Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Council Meeting Minutes	
Date:	May 3, 2012
Time:	12:30 p.m. – 4:00 p.m. ET
Attachments Included with Agenda:	2012 Jurisdiction B DME MAC May Council Q & A 2012 Jurisdiction B DME MAC May Action Items

1. Introductions – All

2. National Supplier Clearinghouse (NSC) Update – Erika Williams
   - **a.** Electronic Department of Appeals Board Filing (www.dab.efile.hhs.gov)
     - i. DMEPOS suppliers have two methods of appealing a denial or revocation of Medicare billing privileges.
       1. Corrective Action Plan or
       2. Request for consideration which is reviewed by a Fair Hearing Request.
       3. If the results are unfavorable by the Fair Hearing Officer the supplier may choose to have the file reviewed by an Administrative Law Judge (ALJ) with the Departmental Appeals Board.
       4. As of February 2012, supplier enrollment appeals may be filed electronically at the DAB Electronic filing system web site – https:dab.efile.hss.gov.
   - **b.** Internet based PECOS changes:
     - i. If suppliers previously used and experienced problems, please give PECOS another opportunity as many updates have occurred.
     - ii. As of February 2012 – e-signature option is available so that suppliers don't have to send in the signature pages within 7 days of submitting the application.
     - iii. Later this year suppliers will be able to upload supporting documents – i.e., surety bonds, licenses, etc.
     - iv. As of April 2012- updating hours of operation was fixed. Also ability to filter location specific enrollments in PECOS was added. This will benefit suppliers who have multiple locations – this feature can be located under the "My Enrollments" page.
     - v. Every 3 months a new release occurs and provides updates/changes to make the

PECOS system more user friendly and up to date.

vi. If suppliers experience system related problems when using PECOS web they should contact the EUS help desk at 1-866-484-8049. General enrollment questions and issues should be directed to the NSC.

c. Revalidation

i. The NSC is fully ramped up and processing revalidations to ensure the March 2013 deadline is met.

ii. The NSC will begin mailing revalidation requests to suppliers in yellow envelopes this process will begin in the next few weeks and will make it easier for suppliers to identify requests for revalidation.

iii. A list is also posted on-line at www.cms.gov documentation who hs been sent a revalidation notification letter.

iv. As of April 2012 suppliers should be able to log in to PECOS to see when the revalidation notification package was sent for a location.

v. Suppliers have 60-days to respond to the revalidation request. Suppliers may request a one-time extension of 60 days but the 60 day counter begins on the date you make the extension request, and not 60 days beyond the initial 60 days. Suppliers can call 1-866-238-9652 to request an extension.

vi. Medicare enrollment fee is $523.00 this year. There are some issues with payments when not going through PECOS due to tax IDs being the only number listed on the form. If a supplier has 3 locations, but all 3 have the same tax ID number how do you differentiate the payments per supplier number. Erika stated that there is a tracking number and they are watching the tracking number to make sure only used one time per NPI.

vii. The PECOS payment address is: https://pecos.cms.hhs.gov/pecos/feePaymentWelcomedo.

viii. The NSC is updating supplier standards - #1, #11 – these are clarifications and not changes. The effective date is April 13, 2012.

1. The abbreviated standards we are currently presenting should be acceptable as long as they contain 30 supplier standards.
2. Suppliers will be notified via listserv if the supplier standards are updated and a new version needs to be provided to suppliers.
3. The detailed version has been updated with some minor modifications but no major changes.

ix. An updated CMS 855 S enrollment application was published in the Federal Register on 4/4/12.

3. Common Electronic Data Interchange (CEDI) Update – Tonya Lewis

a. Gateway upgrade – upgrading front end software system June 1-3, 2012. Gateway will be down during that time. This will provide better security and help features to better serve all involved.

b. Update on 5010 transition - transition shows 98% of claims coming in 5010 format for April. All suppliers must use 5010 by July 1, 2012. However, before supplier can update they must complete transition paperwork which is located on the CEDI Web site.

c. CEDI help sheets for 5010 edits have been developed and are published on the CEDI Web site.

4. National Government Services Connex Update – Lisa Hare

a. Enhancements

i. January – Connex users have been provided the opportunity to submit Redeterminations/Reopenings through Connex.

ii. March – Connex users can check status of reopenings and redeterminations regardless of how the request was submitted (i.e., fax, mail, connex).

iii. April – Connex users can check participation status under the My Profile tab. New search features were also added – ability to see who the LSO is for the account plus LSOs can approve or decline multiple requests at one time. The LSO will also see the first and last name of the person making the request – used only to see the log in name.

iv. All enhancements are communicated via e-mail updates.

v. Council asked once you submit a Redetermination or Reopening via paper (fax, mail) what is the time frame that notice is loaded into Connex. Redetermination and Reopening requests are loaded into the claims payment system (ICOR) once that occurs the supplier will be able to use the Appeals status feature in Connex. **(ACTION ITEM) Update: On average regardless of how the request is submitted (Connex, fax or mail) the status of the request should be available in approximately 7 days. However, suppliers may be able to obtain status quicker for requests submitted via Connex because mail time is eliminated, and for faxed requests additional manual intervention is often required and may result in delays in this information being available. As a reminder all Redeterminations and Reopenings are worked on a first in first out basis regardless of how they are submitted.**

vi. According to DME suppliers, requesting redeterminations via Connex is a very time consuming process. NGS informed suppliers that suppliers only need to load required fields. DME suppliers should take another look at this process.

5. DME MAC Medical Policy Update – Stacey V. Brennan, MD FAAFP:

i. Dr. Brennan introduced the CMS Contracting Officer Representative (COR), Sue Pelella who joined the call. Sue works out of the Philadelphia CMS Regional office. She is the new NGS regional office contact.

ii. Nina Gregory now works part-time with Dr. Brennan plus part-time on CERT error rate.

iii. Dr. Brennan announced that she will be attending DME Conferences in Ohio, Michigan, Wisconsin and hopefully Illinois. Illinois and Michigan were selected due

to the PMD demonstration that is scheduled to begin sometime during the summer of 2012.

iv. The suction pump policy has been released and the DMDs are still working on the pneumatic compression devices policy.

v. Several policy updates will be released soon to incorporate the standard documentation policy language that the DMDs released in March 2012.
    1. Clarifications will be included to refills and education required of beneficiary or caregiver for diabetes.
    2. The DMDs are reviewing CERT errors to see if any policies need updating to clarify policy language to make it more clear and concise.

vi. PMD Prior Authorization Demonstration
    1. Electronic template is being finalized and added to an electronic health record to help physicians carry out necessary pieces/parts of the policy to get the claim paid.
    2. Dr. Brennan reminded the group that there is a call on this project being hosted by CMS at 3:00.

vii. Upgrades – Suppliers will soon see a list serve message released from CMS on this topic. Suppliers may/may not like the article. This will probably be an MLN Matters article.
    1. Dr. Brennan appreciates the feedback she has received from Council regarding this topic.

viii. CERT Error rates
    1. CERT error rate has decreased.
    2. Many reviews are still occurring – oxygen in particular.

    a. #1 reason is the 30 day physician visit – it is either not there or greater than 30 days. Another reason is physician office notes are being signed by nurses and not physicians.
    b. Hospital discharges – notes state that dictated but not electronically signed – these are being denied because all medical record documentation must be "signed".
    c. These reviews being conducted are for technical components – not medical necessity.
    d. Errors are also being found on glucose for request for refill documentation being missing. At times the information provided to CERT states have you nearly exhausted your supplies – yes or no. This is not sufficient. You must ask " how much do you have remaining of each item" and note the response.
    e. Council requested that NGS send out listserv messages on common scenarios for CERT audits. **(ACTION ITEM)**

6. Action Items - All

1. If beneficiary wants to purchase an item that Medicare billing requirements indicate must be rented can a DMEPOS supplier bill the item as a purchase and receive a PR denial?

No. The Centers for Medicare & Medicaid Services assigns each HCPCS to a payment category. If a HCPCS code is assigned to the capped rental payment policy, Medicare payment is made on a rental basis only, although the supplier is required to transfer title to the equipment to the beneficiary after the capped rental payment period (13 months of continuous use) ends. If a capped rental item is billed to Medicare as a purchase, the claim will be rejected for incorrect billing. The DME MAC cannot issue a PR denial in these situations.

Council requested that this action item be submitted to CMS for consideration.

Update: *This is not an issue that can be addressed by CMS because MSP guidelines are based upon Federal laws and regulations. The following information may be found in the Jurisdiction B DME MAC Supplier Manual, Chapter 5 and is consistent with the guidelines provided by the other three DME MACs.*

Medicare Secondary Payer on Rental/Purchase Items:

Medicare as secondary payer can, under no circumstances, pay more than ***what*** *Medicare would have paid as a primary payer. If the primary insurance pays* ***for the lump sum purchase of an item that Medicare will only pay for as a rental (capped rental items, oxygen)****, Medicare cannot make a secondary payment. Medicare would not make a primary payment; therefore, a secondary payment could not be made* ***for the lump sum purchase of such items****. In the above instance, it is not appropriate to execute an Advance Beneficiary Notice of Noncoverage (ABN).* ***Council does not feel that MSP is always involved here and they indicated that suppliers used to be able to get claims through the system and get a denial. Now they cannot get claims through the front end edits and they believe there are a number of instances where it would be appropriate to bill for denial. Council asked if this could be taken to CEDI.***

Update:

CEDI front end edit C172 Invalid Procedure/Modifier fires when the HCPCS code or modifiers submitted are invalid for DME MAC processing.

One example provided by Council was when trying to bill for a gait trainer (E8000NU). According to the Pricing, Data Analysis, and Coding Contractor (PDAC) this HCPCS code is invalid for claim submission to the DME MAC. Therefore, if this code is submitted to CEDI, the claim will hit the front end edit and will be rejected.

Another example provided by Council was for the purchase of a standard manual wheelchair (K0001NU). The

beneficiary does not meet the coverage requirements for the wheelchair because it is only used outside the home. Supplier would like a denial for secondary insurance but cannot pass front end edits. Standard manual wheelchairs fall within the capped rental payment category, beneficiaries are not afforded the option of purchasing they must be billed to Medicare as a monthly rental whether covered or not. If capped rental items are submitted to CEDI with an NU modifier the edit will fire because the modifier is not considered valid for that code. CMS provides technical direction to the DME MACs on what HCPCS codes are considered valid for claim submission furthermore CMS determines what payment category a HCPCS falls into. Based on these instructions the DME MACs provide a list of HCPCS codes and modifiers that are considered invalid which results in the front end edits firing. Therefore, without a directive from CMS, National Government Services and CEDI will continue to reject claims accordingly.

Council requested we again take this back and they believe they should be able to get a denial from Medicare. This is not an issue with just NGS but is an issue across all 4 DME MACs.

Update: Following the January Council meeting, NGS requested claims data and determined that claims are being submitted for capped rental items with the NU modifier to indicate they are being purchased and the claims are passing the front end edits. These claims are processing through the Medicare claims processing system and are being denied with an ANSI denial of CO-108 which states the following:

- *Rent/purchase guidelines were not met*

Furthermore, regardless of whether the claims were billed with a GA, GZ or GY modifier they are still being denied CO-108. If Council can provide some front end CEDI reports that show these claims are not passing the front end edits we can conduct some additional research. CLOSED

2. Council requested that National Government Services provide an overview of esMD.

The Electronic Submission of Medical Documentation (esMD) is a program developed by CMS to give providers a new mechanism for submitting medical documentation. This program will be implemented in two phases.

Phase 1 - Providers will still receive medical documentation requests via paper mail but will have the option to electronically send medical documentation to the requesting Review Contractor. Phase 1 of this program went live on September 15, 2011. National Government Services, the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) began accepting documentation electronically on September 22, 2011.

***Suppliers who opt to send medical documentation electronically to the requesting Review Contractor will be** required to use a Health Information Handler (HIH). Any organization that handles health information on behalf of a provider is an HIH. Many providers already use HIHs to submit claims, provide electronic health record systems, etc. These HIHs are often called claim clearinghouses, release of information vendors, Health Information Exchanges, Electronic Health Record vendors, etc. Some HIHs are beginning to offer Electronic Submission of Medical Documentation (esMD) gateway services as well.*

The following HIHs have been CERTIFIED by CMS to offer esMD gateway services to providers?

HealthPort effective September 2011
IVANS effective September 2011
NaviNet effective September 2011
RISARC effective September 2011
MRO effective October 2011
Health IT Plus effective November 2011

There are additional HIHs that have begun testing and will be available as well.

During Phase 2 of esMED providers will receive electronic documentation request when their claims are selected for review. CMS plans to go live with esMD Phase two in October 2012. ***CLOSED***

For additional information regarding the esMD pilot project, suppliers should refer to the following located on the CMS Web site at:

CMS Web pages
http://www.cms.gov/esmd/
http://www.cms.gov/ESMD/03_Review-Contractors.asp

SE1110
http://www.cms.gov/MLNMattersArticles/Downloads/SE1110.pdf

MM7254
http://docushare.corp.ngsmedicare.com/docushare/dsweb/Get/Document-946335/Revised%20MM7254.pdf

Council asked for additional education on esMD which POE will conduct in the near future.

Update: NGS conducted a Webinar on March 29th and provided education on PWK and esMD. However, according to medical review DMEPOS supplier participation of esMD is minimal. CLOSED

9. Open Discussion - All
   a. POE partnerships with national associations – NGS has partnered with the American Lung Association and the American Diabetes Association in the past and at the last Council meeting Michael Dorris asked if Council thought there might be other associations like these that NGS should consider partnering with to provide education. Council mentioned the American Heart Association. NGS asked what type of education would Council recommend we consider providing to the American Heart Association?

i. Sleep Apnea – PAP, RAD – cardiac disease is associated with sleep disorders.
ii. Oxygen
iii. Venous stasis ulcers with wound care – related to poor circulation from cardiac disease.

b. List serve messages, updates, etc. – Council requests anytime you can highlight the changes it would be helpful as not all changes are appearing in the changes at the end of LCDs and policy articles. NGS indicated that any major changes should be listed at the end of the LCD or article.
    i. For example: Repair vs. Replacement handout that is going to beneficiaries not an update/clarification. NGS wanted feedback from Council. Council didn't realize this was a fact sheet developed to educate beneficiaries.

c. Documentation update – What does "evidence of delivery" mean? Could NGS get clarification on this for Council?
    i. Tracking form – does the full address need to be listed or is the City, State sufficient? For example on the UPS tracking slip it currently lists city and state but not a detailed address (i.e., street address, etc.). **(ACTION ITEM)**

d. RAC Audits
    i. Suppliers have received RAC findings letters for several dates of service for several patients but they have not received an overpayment demand letter. NGS was aware of this issue and has investigated. If this occurs the supplier should contact the RAC directly. The overpayment demand letter is sent once the RAC initiates the adjustment to recoup the payment. In the examples provided the claims in question have not been adjusted and that is why the demand letter has not went out.
    ii. RAC issue with dispensing fee and medication charges on the same claim when part of the payment was applied to the deductible and part was paid. This was an error on the RACs part and is being addressed. The RAC has identified claims involved and NGS is in the process of correctly claims that were inappropriately recouped. However, if you do not want to wait for NGS to correct the issue suppliers can request a Redetermination to have the claim corrected. This should not occur on current/future claims.

e. Long term care take backs (overlapping inpatient stays)
    i. Council indicated that overpayments are being requested when the date of delivery is the same as the date of discharge from the inpatient facility (i.e., hospital, SNF, NF). Council asked why this is occurring. NGS states they have reviewed this issue before and this is not occurring, however if Council members have claim examples they can submit them and NGS will research. **Update: As of 6/6/12 no examples have been submitted by Council.**

f. Council again requested to be able to fax ADR responses to NGS. Currently, NGS is the only DME MAC without a fax line for these. NGS stated they are currently looking to add an enhancement to Connex that will allow suppliers to send responses to ADR requests via the portal. Council was adamant that they still want the option of faxing.
    i. If an ADR response is late, what is the process?
        1. If a supplier fails to respond to an ADR request and receives the N102 ANSI denial. The supplier can request a Redetermination and submit the information. The request will be treated as a reopening and the information will be reviewed by the area that requested the information (i.e., Medical review). The area will make a

determination to either pay or deny based on the documentation submitted. If the determination is to deny, the supplier will have the option of requesting a Redetermination on the denial. This process allows for all appeal rights to remain in place.

g. Same/Similar denials for replacement parts
    i. When suppliers call in they are being told that because it has been less than 5 years the replacement part is not payable.
        1. Are new edits in place?
        2. NGS requested examples in order to research. **Update: As of June 6, 2012 Council has not submitted examples for research.**

h. Question and Answer
    i. Question #5 – If a beneficiary had oxygen for 14 months from a different supplier starting in 2006 and it was picked up because medical need ended, do we, as the new 2012 provider request a break in need/service (BIS/BIN) or can we start a new rental period because it has been 5 years?
        1. Suppliers feel we would need all new information and therefore a new rental would begin.
        2. Need to prove that initial condition did improve or has additional co-morbidities to begin a new rental.
            a. Dr. Brennan stated that this goes back to chronic stable state. Was the patient really in a chronic stable state when they were originally qualified for oxygen?
    ii. Question #15 - regarding non-sterile gloves for non-esrd patients will be moved to an open action item. **(ACTION ITEM)**
    iii. Question #6 – Qualifying oxygen testing being performed by nursing home.
        1. If a nursing facility is CLIA certified can they perform the test? **(ACTION ITEM)**
            a. Update: The standard for determining that a tester is "a qualified provider of Laboratory services" is that the tester must be qualified to bill Medicare for the test provided. Simply having all costs bundled into a Part A payment is not sufficient evidence of being a qualified provider of laboratory services. If the SNF if a Part A provider and holds a CLIA certificate, would this mean it qualifies? No, they have to be qualified to bill Medicare for the test provided. This alone would not qualify. Please request information from your carrier for Part A services for more details about this issue.

10. Schedule Next Meeting - All
    a. The next meeting is scheduled for Thursday, July 12th.