

**JURISDICTION C COUNCIL MEETING**  
**October 21, 2009**

Jurisdiction C Council Attendees: Claudia Amortegui, Cynthia Jarman, Eric Parkhill, Herb Langsam, Jackie Bolt, Kimberlie Rogers-Bowers, Laraine Forry, Laura Williard, Laura Hafford, Mike Hamilton, Pam Dentino-Olson, Peggy Walker, Rick Clark, Stephanie Hess, Sylvia King, Teresa Camfield, Tom Hood, John Shero, Randi Neal, Preston Schoen, Susan Guthrie

CIGNA Attendees: Melissa Kirchenbauer, Dr. Robert Hoover, Erin Moorman, Pat Stephens, Michelle Thomas, Stephanie Garner, Velisa Baker, Ellen Edenfield, Tricia Luna, Jon Bergey, Kim Largent, Damien Moss, Vivian Adams, Max Garner, James Herren, Taveo Perry, Zita Upchurch

**CMS Update – Ed Lain and Karen Jacobs**

1. Karen Jacobs a DME Expert was introduced and on the call with Ed Lain.
2. Claims will still be denied if physician not enrolled in PECOS, with current information; an implementation plan is in the works. Non-enrolled, retired or deceased physicians will also create problems. Suppliers should ask patients if they are seeing a new physician. Ed says that Meeks bill looked passable. Ed Lain asked that the Jurisdiction C Council send recommendations to CIGNA to forward to him on a recommendation for PECOS.
3. The letters sent to beneficiaries by CMS if they had received services from a non-qualified supplier was discussed. Ed Lain had no knowledge of the letters being sent or the logistics surrounding the letters. Issues discussed were that the supplier is not identified. There are also some qualified suppliers that have been dropped from web provider list (Med-Par database). Ed will follow up with information on what timeframe of services were looked at to determine who should receive letters.
4. The issue was raised again as it is becoming more frequent regarding oxygen patients whose suppliers went out of business. Karen Jacobs requested that the council forward to CIGNA to be sent to her any oxygen providers that have gone out of business. Ed Lain stated that we should take these patients on service and as part of taking care of those patients a supplier would be able to provide other medical needs for this patient. It was discussed that with these patients they have normally already exhausted the cap on other needed equipment. CMS is aware of this issue.

**Medical Policy Updates – Robert Hoover, M.D.**

1. Oral appliance policy has benefit category issues and responses to comments; MDs are trying to get a definition that fits DME, along with a change to maybe a 3 year useful lifetime.
2. Study the revision history of modifiers; action required by suppliers to assure proper modifiers are in place before filing. Lack of KX is causing too many change/reopen requests. These will have to go to redeterminations.
3. Pre-Payment Review-Emphasized the need to assure that policies are followed to the letter, as the pendulum has swung back to the anti-fraud side and it is still moving toward tighter enforcement. Medical review usually follows, and will be forced to tighten enforcement. Policies that will either be looked at from prepayment probe are K0823, oxygen, and PAP. Pre-payment audits will increase through the next year. Medical

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- review has been working on a strategy document (work plan) for next year, to be submitted to CMS. Will include tougher checks on PMDs, PAP, oxygen, nebulizers, glucose monitors, diabetic shoes, enteral nutrition. Prepay edits will be turned on to grab a batch of claims, which will be audited to define the type and level of problems; then turned off until a plan is developed. Everyone is moving toward prepayment review, with a 60-day window for processing. Prepayment delays have already moved from 4-6 days to 41 on average. Products and numbers are adjusted to match workload and available staff, but will be 100% for short periods of time. Both supplier-specific and product reviews are processed by age; oldest first...both are in the same claims bucket. Edit for CPAP will be turned on within the next 4-6 weeks; oxygen and power wheelchair errors are well known, but not CPAP. Delays in processing will vary, in part depending on speed of supplier response, mostly between 40 and 60 days
4. Lookback Period- The lookback period was discussed. Issues discovered will result in bulletins, reminding suppliers CERT results affect look-back periods, but different products will have different look-back periods, probably 3, 6 or 12 months. Information may be LCDs, but they may be published only in the PIM. Certainly they will be in the PIM first. There was a question regarding if Jurisdiction C Council had responded to the lookback period. It was stated that the Council's response was included in the AAHomecare response. Dr. Hoover requested that if we were going to do this in the future that we let him know for his meeting with the other Medical Directors.
  5. A new effort has been established to assure that audited suppliers understand why they got audited, what they did wrong, and assure they have a workable plan in place to correct the problems. Will require submitting corrective action plans.
  6. Nebulizer policy has been revised to eliminate requirement for trying short-acting products before Rx long-acting drugs. Matches current clinical opinions.
  7. Electronic signatures are still being debated at CMS and are not expected any time soon.
  8. Prescriber Legibility-CERT denials will enforce legible signatures (identifiers) on orders, progress notes, and any documentation. New information will be published soon. A draft with approximately 3-day comment period will be published, and the final result will apply to all contractors, so it will affect physicians, as well as suppliers. Information on this topic can be found in the PIM at 3.4.1.1.B.

#### **Provider Outreach and Education – James Herren**

An update was given on the Medicare Survival Guide – Partnership with State Associations. James requested again that the state associations push the webinars and ACT calls available that can be tailored to the associations needs.

On IVR, eligibility will show patient is enrolled, but if you check only for CMNs, the message will say no record of patient; actually means no CMN on file.

#### **RAC – Christine Castelli (Connolly Consulting)**

1. (By phone:) (All operations are in Philadelphia) Staff includes doctors, nurses, therapists (PTs & OTs) and certified coders. JOA first established w/ CGS (cooperation level is high)
2. Early in project, beginning in August; DME at end of September, w/ 600 claims (approx). Results (2) posted on web site, so as to educate suppliers. Must be approved by CMS prior to posting, and must be posted before any recovery begins. Wheelchair and urological bundling are the only two DME issues currently approved. [connollyhealthcare.com/RAC](http://connollyhealthcare.com/RAC) look under "approved issues" as well as looking at contact form and customize your address (to assure material gets to the right person); change as needed. Results may not recover huge sums, but might produce recommendations to

CMS for policy or enforcement changes. DME not producing high dollar amounts, but other groups are...the amounts recovered are secondary to changes that CMS will institute as a result of the information discovered.

RAC audit will allow 15 days for rebuttal before generating OP requests.

### **PECOS – Karen Hughes and Mandy Young (Part B – Provider Enrollment)**

1. An update to how PECOS works on the Part B side was given. Forms 885-B, R & I goes to Part B contractors; information from all states available to others; begun 12/2003, moved to Internet 12/2008, available since April 2009, with edits to assure forms filled out correctly. One enrollment required for each TID number. Any physician who has enrolled in Part B since 2003, or who has made a change that affected their Part B, such as name change, new address. New enrollments and changes can be submitted on paper or via a web form. Bulletin has been sent to physicians indicating the need to report changes, but if nothing has changed, they can still be paid. MLN was sent to all enrolled physicians. (Get link for look-up and publish) Warnings are generated by such things as mismatched names, etc., where physician is in PECOS, but information is not up to date.

### **Q & A Review - All**

#### **Operation Process Review – Stephanie Garner**

1. Redeterminations fax moved to server in first or second week in November (same number; will just reduce busy signals and timing)
  - a. Redetermination Letters-New redetermination letters will be modified, geared more toward suppliers, (rather than beneficiaries), will reference an LCD, (not quote it)
  - b. Make sure CBIC information matches what you send to redetermination, or state that information is not available.
  - c. Rivertrust materials should go directly to that contractor, as sending to CGS delays processing about 30 days

#### **CMS Issues Update**

- a. ABNS - CMS position is that education is available, and no exceptions are available. Be very specific in describing reason, and don't use the exact same one every time. Many are too vague, but specific information is required; not the whole LCD.
- b. Repair Limitations – James will follow up on this and report back to the Council.
- c. Rehab Equipment – 7 Element Order - supplier-created forms denied, when what is actually supplied is the CMS-required 7-element order. James will follow up on this and report back to the council.
- d. Oxygen maintenance and service payments will be continued in 2010.

Dates for the next meeting were reviewed and approved. Meeting with CIGNA will be held January 20, 2010.