| Jurisdiction B Durable Medical Equipment<br>Medicare Administrative Contractor (DME MAC) Council Meeting Minutes | |
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| **Date:** | October 25, 2012 |
| **Time:** | 12:30 p.m. – 4:00 p.m. ET |
| **Attachments Included with Agenda:** | 2012 Jurisdiction B DME MAC October Council Q & A<br>2012 Jurisdiction B DME MAC October Action Items |

1. Introductions – All

2. Common Electronic Data Interchange (CEDI) Update – Stacy McDonald, Sally Hopkins
   1. Annual trading partner recertification began on August 1, 2012.
      i. If trading partners do not recertify by December 31, 2012 they will lose their access during the 1st quarter of 2013.
   2. CEDI is currently providing one-on-one training with companies with large error issues.
   3. CEDI is sending out e-mail updates regularly to help suppliers/companies stay informed with current issues and to prevent errors.

3. National Government Services Web site Enhancement Update – Charity Bright, Wendy Mayfield and Nina Gregory
   1. PMD prior authorization demonstration update – Wendy Mayfield
      i. Demonstration began with orders written on or after September 1, 2012.
      ii. National Government Services has processed 287 initial PMD PAR requests since the demonstration began.
         1. 35% Affirmed
         2. 37% Non-affirmed
         3. 26% did not qualify for PMD PAR due to order being written prior to September 1, 2012, beneficiary residence not in IL, MI, request sent to the wrong jurisdiction (i.e., CA beneficiary sent to NGS)
         4. 2% were incomplete
      iii. Out of the 7 states involved in the PMD PAR demonstration only Michigan and

Illinois are with the Jurisdiction B DME MAC, and National Government Services is handling.

iv. Of the 37% that have been non-affirmed, 15 have been sent in as resubmissions and of those:

    1. 60% have been affirmed
    2. 40% have remained non-affirmed. Some examples for the non-affirmations include:
        i. Required 7 element order is invalid (missing elements)
        ii. The most common reason is that medical documentation does not rule out that other MAE could be used by the beneficiary to perform MRADLs e.g., optimally configured manual wheelchair, walker, cane.
        iii. Detailed product description and 7 element order can be signed on the same day. The DPD cannot be dated prior to the 7 element order.

v. National Government Services has experienced some issues related to sequence issues with dated documents rather than date stamp issues. National Government Services is looking at fax date stamps and standard date stamps, and do understand that the fax hardcode date could be wrong.

vi. NGS has been receiving duplicate PMD PAR requests and would like to remind suppliers that submitting duplicate requests will slow down the processing time. If a supplier determines that only part of the fax was transmitted and part did not go through, suppliers should indicate that the fax is a duplicate for that reason and they should refax the entire request.

vii. Council indicated that they have concerns about the effectiveness of NGS receiving faxes, and therefore Council requested that any time NGS is aware of a fax server being down or not working properly to please notify the supplier community via an e-mail update or production alert. **(ACTION ITEM)**

viii. Council asked if a provider receives a non-affirmative decision and if the provider believes the non-affirmative decision was not accurate (i.e., medical documentation/justification was provided but overlooked by reviewer) what is the best way for the provider to handle?

    1. Submit request as a "reopening" to the PMD PAR department and on the coversheet indicate why they believe the decision was inaccurate, and submit all documentation again. No new documentation should be added.

ix. National Government Services is currently processing PMD PAR requests on average

in about 4 days well under the 10 day requirement for initial PAR requests.

**2.** Documentation compliance review (DCR) – Glucose and Oxygen

i. On October 25th, National Government Services has identified 16 suppliers to remove from oxygen pre-pay audits this will take about 2 weeks to implement. NGS did not identify any suppliers to remove from the glucose pre-pay audits at this time. Rationale to remove suppliers from pre-pay audits included:

i. PTAN

ii. Total number of claims submitted

iii. Reduction in denial percentages

iv. Suppliers will not be notified in writing that they are being removed from the pre-pay audit, they will no longer receive ADRs.

ii. NGS will be increasing the number of ADRs for glucose test strips for non-insulin treated diabetics.

1. The number one reason for denials related to glucose is problems with request for refill documentation.

2. ADR letter for glucose test strips is being modified. It currently asks for a testing log, but the claims being reviewed are for non-insulin dependent diabetics testing within parameters, therefore it is not required. Suppliers can indicate N/A if they receive an ADR requesting this information prior to the update.

iii. The number one reason for oxygen denials is the physician visit is either missing or is not signed. The information we are receiving related to the visit is coming from either a nurse in the hospital or respiratory therapist and not from the physician.The next highest reason for denial is oxygen testing either does not match what is recorded on the CMN or no test result is provided.

1. Council asked if there is any tracking of the number of denials taken to redetermination, reconsideration and what the data shows. NGS stated that yes that data is being monitored but at this time they do not have any findings to share.

iv. Reminder: the oxygen and glucose pre-pay audits that are currently occurring as part of the documentation compliance review project are technical reviews and not medical necessity reviews.

v. Council asked if there is a defined time line for ending the pre-pay audits on oxygen and glucose. NGS indicated they were not aware of any defined date at this time. CMS will make the decision and notify NGS on when to stop the pre-payment audits. NGS understands the predicament suppliers are in are attempting to process the audit

responses quickly. However, NGS did indicate that denials are decreasing.

vi. A revised oxygen policy is set to be released in about 2 weeks.

**3.** High dollar DMEPOS claims widespread audit:

i. Audits are being done on both a pre-payment and post-payment basis.

ii. Primary policy groups currently being audited:

1. High dollar drugs (can be as much as $30,000 or more per month
2. Prosthetics
3. Parenteral/enteral nutrition
4. Complex PMDs
5. NPWT, speech generating devices, miscellaneous items

i. Number 1 denial reason – missing medical record documentation to support items provided.

ii. Other reasons for denials include, missing detailed written order, missing documentation to support functional level (prosthetics), missing request for refill documentation, proof of delivery missing or date of service billed doesn't match, failure to respond to request for additional documentation.

iii. The ADR letters associated with the high dollar audits are being revised to include a request for proof of delivery and request for refill documentation.

iv. Council asked if a supplier receives an ADR and determines that a piece of documentation is missing or the medical records don't support the item and expect to receive a denial, should they respond. NGS responded, yes the documentation should still be responded. Failure to respond to any ADR request from any Medicare contractor is a violation of supplier standards.

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

**1.** Introduction of Tim Fickle (Senior Medical Policy Analyst) – 8 years healthcare experience

**2.** National Government Services has hired a second DMD (dedicated to ALJ hearings) his name is Dr. Marc Duerden. He will be on board in December and will attend the next Council meeting. One of his duties will be to attend and participate in ALJ hearing on behalf of NGS.

**3.** Two LCDs were recently revised:

i. TENS

1. Changing coverage due to National Coverage Determination modifications. Covered for chronic low back pain **only** if the beneficiary is enrolled in a CMS approved Clinical Study.

2. An article will be published shortly to clarify clinical study participation.
3. The LCD revision date was dated to June 8, 2012, which is when the NCD was published. Council does not agree with the retroactive date. NGS stated that it is the suppliers responsibility to follow the published NCD – regardless of the when the LCD is updated.
4. No grandfathering allowed from June 8th – current.

ii. Wheelchair options and accessories:
1. HCPC code changes that were put in standard documentation.
2. E1028 hardware bundled with E1020 residual limb support.

iii. Upcoming e-mail updates:
1. Clarification on rounding of numbers in test results
2. TENS policy details

iv. Oxygen policy revision will be published in November.
1. Guidance on PAP patients who also need oxygen
2. Definition of chronic stable state being addresses

5. Action Items – All

1. 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.*

***Update:** On November 1, 2012 CMS issued direction on how to bill for denial of non-covered codes included in ESRD consolidated billing for non ESRD patients. This information was included in the CMS Medicare Fee for Service e-News.*

*Suppliers wishing to bill for one or more of the non-covered codes included in Attachment 5 of Change Request 7476, "Quarterly Update to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS)," must append the GY modifier to the HCPCS code identifying the item.*

*On November 14, 2012 final updates were made to allow claims to process for denial.* ***CLOSED***

9. Open Discussion - All

a. Question #9

i. Council indicated that this question was not submitted due to a specific denial. Council indicated that the PIM speaks to verbal orders but does not state that a supplier needs to sign a verbal order. Dr. Brennan referred Council to PIM 3.3.2.4

1. Dr. Brennan stated that a verbal order needs to be authenticated. It can be electronically authenticated, but if the computer system allows the verbal order to be modified this could be a problem.
2. Council asked if the verbal order signature authentication when lined up with all the other information does it disprove that the patient needs the medical supplies?
3. Question #9 will be retracted from Q and A document before publishing. Council will await clarification. **(ACTION ITEM)**

b. Question #1 – Council indicated they have concerns with the "retroactive" clarification of consumable vs. non consumable supplies.

i. At this point there have been no CERT audits on request for refill requirements.
ii. Council asked if patient walks into the store front to pick up supplies does it need to be documented quantities remaining or reason for request for refill (replacement)? NGS indicated "no" but it must be noted somewhere that the patient came into the store front and requested supplies and received the supplies.
iii. Council asked if the patient calls to order supplies, but comes into the store front to pick up the supplies do they need to document quantities remaining or reason for request for refill (replacement)? NGS indicated "no" but it must be noted somewhere that the patient came into the store front and picked up the supplies.
iv. What if the beneficiary calls the supplier to request a refill of supplies be delivered to their home. Does the supplier need to document quantities remaining or reason for refill (replacement)? Dr. Brennan and Nina will clarify and provide an update. **(ACTION ITEM)**

c. Question #6 – concern with answer regarding 25% payment penalty for beneficiaries with retroactive Medicare coverage dates.

i. Council was referred to the PMD PAR Demonstration Operational Guide – October 19, 2012.

d. Question #8 – telehealth issues. For the policies that require a face-to-face examination, if the patient resides in a remote area and physician uses Skype (or whatever mechanism is available), is this considered acceptable for a face-to-face visit? Dr. Brennan indicated that the doctor must meet the criteria for the telehealth visit.

e. Question #10 – An e-mail update is going to be published that will clarify this issue.

i. Council requests the DMDs and CMS re-evaluate their interpretation of the proof of delivery component for patients who have rental equipment in their possession at the time they become Medicare FFS eligible. Suppliers are obtaining the qualifying documentation to determine coverage criteria. This issue suppliers have is the requirement to obtain a new proof of delivery. **Update:** Listserv article sent out on November 30, 2012 and is also posted

on the What's New page.

10. New Action Items
    a. Listserv reminding suppliers to respond to ADR letters even if they know they have insufficient documentation. – Article was sent out on November 21, 2012 and is posted on the What's New page. **(CLOSED)**
    **b.** Clarification on request for refill documentation requirements when the beneficiary calls the supplier and request a refill of supplies be delivered to their home. **(OPEN)**
    c. Council to write up concerns with delivery ticket dates/issues when rental is initially delivered prior to customer becoming Medicare eligible. **(OPEN)**
    d. Council requested an enhancement be added to the IVR so that they can determine if the CMN/DIF on file is "Dummy" that was set up to pay repairs, supplies, etc. or if it is an actual CMN/DIF. **(OPEN)**

11. Schedule Next Meeting - All – Tentative Dates
    a. Thursday, January 24, 2013
    b. Wednesday, May 16, 2013
    c. Thursday, July 25, 2013
    d. Thursday, October 24, 2013