

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

**TRICENTURION MONTHLY  
CONFERENCE CALL WITH  
REGION A COUNCIL  
**FINAL**  
Meeting Minutes**

Date: JUNE 14, 2006  
Time: 8:30AM – 10:00AM

**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 CAN NOT BE USED TO PROTECT THE PROVIDER IN THE CASE OF AN AUDIT DISCREPANCY.*

Type of meeting: Conference Call

Facilitator: Laraine Forry

Note taker: Laraine Forry

Attendees: TriC/DMERC - Dr Paul Hughes, Karen Waddell, Nancy Skorupski, Karen Grasso,  
DAC – Laraine Forry, Dave Fiorini, Herb Langstrom, Jacki McClure, Kelly Brussell, Kevin Qualia, Tim Pontius, Jim Cooke, Rose Schafhauser, Gloria Murray, Georgie Blackburn, Dan DeSimone, Carol Napierski, Tom Ryan, and Asela Cuervo

1. Since electronic claims submission is required, the only document used to determine qualification is the CMN. The infusion pump CMN and upcoming DIF have only one qualification question and it pertains to pain management therapy. When researching an erroneous payment for inotropic therapy, we were told that the CMN for the pump is in “payable” status, however, the medical record shows that the patient has not had the required tests to verify coverage for inotropic therapy. The GA modifier and a narrative stating the required tests were not performed were submitted on the claim and the claim was paid. When the medical policy states that all criteria must be met and the medical record does not support coverage according to the policy, how can the relevant information be submitted with the claim to ensure the appropriate denial?

**Discussion: Claims processing question, should be sent to the MAC. GA modifier doesn't automatically give a denial. It seems correct to Dr. Hughes**

Conclusions:

Action items: **question for next PCOM**

Person responsible: **Rose**

Deadline:

2. If a patient qualifies for portable oxygen tanks, but the supplier delivers a home fill system to facilitate refilling of tanks that includes a Concentrator (E1390) to fill the tanks and tanks (E0431) to use outside of the home. Can a provider bill for both the E1390 and E0431? Even if the patient is using the concentrator part of the home fill system to fill the tanks.

**Discussion: The question is somewhat confusing. There are multiple responses.1. If a patient qualifies on exercise they qualify for both a stationary and portable system. It would be appropriate for the patient to use the stationary system for ambulation in the home. So both codes can be billed – ONLY WHEN PATIENT IS QUALIFIED BY EXERCISE TESTING**

**Patty's Input – If a patient qualifies at rest then they also qualify for portability and should also be able to bill for the E0431 and E1390.;**

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Conclusions:		
<b>Action items: Needs clarification at next call</b>	<b>Person responsible:</b>	<b>Deadline :</b>
3. Have the supplies for the RAD (E0471 & E0472), which moved from the Frequent & Substantial Service category to the Capped rental policy on April separately billable? This was discussed in a previous call and what to be researched.		
<b>Discussion: That language is in the policy article. Accessories are separately billable.</b>		
Conclusions:		
<b>Action items:</b>	<b>Person responsible:</b>	<b>Deadline:</b>
4. Has there been any discussion regarding the changes in Oxygen policy and the process for providers to follow after the 36 months. I.e. backup system, portable refills, home fills units, supplies, maintenance/service, after hour calls, etc.?		
<b>Discussion: CR out there that requires to change the system as of Jan 1. There is nothing happening at the Medical Directors level. Discussion now is how to count the months. Question should go to CMS for it is a national policy that has a lot of details to it. There was also discussion that the National Coverage Policy needs to change as well as the LMRP since both restrict the purchase of oxygen equipment.</b>		
Conclusions:		
<b>Action items: Should be sent to CMS for next Open Door Forum</b>	<b>Person responsible:</b>	<b>Deadline:</b>
5. MM501 states "DME MACs will limit the total number of months for which they make payment for capped rental DME to 13 months. This does not address Break in service in this policy. Will there be a change in how "break in service" will be handle if there is a change in condition?		
<b>Discussion: There is no intent to change the break in service rules. The question was raised on how the break in service will impact the oxygen patient. Example the patient qualifies and then a few months later the oximetry levels are in the normal range. # months later the patient is tested and again now qualifies for oxygen. The primary diagnosis is COPD. Will the PSC/MAC consider this a break in service? Additional discussion is needed on this. IN GENERAL, A NEW RENTAL PERIOD WILL NOT BE INITIALED PURELY BY 60 DAY BREAK IN SERVICE...THE PATIENT CONDITION OR DIAGNOSIS MUST BE DIFFERENT.</b>		
Conclusions:		
6. Regarding External Breast prostheses – if a provider starts a patient with a L8020 (foam) can the provider also deliver and bill for an L8030 (silicone) prior to the 6months lifetime need for the L8020 or must the provider wait 6 months before dispensing. The usual need is for comfort and getting use to the prosthesis. Can the provider dispense both styles at or within the same time period?		
<b>Discussion: No, considered same/similar devices. If you got one, the replacement rules come into play. Patient preference doesn't apply. May be if there is radical medical justification, SUCH AS ALLERGY TO FOAM, IT will be looked at on an individual basis. FOAM PROTHESIS GIVE 6 MONTH WARRANTY.</b>		
Conclusions:		
<b>Action items:</b>	<b>Person responsible:</b>	<b>Deadline:</b>

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7. CR 4253, effective 7/1/06, defines a new temporary battery code, K0733, defined as having 12-24 amp hour sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)
- a. This code is for use in addition to other established codes and not meant to replace any existing codes, correct?
  - b. CR gave 8 appropriate place of service codes to use – this is applicable to all DME, correct?

**Discussion: A. Yes. That is for a specific type of battery as an alternative.**

**B. Looked into the place of service he thought was complete, but may need to talk to someone else to verify.**

Conclusions:

Action items:	Person responsible:	Deadline:
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8. At the June 7 PCOM meeting, we were advised that CR4296, as of 10/1/06, allows a stamped signature/date on ONLY the newly revised CMN formats (Oxygen, Pneumatic Compression Devices, Osteogenesis Stimulators, TENS, Seat Lift Mechanisms). The old CMN formats may be used during the transition period of 10/1/06 through 12/31/06 but DO NOT ALLOW a stamped signature/date and as of 1/1/07, only the new formats may be used:
- c. May a physician authorize (in writing) a staff member to stamp the new CMN's for him/her?
  - d. If only a physician may stamp/date the new CMN, how would a supplier be expected to authenticate when audited?

**Discussion: This is correct.**

**c. It is up to the physician on how this is done. Not something he regulates.**

**d. Supplier doesn't need to be concerned about this. In the future with electronic CMNs may need to be looked at. Still in section d instructions that the physician must complete the CMN. The expectation that the physician remains the primary authorization person, there is no way to know who stamps the CMN. Now accepted signature and date stamps, is ok on the order only. Providers need to understand that CMNs are not the only form of verifying coverage, and for audit purposes, need information from the pt record must be available to verify coverage for the item.**

Conclusions:

Action items:	Person responsible:	Deadline:
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9. CMN rules state an item must be delivered within 90 days of the Initial Date noted on CMN or signature/date of physician. **Does the same apply to a written Order?**

**Discussion: He does not know if they have ever applied this rule. Haven't been compelled to address for there really hasn't been an issue on this. He is not aware of any other time limitation on written orders. Question was asked about the diabetic supplies requirement for annual recertification on quick reference guide, asked for an update. Dr Hughes would look at it. DR. HUGHES STATED ONLY IN CASES WHERE EXCESSIVE QUANTITIES ARE RECEIVED MUST THE PATIENT BE SEEN BY THE TREATING PHYSICIAN EVERY 6 MONTHS. A ROUTINE 12 MONTH ORDER IS NO LONGER REQUIRED (EFFECTIVE 7/1/05) FOR PATIENTS WHO RECEIVE THE ALLOWED AMOUNTS OF SUPPLIES OR EXCESSIVE SUPPLIES**

Conclusions:

Action items:	Person responsible:	Deadline:
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10. When the PSC is requesting information on a CPAP audit, is it sufficient for the provider to submit the diagnostic study only.		
<b>Discussion: The diagnostic study is all that will be required. Normally split night studies are done so the information on the diagnostic and titration studies is normally submitted. The diagnostic study is the only one that the reviewers require in an audit. The diagnostic study should be available.</b>		
Conclusions:		
Action items:	Person responsible:	Deadline:
11. Since the policy requiring an updated order every 12 month for diabetic supplies will Tri C be updating their "Quick Reference Guide" (4/26/05) to reflect the change?		
<b>Discussion: They will consider updating the document.</b>		

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**DR HUGHES HEADLINE NEWS**

Power wheelchair codes released, the Medical Directors will be working on the policy with the new codes. Should be done by Oct 1 when the codes take affect. Will not be a draft policy that came out last fall. They will not be going through that process again. Looking at comments on coverage criteria that was received during the process and will be adopting some, not all. Question, will it be a little before 10/1? 2 ways to go take existing policy and plug codes in. The other way is to take the policy that went out for comment that was a lot more detail. Base revision off of that version, then he would have to give 45 days notices, would have to be out the middle of August as final with an implementation date of Oct 1. He expects the draft policy from October revised based on comments. Update in the July meeting.

External infusion pumps: a question came up. They added a new drug used evaglobin. Was that addition just for evaglobin or be used for subcutaneous of any IV imoglobin (number of IV imo products). No just written for evaglobin. Separate benefit developed another benefit for the other drugs. Added to infusion pump policy because wasn't eligible for the other.

Power Mobility change in documentation that reminds date stamp of face to face in the event of audit able to determine 30-45 time frames met.

NPWT: Now there are other non KCI products on market, section when coverage ends, section 4, ends 4 months, but need more coverage, send documentation in and will be given consideration. Since hard copy is not accepted, that language was eliminated. Now the claims will be denied after the 4 months. Should be seeking an appeal at the first level of the process. NPWT documentation is pretty extensive will not fit in the 80 characters in the field. Claims will be denied and not developed.

RADs separate payment for supplies questions, information in policy article and not in the policy itself.

Oximetry: CMS and the Medical Directors became aware of marketing materials form some of the web based companies that appeared to be inconsistent with the guidance from last year. The bulletin is to serve as a clarification and a reminder of the provider's role. The providers may only deliver and pick-up the oximetry they may not participate in the testing. It further state that the provide may not be sent the test results. The results must be sent to the physician The physician should contact the lab and the test performed after the IDTF has the order. The unit must be sealed and tamper proof.

There was considerable discussion on the bulletin.

1. Question that the guidance seems to prohibit the ability of the provider to communicate with the physician or the beneficiary regarding required retesting per LMRP. Dr Hughes identified that this was not the intent. It was for initial services.
2. Concerns were also voiced that this would prohibit the normal communication between healthcare professionals. Example: A RCP employed by a company is doing a follow-up assessment on a patient that has a CPAP. During the course of the assessment it is noted that the patient has complaints of SOB and morning head aches. The RCP contact the physician to notify the physician to alert him to these symptoms. The physician then orders an oximetry. The therapist states that they can perform a screening test but that an IDTF must perform the diagnostic study. The physician request that the study be done. A request is then made for an order to perform the test. Him of the change I
3. Comments were also made that CMS is moving towards to preventative services, this type of test is a quantative test, not consumer driven, that providers do a quantative test is just good clinical care. It is good clinician practice to get them diagnosed earlier.

Response: It would be great if everyone approached the process this way. But some providers operate in an inappropriate way; The PSC needs to identify vulnerabilities of abuse in the program. Dr Hughes says there is nothing impeding to inform the physician of the patient's symptoms and leave it up to the physician to order. The bulletin is written broadly, it was suggested that perhaps setting out the perimeters that are appropriate for providers might be helpful. Dr Hughes will talk to the other Medical Directors. IDTF marketing materials may need to be looked at, appear to clearly put the provider in an inappropriate role.

Questions

1. If the provider receives a call from the physician for testing, initiating the order, CMN faxed to physician

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first for completion before going to the IDTF is ok.

Response:

1. No problem of the provider conveying the physician order to the lab. Do not want the supplier contacting the lab to then contact the physician to initiate the order.
2. Providing the details of the test to the provider is a HIPAA violation, for the lab to give it to your directly it is in appropriate, this was questioned and Asela, indicated that the provider is a covered entity and this would not be a violation of HIPAA. She will do further research and contact Dr Hughes.
3. Dr Hughes will discuss some of these issues with other Medical Directors. We offered to provide some examples of how the current bulletin would prohibit the continuity of care. Dr Hughes stated h would welcome the input.

Region B is forwarding our questions to Dr. Hughes and he doesn't address as Dr. Oleck did. As identifying the difference

Work in process of combining the website to include Region A/B policy, no time frame given to when it will be done. Will give references to Region A Region B MACs. It is being worked on.

Neb policy update: looking at the comments received. No further update. The other projects must be done before they finish the work on the policy.

CPAP policy: received a few calls from clinical physicians about the issue about the testing time, clinical organization will approach CMS to revise the policy. They will be in support of this happening.

**Next meeting will be July 5 at 8:30 AM EDT**