

**MAINECARE/NEMED MEETING**  
**442 Civic Center Drive, Augusta, ME**  
**February 9, 2006**

**MINUTES**

Attendees: (NEMED) Jim Greateorex, Claude Levesque, Rebecca Brownell (Black Bear Medical), Scott Clark & Kim Murchison (Acadia Medical Supply, Mary Nicolantonio (New England Life Care), Craig Dennis (Nestle Nutrition), Jim Puckett & Carol Lawyer (Critical Care Systems), Brenda LaViolette (Framington Medical Supplies), Barbara Tucker (Miller Drug), Paul Petros (Coastal Med Tech), Sean Welton (Community Oxygen), Maureen White & Donna Jones (Lincare), Karyn Estrella (NEMED)

(MaineCare) Beth Ketch, Bruce McLenahan (Pharmacy Unit Manager), Ed Simms (Interim payments), Mary Ann Grover

Meeting commenced: 01:30 p.m.

Please provide an organizational chart with title, contact information, area of responsibility, etc.  
(This is not finalized yet.)

Beth Ketch said that MaineCare is going through a re-organization. They will be hiring new division directors and there will be some shifting of staff. Things will be more settled in the next 2-3 months. She anticipates having everyone in place by mid-end of April. Mary Ann Grover said she is hiring two new nurses for the PA Unit.

**CLAIMS PROCESSING**

Please update us on system problems and when outstanding issues expect to be resolved.

Beth said that she is starting to see more claims go through the system. In her on-site visits with providers, she is finding that some providers are submitting claims incorrectly. Providers had inaccurately been told to use a "Y" indicator on the HCFA form when submitting a claim for the MaineCare co-payment (after Medicare has paid). Beth said providers should omit this indicator.

They are working on streamlining the PA process. If Medicare has approved the claim, providers should not need a PA – the claim should go through the system. Staff have been instructed to force claims for reimbursement when the procedure code requires a PA but Medicare has made a payment.

Beth recommended using the various portals on their website (oms.maine.gov). Use this website for: Payment Lookup; Procedure Code Lookup; MECMS Claims Error Report; MECMS Denied Duplicate Claims Lookup; and Prior Authorization. Information is pulled from their system.

Providers stated that they were getting confusing information from claims staff regarding the "emergency PA" policy. Beth stated that the first month rental for emergency discharge does not need a PA. PA is needed for subsequent months only. Beth said she would speak with the claims staff. Some providers were being told to write in "emergency rental" on the area where you put the codes. Beth said this is not necessary. Providers should only need a Y in EMG (24I) field. Claims staff have received instructions to force the PA on claims that show a one month emergency rental. On subsequent PAs, providers should indicate that they had requested a one-month emergency PA.

For non-categorical clients on oxygen, if the oxygen is needed for longer than one month, call any PA nurse and they will extend it for the following month. No new PA request is needed.

MaineCare is working on automatic crossovers. In the future, crossovers will automatically cross to the State. Their plan is to write rules so that these claims will automatically pay. We do not have a date for these crossovers yet.

- Specifically, when and how will contingency checks be resolved? There is a separate Unit, under the direction of Ed Sims, working with providers at this time to resolve the repayment of interim payments.
- How old are the claims being worked on now?
- What's happening with suspended claims from Dec 03-April 05?
  - Providers who have rebilled have been getting paid. To verify that your claims will pay, send Beth a few original claims (about 10% of your claims). She will run them through the system. If they go through, she'll let you know to send the rest. Claims should be sent to Beth Ketch, Office of MaineCare Services, 11 State House Station, Augusta, ME 04333-0011.
- We are seeing claims released from suspend, going back into the suspend file. Why is this happening, and when will it be resolved?
  - For suspended claims - If the provider doesn't get a satisfactory answer from claims staff, they should ask for an errors history. This screen will give you an idea of what's holding up the claim. Providers should call the claims unit, not the PA unit.
- We are getting claims for clients in nursing facilities being denied for not billing Medicare first.
  - According to Beth, the Office of MaineCare Services has provided information that may be attached to claims instead of billing Medicare first.
- Some providers have Prior Authorized claims being delayed for payment, due to glitch in system when processing these claims. These are the highest priced claims.
  - The "glitch" is that the system is incorrectly seeing the PA number as a referral number. Beth is telling her claims staff that if it's a valid PA number, force the claim.
  - MaineCare will be doing MECMS systems adjustments in the near future. Beth will send list to Karyn which will list all adjustments made. She is not sure when this will happen. In the interim, providers should hold onto their claims.
- Many claims with several line items are being paid at a one-two line item pace.
  - Beth said this should not be happening. The claim should not be split up.
    - **ACTION: Providers should send examples to Beth.**

- We are experiencing secondary claims being denied (Medicare/MaineCare) requesting that they require Prior Authorization, when they don't. What is status of this?
  - According to Beth Ketch, staff at the Office of MaineCare Services have been instructed to force claims for payment when the procedure code requires a PA but Medicare has made payment.
- Several providers report having claims that paid at "zero" in July. In November, they were notified that the claims would be reprocessed but this has not happened. Can you tell us when those claims will be reprocessed?
  - This correction is on the list of system adjustments mentioned earlier. Once the adjustments have been made to the system, the claims will be reprocessed. Providers should not resubmit claims.
- Providers are concerned about timely filing guidelines and claims over one year old. How is the State going to handle these claims?
  - There will be a bulletin explaining the guidelines. They are going to open the window.
- As CMS adds new codes, how long will it take the State to add them to the system? NEMED could be a resource for helping develop allowables that will ensure beneficiary access to products.
  - Beth said that codes should be entered into their system prior to implementation.
- **Interim payments recoupment** - Ed Simms said they are sending letters out to providers who have received interim payments. They are staggering these letters, sending out a few hundred letters every week. The letter will include a spreadsheet showing the interim payments you have received between January 2005 through 2006. There are four options on how to recapture dollars. First, Ed advised providers of a 30-day default period. If you do not respond to their letter within 30 days, they will recoup 100%. If you are not ready for the State to recapture, you need to explain why you are not ready (i.e. claims in suspense, claims not paying). Ex: You received \$40,000 in an interim payment but have \$60,000 in claims that have not been paid. They would then put you in the cue and work with people who are ready for recoupment. When you get the letter, you need to identify claims that have not been paid, they'll be able to validate that. If you have aging receivables, they understand. They will work with every provider on recapturing the money. \$430M dollars were paid out. They now have to start getting the money back. It may take 18-24 months to get adjustments and suspended claims paid.

Ed said that Type 50 MR (MR waiver) providers have been carved out. 2005 claims are being held as an offset and 100% toward interim payments that they have already received. If the provider did not get an interim payment, their claims are still being held. Claims should hold until 100% offset happens, then they would be paid. Ed doesn't think that claims can be released. MR provider claims are paying properly. Offset will happen within one week. You should get payment around end of February (best guess). If you have questions, you can call Ed at 287-5001 or 287-4527 (direct line). However, he prefers email or fax at [iprt@maine.gov](mailto:iprt@maine.gov) or 624-5026 (fax).

The letter will be mailed to the address associated with the provider's tax ID number.

MR providers have received a one-page member with settlement sheet showing payments, returned, recaptured, 2005 claims held and net balance. That is not the letter that outlines options for recoupment. Letter has not been dropped to any MR providers.

## **RESPIRATORY ISSUES**

- Discuss the policy for "nocturnal only" oxygen patients. The State will not recognize an overnight oximetry test from the provider and physicians in general do not supply this equipment in order to test.
  - Sean Welton said that the State requires retesting but it's a problem for nocturnal clients. To get them requalified, they are getting a sleep study done but it's very expensive for the State. State does not recognize companies who do this test for \$40. Providers have the equipment but can't do it. Mary Ann said that a visiting nurse can set up machine, go back next day, download report with provider's equipment, and give to it to the doctor. As long as the provider is one step away from the process, there is no problem. MaryAnn also stated the provider could set up the machine and download the report but the physician had to review and approve the oxygen based on those results. Providers should attach a copy of the tape to the PA request.
  - If bled into CPAP, Bipap, vent, Mary Ann said these are automatically approved and there is no need to recertify or get an oxygen saturation. All you need is a PA request. For children, they look on a case-by-case basis.
- Request for clarification – Providers are receiving inconsistent requests for invoices for equipment that's been supplied for years i.e. CPAP, suction machine. It seems to depend on who is reviewing the claim. Please review the policy.
  - Mary Ann acknowledged inconsistencies with PA nurses however the policy asks for invoices. Providers should automatically send invoices. There is a wide variety of prices on CPAP, etc. Sending invoices helps the State identify if prices are increasing so they know where to increase their fees.
- Scott Clark said that the State has recently begun denying claims for oxygen in a nursing home because the provider did not bill Medicare first. Until recently, the State would pay the claim without a Medicare EOMB. If Medicare does not pay for the item in a nursing home, the provider should be able to get a PA and submit the claim without a Medicare EOMB.
  - **ACTION: Beth said she would look into this.**
    - **According to Beth, providers can attach one of the sheets that we sent out and check off that the member is in a NF.**

## **ENTERAL ISSUES**

- Please clarify enteral reimbursement. We specifically need clear policy on reimbursement for specialty formulas.
  - If given orally or no supplies are involved, it should be billed as a pharmacy item. If it requires any supplies, it goes through DME.
  - For enteral equipment & supplies, they observe the B codes. Mary Ann said there are two ways to submit the claim. If provider wants to use B codes and break down all other

supplies, they have to request through normal mechanism, i.e. provide AAC, plus 40% markup. If markup is higher than Medicare cap, they are not allowed to go above. They have to stop at the Medicare mark up. For Parenteral codes only (B9999, B9998), they are considering establishing a dollar amount per day for everything. Beth has policy people looking at the Enteral/parenteral policy. Providers should let Mary Ann know of any specific issues they'd like the State to look at. State would need to know what a "day" cost would be for Enteral. This cost will vary greatly depending on which enteral formula is prescribed so that will need to be addressed. Scott Clark said the pump sets have different costs – may be difficult to come up with a day cost. Mary Ann said to show three most common pumps, average out cost. They will look at setting up one code with dollar amount with description. Craig stated that providers are not being reimbursed enough to cover their costs. Mary Ann said that the State pays ACC + 40% up to the Medicare max (allowable B code). If this is not adequate, she would need cost breakdowns. She added that sometimes the provider is not using the correct B code. They haven't read the full description for code. Providers should contact Mary Ann with any problems. **ACTION: Scott will provide information to Mary Ann. MaryAnn indicated that she did not get enough information. She also indicated that we pay \$175.00 per day on parenteral and enteral.**

### **REHAB ISSUES**

- Members are seeing wheelchair cushions being reimbursed as rentals instead of purchases.
  - **ACTION: Providers should send TCN examples to Beth.**
- The Allowables for wheelchair seating is in many cases inadequate, in that it is at or below cost, the result being that providers are either being forced to supply inadequate product for clients needs, or more expensive components than what could be provided. The most problematic codes are the new ones E2603-E2619 and E0978. Can allowables be adjusted? We would recommend cost plus 40% for these items.
  - Mary Ann said that is it possible to adjust rates up to the Medicare cap.
    - **ACTION: Providers should send invoices for problematic codes to her attention.**

### **INFUSION ISSUES**

- When will the State be adopting the S codes?
  - Bruce will get an answer on that. Jane Bryson is the team lead, HIPAA expert. Beth will talk to Jane about that.
  - Critical Care Systems would be willing to assist Jane Bryson.
- Compound claims - these claims are currently handwritten and submitted on paper. We constantly have to refax them because "claim is not on file". They also take two or more months to process for payment. Currently the claims go to Gould, then sent to the State for pricing, and then back to Gould for payment. When will we be able to submit claims for compounded drugs online, as required by HIPPA?
  - **ACTION: Bruce will get back to us on this.**

- **A follow-up question that we did not get to ask is: HIPPA requires that claims can not be split as they currently are: Drug to Pharmacy....Supplies to DME?**
- Non-Preferred Drugs - often times we are not notified before a drug goes onto the Preferred Drug List (PDL). The PDL is often not up to date and we only find out about the PA requirement when the claim is denied. It is not until we bill the drug that we find out it has been moved to non-preferred. (Example: IV Zofran now requires a Prior auth for all uses. Providers were not notified.) Can providers be notified of these changes in advance?
  - Bruce asked for examples.
  - **ACTION: Carol Lawyer will get them to Bruce.**
- Not all drugs that require prior authorization are on the Preferred Drug List (PDL). Providers are finding out when their claim is denied.
  - Jim stated that they check the PDL, it says PA not required. So the provider files the claim and it is denied for "no PA". Bruce said the claim should go through.
  - **ACTION: Jim Puckett will get examples to Bruce.**
- Suspended claims - How is the state dealing with suspended claims?
  - It is the supply claim, not drugs.
  - How can we find out if a claim is suspended or not?
  - Will those suspended claims be released once the State starts taking the interim payments back?
    - See above on suspended claims.
- Medicare Part D problems
  - Will the state continue to pay for IV supplies for dual eligibles?
    - Bruce thinks the answer is no, but he will check. In MA, supplies are under the DME section so it is paid via an established S code per diem, as required by HIPAA.
  - Home infusion providers continue to struggle with Part D because it is set up from a retail pharmacy perspective. As new issues arise, who should providers call? Would it be possible to designate a point person for all Medicare Part D issues?
    - Bruce is to research this and get back to us.
      - If the Part D plan doesn't cover the drug that the patient needs and there is no alternative, will the State pay?
    - They are not covering non-covered drugs. Bruce said the State is aware of the issue and they are monitoring it. If the co-pay information is not right or are enrolled in plan and can't get the drug they need, the State will override (for the time being). The State can provide an override for high deductibles or co-pays. Bruce cautioned that this is a temporary fix. Overrides will be tougher to get in the future.
    - If the State pays a claim, will the provider be asked to go back at the Part D plan at a later point for payment?
      - Bruce said that the State would not pay for non-formulary drugs but if the drug is not listed, it might. He was to research this for us.

Jim Greator asked about rumors he is hearing about PinRx – new mail order drug company being run by Indians. Jim is hearing that MaineCare is promoting this company as being the

exclusive provider for MaineCare beneficiaries for diabetic supplies. Jim also heard that if beneficiaries go through this company, they do not have to pay their copayment. Beth said she has not heard anything about this. There is no exclusive company for diabetic supplies in Maine. The State had considered putting diabetic supplies out to bid but felt it was a patient health risk so they did not do it.

Jim explained that the industry is waiting for news on Medicare competitive bidding and the impact this may have on the State if DME providers go out of business. Beth said that they would be interested in learning more about this issue. NEMED should send industry issues to Patty Dushuttle so she can review the impact to State.

Meeting adjourned: 04:10 p.m.