Jurisdiction B Durable Medical Equipment

Medicare Administrative Contractor Council Meeting Minutes

January 22, 2015

12:30 – 3:30 pm

Castleton Park Conference Center

5415 Castleway West Drive Indianapolis, IN 46250

Attachments: January 22, 2015 DME MAC Council Q & A

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1. Introductions

2. National Competitive Bidding Updates – Elaine Hensley

   The bidding window opened this morning (014/22/2015). The window closes March 25, 2015.

   February 17 – registration window closed.

   Some suppliers are registering multiple times – they will receive a phone call reminding them they should only register one time. CBIC wondering if providers are registering multiple times due to ability to severe a line of business. Hopefully guidance based on final rule issued November 6, 2014 will be released soon and will alleviate this uncertainty.

   Covered document review date is February 23, 2015. If you participate in the covered document review date it is for financial documents only – all other hardcopy documents are due by March 25th.

   The next Re-compete of Round 1 will occur sometime later in 2015 (after Round 2 re-compete bid window closes.

   Round 2 re-compete changes:

   - CBAs revised to split our counties in different states
   - Product categories changed
   - Enhancements to dBids application: In the past if you had distinct lines of business you may have received errors based on licensure – you do not need to create a separate bidder number for products unique to that location. You can do bidding under one number.
   - The length of the contract is 2 ½ years – allows contract to align with other projects CMS is looking to roll out. 07/01/2016 – 12/31/2018

Previous problems with transitioning patients – does the CBIC foresee any changes in documentation requirements to make transition more efficient.

- CBIC submitted request to CMS program integrity team and discussions are ensuing. Recommendation sent around end of November. A call did occur today with updates but Elaine was not on the call.
- DMACS has not received any Change Requests on transitioning patients.
- In a bid area, enteral patient has pump from non-bid winner, bid winner is providing nutrition needs, pump breaks, non-bid winner doesn't feel incentivized to repair,. Is this a DMAC or CBIC issue – who can help the beneficiary? According to Elaine, it is both and is an access issue. CBIC does have an obligation to invoke grandfathering so the CBIC could reach out to the DMAC to help resolve jointly.

3. Common Electronic Data Interchange Updates –

ICD-10 – test week begins the week of 01/26/2015

ICD-10 April update – last week confirmed 23 new testers, but as of today (01/22/2015) it is up to 32. Forms to volunteer were required to be submitted by yesterday (1/21/15). Any volunteer previously accepted can participate in the tests moving forward. Those who not selected for April testing will be notified via mail of this outcome.

Training occurs Monday, Feb 16 and the CEDI office will be closed

Recertification: 83% recertified with 17% being suspended. Any partner who did not submit recertification, you can re-fill form and be readmitted.

- Recertification for 2015 will begin again on July 1 and end on 12/31/14.

4. PMD Prior Authorization – Kathryn Striewe

Three months into expansion.

Inventory continues to rise – it has not plateaued yet. Staff is in place to handle a higher volume. NGS is monitoring regularly.

Turn-around time is currently 3 – 5 days.

NGS is mulling over how to handle submissions where you know the patient does not qualify. If they made a change, they would need to go to CMS for a change in work load. Must follow demonstration project guide – no way to decipher true medical necessity denials from patient expected denial.

- Providers were looking for an avenue to demonstrate to NGS that we do know the rule and usually know who qualifies and those who clearly do not qualify. At times

patient is insistent we submit for prior auth despite clearly not qualifying – we just don't want these instances to skew the results.

5. Provider Outreach & Education Updates – Charity Mahurin

Staffing changes and expansion in POE.

- Zach Toland has stepped into the lead role for the outreach department
- Amy Musick, Ashley Brambal have been hired as new consultants
- Justin McDowell is the new web reporting analyst
- Hired 6 new nurses – 3 from within and 3 from outside – hired for the documentation review project on hospital beds and Group II support surfaces.

Hospital Bed and Group II Support Surface documentation educational review project is voluntary; may still be subject to audit but hope to remove this as the project evolves. The review team has a goal of 10 days to respond to the documentation review. If the documentation is not deemed acceptable, the provider will be provided reasons for denial. This is an educational review.

- Providers communicated the need to look at 10 day review period as there are a number of patients who cannot wait 10 days – especially patients being discharged from a hospital setting.
- If providers have suggestions on other products to be included in the future, please let Charity know.
- Decisions will be issued as either 'supported' or non-'supported'

Archiving of items on website is limited to 365 days. Provider community is still requesting the 3 year look back period – news items, policy education articles (a little trickier to post because of archiving and placing time stamp on it so it is clear as to when it was written and when it was posted since posting today due to new website.), Q & As are more difficult (CMS requires the information to be up to date. They would have to review the contents every 90 days to ensure it is current which is time consuming. Not sure if move to an archive site if they still need to follow this CMS requirement.)

- Currently cannot search on .pdf document formats. Dear Physician are in .pdf so they created a link to the .pdf to search these.
- Dear Physician letters are under each policy, but if not policy specific, they are found under Dear Physician – not policy specific.
- Per Zach they have all the archive data tagged so once they find a way to post it, they can post it. They just have to work through all the stages to allow them to archive the information.

Connex – appeals section: Many companies are not using appeals via Connex due to limitation of performing one DOS per appeal. This is set as a future enhancement but no time table available. Charity believes there is a work around solution by perhaps using an excel spreadsheet. Charity will

go back and look into this. Zach asked for a rough number of DOS to include: 6 months was the popular number.

Appeals – Could we request an electronic signature on any format of redetermination? A request for change has been submitted, but until CMS makes the change the MACs can't make changes.

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

Articles published since last Council meeting:

- Surgical dressings (will appear today): dressings that make up non-covered situations due to honey, silver, etc.. Any dressing that contain only a non-covered component should be coded A9270. If the dressing contains multiple components, the most predominant component will drive the coding.
- Correct coding – Finger device
- Correct coding – MyoPro assistive device – should be consider DME but under miscellaneous code E1399
- VED – article on pressure of devices. Federal law passed that removes coverage of VEDs after July 2015. (Quality Care for Life Act)
- CERT article – top few denial reasons that are high for each Jurisdiction – external infusion devices and supplies
- November – Medicare coverage for shoes. It is a comprehensive article and published to educational purposes.
- Face-to-face requirements for items on ACA lists – if state requires new prescription. Only exception is when new order is based on state law and not on Medicare requirement.
    - Concerns from provider community on when is a new order really a new order that would trigger a face-to-face requirement.
    - It would be helpful to have examples to help us decipher face-to-face trigger.
- Continuous glucose monitoring device clarification – base item not covered, supplies would not be covered.
- Coverage and correct coding – Quiva (Abbott) drug (immunodeficiency) does not meet criteria to be covered by Part B benefit.
- Fitness monitoring technology – not covered under DME benefit
- Correct coding – integrated respiratory products where RADs can function as a PAP and using as a PAP then code it as a PAP
- Cast covers not covered
- DIFs for enteral nutrition – Recertification for PEN was eliminated but if the DIF is to adjudicate the claim length of need expired, expect to see recertification DIF to extend need. All for DMACs are impacted by this requirement. If length is 99 years – then not impacted. Updated supplier manual to include information.
- Oral Antiemetic Drug Akynzeo – 5HT3 antagonist and NK1 antiemetic – it is covered but need to look and see how to properly bill.

Will be looking at every LCD in the next month or two as they are required to annually review all the policies. Basically proof reading and ensuring correct language – not making substantial changes that would require post and comment period.

Still reviewing policies for ICD-10. Paula asked about wheelchair cushions as some codes were dropped off in error that would create problems. Dr. Brennan stated they would be working on this over the summer and to remind her at that time.

Dr. Brennan will be speaking at some Part A, Part B seminars and if looking to focus on standard documentation language rather than oxygen or PAP. Trying to get them to understand better what we are going through and offer additional education opportunities for their partners.

- NSG is willing to help educate wherever possible and if providers can put together some audiences, NGS will participate. Will do as either a webinar or face-to-face encounter – NGS will even offer CEUs. Events are usually 3 – 4 hours.

7. Open Discussion - All

KE/KY modifier claims – are claims paying correctly as of January , 1 2015? No data available yet. For those paid incorrectly over past year, providers could submit spreadsheets to re-openings but they don't believe the claims have been processed yet and they have received a large number of requests so far. Region C was able to do an express re-processing – can Region B? NGS will get more information.

Modifiers: Statutorily non-covered items: use GY and will receive PR-96 denial reason. Exception would be a manual wheelchair used only for outside the home, obtain ABN for voluntary reasons, submit claim with GY will we receive PR-96 denial. If patient wants to purchase, and we bill with NU the provider will only get CO-108 denial code since provider not following Medicare payment rules which state Medicare will only pay as rental (if claims makes it thru front end edits). This is a CMS issue – not a NGS issue. Need approval to override payment rules. If secondary insurance won't pay on CO-108 can submit to correspondence that states in writing as to what the outcome is if you bill as a purchase. Some secondary insurance companies will accept this letter and override to allow purchase.

Question & Answer concerns:

Question 10 – we have concerns over the order of modifiers. According to Charity, their system will re-order the modifiers once they import the claim.

Question and Answer process – based on the most recent time period we missed vetting the questions more appropriately. We feel crunched on time period currently being followed. By the time we included all stages of review we cannot meet the current time frames. Is it possible to go

back to just submit and review within Region B? Vicky indicated the time the POE has the question could be reduced.

If council has questions prior to meetings and they have checked all the proper channels first, then you may submit the question to dmetraining@anthem.com rather than a POE member so that the question can be logged and tracked.

Region A is looking to send pre-pay audits electronically. Is NGS looking at this? Yes, they are discussing from a Connex standpoint. No update at this point, but discussion occurring.

Discussion on WOPD and signature date: Policy articles do not indicate that two dates are required on script. If a script is sent and the only date is the doctor's signature date, is that acceptable

8. Next Meeting
    a. Tentatively scheduled for Thursday May 14.