

DRAFT
Medicare Jurisdiction A/B PSC and Region A & B Councils
Meeting Notes
February 8, 2007
8:30 am EST
Teleconference

DISCLAIMER:

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Present: Dr. Hughes, Laraine Forry, Tim Pontius, Missy Cross, Todd Dooley, Deb Holman, Paula Koenig, Cindy Folk, Georgie Blackburn, Dave Fiorini, Carol Napierski, Linda Clay, Karyn Estrella, Kelly Barraso, Kimberly Rogers-Bowers, Gloria Murray, Robert Minicucci, Lee Simone, Irene Magee, Jackie McClure, Asela Cuervo, and Rose Schafhauser.

Meeting started at 8:30 EST.

Meeting minutes typed by Rose Schafhauser.

The following were updates from Dr. Hughes:

1. General News:
 - a. Policies: They are wrapping up the policies where there were HCPCS changes. Expect the policies will be released the 1st week of March. The DME MAC's are reviewing.
 - b. Draft Knee Orthosis: Comments were mild.
 - c. Medication Policy: Still working on the Nebulizers. Getting close to the end and should be out in the near future.
 - d. Oxygen Equipment Parts: Dr. Hughes asked for a status from the council for Dr. Edwards is starting to ask for it. Would like to have this by the end of the month. Todd Dooley reported to Dr. Hughes a format has been put together and the council members working on the project will be meeting again.
 - e. Question asked for what the process is when developing a policy for new equipment: Dr. Hughes responded that manufacturers are not required to get HCPCS code or CMS process. Both pieces need to happen. The SADMERC gets the Medical Directors involved.

The following were questions submitted by Council Members:

DOCUMENTATION/REGULATORY:

1. Would you please comment on "Audit implications of a staffer signing a DIF"? This form is new to so many, looks somewhat like a CMN, yet is not an Order. It is disconcerting staff members to sign. Specifically, the 2nd statement in the signature box concerned her that she would be held financially responsible in an unsuccessful audit and not the principals of a company. How is the signature weighted and used if the audit is not compliant.
 - a. **For the PSC and CMS, it is not about who signs the DIF. But attorneys could go after it, therefore theoretically possible if fraud is involved. In audit, the PSC and CMS treat this like any overpayment situation and not go after the individual for it is the responsibility of the company, not the individual.**
 - b. ***Asela Cuervo, Esq., was on call and added she agrees...for other purposes (FRAUD) it may be looked at differently (again implying OIG audit/Fraudulent claims involved)***

2. In TriCenturion's December Bulletin, DISPENSING DMEPOS ITEMS: QUANTITY LIMITS explains that items provided on a recurring basis, as a general rule, may be provided in 3 month quantities and cites items such as DME accessories or supplies, urological and ostomy supplies, drugs, and dressings as examples. The only exceptions mentioned in the article are enteral/parenteral nutrients and supplies and immunosuppressive drugs. Please clarify if this applies to CPAP supplies and wound care supplies.
 - a. **CPAP is considered DME Accessories, therefore you can send CPAP supplies out in 3 month orders. Wound Care is considered Supplies and again, you can send wound care supplies in 3 month orders.**
 - i. **If sending out 3 months of dressings, must still follow CLOSELY to make sure they are used. In audit, this documentation is required. In audit, we'd check that billing was for amount used, billing was for more than shipped or if a periodic adjustment was done to amount shipped due to amount needed on subsequent order. Encourages chart notes/records to be in compliance with requirements.**

ENTERAL/PARTENTERAL:

3. Many suppliers ship FULL CASES when providing nutritional supplement for the month. As a result, the EXACT amount of nutrition shipped may be slightly more than ordered on the CMN. Even if shipping broken cases, the exact amount of calories ordered cannot always match the number of cans sent. Please explain how TriCenturion analyzes, in post pay audit, for compliance with Enteral shipments, specifically addressing the following issues:
 - a. Must the amount billed MATCH the amount shipped?
 - i. **No**
 - b. Must the amount shipped match the calories ordered per day on the DIF?
 - i. **No, it doesn't have to be exact, but close.**
 - c. Can a supplier ship full cases and carry over extra cans to a subsequent month, shipping and billing less quantity?
 - i. **Yes. There must be documentation in the file on why there were cans left over, causing lesser shipment in a subsequent month. Clear documentation must exist showing supplier discussed nutritional needs, changes and adjustments. The major concern that the amount billed is medically appropriate. Audit can be triggered if (1) is supplier is consistently billing for more than what was delivered; (2) is supplier automatically shipping without communication regarding patient requirements and changes.**

REHAB

4. Where can E1038 and E1039 Transport Chair information be found within policy and what is the current medical necessity qualifying criteria for coverage?
 - a. **Not presently in a policy. When the updated Manual Mobility policy is released, it will be included. Coverage really didn't exist prior to the NCD 2005 change that took into account caretakers operating the wheelchair and in his opinion, if a patient could not self-propel any level of manual chair, they qualified for Power – not a transport chair (if they could operate it). Look for new policy guidance.**
5. Clarification is needed on use of the KX modifier'; please confirm if the following is correct:

Wheelchair Seating Policy

With exception of General Use Seat and Back Cushions, a KX modifier is required on all other categories of seat and back cushions or positioning accessories if coverage criteria or qualifying ICD-9 DX code is met?

Yes

PMD Policy

A KX modifier is to be added to the power mobility device and all accessories only if
(A) coverage criteria for product provided is met (B) affirmative ADMC is on file
(B) coverage criteria is met for a Group 3 PWC and a Group 4 PWC is provided

Yes on both

Other KX Modifier issues: Discussed hospital beds with KX modifier – providers have a referral source program and state it would be helpful to be more specific on what documentation is needed. Dr. Hughes will have discussions with the other Medical Directors. He is open to ideas for more specificity.

6. The LCMP Attestation must be signed and dated by a supplier that no financial arrangement exists between clinician and supplier. Must the statement/supplier signature/date be prior to or upon delivery of mobility device?
 - a. **The conflict of interest statement applies prior to supplying the equipment and doing the signature after delivery is inappropriate. The Final Rule intent is fairly strict to prevent over-provision of WC's...rule is meant to restrict. Important to prove there is no financial arrangement.**
7. The Mobility Policy states that Physicians shall document the evaluation in a detailed narrative note in their charts in the format they use for other entries and that the note must clearly indicate that a major reason for the visit was a mobility evaluation.

In audit, you WOULD OR WOULD NOT accept a drafted letter or note from the physician stating he saw the patient for the purpose of mobility?

No, WOULD NOT accept. The requirements are clearly stated and you must be in compliance.

OTHER

8. Other updates, follow up and questions:
 - a. Payment for Parenteral and Enteral Nutrition (PEN) Pumps – option to purchase: Dr. Hughes was to speak to Joel Kaiser from CMS about this.
 - i. **Dr Hughes has not heard back from Joel Kaiser. Suggested we have an attorney address with CMS to get answered more quickly.**
 - b. Oxygen Test date: A Medicare level 2 customer service rep from NHIC told a provider that no longer can our test date be the same date as the initial date on the oxygen CMN based on the change in policy stated below. My question is that the new CMN still states that the test must be "most recent test taken on or before the cert date listed in section A". Is the NHIC rep. accurate?

CERTIFICATION:

For Initial Certifications, the blood gas study reported on the Certificate of Medical Necessity (CMN) must be the most recent study obtained prior to the Initial Date indicated in Section A of the CMN and this study must be obtained within 30 days prior to that Initial Date. There is an exception for patients who were on oxygen in a Medicare HMO and who transition to fee-for-service Medicare. For those patients, the blood gas study does not have to be obtained 30 days prior to the Initial Date, but must be the most recent test obtained while in the HMO.

- i. **The Tri C website, the old oxygen policy is from 2000. This language was in there. Interpreted to include the initial date. The NHIC rep had the incorrect interpretation.**

1. **Action: Karyn Estrella will send an email to Karen Grasso.**

- c. Rental Equipment follow-up: Rental Equipment must be followed with contact every 3 – 6 months etc, demonstrating patient compliance with order and continued use of product in order to be billed to Medicare. Where can this be found?
 - i. **This is not in policy. It has been presented in articles that the supplier is award the beneficiary is still using the equipment. It is actually a billing requirement. Expectation is supplier keeps aware of patient use. Cannot bill Medicare for DME that is not being used. Important to demonstrate follow up with patients, best method is every month.**
- d. DIF for an External pump – if the order is extended or a new order is a new DIF needed.
 - i. **No. Information still applies. If order changes, then yes.**
- e. Oxygen recertification and testing in Group I: Jurisdiction B sent a communication that beneficiaries must be tested with in 30 days of recertification.
 - i. **This is not accurate. This is a national policy.**
 - 1. **Action: Rose Schafhauser to send copy of the communication to Dr. Hughes.**
- f. KX Modifier usage – claims with the modifier were not to deny, but to down code – but claims are getting denied.
 - i. **The policy is set up to pay at the code billing – only down coding is stated in the policy. Jurisdiction B has 2 versions of articles on the KX modifier that is confusing which Dr. Hughes will not put his blessing on.**
- g. Recovery Audit Contractors (RAC):
 - i. **New York is a test site. They are doing a medical review of 2002 to 2004 of old claims. Dr. Hughes had an opportunity to look at some of the decisions. There are some training issues. CMS approached the PSC Medical Directors to do training. Started a few weeks ago.**
 - 1. **Carol Napierski will get back to Dr. Hughes if she hears anything.**