National Government Services
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Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Council Meeting Minutes				
Date:	January 23, 2014			
Time:	12:30 p.m. – 3:30 p.m. ET			
Location:	**Hilton Garden/Northeast Fishers, 9785 North by Northeast Blvd, Fishers, Indiana, 46037** **1-317-577-5900** DIRECTIONS: From 465 take I-69 N. Take Exit #203, 96th Street; turn right off the ramp; turn left at the 1st stoplight (North by Northeast Blvd.); hotel is located 2 blocks on the right. The meeting will be in the Garden Room.			
Information	***Phone #:***	**N/A**	***Login/Password:***	**N/A**
Attachments Included with Agenda:	January 23, 2014 DME MAC Council Q and A Jurisdiction B DME MAC Action Items			

Meeting Agenda:

Item	*Assigned To*	*Duration*
1. Introductions	All	10 minutes
2. Common Electronic Data Interchange (CEDI)	Vicky Combs (for CEDI)	5 minutes
3. National Competitive Bidding Updates	Elaine Hensley	60 minutes
4. Power Mobility Device Prior Authorization Demo	Wendy Mayfield	15 minutes
5. DCR Audit Update	Nina Gregory	10 minutes
6. DME MAC Medical Policy Update	Stacey V. Brennan, MD, FAAFP	20 minutes
7. Medicare Recovery Auditor	Tim Fickle	10 minutes
8. Self-Service Enhancements	POE	10 minutes
9. Action Items	POE Department	10 minutes

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10. Open Discussion	All	30 minutes
11. Next Meeting	All	5 minutes

1. Introductions – All

2. Common Electronic Data Interchange (CEDI) – Vicky Combs (for CEDI)
    a. Trading Partner re-certification - Through Tuesday 01/21/14, 81.30% of CEDI Trading Partners have completed their recertification.
    b. If not received by Feb. 28, they will be suspended until the form is received and processed.
    c. CR8223 - Electronic Remittance Advice (ERA) enrollment form - required if making change or setting up for 1st time.
    d. Only supplier's authorized official can sign the form.
    e. ICD-10 testing week - March 3 - 7 - only done through front end process:
        i. Must register on CEDI website (www.ngscedi.com).
        ii. Claims must be submitted with current dates of service - no future dates. Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected in the system. Testing will not confirm claim payment or produce remittance advice.
        iii. MACs and CEDI will be staffed to handle increased call volume during this week.
        iv. Council asked for an update at the next meeting.

3. National Competitive Bidding Updates – Elaine Hensley
    a. Complaint update - (come directly to CBIC via stakeholder or 1-800 Medicare):
        i. Round 2:
            1. 440 complaints - 50/50 between beneficiaries and suppliers.
        ii. Round 1 re-compete:
            1. 1 complaint to date.
            2. Despite new items in this round - CBIC is not hearing much.
        iii. Modifiers primarily for wheelchairs:
            1. DMEMAC's working on resolution but has not been released to implement - no ETA. Elaine is waiting for a response on ETA.
        iv. CBIC is continuing to receive complaints from suppliers where previous suppliers do not have documentation to support medical necessity for the transition. They have a workgroup looking at this concern.

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- v. Florida issues - oxygen suppliers who have gone out of business have not been following previous notification to notify beneficiary. Questions by CBIC submitted to CMS team on what suppliers can do when this occurs (same goes for PAP patients):
  1. Does Medicare have any time limitations for Polysomonograph tests (PSGs)? Currently there is not one. However, Vicky stated there is an article on sleep studies (A52210) for Part B, but it does not give an exact number covered. Per Part B, Medicare should only allow one sleep study unless there are changes to the patient's medical condition.
  2. Testing will not confirm claim payment or produce remittance advice.
  3. MACs and CEDI will be staffed to handle increased call volume during this week.
- vi. Written Order Prior to Delivery (WOPDs) - CBIC states suppliers are not receiving WOPDs before dispensing products. If patient changes from non-contract supplier, does supplier need face-to-face and WOPD prior to dispensing? If the item is part of the F2F 166 HCPCs codes - then yes. Elaine will check to see if there is any further clarification on this topic.
  1. If change from one PTAN to another PTAN within same company - is this a change in supplier? Or same for merging of companies and PTANs?
     - a. Grandfathering is done at corporate level, not service level. If going from one location to another within same company - this should be allowed. Some state claims deny and we would need to show that the company has received a previous payment for new PTAN to be paid.
     - b. Acquisition piece is different, but similar - however, if doing stock acquisition the history is not there so definitely would need to show something on appeal.
     - c. In acquisition where non-contract buys contract, can you bill a new 13 month rental or pick up at next rental month? No, essentially the same supplier is providing the service.
     - d. In an acquisition, is a new WOPD required or if I acquire you and all CMN documentation is good, then I don't need to get new. PIM speaks to CMN issue - not WOPD. Asset purchase is the most challenging.
     - e. Council could put scenarios together for Elaine to share with CBIC.
- vii. Status on bidding modifiers? Elaine will check status.

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viii. Is the CBIC seeing a lot of requests for add/remove/delete locations? More activity before and right after implementation.
   1. They are seeing licensing issues when go out to verify new location.
   2. CBIC verifies against PECOs and state license board. If CBIC doesn't find license, they ask NSC to look as well to ensure they don't miss it.
   3. When adding locations to contract, confirmation received from CBIC but not showing up on Medicare Directory website. Information is passed on to Medicare, but CBIC is not involved. Medicare Directory updated weekly, but if location is in purgatory with PECOs, CMS - not in true active mode it is treated as "inactive". Once a run report is done to populate Medicare directory it will not update until deemed in "active" status. CBIC sends information to DMEMACs to update their records and then populate the records within following week. If major rollout for the introduction of a competition it could go into dark days for a system release. CBIC will show active in their records and DMEMAC records, but issue is with Medicare Directory.

4. Power Mobility Device (PMD) Prior Authorization Demonstration – Wendy Mayfield, Roberta Zenn
   a. PMD demonstration - It is 16 months into operations. Illinois and Michigan must request prior approval on PMD items since they are part of the demonstration project.
   b. Provider education team doing webinar on PMD documentation requirements. Partnering with J6 contracts who bill specific codes for physician documentation billing. Providing just for state of Illinois today. If state of Michigan interested they would consider repeating for that state. Michigan representatives said yes, they would like the same webinar.
   c. Initial submission affirmation rates are on the rise. If denied, the same documentation issues continue. When identify the same issues on resubmission they may call the provider personally. PMD PAR forms - include correct person's name and phone number so that they contact the right person.
   d. Monthly reason code error rates :
      i. Technical denials have definitely declined from initial roll out.
      ii. Two major issues are conflicting information in medical record and physical capability to handle Power Mobility device:
         1. Looking for trends so can help minimize denials.
         2. Notes say all is well, but look at diagnoses and patient is a train wreck.
         3. Addendums - Seeing notes that basically give word for word criteria and it does not line up with what was in the original notes (contradictions).

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4. Missing from notes on a regular basis - Can the patient use the device? Please explain - no check boxes, narrative is necessary.
5. Look at record as a whole and piece it together.

iii. Questions:

1. Can the supplier document that the patient can safely transfer? Other medical records are supportive, but should be in physician's records as well.
2. Providers have issues with educating physicians. Some issues arise from the physician medical records where they are check boxes or the same information is continued in the medical record even though the condition has changed.
3. PMD PAR department will send a letter to the physician about the discrepancies they are discovering.
4. If physician is a "minimal documenter" and then the PT notes are extremely detailed but there may be some discrepancies how do you evaluate these? It depends; each case is looked at independently.
5. PMD PAR request response - when beneficiary representative payee on file they are excluded from PMD PAR demonstration. Please send to CMS for clarification.
   Post meeting update: The demonstration is based on the beneficiary's state of residence as reported to the Social Security Administration. Prior Authorization is not applicable in a non-demonstration state.

5. National Government Services DCR Audit Update – Nina Gregory
   a. DCR reviews going on for over 2 years - continuing with E1390 and A4253.
   b. Added nebulizers - denying for medical records, either none submitted or nothing in record about nebulizer.
      i. If sent DCR request, please make sure that you are looking at what item is being audited. Have seen oxygen and nebulizer dispensed on same day, DCR for nebulizer, but oxygen notes sent.
   c. 101 training still being offered and those who would like it, just let Nina know.
   d. Oxygen audit - more providers have been removed, however not sure how many have been removed. Nina does receive monthly reports on who the top denial companies are and she will contact them for education.
   e. Nebulizers - if dispensing just the nebulizer, do we need to list the medication on the detail written order prior to delivery? Dr. Brennan and Nina both stated if dispensing the drugs, must have detailed written order, but if only nebulizer machine the drug would not need to be listed on the WOPD.

f. Small pad Rx has a patient name listed at the top, plus a date and the physician signs at the bottom - is this an acceptable signature date? YES.

6. DME MAC Medical Policy Update – Stacey V. Brennan, MD, FAAFP
    a. Policy postings over past 3 months
        i. Updated Urologicals as of 12/15/13 GY, GA, GZ modifiers.
        ii. Feb. 10 comment period ends for Vacuum Erection Devices (clarifying need for this device) and Tumor Treatment (non-coverage policy).
        iii. Jurisdiction B only - posted an article 11/8/13 - TENS joint stimulator device - non-coverage update.
        iv. FAQ 11/22/13 article posted 11 scenarios for oxygen/OSA patients.
        v. Supplier abandonment article 12/17/13 - doesn't answer scenarios provided to the CBIC earlier today. Need to continue to let CMS know of these issues so better guidance can be provided.
        vi. Payment rules reminder for initial oxygen testing - revision sent out (1/7/14).
        vii. Two coming out today/tomorrow
            1. K0900 - joint publication - clarification on customized DME included what you need to submit.
            2. Clarification for continuous passive devices E0939 and E0936.

7. Medicare Recovery Auditor – Tim Fickle
    a. E1028 - pain point for suppliers - inappropriate adjustments pursued. NGS states the high level theme was good for them to have conversations with the RAC and they have had discussions where they have addressed this. For any issues impacted by this can suppliers can go through appeals and do as a large appeal rather than individually. RAC will not do a large re-processing. (For further discussion Tim will work with Paula)

       Post meeting update: Suppliers may send the RAC related E1028 adjustments through the reopening process. Please label the request as "RAC E1028 – review of overpayment". When submitting the detail claim information, mark which claim line(s) you concur with the recoupment and which claim line(s) are in dispute. Additional medical record documentation will not need to be submitted for this review.

8. Self-Service Enhancements – POE
    a. NGSConnex - new enhancements
        i. Submit ADR requests through NGSConnex via My Claims tab. View submitted documentation via My History tab.

ii. Print eligibility information from Entitlement Tab screen.

b. Recertification - please make sure that you recertify or you will have access revoked in February. 70% completed to date.

c. Could LSO receive an e-mail when staff signs up or recertifies so they know to go in and validate them?

   Post meeting update: An enhancement request has been submitted to the NGSConnex development team.

d. Submit the ForeSee survey to improve website and NGSConnex site.

e. Self Service enhancements

   i. KE/KY modifier tool is available. (Paula helped test and validate)

   ii. In December NGS implemented Jurisdiction B tip of the week

   iii. Upcoming Medicare Review and Documentation Review denial tool - enter claim control number and will receive additional denial information (hope to eliminate calling call center) Similar to CERT denial tool. Hope to launch in February.

   iv. Code pricing search tool - allow you to search by code and date of service or download entire file. Launch ETA set for February.

9. Action Items – POE Department

   a. Still having issue with ADR fax line - Nina mentioned that a number of the ADR fax requests were being sent to the wrong fax line.

      i. Found a problem with receiving some partial faxes and it was found to be on suppliers end but NGS was able to communicate with them so it could be fixed.

   b. When submitting data for ADRs, please zip or scan to one file so that don't have to open multiple files for one ADR request.

   c. Question #3 - do you need a new PA # if greater than 120 days? Need to check with Wendy.

      Post meeting update: As stated in the answer to Action Item #3, if delivery of the PMD cannot occur within 120 days from the face-to-face exam, they will need to start over. Therefore, they will need a new PA# along with a new face to face exam, 7-element order, DPD (they will need to submit all appropriate documentation to support the coverage), if the contract supplier chooses to submit a PAR.

   d. Question #5 - thank you for the KE/KY modifier tool.

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10. Open Discussion – All

a. Consolidated Q & A comments

i. From supplier community: rotating questions around between the 4 Councils to edit/change/answer and did have a conference call to discuss before submitting to the DMDs.

ii. At council meetings we discuss the questions and then if there are concerns over questions/answers submit those to DMDs for clarification.

iii. DMDs were concerned with the volume of questions.

iv. This is still a work in progress.

v. Question 16 - if patient transitions from non-bid winner supplier to bid winner - how can we re-qualify if qualifying documentation is not available? Dr. Brennan believes this is a regulatory issue and is not aware of a way to re-qualify a patient other than to collect all information from prior supplier, or else start over. Council maintains that providers need a method to re-qualify a patient if information is missing when transitioning from one provider to another.

vi. Question #27 - deliveries and partial shipments - date of service is based on date of delivery.

vii. Question #29 - Nothing that NGS can do in this case. May be able to go to appeals but may not be able to overturn until ALJ level. Problem is the system shows a skilled stay and there is no way to pay the claim. These are systematic edits that won't allow a claim to be paid - even if go to appeals.

viii. Hot topics

1. PECOS denials - article released that mentioned an issue was identified

a. Potential for denials based on information DME MACs received from PECOs.

b. Alerts triggering 2% based on PECOS in December 2013.

c. If get an order from a non-enrolled PECOS physician - how do we handle the patient? Go to another doctor or patient pays for it.

d. Providers told this is not an ABN situation. Add GY modifier but can we submit claim? No, as not statutorily covered. EY not appropriate as you have an order. A Medicare beneficiary must go to an eligible ordering physician. (Can CMS help answer these situations?) ACA 6406 language makes it a statutory denial opportunity, but does not apply to PECOS.

e. Once physician is enrolled, is it retroactive or effective as of day physician is accepted into PECOS?

   Post meeting update: The Phase 2 edits are effective for claims with dates of service on or after January 6, 2014. If the referring/ordering provider is not allowed to refer/order, or the ordering/referring provider name or NPI is not included on the CMS ordering/referring file or if the ordering/referring provider name/NPI does not match what is included on the CMS ordering referring report when the claim is submitted the claim will deny. However, if the claim is resubmitted and the ordering/referring name and NPI is now included on the CMS ordering/referring report the claim will process and pay so long as the enrollment is current (i.e., does not have a termination date that proceeds the date of service). Example: Claim is submitted with date of service 02/02/14 and claim is denied because the ordering/referring physician does not appear on the CMS ordering/referring report. The physician enrolls in PECOS and is included in the CMS ordering/referring report on 02/10/14. The supplier may resubmit the 2/2/14 claim and the claim will pass the Phase 2 edits.

f. Capped rentals - in SE article 1305: Letter J ordered 13 month DME and paid months 1 and 2 what about months 3 and more if physician is deactivated? Months 3 and later would continue to pay.

g. Jurisdiction C stated they received a new file and they were going to adjust claims denied in error based on previous file received.

h. If physician is deactivated are claims processed based on date of service or claims processing date. Physicians deactivates 7/15/14 but DOS 6/10/14 not submitted until 8/1/14 - will claim process and pay?

   Yes. Claims processed based upon date of service. Any claim with a date of service after the deactivation date will not pass the Phase 2 edits – with the exception of rental items delivered prior to physician’s deactivation.

2. For Scooter Store rental customers –NGS is set to allow payment of repairs of the TSS equipment on or after October 24, 2013, if repairs are

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reasonable and necessary--as per CMS instructions. All Medical Necessity steps still must be followed. If have problems, please contact Provider Care Center.

3. Re-classification of inexpensive and routinely purchased moving to capped rental - NGS did submit comments while policy was in comment period. NGS had many similar questions to what the provider community submitted.
    a. Actuator's and motors - if start rental for one motor and then need to replace second motor - can the system handle this? National Government Services' BSO area will work to ensure that any updates to implement this change will be made prior to the implementation of the change.
4. Oxygen/OSA titration scenarios for timing. Submit to Dr. Brennan.
5. E0441, E0443, do need face-to-face and WOPD prior to dispensing/billing.

11. Schedule Next Meeting - All

Apr 24, 2014

Possible dates for future meetings:

Jul 22, 23, 24 (T, W, TH) or Jul 29, 30, 31 (T, W, TH)

Oct 21, 22, 23 (T, W, TH) or Oct 28, 29, 30 (T, W, TH)