

*Region A Council
A United Voice Representing
HME, Infusion, Orthotics /Prosthetics, and Rehabilitative Technology Providers*

TRICENTURION MONTHLY CONFERENCE CALL WITH REGION A COUNCIL

Date: March 1, 2006 - Wednesday
Time: 8:30AM – 10:00AM

Meeting Minutes

DISCLAIMER:
THE MINUTES FROM THE MEETING ARE NOT OFFICIAL FROM THE PSC. THE MINUTES ARE ONLY THE REGION A COUNCIL'S INTERPRETATION OF THE INFORMATION DISCUSSED AND THE COUNCIL SHALL NOT BE HELD RESPONSIBLE FOR PROVIDERS USE. INTERPRETATIONS CANNOT BE USED TO PROTECT THE PROVIDER IN THE CASE OF AN AUDIT DISCREPANCY.

FINAL

Type of meeting: Conference Call

Facilitator: Patty Reni

Note taker: Patty Reni

Attendees: Tri C- Dr. Paul Hughes, Karen Waddell,

DAC – Laraine Forry, Patty Reni, Dave Fiorini, Georgie Blackburn, , Terri Maggio, Carol Napierski, Jim Cooke, Dan DeSimone, Kimberlie Rogers-Bowers, Karyn Estrella, Jacki McClure, Asela Cuervo, Kevin Quaglia, Rose Schafhauser, Tom Heinrich, Lynda Clay, Missy Cross, Tim Pontius, Jerry Francesco, Jim Cooke, Herb Langsam, Todd Dooley

1. In view of the announcement regarding CMNs, both language changes and deletions, during 2006 will the policies be updated in a coordinated fashion?

Discussion: There is not a lot of policy work that needs to happen -. He anticipates all changes will be published in June. .

Conclusions:

Action items:

Person responsible:

Deadline:

2. (This maybe more a question for DMERC) Is the ABN upgrade policy applicability to a HCPCS coded and recognized oxygen technology such as the Inogen One. We have been receiving some questions from providers wanting to know if they would be permitted to use the upgrade rule to charge the beneficiary extra for the provision of the Inogen One over a less expensive oxygen device to a Medicare home oxygen beneficiary.

Discussion: No it does not apply – upgrade technology only works when you have different codes for upgrades

They are not different than the basic concentrator – This only allows you to bill for portable

Action items: Talk to Health Now regarding how to handle a cash sale for duplicate equipment

Person responsible:

Deadline

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3. Please provide an update on the CPAP policy will the 2 hour time of the diagnostic test be changed back to sleep time or will it remain test time. If it is changing, when will that occur?		
Discussion: The national policy has 2 hrs of recorded sleep time; In response to the sleep community, the MDs changed the policy of 2 hrs of recorded test time. – CMS reviewed the CPAP policy and found that it was out of line with the national policy. The MDs had to change the CPAP policy to go back to 2 hrs of recorded sleep time. For audits - they will be based on policy effective date. The RAD policy will still remain 2 hrs of recorded test time.		
The criteria for CSA has changed for RAD – Newest revision		
Conclusions :Need to go to CMS for a National Policy Request Change		
Jacki will work on talking to the sleep community		
Action items:	Person responsible:	Deadline:
4. When will the new LCD on the RAD devices E0770 and E0471 be released?		
Discussion: The change in pricing category has not been reviewed – downcoded has not been revised in the new releases		
Conclusions: Dr. Hughes is responsible for the RAD policy and will review the policy for downcoding as well as the payment of supplies		
Do not assume that on 4/1 when the change takes effect that providers can bill for supplies. He will try and get an article written		
Action items:	Person responsible:	Deadline:
5. Please give an update on the status of the quality standards		
Discussion: Since the 1/06 calls there have not been another call. He has not had any updates since then. The person leading CMS has been ill and the calls have not been resumed.		
Action items:	Person responsible:	Deadline:
6. Have the DMERC/PSC received any instructions from CMS on the DRA?		
Dr. Hughes anticipates that it will be a while before they receive any instructions on capped rentals and oxygen equipment. Regarding the IFR, Dr. Hughes said that the legislation did not change the requirements for providers. It only impacted what Tricenturion can look at in an audit. Providers should not think that there is a 6-month period where they don't have to get this information. Providers should continue to do face to face visit, Order within 30 days. All the requirements for a written order still apply. If you are in the middle of a wheelchair audit, Tricenturion is not looking whether the face-to-face occurred within 30 days, but providers "should" have it. Dr. Hughes advised providers to meet all the requirements to be safe. After April 1 st , audits that occur will pay attention to the order requirement, did timing of the face-to-face occur in timeframe. If you fall outside the guidelines (not a usual occurrence), make sure that you have good documentation to explain why.		
Action items:	Person responsible:	Deadline:
Waiting for final draft -		

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7. Are the Medical directors working on the repair policy to give guidance on oxygen repairs?		
Discussion: We are ahead of him regarding the DRA with the 36 month or 13 months. This discussion will be held until he has instructions.		
Conclusions: No changes as of yet.		
Action items: Send to CMS	Person responsible:	Deadline:
8. Please refer to Region B Questions		
Discussion:		
Conclusions:		
Action items:	Person responsible:	Deadline:
9. Headline News:		
Discussion: Re: State Association Meetings (Annual) – With Combined regions all funding for travel was omitted – there is language regarding that states associations can offset the charges – if we want any medical directors from any of the PSC – can we pay the travel arrangements, must be approved by CMS. He will need a formal letter. He sent the offer to Region B.		
All the new policies (28) have been revised and will be on the website today. There is also an article (10 pg) that reviews all the revisions. In the documentation section – HIPAA prohibits the PSC from requesting the allowance of sending other documentation with the claims- but there may be indications for “KY” modifier, etc. The question was raised if NHIC will still accept faxed documentation prior to claim submission. – Dr. Hughes referred us back to Amy and Dave Barnett.		

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Region B Council A-Team Questions
Sorted by A-Team

Respiratory Care Equipment/Oxygen Therapy

1. All major IDTFs that are promoting home oximetry (Patient First Testing, Oximetry Company/Web Ox, IDS/Letco Companies, Sleep Solutions) for the purposes of qualifying Medicare patients for O2 therapy are indicating that this type of service can be used for to qualify a patient at rest, with exercise, and/or via an overnight study. Assuming that all of these IDTFs are in full compliance with Medicare Policy regarding this practice (physician ordered test, Medicare approved IDTF, instructions provided by IDTF, sealed/tamper-proof unit) can test results from these Medicare approved testing facilities be used to qualify a patient if the test was performed at rest (spot check)? Can they be used if the test was performed while exercising? Can they be used if the test was part of a 3-Step test (resting, exercise, on O2)? Are they only valid if done as an overnight oximetry study? Please advise as to when and how physician ordered test results from Medicare approved IDTFs can be used to qualify a patient for stationary and portable oxygen as the existing policy is not clear on this issue.

Answer: overnight oximetry only per CMS for oxygen qualification.

2. We billed Medicare for a CPAP mask headgear release clip as A9999RPGA (verified code with the SADMERC) and Medicare changed the HCPC to A9900GACC and denied as CO-B15 (payment adjusted because this procedure/service is not paid separately). We sent a review to Medicare stating that the patient owns the mask and that replacement of the release clip is more cost effective than replacing the mask. We also sent pictures of the part and indicated in the review that the code was set by the SADMERC. The review was denied stating that the headgear clip is not covered because it is included in the allowance for the CPAP mask. Why pay for a new mask A7034 (allowable \$117.64) when we only billed \$11 for the replacement of the clip? The patient's mask is 7 months old and does not need to be replaced. It is not fair to have the patient pay a 20% co-payment for a new mask when he only needs an inexpensive part. Please explain why Medicare would rather we bill for an item that will cost the program and the beneficiary more money?

ANSWER: Theoretically they should pay for repair pieces but he will ask SADMERC

3. Regarding CPAP clients: CPAP patient had a sleep study in the 90's and was on Medicare at the time. According to the Medicare guidelines for coverage **at that time**, the patient did meet the Medicare guidelines so payment was made for the equipment and supplies. Client is returning for supplies, their unit might need repair or the patient has moved into our area and requires replacement supplies.

The patient's sleep study does not have the information required to meet **today's** Medicare guidelines for CPAP. We would not be able to bill using the KX modifier. The main area that is missing from the older sleep study reports is the Pre-treatment time. Often when the person has severe OSA, their Pre-treatment time falls short of the 2 hours required. My questions are: 1- Do these patients need to have a repeat sleep study to determine if they still have OSA and meet today's Medicare requirements? 2- Will Medicare pay for a second sleep study? Is there any Grandfathering in for those patients described above?

ANSWER: CMS states that what happens to someone outside of Medicare is irrelevant-there is not an automatic continuation if they do not meet the Medicare criteria (current criteria) the service will not be covered. In region A it has not been assessed – was there a

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break in service either from non compliance since supplies had not been obtained in many years.

Prosthetics/Orthotics

4. Will Medicare approve and pay for a new lower limb prosthesis for a beneficiary with a lower limb amputation, who has recently taken delivery of a powered wheelchair or scooter that was approved and paid for by Medicare

ANSWER: It is still contradictory equipment – K0 does not get much equipment, Are they able to ambulate and what pieces of equipment can handle their functional deficit. Must do a functional assessment and see what qualifies – use the algorithm. Providers need to be familiar with the lower limb policy

Rehab Equipment

5. We have received a call from a patient's family member that they are checking into a wheelchair for an older parent. They want us to come out to the home to see what might be needed (bath equipment, etc). We check for accessibility, etc. at that time. Is it a problem if we go to the home and do the home assessment BEFORE the physician orders a wheelchair? We cannot find anywhere where it says that the home assessment must be done AFTER the doctor has ordered the wheelchair.

Answer: He does not have any objections about doing the home assessment before the orders. The equipment must be able to function properly in the home. Not important is when you do it but how much documentation is collected when the assessment is performed.

6. The doctor's orders are to be dated within 30 days of the face to face. The orders are also to list all of the items to be dispensed. When the doctor does not order an independent/outside eval by PT/OT (that potentially extends the 30 day time frame), can we prepare the detailed order and ask the doctor to sign off on it for all components since he missed listing some of them? And does that order also have to be signed and received back by us within 30 days?

Answer: Yes for PWD – providers can complete a detailed written order and the MD can sign and date in the 30 day time frame – This is considered a WOPD

7. When we obtain the detailed order for the accessories on a wheelchair will DMERC require the narrative of why the accessories are needed to be on the order?

Answer: No you do not need the medical necessity on the order but they do expect in an audit that the medical necessity should be available from the medical record.

8. When we supply a K0005 wheelchair to a patient, is a letter from the doctor still needed for activity levels or is it now acceptable to get this information on the clinical evaluation and would that be sufficient?

Answer: Yes. The medical record is the medical record regardless of where the data has been collected regarding the functional status

Documentation/Regulatory/Miscellaneous

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9. Would it be accurate to say that coverage situations appearing in the LCD in the "Indications and Limitation of Coverage and/or Medical Necessity" require an ABN in order to receive a PR denial if criteria are not met?

However, coverage situations appearing in the Policy Article in the "Non-Medical Necessity Coverage and Payment Rules" do not require an ABN and should always receive a PR denial because these situations are statutorily excluded, do not meet the definition of a benefit or are classified as non-covered services?

ANSWER: ABN is more in billing; in the LCD is the medical necessity criteria and if you don't meet the criteria the provider will get an CO denial unless you have an ABN; In non-medical it is non covered but he is not sure if you need an ABN and should direct this question to DMERC Operations

Other

10. It gets tougher and tougher to complete in a market where the playing field is not level. When we suspect fraud or abuse as a supplier (Medicare paid a supplier for a power wheelchair that is sitting in the patient's garage and won't even fit in the house, and the patient needs a new manual wheelchair because they are still using their old manual wheelchair in the home and it is worn out, for example), who should we be calling?. We get the runaround when we call to report suspected fraud/abuse. Should we call DMERC Customer Service, Benefits Integrity, OIG?

ANSWER: Contact the Fraud clearing house;

**NEXT TRICENTURION CALL WILL BE
WEDNESDAY APRIL 5, 2006 AT 8:30 AM**