Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Council Meeting Minutes	
Date:	May 19, 2011
Time:	12:30 p.m. – 4:00 p.m. ET
Attachments Included with Agenda:	2011 Jurisdiction B DME MAC May Council Q & A 2011 Jurisdiction B DME MAC May Action Items

1. Introductions – All

2. Common Electronic Data Interchange (CEDI) Update – Sally Hopkins
   - **a.** Network Service Vendor – You must access CEDI through an approved Network Service Vendor (NSV) as of May 1, 2011.
     - i. Transition went smoothly.
   - **b.** Access www.ngscedi.com – for list of approved NSVs.
   - **c.** Re-certification for Trading Partners (Clearinghouses, Billing Services). On website (www.ngscedi.com – EDI Enrollment – CEDI Recertification Form).
     - i. Scroll down to Form #5 (instructional guide is available to help fill out the form).
     - ii. Only person/company who can complete this form is the owner of the trading partner ID.
     - iii. Must be completed by Aug. 31st or ID will be turned off.
   - **d.** April 22, 2011 self service pass word portal went live.
     - i. Located on CEDI website – gateway self service link.
     - ii. Must recertify trading partner ID in order to access this link.
     - iii. Once change ID, you will get an e-mail that password has changed.
     - iv. FAQs are posted on their website.
   - **e.** 5010 testing with vendors began in Jan. 2011.
     - i. Began 5010A1 version in May.
     - ii. Vendors and clearinghouses will test on behalf of trading partner.
     - iii. Informational Calls on 5010 format – April 27th and July 20th.
   - **f.** Update on claim alerts for physicians not enrolled in PECOS.
     - i. October 58.5% ☐ March 9.42% edits ☐ April 9.41% edits (less than 10%).
     - ii. Sally will look into this and share with Charity who will share with us. Sally provided the above information later in the meeting therefore this is now completed.

g. Kentucky PECOS enrollment for physicians – what happened to their enrollment information that was pending? (Issue with transition from NGS to CIGNA due to Part B/physician contract turnover.)

i. NGS transitioned around 200 enrollments to CIGNA, NGS no longer owns this information so you must contact CIGNA for enrollment activity/updates.

3. Interactive Voice Response (IVR) Same/Similar Clarification – Charity Bright

a. Does same/similar option check for power wheelchairs on file if put in a manual wheelchair code in system?

i. It will not look from power to manual or manual to power – only manual to manual and power to power.

ii. **Could you publish a list of HCPCS codes that it checks? (Action Item)**

1. They will look into this. (it was shared that another DME MAC has done this)

iii. IVR resources are available on the NGS website.

iv. Orthotics and Prosthetics same/similar can be obtained through customer care with the beneficiary on the phone as well (it is not accessible through IVR or Connex). This is a CMS requirement.

1. Council questioned: "What is the difference between getting information on the CMN related item and a supply?" The supply requires a three way call to find out when they received an item. Distinction could lie in edits?
2. CMS has provided these guidelines – not NGS.
3. **NGS will take this question to CMS for a response. (Action Item)**

v. Same/similar option - checks Jurisdiction B records.

vi. CMN status option - checks CWF.

vii. Connex will check Jurisdiction B and if nothing found will check CWF. They are trying to move the IVR to do the same as Connex here.

4. National Government Services Connex Update – Lisa Hare

a. Connex on April 2nd added the same/similar option.

i. Will search local record and if information found it will display, if it does not find anything then will check CWF.

b. Adding more enhancements in June.

i. Adding request access for multiple provider accounts will be able to enter faster.

ii. Suspend user account if inactive over 180 days.

iii. Enhancement on Beneficiary info – they will now show the Jurisdiction that they reside in. Many questions arose as to why Connex can't display patient address?

1. **Lisa will ask the team to see if there is a way we could enter the address and can they do a check to confirm the address since they cannot provide the address. (Action Item)**

2. Many other vendors who offer this same eligibility show the address – not sure why other vendors can display this but NGS can't.
3. **Not sure what the real reason is – desk reference disclosure from CMS? NGS will look into this. (Action Item)**

iv. If Medicare is secondary, will show primary insurance information – name and address.

v. Tentative enhancement list.
1. Approve or decline multiple provider accounts at one time so don't have to do each individually.

vi. 253 participants on recent webinar related to CONNEX, so offering another "repeat" webinar in June.

vii. Additional enhancements will be addressed in future releases – those listed below are higher priority items.
1. Display ANSI code – right now only see description.
2. Another way to identify a provider account for those who have lots of PTAN codes.
3. Adding appeal status and ability to initiate an appeal.
4. Ability to show corrected Medicare HICN number (high priority item).

viii. To sign up go to Resource section of NGS website and click on Connex.

5. DME Swipe Card Project Update – Lisa Hare

a. This is a pilot program with CMS.
b. Part B and DME suppliers in Indianapolis area are part of demonstration.
c. Information has been sent to initial testers and working with them to prepare for the launch.
d. The next group will receive information on this in June and then everyone will receive information in July.
e. Looks just like a credit card – it is white with the CMS logo on it. The card is sent in an NGS envelope.
f. There is now a dedicated website for this program – www.dmepilot.ngsmedicare.com.
g. Indianapolis pilot project expected to last a year once it rolls out.

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

a. A lot of bulletin articles have been released lately.

i. Capecitabine (Xeloda®) oral cancer drugs – manufacturer informed the PDAC that there is a shortage so had to approve the European formulation which is a blister pack.

ii. LCA change to Power Wheelchair Group 2 and Group 4.
1. Implemented recent change based on conversations with CMS.

2. Changed to non-covered as of 2/4/11 for Group 2 and 4.
3. CMS reconsidered and changed effective for dates of services as of June 1, 2011 – restored opportunity for coverage (as upgrades) with an ABN.
    a. Leaves a number of wheelchairs between 2/4/11 and 6/1/11 that are in the category of non-coverage.
    b. DME MAC Medical Directors do not have any recourse to retro this back to 2/4/11 – despite numerous discussions during this time period.
    c. Stay tuned.
4. Kudos to Jurisdiction B for alerting providers to this non-coverage of Group 2 and Group 4 product lines. Only Jurisdiction to publish.
5. K0822 with seat cushion – now deny both instead of paying for K0823. Why deny the chair?
6. Please provide evidence based articles – the DME MAC MDs would welcome this.
    a. Address to send this information is located on the web.
7. June 1st change on detailed description order.
    a. Deleted requirements for billed and allowed pricing; deleted requirements for specific mfg/model# on all lines. Now will follow standard requirements for a Detailed Written Order.
        1. Denials won't occur now when the terminology changes between detailed order and repair time frame.
        2. If written description states head rest – if we begin with a medium but need to change to large – we used to have to get a new Detailed Product Description (DPD), but now will not need to – less specificity. – does not need to list manufacturer, model and space. However, if specifics are listed on the DPD and then you make a change you need a new DPD.
        3. Requirements on DPD are similar to detailed written order – no pricing any longer, manufacturer. Need to provide enough information so they know what they are paying for.
        4. Jurisdiction B may consider putting out a clarification article.
        5. Council mentioned that K0020 – should be separately billable due to adjustable not fixed. Policy lists HCPC as fixed height and in the bundling table it shows as included in the base. This was to be fixed during next policy revision but appears to be missed again.
8. Group 4 can still go to ADMC – how do we send?
    a. Has not been discussed as of yet.
    b. In the past for Group 4 is was indicated to use medically necessary for

Group 3.

iii. MLN SE1112 on the face to face requirements for physicians.
    1. Comments were requested by Dr. Brennan. Some are as follows:
        a. Too lengthy – 7 pages. Most doctors are not going to read due to length.
        b. The breakdown of the three groupings has been helpful.
        c. In writing it states only the physician can do the 7 order element order.

iv. The Council is questioning why so much medical review and audits going on?
    1. CERT is very important for DMDs.
    2. DMDs are working with RACs in terms of relationship building.

b. Medical review – can see what audits are occurring under the medical review section of the website. The key areas right now are:
    i. Diabetic supplies.
    ii. Std Power Wheelchairs K0823.
    iii. Urologicals.
    iv. Support Surfaces – Group 2.
    v. CPAP.
    vi. Diabetic shoes – This is now finished.

c. Arterial compression device devices – have very specific uses – DMDs are exploring coverage opportunities.
    i. Questions by Council member: Would they be considered for any cardiac conditions – according to Dr. Brennan – this does not appear to be part of the discussions.
    ii. Distinction needs to be whether venous or arterial.

7. 2011 DME Conferences – Terri Shoup

a. 7 DME conferences (one in each state) covering June through October.
b. One day conference for $120.00 per person.
c. Multiple sessions per time period.
d. Roundtable sessions available at the end of the day – good networking opportunity.
e. Dr. Brennan will be offering a class at each conference (schedule permitting).
f. Offering exhibitor space – up to 5 booths.
g. Offering each State association a free booth at their respective state conference.
h. Information will be on website by end of this month.
i. No print class materials will be provided – go green. If you want printed copies, information will be on website and you can download and print prior to conference.
j. Michigan meeting with be held in conjunction with Part A and Part B (three day seminar).
k. Course descriptions and biographies on speakers will be listed on website. www.medicareconvention.com – choose DME section for details. Links will become live by end of month. Registration will occur here as well.

Other webinars forthcoming:

Connex.
Small suppliers – oxygen call May 31st.
CBTs to be released soon – MSP, website, narrative scenarios.
Attending VGM conference.

8. Congressional Outreach Update – Michael Dorris

a. A letter was sent to 3700 Medicare diabetic beneficiaries who were using multiple suppliers.
   a. Outcome: 2355 removed themselves from having more than 3 suppliers.
   b. Ran letter again in December – data not accumulated yet but expect same success.
b. Fact sheets – People with Medicare section.
   c. Fact sheet – Medicare coverage for DME when receiving home health care – good feedback – Approval to post on website so will soon be on website.
   Will share with all providers.
c. Fact sheets working on developing.
   d. PMDs.
   e. ABNs for Medicare beneficiaries – will probably need more feedback and will request when ready.
   f. Request for refill – back of MSN – beginning stages of this fact sheet.
   g. Council members offer opportunity for feedback prior to publishing.

9. Action Items – Provider Outreach & Education

1. Claims should not be submitted with both a KX and GA on the same claim line, with limited exceptions.

Generally, the KX modifier is appended to inform the DME MAC that the patient meets the coverage criteria outlined in the LCD. The GA modifier indicates the supplier expects that the item will be denied as not reasonable and necessary and to inform the DME MAC they have properly executed an ABN. Therefore, in most cases it would not be appropriate to append the GA and KX modifiers on the same claim line as they are contradictory.

However, for glucose testing supplies the KX is used to indicate that the beneficiary is an insulin-dependent diabetic. Therefore, if the supplier believes the claim will be denied as not reasonable and necessary due to over utilization it would be appropriate to execute and ABN and append both the GA and KX modifiers. Another exception would be when billing for urological supplies. For urological supplies, the KX modifier again is used to indicate the patient has a specific diagnosis (permanent urinary incontinence or urinary retention; , therefore in the case of over utilization it would be appropriate to execute an ABN and append both the GA and KX modifiers.

It would not be appropriate to append a KX and GA modifier to items like wheelchairs and hospital beds simply because you can't determine if the beneficiary had or has same/similar equipment.

What should suppliers do to protect themselves when they provide replacement equipment because the prior equipment is lost, stolen, irreparably damaged or past the 5-year RUL?

It would not be appropriate to execute an ABN when providing replacement equipment just in case Medicare denies for same or similar equipment. Medicare allows for the payment of replacement equipment provided the original item was lost, stolen, irreparably damaged or when the item has reached the 5-year RUL. When replacing an item due to it be lost, stolen, irreparably damaged, or when the item has reached the 5-year RUL, the supplier must submit the claim with the RA modifier and document the reason for replacement by entering a narrative explanation in Item 19 of the CMS-1500 claim form or NTE segment of the electronic claim.

A list serve message titled, "Billing Clarification: KX AND GA Modifier on Same Claim Line" was sent out on July 1, 2010 and advised the following:

Examples of when it would be appropriate to append both the GA and KX on the same claim line include but are not limited to the following:

- *Over utilization of blood glucose testing supplies for an insulin dependent diabetic patient*
- *Over utilization of urological supplies for a patient who has permanent urinary incontinence or urinary retention*

Same and Similar

*Medicare does not pay separately for backup equipment or items that are deemed to be same or similar to equipment that is already in use as they are considered **not** reasonable and necessary.*

If the supplier has evidence to believe that Medicare will not pay for an item because the patient already has or has had same/similar equipment, which has not met the reasonable useful lifetime expectancy, an ABN should be executed to inform the Medicare beneficiary that Medicare will likely deny payment of the item.

It would not be appropriate to execute an ABN simply because you are unable to determine, or you think the beneficiary may have had or has same/similar equipment. This would be considered a generic ABN. Such generic ABNs are not considered to be acceptable, as the ABN must clearly specify the service and a genuine reason that denial by Medicare is expected.

Scenario One:

Joe Smith, a Medicare beneficiary comes into ABC Supplier's store with a prescription from his doctor for a manual wheelchair. ABC Supplier checks the IVR prior to dispensing a manual wheelchair to Joe Smith and determines that Medicare previously paid another supplier 13 rental payments for a manual wheelchair, less than 5-years ago. Therefore, ABC Supplier advises Joe Smith that Medicare is likely to deny this manual wheelchair as not reasonable and necessary because it is considered same/similar equipment. Joe Smith indicates that he wants the manual wheelchair and is willing to be held financially responsible. Therefore, ABC Supplier properly executes an ABN. In this scenario, it would be appropriate for ABC Supplier to submit a claim for the manual wheelchair with both the KX and GA modifier appended to the manual wheelchair HCPCS code and receive a patient responsibility denial

from Medicare.

Scenario Two:

Jane Smith, a Medicare beneficiary comes into ABC Supplier's store with a prescription from her doctor for a manual wheelchair. ABC Supplier checks the IVR prior to dispensing the manual wheelchair to Jane Smith and the IVR does not indicate any same/similar equipment on file. ABC Supplier asks Jane during the intake process if she has ever had a wheelchair before. Jane indicates that several years ago she broke her leg and used a wheelchair but she doesn't remember when or if Medicare paid for it. She also doesn't know what happened to the wheelchair. Therefore, ABC Supplier advises Ms. Smith that Medicare may deny the wheelchair but they aren't sure so just in case they execute an ABN. In this scenario, it would ***not*** *be appropriate for ABC Supplier to submit a claim for the manual wheelchair with both the KX and GA modifier appended to the HCPCS code for the manual wheelchair and receive a patient responsibility denial.*

A request for clarification regarding the definition of a "Generic ABN", how specific the information included in Blank (E) of the ABN must be, and whether it would ever be appropriate to append the KX, GA modifiers on the same claim line was sent to CMS. We are waiting for a response from CMS as soon as the information is received we will forward it to Council.

An update will be provided during the meeting. An update from CMS was not available at the time of the meeting. OPEN

2. **Council requested information concerning change in address updates. Who needs to be contacted (i.e., CEDI, NSC, NPPES, DME MACs to update EFT agreements, etc)? In what order should these contractors be contacted?**

National Government Services continues to work on a resource document for suppliers to follow when a change of address is required.

Update: *On April 4, 2011 a News Article titled "Address Change Checklist for DME MAC Suppliers" was sent out in an email update. This article provides DME MAC suppliers with instructions on which entities and in what order they should be contacted when a change of address occurs.* ***CLOSED***

3. **Council requested an enhancement to the Same/Similar Option on the IVR. The same/similar option provides same/similar information on items that were denied. Council asked if the IVR option could be modified to indicate whether the same/similar item was approved for payment or denied.**

It is possible to make this modification to the IVR same/similar option however first we will need to do a cost benefit analysis. We need to determine how many suppliers are actually selecting to speak to a Customer Care Representative to clarify the information provided by the IVR. If it is determined to be a beneficial change to both NGS and the supplier community a team of subject matter experts will get together to decide what exact changes need to be made. We do not have an estimate on how long it will take to accomplish these tasks but once approval is received it will take

approximately 4-6 months to implement the change. No update at this time.

Currently the IVR and Connex look for CMNs that are in a payable status. However, National Government Services is aware that CMNs in denied or deleted status sometimes cause a provider's claim to deny. The requested enhancement has been added to the IVR enhancement list. Updates will be provided, as they are available.

Update: *The IVR same/similar option cannot be updated to provide the supplier with information indicating whether the CMN paid or denied due to the desk reference disclosure requirements. However the IVR/Connex team is looking into adding some additional programming logic that will provide same/similar CMN information regardless of whether the item paid, denied or a CMN is pending. This will assist suppliers in determining whether or not an ABN should be executed.* ***CLOSED***

4. **Council asked if it would be possible to archive training letters, FAQs, and What's New articles for longer than one year. The DMEPOS supplier community relies on this information to successfully bill the DME MAC. Council also requested that the Council Q and A postings be moved to a better location on the National Government Services Web site.**

Corporate Communications stated that CMS mandates that certain items be maintained on the Web site for designated periods of time. The items that Council is requesting to have available longer are not mandated by CMS. Charity Mahurin will meet with Shelly Elliott to determine if some items can be kept on the Web site for longer periods of time.

Update: *National Government Services has added an archive to the* ***News Articles*** *section of the NGSMedicare.com Web site. Effective, April 11, 2011, news articles will remain accessible on the site for an additional two years beyond the 365-day period that was previously in place. Therefore, News Articles will be available for a total of 3 years. An email update was sent to the supplier community announcing this new feature on April 11, 2011.*

The Jurisdiction B Council Q and A documents will remain on the Web site indefinitely. ***CLOSED***

10. Open Discussion - All
    a. Any update on DME face to face requirement due to PPACA?
        i. No update yet.
    b. Clarification on RUL for oxygen stationary and portable.
        i. What date do you use for the RUL on portable system – probably the stationary system? Charity will verify and let us know. Action Item
    c. CO-97 denials.
        i. Tamara is researching – issue with system and production alert came out May 18th.
        ii. Charity will get back with us with an update. Action Item
    d. LCA change for enteral issues
        i. Specialty formulas when dispensing over 35 kg per calorie.

1. Enteral policy has experienced changes where information has been removed from LCD but not NCD.
    a. 20 -35 kg per calorie.
2. Disease specific formulas used to have requirements listed in the policy – no longer there. Dr. Brennan will bring up with her colleagues. **(Action Item)**
3. LCA issues they can work on and will present back to us – but may not be as detailed as DME community would like.
4. How do we bill for over-utilization – is it a two line billing?
    a. POE is not aware of this issue and is seeking examples. **(Action Item)**

e. Oxygen testing - #4

i. In post pay audit – need to show that person who performed the test was appropriately trained? Looking for a chain of responsibility.
    1. Can the answer be revised? Council will withdraw question and resubmit. **Council did not submit a revised question with the minutes.**

ii. Can we withdraw question #6? Agreed to withdraw and resubmit. **Council did not submit a revised question with minutes.**

iii. Question 7 – won't pay for replacement but will pay for repairs. If repair is more costly to repair – will Medicare pay the higher fee for the repair? This is a question for CMS. **(Action Item)**

iv. Question 9 – can we bill as K0823 with GL? **(Action Item)**
    1. Region C said yes you can do that.

v. RA/RB question – conflicting info between regions on whether instructions on use of RA and RB modifiers are specific to competitive bid areas/products, or whether these new definitions apply to all. **(Action Item)**

vi. Question 11 –
    1. Statutorily not covered – so don't need ABN – but it will deny stating you are billing incorrectly – must be rented, not purchased.
    2. Use ABN as voluntary notice – they can choose #2. They have one year to change decision.
    3. Send to CMS – if beneficiary wants to purchase – can we get a PR denial? **(Action Item)**

11. Schedule Next Meeting - All

a. The next meeting is scheduled for Thursday, August 25, 2011.
b. The final meeting for 2011 is tentatively scheduled for Thursday, November 17, 2011.