Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Council Meeting Minutes	
Date:	October 12, 2010
Time:	12:30 p.m. – 4:00 p.m. ET
Attachments Included with Agenda:	2010 Jurisdiction B DME MAC October Council Q & A 2010 Jurisdiction B DME MAC October Action Items 2010 Jurisdiction B DME MAC Provider Outreach & Education Update 2010 Jurisdiction B DME MAC Provider Outreach & Clinical Education Update

1. Introductions – All

2. Competitive Bidding Implementation Contractor (CBIC) Update – Elaine Hensley
   a. **Update: Still in contracting process --** once fully executed contracts implemented and non-contract notices are sent the CBIC website will be updated with the following:
      i. Winning bidders by name, product categories
      ii. Grandfathering process will be detailed
      iii. Direction on subcontracting processing (10 days to notify CBIC of subcontract changes)
      iv. Extensive outreach in competitive bid sites with CIGNA, NHIC, NGS, occurring right now.
      v. Working with some State Associations
         1. Recently in New Jersey
         2. Thursday with Florida
         3. Texas on Monday
         4. Ohio in November
   b. **Collaborating with CMS Regional Offices through outreach**
      i. SHIP agencies
      ii. Referral agencies
      iii. Attending some larger National Associations – Diabetic Association
      iv. DME MACs
   c. **Will meet with beneficiaries closer to the date**
      i. Their research shows if education to the beneficiary community whose age is greater than 65 occurs more than 45 days out the education is not effective as the population tends to forget.
   d. **Open Door Forums will occur once contract information is released**

e. Council questions related to Competitive Bid:

i. 10 weeks out from implementation date and DMEPOS suppliers are still uninformed regarding changes

ii. Supplier community concerned about CMS/CBIC not hitting "target dates" Elaine could not provide any additional dates as to when education will be forthcoming. Elaine indicated the dates previously provided were "target dates" and not hard dates.

iii. Is there potential for delays in CB due to target dates not being met? No comment.

iv. Capped rentals – CPAPs in particular if beneficiary changes from a non-contract supplier to a contract supplier – does a new 12 week trial re-surface? Dr. Oleck indicate a new 12 week trial would not be required as medical necessity would have already been established. Council asked how that would be indicated on the claim.

v. Will there be specific modifiers to indicate grandfathering vs. non-grandfathered suppliers? How is CEDI and the claims processing system set up to handle these situations?

vi. If State Associations would like to have education regarding CB provided by the CBIC they should contact Elaine Hensley at Elaine.Hensley@palmettogba.com or call 803-763-5745

vii. Per Charity – the BSO has put the edits in place and they have tested a large number of sample claims.

viii. Question – Elaine are there enough signed contracts in all CB areas to take care of Medicare Beneficiaries? No comment.

ix. PMD – after Jan 1 non-competitive bid patient moves to bid area and needs PMD do they need to start over with medical documentation? A new assessment would not be necessary after each move. To append KX modifier you need to be able to prove medical documentation would you need to bring all your medical documentation when you move? A change in provider should not change medical necessity.

x. Request from Council to NGS – any education you can provide DME providers on claims processing due to Competitive Bidding would be most appreciated.

xi. Further, the practice location must be prepared to submit valid Medicare claims, and equipped or stocked to furnish these items or services. The Centers for Medicare & Medicaid Services (CMS) does not consider the business to be operational if no one is available at the place of business during routine deliveries or off-site maintenance of supplies or products to Medicare beneficiaries.

3. Common Electronic Data Interchange (CEDI) Update - Stacy McDonald

a. Three current initiatives –

i. Created a Web page on the CEDI website at www.NGSCEDI.com for ANSI 5010 and D.0 transition

ii. Jan 2012 – must use 5010. (testing can begin 1/3/2011)

iii. Stacy is getting with her group to get something more "supplier" oriented on what non-technical suppliers need to do to prepare to 5010.

b. New timeframe for password on CEDI gateway – currently 90 days but in Jan 2011 the passwords will expire every 60 days. If after 90 days the NSV has not logged in the account will be suspended.

c. Initiative to require CEDI gateway connectivity to enter through a Network Service Vendor (NSV).

i. FAQ on website in regards to gateway connectivity
   1. FAQ is being updated with more Q & A and will be available soon, watch CEDI listserv for announcements.

ii. More listserv messages will go out to educate providers on CEDI gateway connectivity.

iii. Effective November 1, 2010 - all new request must go through NSV.

iv. April 30, 2011 – last day to access dial-up

v. May 1, 2011 – must use Network Service Vendor (NSV) – dial up disappears.

vi. NSV – is only a method of transferring data (pipeline only) – they manipulate no data, they do not format data, etc…

d. PECOS

i. Any discussion on extending Jan 2011 implementation date? Not at this time.

ii. Current percentage of how many claims are receiving the warning message? Currently 16.5% are receiving the PECOS warning message edits. This is a drop of 4.7% from August. In September CEDI saw a 3.1% drop in edits.

iii. Patient Protect Act legislation – providers are holding claims rather than submitting and that could impact drop?

iv. Reports of physicians going through without alert and now receiving an alert? The physician was in the PECOS file in February but is no longer on the list as of August? Stacy McDonald requested that the example be sent to her at Stacy.McDonald@Wellpoint.com. Please include your e-mail and telephone number so she can get back in touch with you after she researches the issue.

4. Corporate Communications Web Site Update – Shelly Elliott

a. Joining on call Rob Floyd (Web Architect) from Corporate Communications

b. Survey responses from Web site – please take the survey as it helps National Government Services to enhance the site and provide a better product for everyone.

c. New Web site platform – always evolving Web site to keep up with business needs

d. Enhanced navigation cues

i. User Centered Design Study

ii. Bread crumb navigation trail – shows where you are in context of website (located on left hand side right underneath banner). Will follow user to top level page.

iii. New look and view as well as how you move around

iv. Accessing Web site – come to start page (homepage)

v. Prompted for line of business – click save settings – once this is completed the Web site will remember on subsequent access

vi. Significant change – secondary navigational level this will remain consistent as user moves through the Web site and will assist in guidance through the Web site

vii. Switch to another line of business anywhere in the Web site and receive a pop-up to change rather than back tracking to find and make the change

e. Hot topics to be highlighted

f. Latest production alerts will be highlighted

i. Claims systems issues to be announced

ii. Any change in work flow that needs to be announced

g. Quick links are items that are found to be used the most frequently due to analytics.

i. Request for Q and A to be more easily accessible (Charity Mahurin and Shelly Elliott) will discuss further

h. Action items: Can information be retained on the Web site longer?

i. CMS content Mandated:

ii. CMS requires news articles to be retained for 3-months – National Government Services maintains What's New articles for 12 months.

iii. CMS requires Quarterly Jurisdiction B Bulletins to be retained for 2-years

i. Surveys state: Users want to see less in search results

i. Content structured on site to accommodate survey results

ii. Web site is not meant to be a research for endless data

j. Council has come to rely on the historical information stored on the Web site.

i. We used to print everything but stopped because the information was on the website it would have been nice to have notice when information was removed.

ii. Rob noted that they could put out information as to what their retention process is until this can be re-reviewed so that internal standards and council requests can be addressed

iii. NGS staff will investigate options for longer archiving

5. DME MAC Medical Policy Update – Adrian Oleck, MD

a. Glucose monitor policy

- Change – two levels of testing to 4 levels of testing

i. Non-insulin treated: Testing 1 time per day is staying the same.

ii. Insulin treated patients – 3 groups

1. Insulin injection one time per day testing
    a. 2 times per day testing
2. Insulin multiple times per day or by pump
    a. 4 times per day
3. Insulin multiple times per day or by pump – with additional documentation
    a. 6 times per day

iii. Multiple modifiers – upgrade modifier to accommodate those who test more than what is covered according to the policy.

iv. Comment period through Nov. 8th

v. National meeting in Baltimore on Oct. 26 – all 4 Medical Directors will be in attendance

b. PAP Policy

- Revised documentation requirements for ineffective therapy with CPAP

i. Good interface

ii. Pressure problems – due to symptoms on lower levels but can't tolerate higher pressure

c. Revision of PMD Dear Physician Letter (released a couple of weeks ago)

i. The Council thanked Dr. Oleck/NGS for this revision

d. Published article on request for refills/recurring supplies

e. Medical Review activity

i. Glucose Monitors remain a big issue

1. High volume area and that is about to increase
2. CERT error rate is a driving factor

3. OIG and RAC activity here as well
4. Developing a large number of these claims and that will increase due to increased funding from CMS. This is a high volume claim area – over 3 million claims (20% claim volume)
5. Upgrade modifiers – use modifiers if patient is testing more often than basic guidelines and there isn't documentation to support the hhigher frequency of testing. Pay standard units of service and deny excess
6. Comment from council – policy appears fair but concerns arise regarding the reliance on physician documentation and their need to document the information required by the policy

f. Therapeutic shoes for diabetics
g. Power wheelchairs
h. Urologicals
i. Vacuum Erection Devices
j. Dressings
k. Negative Pressure wound therapy
l. Medical Review activity
m. Dr. Oleck informed the Council that he will be leaving the DME MAC at the end of the year. Dr. Oleck has been the Jurisdiction B Medical Director for 22 years. National Government Services is currently seeking a replacement for Dr. Oleck and he will assist with the transition. Council expressed their well wishes and appreciation for Dr. Oleck's willingness to always be open in communication with Council.

6. Jurisdiction B DME MAC Award Implementation – David Barnett
   - **a.** National Government Services was awarded the Jurisdiction B DME MAC
   - **b.** Implementation
     i. Will not experience a number of issues as last time they were awarded the contract as states in the jurisdiction will remain the same, therefore work load will not need to be transitioned in or out.
     ii. No change in contract number
     iii. No significant changes to the Statement of Work
     iv. National Government Services has not heard anything on other Jurisdiction Announcements, however, expect to hear something regarding NHIC very shortly.

7. Provider Outreach & Education Staffing Changes – Charity Mahurin
   - **a.** Sharon Gulley has moved from her role in POCE to CERT coordinator
   - **b.** Stacie McMichel will be taking Sharon's role in Clinical Education for Ohio, Kentucky, Wisconsin, and Minnesota and will work closely with Nina Gregory
   - **c.** Terri Shoup – Indiana POE Consultant
   - **d.** Lisa Hare – Michigan POE Consultant
   - **e.** Charity Bright – Minnesota, Wisconsin POE Consultant
   - **f.** Vicky Combs – Ohio, Kentucky POE Consultant
   - **g.** Nikia Simmons – IL POE Consultant
   - **h.** **Connex Update – Lisa Hare**

- Web application to obtain beneficiary eligibility, claim status, order duplicate remits, etc.
  i. Released to all DME MAC suppliers
  ii. Need internet access and an e-mail address in order to use
  iii. Free
  iv. Connex will be demonstrated at Fall conferences
  v. www.ngsconnex.com
  vi. Instructions and training materials found on Web site
  vii. Provider Contact Center – Support for Connex Option 5
  viii. Council asked when the same similar option will be added to Connex? This request has been added to the enhancement list but no ETA on when this option will be added.
  ix. For each provider account (PTAN/NPI) you must register and enter information – don't need different LSO for each one.

8. Action Items – Provider Outreach & Education

1. **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.

   Update: CMS has received similar inquiries and has planned to update the IOM instructions incorporating the following response.

   Response: If the supplier cannot obtain the original delivery slip, the contractor can look at their internal

records (i.e., CMN file) to determine the initial date for establishing the start date of the reasonable useful lifetime (RUL) of the oxygen equipment in replacement equipment situations. Suppliers should enter RUL xx/xx/xx in NTE segment of electronic claim or Item 19 of paper claim and NGS will verify the date with what they have on file. Suppliers should continue to make every effort to obtain the information – if information cannot be obtained then suppliers must document what steps they have taken. **CLOSED**

2. **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.*

Council requested that this issue be taken back to for further discussion as they believe it would be appropriate to execute an ABN for Scenario Two.

National Government Services requested clarification from CMS in regards to this issue. 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 they will forward it to Council. **OPEN**

3. **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.**

   In order for National Government Services to implement the requested change we are required to obtain approval from CMS. In order to request this approval we must determine the cost associated with this change and show the benefit would outweigh such cost. We are currently in the process of making those determinations. An update will be provided at the next Council meeting scheduled for October.

   National Government Services has determined that this change cannot be made at this time. However, this request may be revisited in the future. **CLOSED**

4. **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.

   National Government Services is still awaiting clarification from CMS. Therefore, no update is available at this time. We will provide clarification on this issue to Council as soon as we receive it from CMS. National Government Services believes the RA and RB modifiers are impacted by Competitive Bidding and clear instruction will be released at some point down the road. If an RA modifier is appended on the claim the claim is stopped for manual intervention of a claims processor. **OPEN**

5. **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?

ANSWER: National Government Services is currently working on a resource for suppliers to follow when a change of address is required. This resource should be completed by the next Council meeting in October.

Lisa Hare is currently working on this document which will include what addresses to update when a change is made and what addresses from the NSC go to what department/business. Nina Gregory advised council that audit letters go to payee address. Paula Koenig volunteered to help spot check addresses.

NGS is currently working on a resource for suppliers to follow when a change of address is required. An update will be provided once complete. OPEN

6. **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.**

   ANSWER: 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 National Government Services 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. ***OPEN***

7. **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.**

   ANSWER: Corporate Communications stated that they only mandated by CMS to keep certain items on the Web site for a designated period of time. The items that Council is asking to have available longer are not mandated by CMS, but those present at the meeting (Charity Mahurin) will meet with Shelly Elliott to determine if there are other items that could be kept on the Web site for longer periods of time. ***OPEN***

8. **Council requested an update on PECOS edits. Response: An update will be provided by CEDI during the October 12, 2010 meeting.**

   ANSWER: PECOS update provided by CEDI see notes from agenda item 3. Future updates will be provided in upcoming meetings. ***OPEN***

9. **Council asked if it would be possible to develop similar "Dear Beneficiary" letters like the one sent out to beneficiaries who were receiving diabetic supplies from multiple suppliers.**

   ANSWER: National Government Services received notification from CMS that additional funding would be provided for CERT education. We are still in the process of identifying the top ordering/referring physicians to determine if there are trends based on ordering/referring physician documentation errors. AN update will be provided once available. National Government Services plans to mail a CD to each supplier in regards to their responsibility due to CERT, top CERT offenders will receive supplemental education in order to reduce errors, documentation checklists for the top 10 policies with the most frequent CERT errors,

additional "Dear Physician" letters that are policy specific are being drafted, looking into sending information directly to physicians associated with the errors, and calling top 10 suppliers with the top ten errors. ***OPEN***

9. Open Discussion - All
    - **a.** Q & A #5 – PAP LCD – Dr. Oleck will speak with other Medical Directors
        i. Example provided – patient needs replacement machine
    - **b.** Q & A #11 – please share response with Council not just other provider
    - **c.** Q & A #12 – wheelchairs coded as pediatric vs. adult per PDAC
        i. Bill as adult equivalent code – manual chairs do not have to go through PDAC coding
        ii. Use adult/peds code based on seat width
        iii. PDAC doesn't routinely say if less the 14 then use this code
        iv. If manufacturer submits as pediatric but does not indicate it comes in adult sizes they are not going to code both ways. This happens both ways but more often when going from pediatric to adult
        v. Dr. Oleck will follow-up with Council.
    - **d.** Q & A # 26 – providers hit hard by refund requests due to home health, inpatient hospital and SNF stays, etc.
        i. Limited opportunities to rebill
        ii. Problem lies with beneficiary -- Council indicated why not add PR denial code once claim is reprocessed?
        iii. A lot of room for improvement on this process and as such a work group is forming to respond to this issue
        iv. David Barnett offered to work with some providers for feedback – Paula mentioned that there were at least 3 Council members willing to assist. Paula will send names to David (Missy Cross, Deb H. and Mary Ellen Spradlin)
        v. Response on payment plans: Checks submitted and cashed but offsets occurred as well.
    - **e.** Fourth Quarter Clinical Updates handout will be forwarded to Council by Charity Bright
    - **f.** Oxygen – greater than 4 LPM submitted without modifier they are paying at 1 and a half times. Please fax examples to Charity Bright
        i. CMN shows 5 liters, but no modifier
    - **g.** BIS claims – not loading CMN information – please fax examples to Charity Bright

10. Schedule Next Meeting - All

    Reminder 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, January 13, 2011