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A CMS Contracted Agent

Medicare

Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Council Meeting Minutes	
Date:	October 29, 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 Third Quarter Top 10 Supplier Telephone Inquiries 2009 Third Quarter Top 10 Supplier Written Inquiries 2009 Third Quarter Top 10 Supplier Claim Submission Errors 2009 Third Quarter Jurisdiction B Appeals Update 2009 Third Quarter Jurisdiction B Claims Update 2009 Third Quarter Jurisdiction B Correspondence Update 2009 Third Quarter Jurisdiction B Customer Care Update 2009 Third Quarter Jurisdiction B Overpayment Recovery Unit Update 2009 Jurisdiction B DME MAC October Council Q & A

1. Introductions – All

   Meeting opened with introductions. Martin Furman, CMS contract officer present by phone. Mary Hoffman, Recovery Audit Contractor (RAC) Director for Jurisdiction B, Dr. Earl Berman, RAC Medical Director, and David Wyatt, Project Director for PRG Schultz (RAC subcontractor) were in attendance to represent the RAC.

2. National Government Services Staffing Update – Terri Shoup

   AJ Hanna is no longer with National Government Services. Rod King has assumed his responsibilities as Director of Provider Outreach and Education and Provider Enrollment.

3. Common Electronic Data Interchange Update - Sally Hopkins, Stacie McDonald

   Enrollment update: National Government Services is currently working on receipt date Oct. 27 (well within 5 day turn around time). Currently pursuing the possibility of adding an Interactive Voice

Response (IVR) system option for suppliers to be able check enrollment status, hoping to have implemented by February 2010.

Conversion Update: A listserv message was sent out in early October. CEDI will begin converting all Express Plus users to PC-ACE Pro32 software. To date CEDI has converted approximately 1% of users. PC-ACE Pro32 was chosen because it is more efficient for the user, as it holds data and eliminates a lot of manual data entry. A conversion tool is available for download on the Web site, however if you problems with installation, send the EDI helpdesk an e-mail and they will help. Goal is to have conversions done by April 2010. E-mails should be sent to: ngs.cedihelpdesk@wellpoint.com.

NCDP conversion to CEDI : This conversion will move front end edits from the DME MACs to CEDI. Transition will begin during the next scheduled CEDI update. Claims will be sent to all four of the DME MACs and CEDI. The DME MACs report should be utilized by suppliers to work denied claims. However, suppliers should compare the reports and provide feedback on discrepancies. Testing to date has been successful and they don't envision problems at this time. Scheduled to finalize in December 2009.

CR6421: Verification of ordering/referring providers with PECOS. The 4 DME MACs and CEDI have documented issues and concerns regarding this CR and have forwarded them to CMS for feedback. A web site is available to help confirm if a physician is in PECOS through Medicare.gov, however, CEDI is not sure about the accuracy of the information provided which is the reason they have not published anything to this fact. Two things that have been identified but not 100% confirmed are if a physician enrolled in PECOS before the NPI was required, and has not updated their NPI the system will not find a match. The second is that names submitted are not always populating correctly – there are separate fields for Last Name and First Name. Some suppliers are entering the physicians entire name in one field, which results in a mismatch. The purpose of CR 6421 is to verify that physicians/non physician practitioners are eligible and enrolled in Medicare to prescribe equipment/suppliers for Medicare beneficiaries.

If a provider enrolled in PECOS but received the NPI after they enrolled this will create an issue. CEDI was instructed to: check PECOS against the ordering/referring physician's name and NPI indicated on the claim. If a match is not made they were instructed to issue the warning message. The first 4-letters of the last name and the 1st letter of the 1st name must match, otherwise the message will be issued. If names are not populated correctly (i.e., last name appears as Smith John MD), the message will be issued. CR6417 indicates that a validation against PECOS should occur first and if a match is not found then a check of the Medicare Part B claims system can occur if a match is made then the claim can be processed and paid. However, for DMEPOS claims this file is not available as CEDI does not have access. CEDI is aware of how "hot" an issue this is and they are taking suppliers concerns and issues very seriously.

CEDI cannot share the document they sent to CMS because it has some questions that should not be publicized.

Per CEDI, anywhere from 57% up to 70% of total claims received in one day are affected by these edits. Three ways an edit can be counted (claims, claim lines, doctor names?). They are tracking claim count.

CMS is very aware of this issue. They are trying to coordinate a meeting with the CMS Business components and the DME MACs to address these issues. The message is being heard loud and clear.

Providers understand reason for pursing the validity of the ordering physicians but find it inequitable that DME provider's claims will not be paid, but the physician's claims will be paid. Industry concerned about large number of physicians that need to update their records in PECOS within the next 60 days.

Is there a department at CMS that is responsible for this – Office of Financial Management and then the Office of Enrollment.

PECOS is the enrollment for physicians, the way the NSC enrolls DME providers. However, if DME doesn't update with the NSC their claims are not paid, but with PECOS if the doctor doesn't update they are still paid and DME providers are not.

Most common issue seen is that the NPI is not in PECOS. Which means provider was enrolled in PECOS prior to NPI being issued. This could be why physician is on Medicare.gov but claims still have warning.

If edits are not fixed as of Jan 4, claims will reject. Rejections based on process date, not date of service. Once PECOS is updated, claims can be re-submitted and paid.

CEDI has asked CMS for Suppliers and third party billers to have access to a validation process to know if physician is setup appropriately in PECOS.

Can we get an ABN for a patient who needs services and has a script from a physician who is not in PECOS? Answer – NO, not a medical necessity denial

As part of 6421, you still have the EY modifier ability and the PECOS check will be bypassed if EY is on every line on the claim – must be for the claim – not the line.

Most claims denied for lack of orders are denied for medical necessity and are not denied as non-covered.

4. Recovery Audit Contractor – Mary Hoffman

Mary Hoffman is the Director of Recovery Audit Contractor (RAC) Jurisdiction B, Dr. Earl Berman is the Medical Director and David Wyatt is a Project Director with PRG Schultz a RAC subcontractor.

The RAC provided a high level overview regarding their role. They indicated they have weekly conference calls with CMS. They look for underpayments and overpayments – the contingency fee they receive from CMS is the same for both. All RACs are required by CMS to have credentialed experts on

staff.

Three keys to RAC program success:

   i. **Maximize transparency** – the RACs will share, share, share. Anything you want to know they will share. There is no GOTCHA in the RAC. They have a website with all their contact information. Their website has a lot of valuable information please take the time to access the site. Guarantee a response to e-mails within 24 hours. They have an e-mail list serve as well.
   ii. **Ensure accuracy** – new issue review process in place. Before a RAC can target an issue they must submit a package to CMS for review. CMS must authorize authority to pursue the new issue. This is to ensure the RACs understand the issues and make good decisions.
   iii. **Minimize provider burden** – limit medical records. RACs have system to track reviews. RAC audits can start with dates 10/31/07 and after.

b. RACs do not audit beneficiary-liable claims.
c. **Medical record limit** = 1% of average Medicare monthly services not to exceed 200 medical records in a 45 day time period, per NPI.
d. **Communication is key** – ask questions and work through NGS, PRG, etc. PRG is not there to educate on policy. They will answer questions on the RAC process.
e. **Role of Contractor Medical Director (CMD)** – Very important for providers to know who PRG is as they have a face and they will answer whatever questions you have on the processes and what they do. If you have problems – please contact PRG. First call resolution is very important to PRG. There is a project file for every audit. They are available and accessible. The RACs are the subject matter experts on policy – LCD and NCD. They want to verify that their interpretation of the policies are in line with the DME MACs. They are in concert with the error rate reduction that CMS set. They want to make sure the rule interpretations are consistent and as such they have CQI review processes in place. "Clear, Concise, Considerate and Correct".
f. **Discussion period** – This is unique to RAC program. Discussion period is outside the appeal time frame that provides you with an opportunity to discuss the outcome. Send a tamper proof envelope to RAC – not electronic at this point. Fill out form and point out problem – they will review and pull claim for payment if they agree. Must provide evidence why that claim failed. Free claim text section – if disagree then send evidence as to why the claim should be paid – please re-consider. If agree, pay the claim.
g. **Go to website to see issues that are approved and posted for auditing this year.** If fee for service – you are eligible for a RAC audit. The RACs cannot go after beneficiary liability.
h. **Audits** – target issues not providers. Audit targets will very from region to region and state to state – lo
i. Appeals:
   i. First level of appeal is at DME MAC. The RAC will sent a package (Internal review guidelines are not discoverable) to the contractor.
   ii. Second level of appeal is at QIC.
   iii. ALJ is third level appeal.
j. **RAC website**: http://RACB.CGI.com

5. DME MAC Medical Policy Update – Dr. Adrian Oleck
   a. Several policy revision have been recently released but those mainly dealt with KX, GA, GZ modifiers.
   b. Nebulizer policy – no longer need trial period for long-acting beta agonists.
   c. There continue to be issues with PMD policy in regards to the detailed product description. CMS felt that more specificity was needed. Therefore the policy was revised to state that both a narrative description and the make/model number of the PMD that will be provided need to be included. The narrative description does not need to be full HCPCS description – mainly a good description of the item. The 4 Medical Directors are working on a clarification document.
   d. CERT contractor is being very "comprehensive" in policy determinations. For example, when reviewing oxygen claims, they are looking for the CMN, the report of the oxygen test that is referenced on the CMN, the physician evaluation prior to ordering oxygen, the physician evaluation prior to recertification, plus, for patients who have been on oxygen for an extended period of time, notes from the physician that indicate that they beneficiary continues to need and use the oxygen. There are similar issues with documentation of ongoing medical necessity for other rental items. The look back period – i.e. how recent prior to the DOS on the claim that documentation should be – needs clarification. NGS is holding off on education while waiting for CMS instructions.
   e. Illegible physician signatures is another reason for CERT denials. Also awaiting CMS instructions on this issue.
   f. CERT has been re-opening claims that have been previously reviewed. Dues to changes that have occurred over the year they are re-looking to make sure the claims are adjudicated consistently. (Some providers have seen claims re-opened from 2 years ago.)
   g.

6. Action Items - POE Department

- Oxygen PR Denials – Stacie McMichel

  Council members requested information on how to submit oxygen claims for denial when the patient refuses to have required testing (i.e., ABG levels, Saturation levels) or oxygen is prescribed for a diagnosis which is not related to lung disease (i.e., cluster headaches). Claims will reject if a CMN is not submitted or 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 submitted and the claim was paid in error. 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, a solution which allows suppliers to submit these claims electronically has not been found yet. Therefore, a proposed solution was to allow suppliers 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% and questions 7-9 unanswered on paper.

  This proposed solution was discussed by National Government Services at an Interdepartmental meeting and it

was determined that further discussion needed to take place between the other jurisdictions to determine how these claims are being handled. After discussions with the other jurisdictions, it was determined that once the claim denies for no CMN, the supplier can then request a reopening to correct the denial and liability. Currently, this is the process for Jurisdiction B too. Test claims have been submitted and are currently being reviewed to see if there is a way to handle this situation during the initial processing of the claim. **(OPEN)**

- <u>Span Dates/PAP Accessories - Stacie McMichel</u>

  POE is currently working with systems department to identify items that require span dates. Currently, systems 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 was 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 Jurisdiction B DME MAC Supplier Manual, within the payment policy and claim submission chapters, which will advise suppliers on items that require span dates. A council member also requested that a list of items that can be prorated also be added to the supplier manual. *National Government Services is currently in the process of developing a listserv article that will be sent out within the next couple of weeks.* **(OPEN)**

- <u>Clarification on RA Modifier Usage – Vicky Combs</u>

  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, or 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 on the What's New section of the Web site. *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 modifier on subsequent claims the subsequent claims will be denied same/similar (CO-151).* The Council members asked for clarification on whether the RA modifier is required for a replacement seating cushion, or if the RB modifier should be used. National Government Services will research and provide clarification on RA/RB modifiers. *National Government Services is currently seeking clarification from CMS on their interpretation of the RA/RB modifiers. National Government Services is also currently seeking clarification from the other DME MAC Jurisdictions to see how they are educating suppliers on use of the RA, RB modifiers.* **(OPEN)**

- <u>Addition of Offset Request form to Overpayment Demand Letters:</u>

  The Council members requested to have the Overpayment Recovery Offset Request form added to the demand letters. By adding the Offset Request form to the demand letters suppliers would be able to respond more timely and accurately to the request for refund. *This suggestion has been forwarded to the Overpayment Recovery Unit for research and development. An update will be provided at the next meeting.* **(OPEN)**

- Redetermination/Reopening Requests:

  The Council members indicated that requests for reopening and redeterminations are being returned due to lack of the last five-digits of the tax-id number. This authentication element is not required for appeal requests. National Government Services will do some further investigation and try to determine why the requests were returned.

  Appeal requests are not returned due to the last 5-digits of the supplier's tax-id number not being included. However, if a supplier submits either a redetermination/reopening request which is invalid, the request is then forwarded to written correspondence where the provider authentication elements are required. Written correspondence will look for the tax ID digits, and if written correspondence cannot obtain those the request is returned to the supplier asking for the provider authentication elements. If Council members have any examples where valid redetermination/reopening requests are being returned in error they should contact the Provider Contact Center for further assistance or fax the examples to Charity Bright for further investigation.

  National Government Services is currently working on having a field added to the forms so suppliers can include the last five-digits of the tax-id number for consistency. **(OPEN)**

7. Provider Outreach & Education Updates - POE Department

- Claim Submission Errors – Stacie McMichel
- Telephone Inquiries – Stacie McMichel
- Written Inquiries – Stacie McMichel
- Congressional Outreach – Michael Dorris
- DME beneficiary fact sheets are provided today that have been updated. They are on the NGS website under "People with Medicare" section. These sheets were reviewed by CMS therefore they do not need to get approval every year to update. If new items added then CMS would need to approve. Updates are made yearly but reviewed quarterly as well. If the Council makes a request, they will review and consider updating. The top inquiry from Congressional offices is oxygen. The fact sheets are shared with the congressional offices as well. Reimbursement issues are the second highest call volume. The third call volume relates to power wheelchairs while the fourth is lenses and frames. Seat lift mechanisms receive a decent call volume as well. CMS is looking to update coverage guide on DME. CMS likes the fact sheets. National Government Services asked if Council would review the new fact sheets prior to posting. Council agreed.
- Web site Revitalization Overview – Robert Floyd
- They have seen a lot of success and a few pain points since the launch of the revitalized Web site. They have received a high score of 93.5% rating for usability and accessibility for people with disabilities. Two areas not passing on first test will be addressed and will hit the 99% mark. Improvements were function, view, font size for readability, and cosmetic; the group is excited about the changes. The site loads more

quickly and efficiently. Many of the subtle changes will add value to the overall experience. The biggest paid point experienced to day relates to the policy section and resulted in a temporary page for the LCDs. National Government Services is still in the process of correcting this despite 17 days having passed since implementation. National Government Services hopes to have the updated page posted within the next week and a half with sorting capabilities intact.

- Upcoming Educational Opportunities – Charity Mahurin

  - November 12, 2009 at 2:00 – Open Q and A ACT call. No presentation just questions and answers. Participation from all Operational Areas will be present for the call.
  - Computer Based Training – A current Modifier CBT was just posted, announcement will be sent out via list serv. Clinical Education will be posting an Oral Anti-cancer CBT in November. In December POE will be posting a CBT on Supplier Enrollment.
  - December 9, 2009 and December 10, 20009 -- Medicare 101 Webinars will be conducted. December TBA – Small Supplier Ask-the-Contractor teleconference call.
  - Online Virtual Convention – Week of November 16-20, 2009

  Please register at www. Ngsmedicareconvention.com; on-line registration ends November 10, 2009. Sessions are color coded so you can more easily locate your line of business. There are some courses that will cover all lines of business and they are noted. During the week of the convention you will sign up for the classes you would like to attend. Power point presentations will be shared with paid attendees the week before the convention. When you attend the session you will hear the speaker and will see the presentation. You will have a chat forum so you can ask questions. There will be an on-demand feature available for 30 days after the convention so that you can listen to the presentations after the fact. Currently the registration is lower than expected but National Government Services believes it will increase closer to the November 10th registration dead-line.

- Electronic Data Interchange – Tamara Hall/Lisa Hare
  - Claim Status Inquiry (CSI) now provides suppliers with access to CMN information – Same/Similar. You must enter the HCPCS or partial HCPCS to get the information. Only access to Jurisdiction B records through the CSI. More information will be provided on this topic at the Virtual Convention in the CSI session.
  - Think Green Go Paperless – EFT/ERA Promotion

8. Provider Outreach & Clinical Education Updates - POCE Department

- Upcoming Educational Opportunities – Nina Gregory
  - National Government Services will be conducting Lunch and Learns on the following topic over the next couple of months.

i. Oxygen
ii. Negative Pressure Wound Therapy (NPWT)
iii. Spinal Orthosis
iv. External Infusion Pumps

Virtual Convention topics are:

Documentation and ADR Requests – In terms of Fraud and Abuse, PAP, RAD, and PEN

- CERT Update – A CERT teleconference was held on September 23, 2009, if you missed the call you can still obtain the information on the National Government Services Web site.
- If any State Associations would like Provider Outreach and Clinical Education to attend any upcoming events they will need to submit a request.

9. Open Discussion - All

- **PAP Questions:**
- **Failed 12-week trial period – what is the purpose of the repeat sleep study?**

The thought behind this was due to inclusion of the home sleep study; if there was a failure then a sleep lab study would help catch these problems. If there are concerns regarding the repeat sleep study, physicians can submit a policy review request. It is better if this type of request comes from an organization rather than and individual – need a valid, compelling argument of what to do different/better. CMS specified the trial period for compliance and the start over process needed to include something to necessitate a new trial period. Trial of different masks and types of machines should occur over the 12-week trial period. The real question is why are people failing and what are the next steps that need to occur to help beneficiary benefit from therapy.

- CO-35 denials – This has been brought to National Government Services attention and they are researching.
- Confusion over PA, CNP can perform face-to-face – Councils understanding is that they can perform this but they are being told they cannot by Customer Care. Keith Johnson requested specific examples so that he can make sure this is addressed by training with the Customer Care representatives.

- **Repair Claims for PMD:**
  - Repair claim denials because the purchase date for PMD does not match the initial date in the CMN file. National Government Services requested additional information and examples be sent to Stacie McMichel for further investigation. This information is only required when traditional Medicare fee-for-service did not pay for the PMD being repaired.
- **Five Year Reasonable Useful Lifetime (RUL):**
  - Council requested clarification on replacement of DME equipment after the 5-year RUL. Can all DME equipment be replaced at the end of the 5-year RUL even if the equipment is not worn or broken

beyond repair? Yes, this applies to all DME the beneficiary must decide whether they want new equipment but suppliers are not required to document what is wrong with the equipment to justify why it is being replaced. Suppliers do not need to have documentation regarding damaged beyond repair or cost comparison between repairing vs. replacement once the 5-year RUL has been met.

- **CMS is sending letters to beneficiaries indicating supplier is no longer accredited:**
  - The letter does not state who the supplier is, just that your supplier is no longer accredited and instructs them to go to www.Medicare.gov to locate qualified suppliers. David Barnett requested examples of the letter be sent to him. Council indicated that a rumor is this was a mistake and that another letter would be sent out by CMS retracting this.
- **Documentation Question:**
  - Are addendums acceptable? Annotated notes are acceptable in other areas. The general answer is that when verifying medical records more weight is given to notes made during the actual visit. Addendums are weighted less. If the addendum is done close to the original visit date it may be considered, however, if done many weeks or months later then much less weight would be provided.
- **Question #7: Documentation Question:**
  - Council has indicated they seeing oxygen content claims denied as CO-97, the claims were taken to Redetermination and they were paid. However, the subsequent months claims denied. This situation appears to be happening when a patient has had a change in modality during the 36-month cap and the combined payments equal 36. Council also indicated they are receiving the CO-97 denial on content claims where 36 payments were made solely on one modality. Please clarify this situation and is a resolution in sight? **Answer:** National Government Services is aware of this issue and currently working to resolve, however, in the mean time suppliers who believe their claims have been denied CO-97 in error should submit a request for Redetermination.

10. Schedule Next Meeting - All
    - **Next meeting is scheduled for Thursday, January 21, 2010 in the usual location.**