Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Council Meeting Minutes	
Date:	January 26, 2012
Time:	12:30 p.m. – 4:00 p.m. ET
Attachments Included with Agenda:	2012 Jurisdiction B DME MAC January Council Q & A 2012 Jurisdiction B DME MAC January Action Items

1. Introductions – All

2. Competitive Bidding Implementation Contractor (CBIC) Update – Elaine Hensley
   - **a.** Bidding Round 2 and National Mail-Order
     - i. Registration window closes February 9, 2012 at 9:00 p.m. ET. The previous dates published were target deadlines. You must register before you can submit a bid. The bid window is scheduled to open Monday, January 30, 2012.
     - ii. When a bid is submitted you must be licensed and accredited for the items you are submitting a bid for with the CBA.
     - iii. February 29, 2012 is the covered document and review date which will let you know if you are missing any financial documents. You will be notified of what is missing and be provided with a date by which the missing documents must be returned. Please note it does not validate the information – it only looks at document types for missing information.
     - iv. Credit reports clarification published January 25, 2012. Credit reports must be dated no more than 90 days prior to January 30, 2012. They can also be dated after January 30th regardless of what some industry consultants have stated.
     - v. Registration questions are still coming in about backup officials – adding a new authorized official to serve as BAO for bidding is not as easy as just submitting the CMS 855-S. There are specific requirements that must be met in order to qualify as a backup official. Please refer to the CMS 855-S enrollment application for specific instructions.
     - vi. The only people who must be on file with the NSC are the authorized official or backup authorized official. Each company can then sign up end users to enter bid information, but the authorized or backup officials are the only people who can certify and submit the bid.

vii. Bids are due by 11:59 p.m. ET on March 30th – Hard copies of required documentation must be received by the CBIC prior to 11:59 ET on March 30, 2012.

viii. Five web casts have been posted on the CBIC Web site for providers to review. The web casts review various rules and program guidelines to help providers better understand the program. Web casts have replaced open door forums for Outreach & Education.

1. How is the CBIC sharing questions and educating the provider community? Each provider should submit their questions to the CBIC via e-mail. If the CBIC sees the same question asked multiple times they will send out a listserv message to help educate suppliers.
2. Council asked about issues with non-contract suppliers billing for statutorily non-covered enteral nutrition and receiving a denial indicating these items must be provided by a contract supplier. This issue has been elevated to the standard system maintainer. This is being addressed for correct processing.

3. National Government Services Connex Update – Lisa Hare

a. Redetermination/Reopening enhancement

i. The Redetermination/Reopening enhancement went into effect and suppliers now have the option of initiating Redeterminations/Reopenings via NGS Connex. Attachments can be included and instructions are available on the Connex Web site.

ii. In early March suppliers will also have the option of checking status of their Redeterminations or Reopenings. Council asked if they could only request status of Redeterminations and Reopenings submitted via Connex or status of all Redeterminations and Reopenings. **Update: Suppliers can check status of all Redeterminations and Reopening regardless of how they were submitted to National Government Service.**

iii. NGS will continue enhancements to Connex in the future.

4. Medicare DMEPOS Beneficiary Fact Sheets Update – Michael Dorris

i. Fact sheets are located on the National Government Services Web site under "People with Medicare" – There are 14 total fact sheets so far.

ii. NGS developed and posted 3 new fact sheets last year. They were related to eye wear DME while receiving home health and Power Mobility Devices

iii. The Fact sheets must be approved by CMS and must adhere to certain language requirements – Plain Language Act 2010

iv. NGS plans to develop and post two additional Fact sheets in 2012, which include Medicare coverage of DME while in Hospice, and Medicare coverage of DME during repairs and replacement.

v. NGS has received some feedback on these 3 draft Fact sheets and revisions have been made. NGS will ask for additional feedback before finalizing.

vi. NGS has reached out to the American Diabetes Association, and American Lung Association regarding coverage guidelines; looking to them as another avenue to provide education since oxygen and diabetic testing supplies remain high on the CERT error rate.

5. DME MAC Medical Policy Update – Dr. Stacey V. Brennan

a. Dr. Brennan is present to provide an update.

i. Question #20 in the January 2012 Council Q and A asked about the CERT Task Force presentation at Fall MedTrade and the CERT Task Force Webinar held on December 13th. Nina Gregory advised Council for the 1st session 1222 suppliers signed up to attend and 777 participated, during the second session 500 suppliers signed up and 300 participated. There were a total of 324 questions after duplicates were removed and the Task Force continues to work on getting those finalized. Once completed a listserv message will be sent out to notify suppliers. Power Mobility Device (PMD) project – no update yet, but NGS is ready to move forward once notified by CMS to move forward. NGS will notify Council when they are notified.

ii. The DMDs are almost finished with thir decision on the draft automaticexternal defibrillator LCD.

iii. The DMDs are working on the ICD-10 initiative and trying to get the LCDs updated to reflect ICD-10 coding.

iv. The DMDs are working on adding standard documentation language to the LCDs – they believe this is a very important change and will make it easier to understand these requirements. NGS understands how much documentation providers must provide so their intent is to help providers comply with the documentation requirements. A listserv message will be forthcoming within the next 6 weeks and will provide some of this standard language.

6. Action Items - All

1. Council asked if National Government Services could publish a list of HCPCS codes for each category that the Interactive Voice Response (IVR) system uses when checking for same/similar equipment.

Provider Outreach & Education has drafted a Same/Similar Reference Guide. The resource guide is currently being reviewed by internally by internal operational areas prior to publishing. A listserv announcement will be sent out when the resource guide becomes available. An update will be provided at the next meeting.

Provider Outreach & Education has drafted a Same/Similar Reference Guide. The resource guide is currently in final review and should be published shortly. A listserv announcement will be sent once the resource guide becomes available. Update: A listserv announcement was sent out on February 2, 2012. This guide will also be posted on the Web site under Tools & Materials and the What's New page. ***CLOSED***

2. **Council asked if an enhancement could be added to Connex which would allow suppliers to receive both the beneficiary address along with the jurisdiction they reside in.**

The Connex team is currently researching this issue. The Connex team did not have an update regarding this issue. An update will be provided at the next meeting. No update. ***CLOSED***

3. **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. ***OPEN***

4. **Council wanted to know why suppliers who use Connex to obtain information (i.e., same/similar) are being referred back to the Interactive Voice Response (IVR) system when they contact the Provider Contact Center to verify or obtain additional information.**

Provider Outreach & Education researched this issue internally. After researching, suppliers who obtain information via Connex should be able to contact the contact center for assistance without being referred back to the IVR. Additional training will be provided to the contact center representatives in the next few weeks. Suppliers are reminded when contacting the Provider Contact Center for additional information after using Connex that they should inform the PCC Representative that they have used Connex and need additional information, they should have the Medicare Remittance Advice associated with the claim they are calling on available, and should be able to provide the Provider Contact Center Representative with the ANSI denial code (s) and description. ***CLOSED***

5. **Council asked about National Government Services providing a fax line for suppliers to respond to Medical Review additional documentation requests (ADRs). Council indicated that often suppliers cannot obtain the documentation requested in order to meet the 30-day requirement to respond.**

In an effort to meet the needs of the supplier community, National Government Services, the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) is now offering an alternative address for responses to Additional Documentation Requests (ADRs), which is included below. A listserv announcing the new physical address was sent out via listserv on Friday, January 20, 2012. National Government Services is currently working on implementing this feature into Connex. This feature is added to the Connex enhancement list. Once available, information will be communicated via listserv and Web site. Suppliers also have the opportunity to volunteer to participate in the esMD pilot project is conducting. CMS has developed a new mechanism for contractors to receive medical documentation electronically from providers and suppliers, in response to an Additional Documentation Requests (ADRs). National Government Services began accepting documentation electronically on September 22, 2012. Please note that participation of the esMD project is ***not*** *mandatory, but suppliers do have this option as well to submit ADRs electronically.* ***CLOSED***

New Physical Address
National Government Services, Inc.

8115 Knue Road
Indianapolis, IN 46250

6. 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. CLOSED

9. Open Discussion - All
   a. Refund issue – NGS is not recovering voluntary overpayments in a timely manner, resulting in interest being recouped in addition to voluntary overpayment amount. This started occurring about the same time the fax numbers for voluntary overpayments changed (December 15, 2011). Update: Issue was research and determined it did not result from change in fax #s but was due to a workload issue during the holidays. This issue has been resolved. If interest was recouped in error, suppliers should contact Customer Care and have the claim escalated to PRRS to get the interest returned.
   b. PECOS – Ordering/Referring suppliers are now receiving an N544 warning message on remits. As of Sunday, January 30, 2012 providers will no longer received warning messages on front end report from CEDI. The warnings will only be on the remit. Council asked if NGS was aware of when the warning messages would change to denials. NGS has not been notified of a timeframe on when Phase 2 will begin.
   c. Transition to 5010 and D0 – 80% of suppliers are using this format as of January 2012. CEDI will continue to provide education to the 20% currently not using the 5010 format to submit claims. Issues were identified due to suppliers entering rendering provider information into the 5010 claim format. DMEPOS suppliers should not enter rendering provider information for DMEPOS claims in loop 2310(B) and 2420(A). Other 5010 problems were related to CMNs and the NTE segment. The issue related to the NTE segment is in reference to NOC codes, suppliers can enter information into two different loops. NGS is in the process of drafting a listserv message in response to this issue. The CMN was an initial problem and has since been resolved. Council asked if suppliers received the CO-170 denial related to the CMN issue can these claims be resubmitted.
   d. Council asked if NGS had heard anything about the face-to-face visit requirement for all DMEPOS items. NGS indicated not yet. Note: Some state Medicaid programs are having issue with the face-to-face requirement. If Council has examples please share with David Barnett to elevate to CMS.
   e. RAC – The RAC is auditing claims for medications and dispensing fees (inhalation) on same claim but because the payment for the dispensing fee is applied to the deductible they are denying the medication. NGS is aware of this issue and has received some examples. If Council has other examples they should send those to Charity Bright. NGS asked if this was an issue only in J-B or across all DME MACs. However, Council wasn't sure.
   f. Long Term Care facility refunds are still an issue – timing issue related to when the Part A facility

bills their claim. NGS is researching the size and scope of this issue. Council again reiterated this is a huge problem.

g. Swipe Card Project – NGS is stopping outreach efforts related to this project because the pilot timeframe is coming to a close. NGS continues to analyze the data that has been obtained from this project. DMEPOS suppliers currently involved in this pilot should continue until notified by NGS. We appreciate the DMEPOS suppliers who volunteered to be part of this pilot.

h. Question and Answer – Question #1 – Breast pumps – electric is better than the disposable ones. Dr. Brennan asked if there were outcome studies that supported this? Council referred her to Medela. (Follow up: as per the DMD workgroup, the usage of these traditionally has been considered to be convenience so is not a covered benefit).Question #2 – Medical necessity did not change, the hospital bed is still the same, why do we need a new order? This was and is a controversial question that was difficult for NGS to answer. The IOM states that if there is a change in the item/order, a new order is required. Technical components and documentation requirements have changed which prompted NGS to respond as they did. Council will take another look at this question and re-submit. Question#14- Response stands. Medical policy cannot answer- this may be a regulatory issue. Paula will research and provide a response to another question that was similar from about a year ago and share with NGS. PDAC may need to be involved to help with coding issues to bill appropriately. Correct coding is imperative. Question #19 – Vicky and Charity will speak with Medical review and appeals to see how they look at these claims with and without an ABN.

i. Updates with contract from David Barnett – 5 year contracts – base year with 4 optional years. NGS just finished base year. Project officer to COTAR – Martin Furman has just accepted a new position. New CMS representative assigned January 3, 2012 her new title is COR (Contract Office Representative) and her name is Susan Pelella. She covers J-A and B. Jurisdiction C and D are covered by a new COR his name is Jim Rawls.

10. Schedule Next Meeting - All

a. The next meeting is scheduled for Thursday, May 3, 2012
b. Thursday, July 19, 2012 – **Tentative**
c. Thursday, October 25, 2012 **– Tentative**