Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Council Meeting Minutes	
Date:	November 17, 2011
Time:	12:30 p.m. – 4:00 p.m. ET
Attachments Included with Agenda:	2011 Jurisdiction B DME MAC November Council Q & A 2011 Jurisdiction B DME MAC November Action Items

1. Introductions – All

2. Common Electronic Data Interchange (CEDI) Update – Sally Hopkins
   - **a.** 5010A1 migration
     - i. Last day to submit 4010 claims is 12/30/11
     - ii. CEDI will come down at 3:00 p.m. ET on 12/30/11 so claims must be received before that time
     - iii. A list of 5010 vendors who passed testing is found at www.ngs.cedi.com.
     - iv. All suppliers must complete a migration form before submitting 5010 claims. Suppliers must indicate the date they wish to begin 5010 and as of that date they must submit claims to CEDI in the 5010 format. CEDI is currently processing 5010 migration forms almost immediately but as the number of migration forms received increases it may take between 7-10 days to complete.

3. National Government Services Connex Update – Charity Bright
   - **a.** Redetermination/Reopening enhancement
     - i. The Redetermination/Reopening enhancement went into effect over the weekend. Suppliers now have the option of initiating Redetermination/Reopening requests via Connex. However there are a few technical issues that should be resolved very soon. Suppliers may want to wait a few days before they begin using the new enhancement.
     - ii. A Quick Steps job aid was developed to assist Connex users and is now available.
     - iii. Currently Part B providers can check status of Redetermination/Reopening requests via Connex. DME hopes to have this feature available to DMEPOS supplier by the end of December or early January 2012.
       1. Council indicated that some suppliers who are trying to use Connex are having issues. Council asked if Connex requires users

to use a specific type of Web browser.

Update: The National Government Services Connex Web site is accessible from several different Web browsers. However, only certain browsers are supported. Please view the chart below to determine the browser requirements for utilizing Connex.

Also in the Connex User guide we have the following:

* Note to Internet Explorer (IE) Users: When accessing the www.NGSConnex.com application home page, if you receive a Page Cannot Be Displayed error, please follow these steps:

- From the IE browser, go to the menu and select Tools > Internet Options
- Click on the Advanced tab
- Under Settings, scroll down to the Security section and check the Use TLS 1.0 checkbox
- Re-launch the www.NGSConnex.com application

4. Qualified Independent Contractor (QIC) Transition – Charity Bright
   - **a.** The new QIC is C2C Solutions, Inc.
     i. All requests for reconsideration on or after November 15, 2011 should be sent to the new QIC.
     ii. If a request is sent to RiverTrust after November 15, 2011 it will be forwarded to C2C Solutions.
     iii. Council indicated they were concerned with the short notice of this transition. National Government Services advised that they were provided with the same notification.
     iv. Council asked if National Government Services could indicate by highlighting or changing the font color of the revised language when a revised listserv article is sent out. National Government Services advised that they would start doing this.

5. DME MAC Medical Policy Update – Dr. Stacey V. Brennan
   - **a.** Dr. Brennan is present to provide an update.
     i. New HCPC code update for 2012 – no major changes
     ii. Comment period for 3 draft policies has ended; the DMDs are reviewing comments and will respond to comments but they have not determined how long that will take.
     iii. CR 7452 Prospective Billing and Refill Policy – any changes would have to come from CMS so until such time CMS makes a change to the refill policy it is imperative that suppliers follow the refill requirements:
        a. To whom you spoke
        b. What of the refill is for – be specific
        c. How much of the supply they have remaining

d. What day you spoke with them
e. Must occur within 14 days of anniversary/projected new delivery date
f. DME industry still has huge concerns over this requirement applying to oxygen contents. Council asked who those concerns should be forwarded to? Dr. Brennan advised that all 4 DMDs have received those concerns. Dr. Brennan indicated she would find out who DMEPOS suppliers can forward these concerns to at CMS**. Update: supplier concerns may be forwarded to the Office of Financial Management at CMS.**

iv. CERT – DMEPOS suppliers should expect to hear rating soon. The error rate has been around 60% in the past. National Government Services is hoping this percentage has gone down.

v. Pre-pay demonstration for power mobility devices was announced November 15, 2011.

a. Jurisdiction B states chosen were Michigan and Illinois
b. National Government Services will share additional details and provide education to the impacted states as well as other states within Jurisdiction B as soon as they are available.

c. Council had several additional questions.

1. Is this demonstration for all PMDs or just Group II – discussions are occurring and National Government Services will provide an update. (Update: all PMDs other than Group III single and multi-power)
2. Initial pre-payment roll out starts with dates of service 1/1/12.
3. Council asked if the DME MACs have ramped up staffing to accommodate this project. National Government Services advised that they are in the process of doing that now.
4. Council asked about Phase II and if National Government Services had any idea what direction this might take or when Phase II might begin. National Government Services informed Council that they believe that Phase II will begin somewhere between 6 and 9 months after Phase I but they have not been given any exact timeframes or dates.
5. Council indicated that CMS Fact Sheets state that during Phase II the ordering physician will initiate the prior authorization for the PMD and Council indicated there are concerns with this since they currently have such difficulties in receiving documentation from physicians.

vi. Dr. Brennan provided her new telephone number which will be effective December 1,

2011 – 803-201-8728

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. ***OPEN***

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. **OPEN**

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. (OPEN)

4. **RiverTrust has stated that they are more than 3 month behind in processing redetermination requests due to a dramatically increased workload. This is adding a substantial amount of time for our outstanding claims. We have also had issues where, when we contact RiverTrust about an open reconsideration, we have been told that a decision was made, and a letter mailed - which we never received - and now we are out of time to file the next level of appeals. We know this is not an area that National Government Services can directly address, but can National Government Services help us find someone at RiverTrust or CMS who will work with us to resolve QIC issues?**

Revised New Qualified Independent Contractor (QIC) - C2C Solutions, Inc.
Reconsideration requests, the second level in the Medicare appeals process, are processed by the Qualified Independent Contractor (QIC), who is currently RiverTrust Solutions. Effective November 15, 2011, C2C Solutions, Inc. will take over the QIC contract and begin processing reconsideration requests for all four of the Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

> All requests for reconsideration received by RiverTrust Solutions, on or after November 15, 2011 will be forwarded to the new Qualified Independent Contract (QIC). All requests for reconsideration received on or before November 14, 2011 will continue to be processed by RiverTrust Solutions.

Effective, November 15, 2011 DMEPOS suppliers should send all requests for reconsideration to C2C Solutions, Inc. Below is the address and contact information for C2C Solutions, Inc.

> C2C Solutions, Inc.
> Attn: DME QIC
> P.O. Box 44013
> Jacksonville FL 32231-4013
>
> Web site: www.C2Cinc.com

C2C Solutions, Inc. also holds the QIC contract for Medicare Part B Reconsiderations in the Northern Jurisdiction. The DME MACs and C2C Solutions, Inc. will strive to make this transition as seamless as possible for DMEPOS suppliers.

All requests for reconsideration received on or before 11/14/11 will continue to be worked by RiverTrust. RiverTrust will also continue to work their current pending inventory on a first in, first out basis so that the oldest cases are processed first. Council members should watch our listserv for future updates regarding the transition from RiverTrust to C2C Solutions, Inc. **CLOSED**

9. Open Discussion - All
   a. Use same/similar in Connex. Information does not appear complete so they call CSR and CSR refers provider back to IVR or Connex. This was brought up yesterday on POE AG meeting and NGS is researching this.
   b. Provider issues with CSR staff – i.e. rudeness – please collect information and share with David Barnett. (Need dates, times, people involved – the more detail that can be provided the more helpful that will be.)
   c. KXGA CO-16 denial. When provider calls NGS, staff stating that you are not supposed to be using both modifiers together. However, there are instances where this is appropriate (per previous list serve message.). Please provide examples to Charity to research. CO-16 should not be correct.
   d. Faxing in re-opening requests for quantity changes and these were changed to re-determination. Changes for units of service are appropriate for re-openings. If submit re-opening you will get an acknowledgement letter stating it is approved for re-determination. However, in most cases they will be treated as a re-opening. Re-openings have 60 days to process. If providers have examples where it appears it should process as re-opening but is moving to re-determination please share with Charity.
   e. KE modifier concerns with other Regions – i.e. Region D. Has Jurisdiction B come across any issues? NGS vaguely remembers there was some discussion here but cannot remember the specifics
   f. Oxygen policy questions – Exercise testing and misunderstanding with review nurses and the time frame between each test – i.e., resting, exercising with oxygen and exercise without oxygen. Is there a time frame between each test? (Jurisdiction C issue)
   g. PSG and oxygen qualifications – what is a chronic stable state?
   h. If patient in a titration study and RAD or PAP device applied and patient is under the AHI requirement for PAP and still desaturates for greater than 5 minutes, would the patient then qualify for oxygen coverage? NOTE: this was further discussed by me at this council meeting, and there were interpretations about my comments that I wanted to clear up. So this led to me speaking with two of the council members on a call a few weeks later (Nina will furnish you with their names – one was Teresa?). In essence, I feel like this setting would rarely if ever be an appropriate one to show that a beneficiary qualified for oxygen. However, in the rare circumstance where this was the second or third sleep titration test, and where the OSA had been maximally treated, and during which the beneficiary was on the appropriate amount of PAP as required, then perhaps it would qualify. However, it would be important for this type of test to be interpreted by the properly credentialed sleep physician who was also overseeing the treatment of the beneficiary's sleep apnea and other concomitant pulmonary disease.
   i. Q & A questions – Question 5 regarding wheelchair cushions and 5 year RUL – there may be some models with a life expectancy of 5 years, but most cushions are not going to last 5 years. Industry feels cushions should have less than 5 years. Dr. Brennan indicated that this issue was discussed

with CMS yesterday and that CMS stands by the decision that these items have a 5 year RUL.

j. Council asked about National Government Services providing a fax line to respond to Medical Review requests for additional documentation. Council indicated that providers often cannot meet the 30-day requirement to respond. If suppliers go by date on letter, by the time you receive the letter, obtain the information, and send the paperwork back into NGS the 30 day window narrows quickly. Per Charity, they will not deny the claim until the 45th day. Council also believes this will be a bigger issue with the implementation of the prepayment demonstration on PMDs.
k. **Competitive Bidding claims** – Has NGS had any claims issue? No per NGS.
l. **Swipe Card update –** No update. NGS did hand deliver the swipe cards to several physicians and DME suppliers in the Indianapolis area, and did have some participation from physicians based on this outreach effort. Council asked if this pilot was going to expand to other areas, and NGS indicated not at this time.
m. **PECOs warnings update** – The warnings are continuing to drop. (Last meeting around 12%, but is down to 6.8% as of October. No update on ordering/referring edits being changed from warnings to rejections. No update on when B-17 accreditation edits will be turned back on.
n. **P & O questions -** Diabetic shoes – physician notes regarding circulation – physician should know the rules. Dr. Brennan does not want to put statements out there because she does not want that to preclude medical judgment.
o. Problems with notes states venous insufficiency but nothing demonstrating a foot "examination". Podiatrists do a good job documenting but GPs may lack detail. Medicare Contractors are looking for objective data not subjective. Need to have an exam, not just the words "venous insufficiency" which is a diagnosis.
p. Dr. Brennan stated that the DMDs would be willing to attend State Medical Association meetings within the states to help educate providers, and to tell us if we can help set this up.
q. Concern that EHR records are not beneficial to documenting need for DME as the check boxes do not support Medicare coverage criteria. Some EHR is different and does not only include boxes to be checked.
r. CERT/RAC will not be able to look past the defaults and go to the limited written summaries concerning the medical findings where the findings contradict the default values which we overlooked. Typically, there is a way to remove the exam of the areas that do contain abnormalities and of course add in the abnormal physical findings that would document the need for the DME. Providers just need to know how to do that for their own EHR.
s. Prescriptions that have the date electronically listed but the physician physically signs the form – could this be re-evaluated for acceptance.
t. Part B deductible for 2012 is $140.00.

10. Schedule Next Meeting - All

a. The next meeting is scheduled for Thursday, January 26, 2011
b. Thursday, April 26, 2012 – **Tentative**