Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Council Meeting Minutes	
Date:	May 16, 2013
Time:	12:30 p.m. – 3:30 p.m. ET
Attachments Included with Agenda:	Jurisdiction B DME MAC May 16, 2013 Council Q & A Jurisdiction B DME MAC Action Items

1. **Introductions – All**

2. **Common Electronic Data Interchange (CEDI) Update – Stacy McDonald, Sally Hopkins**

   CEDI present to address questions. No questions from the council.

3. **National Competitive Bidding Update-Elaine Hensley**
   - **A.** Grandfathering: letters must go out by 05/17/13. Not necessary to obtain proof of delivery of the grandfathering letter but keep a copy as confirmation of submission if requested in an audit.
   - **B.** Enteral and diabetic supplies can't be grandfathered.
   - **C.** If not a bid winner, can still send claims for dates of service as late as 06/30/13.
   - **D.** Enteral patients with oral formula: must go to competitive bid contractor?
     - i. No, oral formula is statutorily non-covered so patient can go to any provider. Per NGS, when billed with modifier BO to indicate oral administration the claim edit would deny with a PR since the patient's formula is statutorily non-covered.
   - **E.** Replacement of parts must be by competitive bid contractor. Repair can be any supplier.
     - i. Conflict between what suppliers understand about this policy.
       Update: The CBIC provided the following clarification following the meeting. If suppliers are providing wheelchair batteries, tires, or wheels to make the base equipment functional, that is a replacement of parts with a repair. Replacement of parts associated with a repair may be obtained by any Medicare-enrolled supplier.
   - **F.** Sub-contractor can't fulfill any roles that must be performed by the contracting provider.
     - *i.* Question about the physical inspection of the home as part of the delivery documentation. Can a sub-contractor conduct the home inspection?
       Update: Received the following information from the CBIC following the meeting. Per an

FAQ on the NSC website:

Under the supplier standards, may a supplier subcontract out for other services?

A supplier may subcontract for the purchase of inventory, delivery and instruction on use of the Medicare-covered item, or the maintenance and repair of rented equipment. Services such as intake and assessment, coordination of care with the physician, submitting claims on behalf of the beneficiary, ownership and responsibility for equipment furnished to the beneficiary, and ensuring product safety are all services for which the primary supplier is responsible.

Additional information from the CBIC website and the Subcontracting of DMEPOS Services fact sheet:

In addition to complying with the supplier standards, DMEPOS suppliers must meet the quality standards, which have been issued consistent with the mandate in section 1834(a)(20) of the Social Security Act. The quality standards delineate the services that a supplier is required to perform in the course of furnishing quality items and services. While the quality standards are not meant to be an exhaustive list of services a supplier performs when furnishing DMEPOS, they do highlight many of the services that a primary supplier performs in the course of furnishing the item and coordinating the care for the beneficiary. Services such as intake and assessment, coordination of care with the physician, submitting claims on behalf of the beneficiary, ownership and responsibility for equipment furnished to the beneficiary, ensuring product safety, etc., are all services for which the primary supplier is responsible.

G. Ensuring consistency between CBIC and 1-800 Medicare staff. Suppliers getting feedback from patients that they were told to transition to contracted providers now. Elaine provided education to the 1-800-Medicare management.

H. Is there communication to beneficiaries regarding diabetic mail order program information?

i. CMS mailing information to patients about the mail order supply program. A copy of this information is on the CBIC Web site at: http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/DMEPOS_Toolkit.html

I. Question about issues of non-licensed suppliers being given contracts. CMS extended the proof of licensure to be provided by May 1, 2013 to the NSC. This was to accommodate states with backlog getting licenses completed. If the state created new licensing requirements since the bidding window opened on January 30, 2012, the CBIC based contracts on what was required prior to the bid window opening. The new license had to be obtained prior to July 1, 2013 or the provider would be in breach of contract.

J. Tennessee has required an in-state facility since 2003. Michigan has required a Pharmacy Wholesale License for Oxygen and other equipment. Companies would be considered in breach of contract for all contracts if not appropriately licensed.

K. What would happen if companies lose contract?

i. That would be a CMS decision to offer contracts to other companies. Non-licensed companies could potentially be given the ability to create a corrective action plan.

L. Should providers notify the CBIC of licenses that aren't on the NSC website?

i. Yes. The NSC is the ultimate resource for validation of licensure but providers are required to know and adhere to all guidelines.

M. Detroit city bed license. NSC only oversees licensure at a state and local level but suppliers are required to meet all requirements per Supplier Standards.

N. If there are many suppliers whose contracts are breached due to inappropriate licensure, would there be a rebid process or would the SPA be altered?

i. That would be a CMS decision but Elaine will provide that feedback to CMS.

O. Bid modifiers: MedLearn Matters article about modifiers. Can we get more information/training about the CB modifiers?

i. Yes, NGS can assist with education.

4. **Power Mobility Device Prior Authorization Demo -- Wendy Mayfield**

A. Only applicable to MI and IL right now in NGS. 01/01/12-12/31/12: In non-demo states, drop of $6m in spending on PMD and in demo states, drop of $9m in PMD spending.

i. CMS has received positive feedback about the program and no complaints from beneficiaries.

ii. 09/01/12-03/12/13 approximately 12k patients gone through process and approximately 50% approved.

iii. NGS turn –around time: 2 days

iv. Date on response letter to mail time should be approximately 2 days.

v. Seeing trends in amounts of approvals?

vi. Packets have improved since September. Seeing the same errors from the same individuals but PMD PA group at NGS reaching out to providers/physicians. Educating on documentation.

vii. Majority of denials are resubmitted and there is a higher rate of affirmations with resubmissions.

viii. Implemented 140 denial reasons specific to PMD and are using them.

ix. Seeing subjective instead of objective information like standardized language from LCD.

B. Dr. Brennan indicated CMS will be presenting more education to physician about documentation.

5. **Documentation Compliance Review (DCR) Audit Update -- Nina Gregory**
   A. All 4 DME MACs auditing oxygen and glucose supply claims
      i. DCR auditing month 1 oxygen and non-insulin dependent diabetics not over-utilizing
      ii. Other medical review audits are looking at non-insulin dependent diabetics over-utilizing
         a. 41% not responding to glucose supplies, mostly pharmacies.
         b. Glucose denials: request for refill missing or patient has excess on hand
      iii. 9% not responding to oxygen audit
         a. Top denial reason: No initial evaluation at all, the evaluation not within 30 days or not signed.
         b. Test doesn't match the CMN, test on order only and not in the medical record.
   B. Nina has educated 18 companies in 2013 but did 53 in 2012. Nina can set training up with provider who can bring denied claims to discuss. Email Nina Gregory to request special training at Nina.Gregory@wellpoint.com.
   C. For training on other items/issues or other denials to walk through one on one email: DMEtraining@wellpoint.com
   D. About 200 providers have been removed from prepayment audit.
   E. In future, they will change the oxygen and glucose reviews to other products. They will provide an education article in advance.
   F. These audits do not have the ADR designation.

6. **DME MAC Medical Policy Update -- Stacey V Brennan, MD FAAFP**
   A. ICD-10 is a high priority for the DME MACs. There are a lot of considerations within the DME MACs and they have completed their ICD-9 to ICD-10 crosswalk for all diagnosis-driven items in the LCDs.
   B. Cross walk expected to be published Q1 2014 but that may be subject to change.
   C. Expecting some educational electronic transmissions about July 1, 2013 face to face requirements. Council voiced issues with the requirement to have physicians sign off on all face to face documentation.
   D. Wheelchairs: Discussion about face to face date article that came out in early April. Specific to PMD on the face to face date.
   E. Definition of K0009 custom wheelchairs -- as of June 1, 2013 will need to go through coding verification. Council questioned whether they can bill as E1399 and if it would be considered for coverage? Dr. Brennan responded that products have not been reclassified under an existing code may be submitted as E1399 and will be handled in a similar manner as other NOC codes.
   F. Council stated that K0009 chairs that are now coded as K0005 has brought up issues with upgrading and has impacted providers' ability to provide requested chairs to patients. Paula

suggested a work group to discuss and NGS indicated they would be open to it.

G. A request was submitted to reconsider adding ICD-9 codes to certain wheelchair cushions and this has been completed – see version on web page for additions made.
H. RAD policy: Council requested that Medicare allow studies prior to Medicare effective.
I. Enteral policy: If HCPCS for product is assigned where the product was coded as NOC, a revised DIF is required.
J. Oral anti-cancer drugs: billed before HCPCs assigned so there were issues with dosages.
K. For pressure reducing surfaces, groups I-III, removed certifying physician's statement.
L. Face to face issues for July 1, 2013, Dr. Brennan asked the council to create a list of questions she could take back.
M. Council asked whether the supporting documentation must be obtained by the provider before delivery or just the WOPD? Pending more information.

7. Action Items -- POE Department

A. Connex enhancement to denote when "dummy" CMN loaded to pay repairs, supplies, etc...
B. Fax e-mail list serve message sent out if experiencing fax receipt issues
C. Non-responder letters: Council questioned the response. The ANSI denial code doesn't provide information. NGS is working to revamp their response. Some providers are submitting ADR responses to the Redetermination number.

8. Open Discussion -- All

A. Q&A questions:

i. Question 2: The answer to question 2 prompted the following question: If the patient is tested in the SNF and the test doesn't qualify because the test was conducted in the SNF, what are the options? They would need to acquire a valid qualifying test, and that may require them sending the beneficiary to a lab, to the hospital lab, or having a qualified provider come to the beneficiary in their location.
ii. Question 4: Does a home sleep test have to be conducted in the patient's home or can it be in a truck stop bed, hospital, hotel, etc.? The Q&A document answer for question 4 was updated after the meeting to provide additional clarifying information.
iii. Question 8: If a current provider of a PMD opts not to grandfather, the complexities of the PMD policy and the timelines complicate what the CBIC expects about switching out patients. NGS indicates this is a question for the CBIC to answer. National Government Services expects all Medicare rules to be followed.
iv. Question 9: Questioning the answer. If a patient has equipment out in the field and the provider closed but hasn't gone bankrupt, what are options if patient needs repairs? If company provides a letter saying they went out of business, would it be accepted? NGS indicates their system would not consider the

equipment to be patient owned until 13 months of rental have been paid. The Q&A document has been updated to reflect that National Government is looking into this issue.

v. Question 10: J4 modifier for non-contracted hospital providing a wheelchair upon hospital discharge. J4 is applied for each month of rental and the hospital will be paid for the full 13 months. Paula will send the questions and NGS will provide more detail.

vi. Question: patient qualifies for oxygen during exercise but the physician orders oxygen for sleep. NGS will provide more information but thinks it will deny. Update: NGS discussed and determined a claim for oxygen for sleep prescription qualified with exercise testing would deny if subject to review.

vii. Question 6: Coding of AFO: L1930 doesn't require PDAC coding verification; does the provider use their judgment to determination when an item falls into this code? Yes.

9. Next Meetings:
   - Thursday, July 25, 2013
   - Thursday, October 24, 3013