Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Council Meeting Minutes	
Date:	April 29, 2010
Time:	1:00 p.m. – 4:00 p.m. ET
Attachments Included with Agenda:	2010 First Quarter Top 10 Supplier Telephone Inquiries 2010 First Quarter Top 10 Supplier Written Inquiries 2010 First Quarter Top 10 Supplier Claim Submission Errors 2010 First Quarter Jurisdiction B Appeals Update 2010 First Quarter Jurisdiction B Claims Update 2010 First Quarter Jurisdiction B Correspondence Update 2010 First Quarter Jurisdiction B Overpayment Recovery Unit Update 2010 First Quarter Jurisdiction B Provider Contact Center Update 2010 Jurisdiction B DME MAC April Council Q & A 2010 Jurisdiction B DME MAC April Action Items Billing for Oxygen Denial Listserv Message Span Date Article

1. Introductions – All

2. DME MAC Medical Policy Update - Dr. Adrian Oleck
   a. **CERT Update**
      i. CMS published an error report and the new DMAC error rate is 52%. The previous error rate was 9%.
      ii. National report did not breakdown report by contractor, code, etc…
      iii. NGS internal analysis showed that for Jurisdiction B:
         1. Oxygen error rate was highest
         2. Glucose monitor was next – emphasis on non-insulin diabetics requiring higher than stated quantities and/or refills. Medical necessity looking at physician documentation as well as log to support number of testings per day.
            a. Extensive literature review on testing frequencies to assess value of one time per day vs more than one per day for non-insulin users. Literature does not

support testing more than once per day for non-insulin users. There is evidence to support testing more than 3 times per day for insulin diabetics – e.g. patients on insulin pumps or multiple doses per day.

3. Nebulizers
4. CPAP
5. Surgical dressings
6. Power Wheelchairs
7. Lower limb orthosis and therapeutic shoes (surprises)

NGS will be focusing on these areas for Medical Review, highest volume is diabetic supplies. Stressed need to document that beneficiaries requested the refill.

b. Physician Signature issues

i. CMS released final CR where they defined things very meticulously.
ii. Illegible signatures and method for correcting this via a signature log. (Reference: MM6698 or NGS listserve message dated 4/5/10 – Signature Requirements)
    1. Printed name with written signature – can be done at any time – even after the fact.
iii. Missing signatures only relate to medical documentation records – not orders.
    1. If medical records/progress notes are not signed, an attestation can be obtained later. (If an order is not signed, it is not valid)
iv. For claims being reviewed by medical review, if the only problem is with illegible or missing signature, not with other documentation, then a 2nd request will be sent out for clarification on signature. This does not happen very frequently because usually there are issues other than signature that result in denial.
v. Educational articles have been disseminated on the signature requirements.

c. Detailed written orders (reference NGS listserve message sent 4/8/10)

i. Items included on written order that were not part of the dispensing order i.e. diabetic example.
    1. Diabetic supplies ordered, but the detailed written order includes other <u>non-related</u> items.
    2. Addressed checklists on detailed written orders
    3. Question related to example listed on PAP supplies with the mask.
        a. We go through a trial period with trial of different mask, but are not able to list multiple interfaces but need to try them based on what the patient requires.
        b. Problem is with choice – they want detailed written order to be specific.
        c. Need to be sure that the interface that is provided and billed for is included on the order. Interfaces that are trialed but not billed for would not have to be listed. However, when a replacement interface is billed must have the correct order.

d. Policy revisions

i. Infusion pump policy update released today – no least costly alternative for some specific drugs.
    1. Pricing stays the same.

ii. **Oral anti cancer drugs**
    1. Added ICD-9 codes for all the drugs

iii. **PAP policy**
    1. Major changes were the statements from CPAP to RAD.
        a. Specific reasons needed to be indicated
            i. Rule out interface problems
            ii. Pressure settings – as pressure goes higher patients have problems tolerating.
        b. What if pressure setting is ordered at 25 cm – CPAPs will not go above 20?
            i. Dr. Oleck will look at this.
        c. NGS will research the multiple interface statement plus the ANDs listed between each statement.
            i. If the patient is fine on the first interface, other interfaces do not have to be tried.
        d. List serve message was received about 1 ½ weeks prior to effective date.
        e. Requirement that multiple interfaces must be tried, but Medicare only pays for one.

Side Note: Health Care Reform: Any update on face to face requirement? No instruction has been sent from CMS to NGS as to how and when to implement. Good question to raise. (Rumor: Face to face look back period is 6 months for the face to face requirement. Supposedly this is in draft format – have the DMACS heard or seen anything? We, as providers, are concerned because face to face issue is now law but we don't know how to interpret yet.) NGS stated they have not heard any direction on this issue from CERT perspective.

3. Action Items - POE Department

- 2010 Jurisdiction B DME MAC April Action Items

2. If a supplier takes on a new oxygen patient who previously had oxygen from another supplier and the previous supplier has either went out of business or refuses to provide the new supplier with documentation (i.e., original delivery ticket) what recourse does the new supplier have?

CMS has published guidance when a supplier files bankruptcy but the MDs have requested that CMS provide guidance for other scenarios where bankruptcy doesn't apply.

Also in the case where the equipment is past the 5-year RUL and the supplier cannot obtain the delivery ticket for the original equipment which reached the RUL, Council indicated that in most cases the DME MACs have information regarding the initial date of when the patient received the equipment in their records. Why is that information not sufficient?

National Government Services has not received any additional information regarding this issue. As is the case for all DME items, suppliers must maintain proof-of-delivery documentation in their files for replacement oxygen equipment. (See the CMS Internet-Only Manual [IOM] Publication 100-08, Medicare Program Integrity Manual,

Chapter 5, Section 5.8.) In addition, for equipment that is being replaced because it has been in continuous use by the beneficiary for the reasonable useful lifetime and the beneficiary has elected to obtain new equipment, the supplier must also have proof-of-delivery documentation in their files for the item being replaced that documents that the oxygen equipment has been in use for at least five years.

These questions/concerns have been submitted to CMS for further guidance, however at this time a response has not been received. **OPEN**

3. 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 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?

Medicare will cover replacement equipment if the equipment is lost, stolen, irreparable damaged or has been in continuous use for the reasonable useful lifetime of the equipment, generally five years. Suppliers must bill the first claim following replacement with the RA modifier appended to the HCPCS code of the replacement item and include a narrative explanation as to why the item is being replaced, in Item 19 of the CMS-1500 claim form or NTE segment of the electronic claim.

The ABN is used by suppliers in order to protect themselves from financial liability. Suppliers should not issue an ABN every time they provide replacement equipment; simply because they "might" receive a same/similar denial this would be considered a blanket ABN.

Council indicated that they still believe that there are legitimate times where it should be acceptable to append both the KX and GA modifiers. Charity Bright will take this question to the National Government Services Interdepartmental workgroup and will provide an update at the next Council

Meeting. **OPEN**

5. **Council asked about claims that have been billed and paid with span dates and now those payments are being recouped because during the span of dates billed, the patient went into a Medicare Advantage Plan, inpatient stay, Home Health Episode, etc. The entire payment is being recouped and not being prorated. National Government Services is aware of this issue and has voiced concerns to CMS, however, at this time the suppliers only recourse is to file a request for Redetermination. Council asked how Redeterminations would handle these requests (i.e., would the overpayment be upheld, or would the supplier at least receive partial payment).**

   Suppliers have the right to appeal a refund request if they believe the money has been requested back in error. Suppliers should refund the amount requested and then file an appeal. This will help suppliers avoid an offset with interest charges. If a refund is not received before the deadline date identified in the refund request letter, an offset will begin. Medicare will reduce any future payments by the amount of the refund. Medicare will also take interest on the overdue amount. Suppliers should file a redetermination and indicate they believe that the amount requested was incorrect and resulted from an issue related to claims with "span dates". **CLOSED**

   Action Item #5 – when going to reviews they should pay for the time patient used eqiupment and this was confirmed by a provider in the room. They have seen payments here after a review.

7. **Council requested to have the Overpayment Recovery Unit's Offset Request form added to the demand letters. By adding the Offset Recovery form to the demand letters suppliers would be able to respond more timely and accurately to the request for refund. This suggestion has been forwarded to the Overpayment Recovery Unit for research and development. Approval is necessary from CMS before making any changes to the demand letters.**

   No update at this time, an update will be provided at the next Council meeting scheduled for July 2010. **OPEN**

8. **Council requested clarification on RA modifier usage. Council asked if the RA modifier should be appended to any DME item being replaced regardless if the item is lost, stolen, irreparably damaged, or has met the 5-year RUL? A listserv article was sent out in April 09 clarifying the use of the RA, RB modifiers.**

   The article indicated that suppliers should not append the RA modifier on subsequent rental months following replacement. The RA modifier should only be appended to the initial claim submitted for replacement. If the RA modifier is submitted on subsequent rental claims the claims could be denied for same/similar equipment ANSI CO-151.

   Council asked for clarification on whether the RA modifier is required for a replacement seating cushion, or if the RB modifier should be used. National Government Services will research and provide clarification on when the RA and RB modifiers should be used. National Government Services is currently seeking clarification from CMS on their interpretation of the RA/RB modifiers. National

Government Services is also seeking clarification from the other DME MACs to see how they are educating the supplier community on use of the RA and RB modifiers.

CMS has not provided clarification on this issue. Therefore, no update is available at this time. An updated will be provided at the next Council meeting scheduled for July 2010. **OPEN**

4. Open Discussion - All
    a. Council meeting changes:
        i. Quarterly statistics – it is OK to stop providing these.
            1. We ask that NGS shares with us when they notice a blip or allow us to point out areas that may need more intense scrutiny.
        ii. We want the Q & A.
        iii. We like the timely list serve messages
        iv. We want the upcoming education on paper
        v. We discussed the length of the meetings: Is there an opportunity to start the meeting earlier? 12:30 would be acceptable and would allow us to wrap up earlier.
    b. Knee walkers
        i. Concern has been with safety in the elderly. Literature was limited when they looked at the product.
        ii. If there is clinical literature available Dr. Oleck would be willing to review and share with the other Medical Directors. It needs to be well established in therapy.
        iii. Noted that these are currently considered 'not medically necessary' – which is not the same as non-covered. Claims must be filed when provided under doctors orders to Medicare beneficiaries (get appropriate ABN).
    c. Oxygen – maintenance and servicing
        i. Discussion on warranty issues has occurred. What providers do for maintenance and service does not relate with warranty therefore warranty should not be part of the maintenance and service discussions. If the equipment has parts and labor issues that responsibility falls to the provider since they own the equipment and thus should not be involved in the maintenance and service.
            1. Dr. Oleck has offered to accept any documentation from us to help educate on this effort.
    d. EFT message handout
        i. Address changes have been provided to the NSC but we were not aware that EFT required an address update.
        ii. If operate in all four regions then do we need to update our address with all four?
        iii. Listing authorized/delegated official – if there is a change we need to update with EFT as well.
        iv. Does CEDI need to be notified or just EFT? Yes, CEDI will need to be notified.
        v. ACTION ITEM – what and who needs to be notified when addresses change.

e. CR 6566:
    i. When we enroll in NSC we list our product categories. In July 2010, an update will occur that will match products to categories and we may not assign the same item to the product category as the NSC does. Does anyone have a more detailed list? We are concerned. Will you only be editing for what was listed in CR 6566?
        1. **ACTION ITEM - Charity will take this back and provide an update. They will try and get this back to us quickly since July is the implementation date.**

f. New Health Care Reform: Discussion about new suppliers and what steps they need to adhere to prior to getting a number, and new pre-payment audits and holds for these new providers. Implications in the rule could be quite onerous.
    i. NGS has responded to the draft presented by CMS by submitting several responses/questions on interpretation and implementation.
    ii. NGS has requested a face-to-face meeting with CMS to discuss the issue.

g. ABN question:
    i. Clarification on what to do if patient refuses to sign an ABN?
        1. How does witness work? Can it be one person? Yes
        2. Can it be another one of our employees? Yes
        3. If mail and send certified? Can use date sign certified letter? yes

5. Schedule Next Meeting - All

Meetings will now begin at 12:30 p.m. instead of 1:00 p.m., this will allow those traveling in to get earlier flights home.

a. The next meeting is scheduled for Thursday, July 15, 2010. We were originally scheduled to meet on Thursday, July 22, 2010. Please mark this change on your calendars.
b. The following meeting is scheduled for Thursday, October 14, 2010