DME MAC Jurisdiction C Council MEETING MINUTES

In Attendance

From CIGNA Government Services:

- Christi Courson Claims
- Michelle Thomas claims RAC, Pat Stevens POE
- Olga Sundstrom
- Mark Loney
- Max Garner
- Dr. Robert Hoover, MD
- James Herren
- Ed Lain CMS Contracting Officer Technical Representative
- Zita Upchurch POE

From the Council:

- Laura Hafford
- Todd Tyson
- Tom Hood
- Preston Schoen
- Herb
- Rick
- Kim Brummett
- Stephanie Hess
- Sarah (new guest)
- Peggy Cynthia Jarman
- Teresa Camfield
- Eric Parkil
- Susan Guthrie
- Tom Heinrich
- Donna Leslie
- Claudia
- Laura Williard
- Pam Dentino Olson
- Kimberly Rogers Bowers

CIGNA Government Services

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Document created on February 17, 2011.

Ed Lain, CMS Contracting Officer
(by teleconference)

DME Jurisdiction B has been awarded to NGS and Jurisdiction A is due to be awarded in November.

Any PECOS system warning messages with referring ordering physicians are legitimate. Physicians are still currently enrolling. Warning messages are trending lower.

Competitive Bid program everything is a go and is on track. This program is driving a lot of system changes.

Competitive Bid contracted winners not announced yet. Ed has a meeting to get an update.

Questions from Council for Ed

(Question from Council for Ed) The DME industry has PECOS questions regarding existing patients with MS claims for capped equipment 5-7 years old. RX is lifetime and no requirement to get new RX, MDs may have retired or died. Ed will inquire and have an answer at the next meeting.

(Question from Council for Ed) Request a new provider oversight update: CR went out and was taken back. No new CR issued on this topic yet. It would require system changes which require appx 5 months at a minimum. It would not be able to be implemented for at least 6 mos once announced.

(Question from Council for Ed) FTF requirement for DME: any education issued from CMS on the ACA requirement to have a FTF prior to service. Opinions have been requested of the DME MAC MDs, but no change requests have been issued as to which equipment would be applicable to this requirement. CMS has the option to implement. Several items already require FTF. No new info on this topic.

(Question from Council for Ed) Look back Period/Contemporaneous documentation: no updates on provider compliance group updates or change requests. Ed will look into this and determine if there are any other updates to this issue from provider compliance.

Dr. Robert Hoover Jr., MD, MPH, FACP, Jurisdiction C Medical Director

Medical Policy Updates: (Hizentra and infusion pump LCD) we want to see it included in the LCD. A new J code has been requested currently J7499 but will eventually incorporate into the LCD.

The medical directors are holding a joint public meeting on the Draft Diabetic Supplies LCD 10/26 in Baltimore for Glucose monitor update. This is the first joint public meeting on the topic. Request that providers register to attend if they want to attend or speak. Send comments to any of the medical directors. Send it to the policy comments email address.

(Question asked of Dr. Hoover) What prompted the opening of the LCD? data on utilization, use of the KX modifier, try to update according to current literature for NIDD now long acting doses of basal insulin (make room for those patients) allowances for insulin treated are more than necessary for those taking insulin once a day.

Council is collecting comments and will be forwarding shortly.

Therapeutic shoes policy and article update. Now requires FTF visit and clinical notes. LCD based on 18621A1 1861N (article). Trying to bring it up to date with info in statute as well as quality and supplier standards.

RAD policy qualification for pts with CSA. Central apneas/hypopneas > 50% intent was central apneas and central hypopneas (only measured in academic labs – working with AASM on this issue). Otherwise as it is currently explained in the policy, it leaves a wide door for pts that do not really meet criteria for CSA. Working with AASM to clarify the diagnostic criteria. Todd wants to have Respiratory Event Related Arousals (RERAs) clarified as the LCD states it is not included when calculating the AHI calculation. AASM education contradicts this in the education and physicians are sometimes including them in the calculation.

HCPCS Codes for next year to be announced in a couple of weeks. LCDs w/b updated between Nov-March to reflect new codes.

The Medical Directors are contemplating the idea of updating many policies that will require notice and comments, and would like to update them all at once to add utilization parameters and other language changes that have to go out for notice and comment. Testing out joint comment meeting to streamline resources.

No updates to manual wheelchair codes. The Medical Directors are discussing center mount leg rests and possibly creating a new code other than K0108. Initial response from CMS is that cannot be done because of Competitive Bid. The Medical Directors are still dialoguing on this.

Heat Therapy policy update is slow to progress and has been problematic mainly because of the least costly medically appropriate alternative elimination. Hayes decision from last year requires MACs to address the issue. It is likely the last major policy to be released. Oral appliances for sleep apnea will come out, also working on joint stimulation policy.

26 policies have to be updated as a result of least costly alternative.

Melissa Kirchenbauer, CGS DME Project Director

Melissa provided an overview of the Provider Satisfaction Survey (MCPSS) results. Jurisdiction C got the best score of the four DME-MACs. CGS took a different approach for 2010 and focused on provider inquiries, consistent responses and courteous service. Anyone at the service center that contacts providers has been trained in etiquette and soft skills from claims, reopening, medical review, etc. CGS also focused on the website, including a major redesign for improved navigation. Quality and timeliness of content was also a focus. CGS had the top website scores of all the DME-MACs. POE focused on 1 on 1 education with the top 50 suppliers that caused returned/rejected claims and CGS has seen a 90% improvement. Suppliers that have a high number of reopening requests are also receiving one-on-one education.

In 2011 POE will focus on big venues for offsite education, and spend more time conducting one-on-one education focused CERT and medical review outcomes. POE is in the middle of a project to visit the 60 suppliers who have received the most CERT errors. CIGNA has analyzed data and billing practices, the medical directors and claims specialists and subject matter experts are involved to ensure this project is successful. CMS gave more funding for this line of education. CGS is working with all four regions when dealing with national providers. May see that other jusridictions share data to try and centralize education efforts.

MCPSS will publish a bulletin on what they heard from provider community, subsequent actions taken, and the results. Please continue to provide feedback. Part of the culture is continuous improvement. Let us know how we are doing and how we can improve.

(From the Council members present) General consensus is Jurisdiction C is the most helpful.

James Herren, CGS POE

James announced newest addition to POE is Olga Sundstrom.

CMS is very aware and mindful of CERT education and directives. Therefore the MACs are very focused on one-on-one education, LSOM program large supplier outreach managers program, look at supplier that are highest billers and attaché someone from POE to service their educational need at a higher level for trends management, or targeted education/webinars for those companies. CGS will also continue to work with State Association as the results have been very fruitful. Can do ACT calls and webinars for state associations. Workshop schedules will be revamped, POE is considering covering general topics in the mornings and specific policies in the afternoon. Providers will also see more specific webinars on LCDs. "Mega" workshops are considered, giving supplier attendees the option of customizing a track of education. Ideas from the council are solicited and welcomed. James will provide a list of previously conducted webinars to state associations to offer them as a service to the members.

Presidents Day (Feb 14, 2011) would be the preferred date to do the product demonstration. Rick and Claudia will coordinate from the Council. Will also coordinate the Council meeting from January to coincide with the product demonstration.

POE will also deploy a map of where workshops are being offered.

Michelle Thomas, CGS Operations

Michelle provided a RAC update: still looking at same information no new data. Date of Delivery, inpatient, unbundling of wheelchair accessories, urologicals, and utilization of inhalation solutions are still areas of focus. Known issue with the 30 day vs 90 day for budesonide. Corrected file from RAC was received this week, and some claims will be corrected shortly. Aware of issue with urological bundling with extra leg back being separately payable, and working with RAC how they did this. Some recoupments were issued on this and RAC will determine if there is a corrected file required in this case. Suppliers should still pursue the reopening/appeal process. As CIGNA can correct they will withdraw anything in appeals.

Round Table

With neb meds requirement for span dates to be entered, or narrative for 90 day supply when dispensing fee reflects a 90 day supply. CIGNA will take it back and look at this issue.

Discharge dates with inpatient stays should be able to bill on date of

discharge, or if only part of stay is covered by the inpatient stay should not recoup the full service.

Have examples where offsets occur prior to letter of notification that the RAC would recoup. Please send the CCN and AR #.

Much discussion was had about shipping enteral nutrition to patients in SNF's. Several members of the council had suggestion as to how to make it simpler or easier, but these have all been discussed in the past and none of them meet the statute requirements. The current published instruction is correct.

The number of audits going on is extensive. Looking at specific HCPCS and not as much specific supplier. Expanded number of HCPCs on pre-payment review. Don't expect the number to go down. Have new nurses and new funding in increase, possibly consider new medical director to expand educational resources. Look for the January edition of the DME Insider, CGS will publish some of the directive. The top 10 policy groups do not change dramatically. From utilization, CERT, appeals and similar perspectives, there are no major changes. Wheelchairs, diabetes supplies, neb drugs, PAP support surfaces, enteral nutrition, urological supplies, walkers, lower limb prosthetics, surgical dressings will all be areas of focus in 2011. Service specific will also focus on KX modifier issues with policy focus on GA/GZ usage. From 2008-2010, GA modifier usage was highest for E0570, 6.19% of all claim lines with GA/GZ. K0001 was #2, Oxygen was #4, E0601 was #6 and E0431 was #9. It will compliment the OIG and CMS directives.

Council members inquired as to diversification of the number of audits attributable to different providers. Do a widespread then make decision to more specific service specific edit. CGS announces service specific edits publically. Council suggests webinars and documentation checklists and resource pages be presented ahead of the edit being put in place, so that the education is there before the probes are initiated. From a technical standpoint CGScan use a skip factor for every 4th 10th or 100th claim. Rarely will they do any 100% service specific reviews because of the resources necessary to review those documents. Council request pulling together resources for the "Lessons Learned" documents, and put them together in a centralized location on the website. Documentation check lists are also a very great education tool as well.

CEDI Update

PECOS warnings down to 17%. NSVs required as of April 2011.

EDUCATION

Q2: Gait training or walkers for transfers in the bathroom. Strict reading of the NCD requires a stepwise approach, the algorithm forces a binary decision. Dr. Hoover will take concerns back about clinically documented transfers to the bathroom

RESPIRATORY

Q1 Respiratory - Michelle will take example back to RAC to inquire as to reasonableness and justification for 90 day supply.

Q2 CUE Clinically unbelievable edits implemented to automate claim processing to enforce utilization and max usage.

Question posed that the patient changes to high liter flow. Changes in equipment and new testing information must be provided along with a change in equipment. Could this be considered as a new capped rental period? Dr. Hoover will look into it and research.

REHAB

Q11 wheelchairs are different and subject to new rules. The Physician is the only one that can complete the 7 element order, not the PT or other employee of the physician. Final regulation in April 2006 are just shy of requiring handwritten order not typed or electronic unless generated by the physician and that must be clear.

DME

Q1 All of these are ZPIC denials – these are auto denials. Feedback from the council indicated CO-112 denials told that they would get a letter for additional documentation from Advance Med. Another provider was told that it was an issue of proof of delivery the item specified make and model, but not a product or use of CPAP. Also had issue that physician stated they did not order DME. These claims must all go back through the appeals process. Oftentimes we feel this is the result of how the ZPICs are asking the questions. Can be NPI, HCPC or supplier based. Physician needs to contact the ZPIC directly to have the edits removed. Once data comes back from the physician and provide an affidavit to validate that equipment was prescribed. Physicians do not have a contact person or number at the ZPIC to rectify the issue going forward.

Q2 How will this be implemented systematically. 13 paid months, or expected end date on the dummy CMN? Also how will this affect claims that are under MS for ongoing supplies.

Q3 Products billed by "each" need LT and/or RT (no special order) versus "pairs".

DOCUMENTATION

Q3 Internal compliance document that the patient has the equipment prior to an audit. Pt has the equipment and paperwork is missing, what can we do to rectify this when it is identified? Can refund stating no proof of delivery, other option is to document in files other corroborating information to substantiate that pt has the equipment and received it timely… as long as this is not a recurring issue. RACS and ZPICs are going to be looking at this most closely (if documented with corroborating documentation, providers will hopefully be okay). Include as much collateral documentation and explain the situation as best as you can. Dr. Hoover will look at the question and consider modification or removal of the question.

ENTERAL/IV/PARENTERAL

Q1. Part 1 Do have some wiggle room as to 7 day contact rule and 5 day shipment rule. If patient initiates the return of a response card. Suggest that patient is advised of when to send in response (if have only 10 days remaining, or by a certain date). // Part 2 As long as system identifies the individual patient that is acceptable, but must be in the context of what information is available when logging the note. // Part 3 the manual stipulates what Medicare can and cannot do. DMDs do not have discretion. Oftentimes good clinical judgment results in inconsistencies and errors when applied to the strict guidelines set forth in the PIM, CIM and MCM. Contractors do not have control over statutory guidelines.

Q8. Dr. Hoover will revisit the answered in light of the new direction received from CMS on POD.