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

1. Introductions – All

2. Common Electronic Data Interchange (CEDI) Update – Stacy McDonald, Sally Hopkins
   1. Front end upgrade implemented July 1, 2012 – appears to have incurred a seamless transition and no impending issues.
   2. June 29 last 4010 claims received as of 5:30 on June 29 only 5010 formats allowed to be received
   3. 80 trading partners tried to send 4010 claims since July 1 and outreach is occurring to help the transition
   4. July 2 trading partner recertification was initiated for 2012.
      i. www.ngscedi.com is where the document is that needs to filled out for the recertification process.
      ii. The owner of the submitter ID is the person that needs to complete the recertification form.

3. National Government Services Web site Enhancement Update – Charity Mahurin
   1. CERT denial reasons can now be obtained on the NGS Web site by utilizing the CERT Denial Reason Finder
   2. Included new electronic opportunity for recoupment as of July 1, 2012
      i. No longer need to mail or fax can simply complete the on-line form.
   3. Additional quick links added to the DME Homepage.
   4. POE is working on reorganizing the Clinical Education and Tools and Materials pages to make it more efficient for suppliers to locate resources.
   5. Council indicated they like the changes made to the Home Page layout.
   6. Council requested clarification on where to locate the Council Q and A documents.
      i. Resources > Tools and Materials > Question and Answer Resources
      ii. Rotating Banner on DME Home page.

4. 2012 Jurisdiction B DME MAC Conferences – Terri Shoup
    1. Conferences
        i. July 17 – Columbus, Ohio (68 attendees, 5 exhibitors)
        ii. July 19 – Lexington, KY (86 attendees, 3 exhibitors)
        iii. July 31 – Middleton, WI (68 attendees, 1 exhibitor)
        iv. August 2 – Minneapolis, MN (78 attendees, 3 exhibitors)
        v. August 15 – Novi, MI (121 attendees, 3 exhibitors)
        vi. August 28 – Alsip, IL (50 attendees, 3 exhibitors)
        vii. August 30 – Indianapolis, IN (42 attendees, 5 exhibitors)
    2. Medical Directors attending (who and when)
        i. Dr. Brennan – OH, WI (NGS)
        ii. Dr. Perez – KY, MI, IN (CERT)
        iii. Dr. Cope – IL, WI (Advance Med)

5. DME MAC Medical Policy Update – Stacey V. Brennan, MD FAAFP:
    1. Power Mobility Demonstration Project
        i. No date has been announced. Once announced we will have a 30 day implementation date.
        ii. Questions about the process were asked but NGS stated instructions have not been announced publically as of yet so they are not at liberty to share as of yet.
        iii. Another open door forum will occur – Dr. Brennan suggested sharing some of the comments from today on this call.
        iv. Project with be turned over to another division in terms of the electronic template
    2. Revised Glucose Monitor LCD which had been published but not implemented was retracted.
    3. Oral Appliance for OSA LCD was updated
        i. Tongue retaining device has been removed
        ii. Interpretative personnel was updated to include some additions
        iii. A section was added describing exclusions.
    4. Knee – Ankle – Foot LCD received some updates
        i. Coding verification requirement was added but then rescinded for certain HCPCs.
    5. The "Standard Documentation Language" published in March 2012 is being enforced although several policies have not been updated to include this language yet.
        a. ICD-10 has been delayed until October 2014

6. Action Items – All

1. Council requested that National Government Services develop and send out E-mail updates on common CERT audit scenarios.

The Jurisdiction B DME MAC Provider Outreach & Education team is in the process of developing educational materials based upon CERT audit findings. This information will be included in the September bulletin and we will look into providing CERT education on a more ongoing basis. (CLOSED)

2. Council requested clarification on what "evidence of delivery" means, specifically does the "delivery address" have to include the full address or is the city and state sufficient.

This issue was taken to the DMD workgroup and discussed below is the response the four DME MAC Medical Directors have provided.

Although suppliers are not required to provide a single record to meet all requirements to show proof of delivery for method 2, there must be a way to easily identify that these requirements are met. For instance, if the patient's full address is on the supplier's invoice and a customer database ID (reflecting the street and city address) links the invoice to the delivery slip/form from the shipping service, both the invoice and tracking slip are required. All elements must be met between the two pieces of documentation and there must be some way to link them. (CLOSED)

3. Council asked about the denial suppliers are receiving for non-sterile gloves (A4927) for non-end stage renal disease (ESRD) patients. Suppliers need a patient responsibility (PR) denial for secondary insurance.

The Centers for Medicare & Medicaid Services (CMS) issued instructions regarding End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services, the instructions included non-sterile gloves (A4927) and indicated that they are no longer separately payable to DMEPOS suppliers. National Government Services has received numerous inquiries regarding this issue and understand that suppliers are not expecting payment but instead are looking for a patient responsibility denial for secondary insurance purposes. According to CMS instructions these claims are being processed correctly and suppliers are receiving the correct denials. However, we have elevated these concerns to CMS and once we

receive a response we will update the supplier community via an e-mail update.

Update: This issue is being reviewed by CMS at this time we do not have an update. National Government Services will provide a response to Council and the supplier community as soon as CMS provides a response. (OPEN)

9. Open Discussion - All
   a. Hot topic discussion
      i. CMN section C response: DMDs reviewed and their response was the typed plus handwritten data must be authenticated by the physician because there is no way for them to know when the information was entered into Section C.
         1. The council still disagrees. Where is it stated that both handwritten and typed information would need to be authenticated as to the validity of when the information was entered into Section C?
         2. The interpretation of annotating changes with initials and date of physician is the physician must initial and date if a change is made after the physician signs and dates the handwriting. *Update: This issue is currently being looked at by the 4 DME MAC Medical Directors and CMS and we should have better guidelines soon on changes to an order and what is considered acceptable.*
      ii. Hospital discharge notes as proof of office visit
         1. Per Nina Gregory, NGS is accepting these as proof of visit
            a. Most of denials she has seen is because no signature or RN signature rather than physician signature.
      iii. Proof of delivery

         DMDs feel the instructions are clear on Medicare proof of delivery. No credit or consideration is given to equipment provided to beneficiaries prior to Medicare effective date. Update: To further clarify the CMS IOM Publication 100-08, *Medicare Program Integrity Manual* Chapter 5, Section 5.3.1 provides the following information in regards to delivery date/date of service. The "Delivery Date/Date of Service" on the claim must not precede the "Initial Date" on the CMN or DIF or the start date on the written order. To ensure that an item is still medically necessary, the delivery date/date of service must be within 3 months from the "Initial Date" of the CMN or DIF or 3 months from the date of the physician's signature.
      iv. Need for print out of oximetry results
         1. Currently, this is **not** a Jurisdiction B requirement, if you have examples of claims denied for this reason please share with Nina Gregory and Charity Bright.
      v. Question #3 on Oxygen CMN
         1. Nina Gregory indicated that Jurisdiction B is currently not looking at Q.3 as part of the audits, however suppliers are being told otherwise by Customer Care. If Council

has examples of claims being denied for this reason or if Council has specific information where this information is being provided by Customer Care please provide to Charity Bright and Nina Gregory.

vi. CMN is provided along with a separate detailed written order
    1. If detailed written order is signed after setup date, they are looking for the dispensing order. The dispensing order can be verbal or written. If you have examples of denials here, please share with Nina/Charity for research.

b. Problems with mail room and documents being misdirected/lost
    i. Could a fax line be added to eliminate mail room mishaps?

c. 2012 Jurisdiction B DME MAC July Council Q & A
    i. Question #2 wheelchair/walker dispensing was revised the following is the revised response.

Answer: The patient must first qualify for the wheelchair even if he/she only needs the walker for minimal use such as getting into the bathroom to pivot/transfer. The documentation should support the general need for the wheelchair as the primary MAE and then describe the needed usage for the walker. For example, if the walker is being used for the bathroom because the wheelchair cannot fit, we would need documentation regarding coverage criteria for the wheelchair being met, room dimensions, and that the patient is able to pivot and transfer with the walker to get to the toilet. In most cases the beneficiary would not have a need for both items.

1. The answer is yes a wheelchair and walker may be dispensed at the same time in rare circumstances.
    a. The patient must first qualify for the wheelchair. The documentation should support medical need for wheelchair first and then documentation as to need for the walker. (i.e., patient qualifies for wheelchair but needs walker for gait training, bathroom, etc.)

ii. Question #1 – the answer does not explain why claim was split into two lines.
    1. The reason the claim was split is due to system editing/programming.

iii. Question #11 – same day assignment/non-assignment (Council likes the answer)
    1. *Update: Jurisdiction B DME MAC POE has interpreted the Internet-Only Manual, Publication 100-04, Medicare Claims Processing Manual, Chapter 1, and Section 30.3.2 to mean that a non-participating supplier may on a claim- by- claim basis chose to accept or not accept assignment, this could be for items provided on the same day. For example, diabetic testing supplies and therapeutic shoes dispensed on the same day. The supplier may submit a claim for the therapeutic shoes as assigned and a claim for the diabetic testing supplies as non-assigned.*

d. Recent Publications
    i. June 29 – "billing a not otherwise classified code list serve message
        1. Council asked for clarification about how this is being implemented by NGS.
            a. Claims stop for manual intervention (nurse). NGS is seeing NTE segment that state "walker", "hospital bed", etc…. These descriptions have established codes so these are being kicked back. Due to many wheelchair parts not having codes, K0108 may not experience a lot of overrides.

ii. Pre-pay audit on high dollar claims.
    1. Council asked if any additional specifics (i.e., threshold) could be shared. National Government Services indicated that all of the information they are at liberty to share per CMS has been provided.
iii. Items Provided on a Recurring Basis and Request for Refill Requirements
    1. List serve message published June 7 (stating revised) with an effective date of August 2, 2011. Refill documentation – consumables vs. non-consumables.
    2. DMDs revised many questions on what is used up and consumed.
    3. Because this came out in June 2012, is Medicare going to hold us accountable for documentation on functionality between June 2011 and June 2012.
    4. "Functionality" of equipment – this must be documented if we delivery to patient. If they walk in, this does not need to be documented.
iv. E1161 issue is being discussed and an announcement will be forthcoming.
v. Redetermination appeal submitted based on audit denial and subsequent CO-50 was received stating appeal submitted too quickly.

10. Schedule Next Meeting - All
    a. The next meeting is scheduled for Thursday, October 25th.