not submitted. CMNs are rejected if testing information is left blank. A test claim was submitted by a council member with dummy CMN information, however, the claim rejected. Another test claim was recently submitted and is currently pending in the claims payment system. Charity Bright is following the claim to determine if the appropriate denial is given.

- **Charity Bright, Lisa Hare and Michael Todd have worked on trying to find a solution for suppliers billing Medicare for oxygen denials where test results are not available. However, to this point a solution, which allows suppliers to submit these claims electronically, has not been found. Therefore, suppliers will be able to submit these claims on paper utilizing the current ASCA exception in place, which allows suppliers to submit oxygen claims with oxygen saturation levels greater than 89%, where suppliers do not have responses to questions 7-9. If suppliers do not currently have an ASCA waiver on file they will need to submit one in order to bill on paper. An implementation date has not yet been established to start this procedure. Charity Bright will send out instructions. Jay Cain asked whether a supplier who has an ASCA waiver on file for this reason only, will be able to drop claims to paper for any other reason. No, the supplier should only bill paper claims for a valid ASCA exception. (OPEN) (ACTION ITEM)**

- CEDI GenResponse Report - Sarah Leonetti and Sally Hopkins

A Council member at the last meeting informed us about an issue with the CEDI GenResponse report being very large and time consuming to look through and requested if the report could be revised to make it more user friendly. After research it was determined that the CEDI GenResponse report is used by other entities and would require their approval before these reports can be changed. CMS is looking at standardizing the front end reports, therefore CEDI is waiting for that direction before making any changes to the current format.

- **As discussed above the GenResponse report length and format will not be changed at this time. If suppliers need assistance with the GenResponse report they can contact Dave Krupla with National Government Services, CEDI. (CLOSED)**

- Span Dates/PAP Accessories - Stacie McMichel

  POE is currently working with BSO to identify items that require span dates. Currently, BSO has identified blood glucose testing strips, PEN and CPMs. However, POE is still currently researching the LCDs and policy articles to make sure that all items are identified before developing educational material.

  - **After researching this issue it has been determined that span dates are not required for Positive Airway Pressure (PAP) device supplies/accessories. Currently POE is working on adding a section to the payment policy and claim submission chapters of the supplier manual to advise suppliers on items that require span dates. A council member requested a list of items that require prorating also be added. (OPEN) (ACTION ITEM)**

- Clarification on Date Stamps and Stamped Signatures - Charity Bright

  Council requested that clarification be sent out via a listserv message concerning clarification on date stamps and stamped signatures. The original education indicated that date stamps and stamped signatures are not acceptable on CMN's and DIF's, however, physicians often use a date stamp or signature stamp on other forms of medical documentation. Date stamps and stamped signatures are not acceptable on any form of medical documentation. A listserv article was sent out via listserv in February. A copy of the listserv announcement was provided as a handout and is posted in the What's New section on the Web site. **(CLOSED)**

- Clarification on Proof of Delivery Requirements - Charity Bright

  Council requested clarification on Proof of Delivery Requirements in the IOM. The IOM used to include a statement indicating that brand name, model number, and serial number were required. However, now it simply states proof of delivery "should include" and it no longer states it "must include". The Program Integrity Manual and the Jurisdiction B Supplier Manual, Chapter 7 both provide information in regards to the components of proof of delivery. The brand name, model number, and serial number are not required but are suggested. The Sections of the PIM specific to delivery documentation requirements include: Chapter 4, Benefit Integrity, Sections 4.26 and 4.26.1 and Chapter 5, Items and Services Having Special DME Review Considerations, Section 5.8. **(CLOSED)**

  - **Brand name/model/serial numbers are suggested but not required elements on proof of delivery documentation.**

- Clarification on RA Modifier Usage - Charity Bright

  Council requested clarification on RA modifier usage. Should the RA modifier be appended to an item being replaced after the 5 year reasonable useful lifetime? The RA modifier must be appended to any

DME item being replaced regardless if the item is being replaced due to RUL or loss, damage, irreparable repair. A listserv article was sent out in April clarifying the use of the RA, RB modifier. A copy of the listserv was included as a handout for today's meeting. This article is also published in the What's New section of the Web site. **(CLOSED)**

- **Suppliers should not append the RA modifier on subsequent rental months following replacement. The RA modifier should only be appended to the initial claim submitted for replacement. If a supplier submits the RA on subsequent claims they will receive a same/similar denial (CO-151).**
- **ACTION ITEM: Is RA modifier required for seating cushion, or RB? We will research to determine whether the RA or RB is required. Possible rationale: If seat cushion was part of base then RB? If seat cushion was purchased as separate item, then RA?**

5. Provider Outreach & Education Updates - POE Department

- Claim Submission Errors – Charity Bright
- Telephone Inquiries – Charity Bright
- Written Inquiries – Charity Bright
- Upcoming Educational Opportunities – Nikia Simmons
  - **Reopenings / Appeals 200 level CBT was recently added to Medicare University.**
  - **NGS will be hosting a Webinar on May 28, 2009. The topic is: National Government Services Website navigation.**
  - **Indiana Rural Health Association (June)**
  - **VGM Heartland Conference – June 8, 2009-June 11, 2009**
  - **National Government Services will be hosting an ACT call in June the topic has not yet been determined.**
  - **An ASCA CBT will be released in June.**
  - **POE will be conducting 101 Webinars in June.**
  - **Spring Seminars begin on May 12th and run through May 21, 2009. On May 12, 2009 in Dublin, OH Indianapolis; May 14 in Lexington, Springfield; May 19 in Bloomington and Lansing; May 21 in Brookfield, WI**
- Electronic Data Interchange – Lisa Hare
  - **CSI and EFT forms are still handled by National Government Services EDI department. The CSI form can now be completed online. The EFT form is not available online, because this is a CMS form not a form created by National Government Services.**
  - **National Government Services EDI department encourages all suppliers to utilize the electronic**

remits and electronic funds transfer features.

6. Provider Outreach & Clinical Education Updates - POCE Department

- **Upcoming Educational Opportunities – Sharon Gulley**
    - **National Government Services will be conducting Lunch and Learns on the following topic over the next three months.**
        i. **Nebulizers - May**
        ii. **Enteral nutrition – May 28th**
        iii. **Surgical dressings – June**
        iv. **Knee Orthoses – July**
- **National Government Services will be creating CBT courses based upon our previous Lunch and Learn topics. We will begin with three topics and would like council input on which three would be most beneficial. Please send your top 3 selections to clinical education at: clinical.education@wellpoint.com.**

Options include:

- **Respiratory Assist Devices**
- **Manual wheelchairs**
- **Hospital beds and accessories**
- **NPWT**
- **Refractive lens**
- **Parenteral Nutrition**
- **Immunosuppressive drugs**

- CERT Update – Dawn Hermes – **Update was provided by Dr. Oleck previously**

7. Open Discussion - All

- **<u>CPAP</u>**
- **Council requested that we take another look at question #16 of the Q and A document. They felt the answer did not correctly address the question. (Dr. Oleck)**

We have a patient who received a CPAP (E0601) on December 5, 2008 from a different supplier. The patient had a physician visit on October 31, 2008 and sleep study that qualified on November 17, 2008. The patient returned their CPAP on their own to that supplier on January 19, 2009 due to mask issues. The

patient saw their doctor on January 2, 2009. The doctor has notes where the patient used the machine 64% of the time when he had the machine and still required CPAP therapy. Therefore, the patient was not compliant and did not show improvement. We have been contacted by the patient to set up the CPAP machine on March 6, 2009. Does this patient need a repeat sleep study and another face to face clinical re-evaluation? Or since the patient did not have the CPAP for a continuous 12-week initial trial, can we bill the third month? If we can bill the third month and the patient is still not compliant with usage after the 30 days, will he need a repeat sleep test and start over the 12-week trial?

UPDATED ANSWER: In the scenario presented, a repeat clinical re-evaluation and sleep study are not required for coverage of the March 6th claim because that would still be considered part of the 3 month trial. A 3 month trial is three billed rental months. In this scenario, since the CPAP device was billed on 12/5 and 1/5 and the patient discontinued using the device between 1/19 and 3/6, one additional month can be considered to be part of the trial, even though the third month of use began more than 3 calendar months from the initial issue of the CPAP device. As stated in the LCD, patients who fail the initial 3 month trial must have a clinical re-evaluation by a physician and repeat sleep test in a facility-based setting in order to requalify for a PAP device. In this scenario, if compliance is not documented during the 31 days after March 6, then it would be considered a failed trial.

- **Council asked if Medicare will pay for a second sleep study for a patient that failed the initial 12-week trial period? Dr. Oleck advised that this would be on the discretion of the local Part B Carrier and may vary state to state. POE did some additional research regarding this issue and this is the information identified regarding coverage of sleep studies: Medicare Part B physician services does consider coverage on sleep studies for beneficiaries. In regards to retesting, as long as it is deemed medically necessary (not a preventative service or an unrelated diagnosis [broken leg]), the beneficiaries' retesting would be considered for payment. The beneficiary would be responsible for their 20 percent co-pay if they do not have supplement insurance and their annual Medicare Part B deductible has been met. For further assistance with coverage on sleep studies, please contact your local Part B physician services carrier or 1-800-MEDICARE.**
- **Council asked if the patient fails a 12-week trial period is a new facility based sleep study (baseline) be required or would a titration be acceptable. Dr. Oleck indicated a new sleep study will be required.**
- **Council asked for clarification on using an ABN for PAP patients. Can an ABN be issued to a patient initially receiving PAP indicating if they do not have all necessary testing or do not follow-up with the physician they will be held financially responsible? CMS has clarified this issue and indicates that an ABN cannot be issued in this situation. Clarification regarding this will be sent out via listserv. National Government Services advised that suppliers may put in writing what the beneficiary's responsibilities are and require them to sign it, but an ABN cannot be used in this situation. (ACTION ITEM)**
- **Question #3: Council indicated some providers are billing the PAP device and accessories on the same claim and accessories are denying. National Government Services indicated that about 90% of**

the claims looked at show the accessories were billed prior to the base equipment. Suppliers should make sure the base equipment is billed on the first line of the claim. National Government Services is aware that there were claims rejected when the initial claim was submitted; suppliers will now be able to resubmit those claims. National Government Services will send out a listserv advising suppliers of this fact and advising suppliers that when billing the initial claim to bill the base code on claim line one. (ACTION ITEM)

- **<u>Oxygen</u>**
- **If a beneficiary travels and doesn't work with the "home" supplier (notify) them to make arrangements for oxygen, who is responsible for payment? In this situation the beneficiary would be responsible. The beneficiary must notify the "home" supplier in advance and the supplier must make arrangements. If the beneficiary makes arrangements on their own without notifying the "home" supplier, the "home" supplier has no obligation to reimburse the beneficiary.**
- **<u>Replacement oxygen after the 60-month reasonable useful lifetime (RUL):</u>**
  - **If a beneficiary opts not to receive new equipment and the supplier transfers title of the oxygen equipment, will Medicare pay for the contents? Yes, Medicare will allow for the contents. However, Medicare will not allow for supplies, repairs or maintenance. These items will be denied as statutorily non-covered.**
- **If a beneficiary has portable oxygen only and the portable system caps, will Medicare pay for contents for the portable system only?**
- **Proof of Delivery: What happens if supplier is unable to obtain proof of delivery for the original equipment from the original supplier? This question was submitted to CMS for input. CMS responded that a delivery slip from the prior equipment is not needed if there is information in the DME MAC system indicating that the 5 year RUL period is met.**
- **<u>Oxygen months 37-60:</u>**
  - **Does a break in billing/break in need extend the RUL? No, the RUL is based upon the delivery of the equipment to the customer receiving benefits under fee-for-service Medicare.**
- **Council asked if the 1-800-Medicare line is tracking questions pertaining to oxygen. What is the 1-800-Medicare line telling beneficiaries when the call with questions regarding oxygen?**
- **Are there any payment issues involving the KE modifier? If a claim with the KE modifier was paid incorrectly, suppliers should contact the Customer Contact Center so that this issue can be researched. If claims were paid incorrectly suppliers can contact the reopening line to have these claims adjusted.**
- **If KE was inadvertently omitted from claim, the supplier must resubmit the claim.**
- **<u>Repair Labor UOM</u>**
- **Council asked if anything is being looked at regarding thee maximum units established. Dr. Oleck indicated that the medical directors are not actively re-reviewing these maximum units. Council members should submit a request in writing to have these units reviewed if they believe they are not accurate.**

- **Same/Similar Questions: NGS will provide additional information.**
- **Council asked about documentation requirements to support the beneficiary's option to elect new equipment after RUL is met for oxygen. Per CMS, suppliers may obtain signed letter/attestation from beneficiary and keep in file.**

8. Schedule Next Meeting - All

Next meeting will coincide with the face-to-face Provider Outreach and Education Advisory Group meeting. Next meeting tentatively scheduled for Thursday, July 23, 2009 in the usual location.

- **This date did not work the next Council meeting is scheduled for Thursday, July 30, 2009.**