

CIGNA

**Moderator: Ronja Roland
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1:00 pm CT**

Operator: Good day everyone and welcome to today's specialty Ask the Contractor teleconference. As a reminder, today's call is being recorded.

I would now like to turn the call over your host, Ronja Roland. Please go ahead.

Ronja Roland: Good afternoon everyone and welcome to our specialty CIGNA government services Ask the Contractor teleconference. I am Ronja Roland who will provide outreach and education today. So I will focus strictly on glucose monitors and supplies.

I would like to say thank you to all suppliers that are also participating in today's call. Your participation is an important way for us to better meet the needs of you, our supplier community. Representatives from our medical review department are available on today's call to loan their expertise, to answer your questions pertaining to glucose monitors and supplies.

Today's call will highlight key requirements for glucose monitors and supplies. We do encourage you to read the local coverage determination as well as the policy article in its entirety. The LCD for glucose monitors and supplies is L11520. The policy article for glucose monitors is A33745.

Let's begin by looking at the coverage criteria. In order for Medicare to consider coverage for glucose monitors and supplies, the patient must meet the following criteria. The patient has diabetes as diagnosed by specified ICD 9 codes 249.00-250.93 and their diabetes is being treated by a physician, the glucose monitors and supplies are ordered by the treating physician who maintains records reflecting the care provided including, but is not limited to, evidence of medical necessity for the prescribed frequency of testing, the patient or caregiver has successfully completed training or is scheduled to begin training for use of the monitor, and supplies. The patient or the caregiver is capable of using the test results to assure appropriate glycemic control, and the device is designed for home use. If the basic coverage criteria are not met, the items will be denied as not medically necessary.

Glucose monitors with special features are covered when the basic coverage criteria are met and the treating physician certifies that the patient has a severe visual impairment requiring use of special monitoring system.

Let's take a look at the utilization guidelines for insulin and non-insulin treated patients. For a patient who is currently being treated with insulin injections, they're allowed 100 test strips and up to 100 lancets every month. For patients that are not being treated with insulin injections, they are allowed 100 test strips and 100 lancets every 3 months.

For patients that require more than the utilization guidelines, there should be evidence that the treating physician has documented in the patient's medical record the specific reason for the additional materials for that patient. The treating physician has seen and evaluated the patient's diabetes controls within 6 months, prior to ordering quantities of strips and lancets.

There must be documentation in the physician's record. For example, a narrative statement that documents the frequency at which the patient is testing or within the supplier's records there can

be a copy of the beneficiary's log that shows the patient is actually testing it at a frequency that corroborates with the quantity of supplies that have been dispensed.

If the patient is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every 6 months. Suppliers should remember that you must not dispense a quantity of supplies, exceeding a beneficiary's expected utilization.

Suppliers should stay attuned to atypical utilization patterns on behalf of their clients and their file with the order of physician that the atypical utilization is in fact, warranted. Regardless of utilization, a supplier must have dispensed more than a 3-month quantity of glucose testing supplies at one time.

Let's focus now on the documentation requirements for monitors and supplies. The order for the monitors and supplies must include all of the following elements; all items to be dispensed, that will include the monitor and of course, any supplies to be used with that, the specific frequency of testing, the treating physician's signature, the date of the treating physician's signature, and a start date of the order.

And that is only required if the start date is different than the signature date. Please remember that an order that states as needed will result in those items being denied as not medically necessary.

A new order is required when there is a change in the testing frequency. For additional details regarding documentation, as well as proof of delivery requirements, you can refer to chapter 3 of the Jurisdiction C Supplier Manual.

Billing reminders for providers include the use of the appropriate modifiers. The modifiers used with glucose monitors and supplies include KX, KS and KL. A KX indicates there is specific

required documentation or file. If the patient is being treated with insulin injections, a KX modifier must added to the appropriate code on every claim submitted.

With the KS modifier, that in indicates these supplies are for diabetic patient not treated with insulin. A KL modifier applies to those diabetic testing supplies that are delivered by mail. This is part of the competitive bidding implementation. So remember, if the items are delivered by mail, you must append the KL modifier. The codes would also include any appropriate pricing modifiers as needed.

For providers of glucose monitors and supplies, the Jurisdiction C Medical Review will be initiating prepayment reviews of overutilization claims. The reviews will focus on codes A4253 which is monitor test strips and A4259 lancets and that is for claimed bills for non-insulin treated beneficiaries. Non-insulin treated beneficiaries are identified by use of the KF modifier.

Jurisdiction C has received a high volume of claims for over utilization for non-insulin treated beneficiaries. As I mentioned, the utilization guidelines for non-insulin treated patients are 100 test strips in a 90-day period and 100 lancets in a 90-day period.

Suppliers who have submitted claims selected for review will receive a documentation request letter in the mail, asking for specific documentation that must be returned within 30 days of the date of the letter or your claim will be denied as not medically necessary.

Once the letter is received, the provider's response to the letter should include a copy of the order for the testing supply, documentation of medical necessity for the testing frequency and documentation about usages of supplies, proof of request for refill, proof of delivery, and patient or caregiver education.

We will take a moment to focus on items 2 through 5. When documenting the medical necessity of testing and usage, documentation must be actual medical records and not something like a physician's letter or signed attestation on a supplier form.

Also, the reason for the usage should be patient specific and not a generalized statement. For refill, supplies must contact the beneficiary no sooner than 7 days prior to the delivery of shipping date. This is to ensure the refilled item is necessary and to confirm if there are any modifications to the order.

There are two ways to document this information a signed and date of reply card of phone conversation with the beneficiary. If the beneficiary is contacted by phone, documentation should include the patient's name, date of contact, statement indicating the supply was nearly exhausted, and the initials or name of the employee taking the message.

Delivery requirements are outlined in chapter 3 of the Jurisdiction C Supplier Manual. There are three methods of delivery for glucose monitors and supplies. For deliveries direct to the patient, the delivery ticket should include patient's name, quantity delivered, a detailed description of the items delivered, and the brand name or serial number.

Remember that if someone, other than the beneficiary signs for the supplies, the delivery slip must clearly identify the name of the designee and their relationship to the beneficiary. A return postage-paid delivery invoice is acceptable as long as the information on the item delivered and required signatures are included.

If a shipping service or mail order service is used, proof of delivery would include the service's tracking slip and the supplier's shipping invoice. The supplier's records should include the service's specific package ID number. The tracking slip should reference the individual packages.

Regardless of the method used, it must be clear from the documentation submitted for proof of delivery who received the supplies and when. Medical review staffs often has difficulty with some of the delivery services tying a specific package to a specific beneficiary.

And lastly, documentation of patient or caregiver education should be documented by the treating physician and should include evidence that the patient or their caregiver has completed training or is scheduled to be in training on the use of the monitor and supplies, and evidence that the patient or caregiver is capable of using the test result to assure appropriate glycemic control.

Before we close, I would like to include a few examples of errors found by medical review nurses. 46 of 69 claims reviewed had no documentation or lack of documentation from the physician for the additional quantities.

5 of the claims have documentation greater than 6 months old, 13 of those claims lack proof of delivery, there was no address on the tracking slips on no signature that the patient had actually received the supplies and with many of the claims, unable to tell what was shipped, where it was shipped and who actually received it.

Other issues identified in some of the claims reviewed, the patient log is different from what the physician is ordering. The physician order is not complete, the wrong modifier is used, whether it should be the KS for non-insulin patients or KX for insulin treated patients, and there were multiple changes to the physician's order. However, no initials or date were included on those changes. The physician orders may state three times per day written in, however, it may be right next to that two times a day.

The Jurisdiction C Medical Review Department has a section on the DME MAC homepage under the medical review section.

You will find the link blood glucose monitors prepayment and its resources. This section contains information related to glucose monitors and supplies such as our Medicare minute, a video presentation by our Medical Director, Dr. Robert Hoover. Please visit this section for additional information.

In conclusion, this covers the coverage criteria portion of the call. We will now open the phone lines for your questions. Please keep in mind that our questions should be related to today's topic of glucose monitors and supplies. We will also be unable to address questions about individual claims or claims specific denial.

If you have questions regarding that, you may contact customer service at 866-270-4909. We would like to thank you for participating in today's call and we will now open the lines for questions.

Operator: Thank you very much. If you would like to ask a question today, it is the star key followed by the digit 1 on your touchtone telephone. A voice prompt will come on the line and let you know that your line is open to ask a question. We do ask that you state your name before posing your question. Once again it is star 1 if you would like to ask a question.

We'll take our first question now. Your line is open, caller. Caller, your line is open. Please go ahead.

Male: Instead of utilizing a patient log for verification on utilization of testing supplies, whether they be insulin or non-insulin, a downloading of a particular meter itself and print out on a Excel spreadsheet. Would that be acceptable in lieu of a log?

Ronja Roland: Yes. That would be considered a log, so that is acceptable.

Male: Thank you.

Ronja Roland: Thank you.

Operator: We'll move on to our next question now. You're line is open, caller. Please go ahead.

Female: My question is about the placement of the KL modifier. I've been told by Jurisdictions A, C, and D that it doesn't matter where the KL goes. Jurisdiction B is insisting that it goes in front of the KX. Does anybody have an answer for me on that?

Ronja Roland: Your pricing modifier should always come first which would be this case and you – and at that point, you will either append your KS or KX and then your KL modifier.

The KL is simply an informational modifier so that we know to apply the 9.5% reduction based on that being part of the round one competitive bidding.

Female: OK. Excellent. One more question.

Female: End-stage renal disease. Patients now are testing four to five times a day with the 205.4 diagnosis code. Is that enough in the medical records? Is that justify testing that many times?

Ronja Roland: And you said this – I'm sorry. You said it's for end-stage renal disease patients?

Female: Exactly. And the doctors are testing blood sugars five to seven times a day due to and then the diagnosis code is the 205.4. Is that justification for testing five to seven times a day?

(Robert Hoover): No. This is Dr. Hoover. And let me get the diagnosis code correct. You said, 205.4.

Diabetic supplies are covered under a specific place in the Medicare benefit and it's only for diabetic patients and so that's why we have that 249.00 through 250.93 as the – as the only acceptable ICD-9 diagnosis codes.

It's one of those situations where it may be medically appropriate for that end-stage renal disease patient to be testing their blood sugar, but unfortunately, it's a situation where there's no Medicare benefit for those supplies.

Female: All right. Understood.

Ronja Roland: Thank you.

Female: All right. Thank you.

Operator: Thank you. Once again if you would like to ask a question, it is star 1. We'll be going to our next question now. Your line is open, caller. Go ahead please.

Female: Yes, I have a question. If I currently have a patient that the doctor has requested three times a day, but they only check themselves two times a day, is it my responsibility to get a new prescription every 6 months because they're not compliant what the doctor has said?

Ronja Roland: OK. In your situation, you're dispensing what the physician has actually ordered. So in this instance, we cannot determine over utilization, so new documentation would not be required.

Female: OK. So then it is OK like if the doctor puts three times a day, but don't need to do it twice because a home health nurse does it one time a day with their own supplies?

(Robert Hoover): Well, this is Dr. (Hoover) again. I think what – you know the point of the policy in it and it talks about you know monitoring the patient's utilization, if your – if the patient is only testing twice a day and in terms of supplies from you, then that's what you would be dispensing to them and bill to them and we would take that into account in a review of we were looking at the physician's order.

Female: OK. But I don't need – that's what I'm saying, like you know – we took them and you know they said three times a day and then when we – when we were calling before the 7 days to dispense, and they told me no. But my question is, am I supposed to ask them why not? Or just like, "No. I have enough that should be sufficient for me. Call me back in a month."

(Robert Hoover): I don't think you have to challenge the patient on that. I think you probably want to document in your files you know that you've contacted the beneficiary and they haven't exhausted their supply due to testing with your material twice a day and an additional test per day from a home health nurse.

Female: OK. That's what I need to know. Thank you, doctor.

Ronja Roland: Thank you.

Operator: Thank you. We'll move on to our next question. Your line is open, caller.

Ronja Roland: Yes, hello. Go ahead with your questions.

Female: Yes. When you were giving instructions about the billing, you said that we have to have evidence of training by the physician for the patient or the caregiver. That training has to be done in the physician's office?

(Robert Hoover): No. There just have to be documentation in the patient's medical record from the physician, the treating physician that the patient has been or their caregiver has been trained on the device and that they know how to use it.

You know there is a benefit within Medicare for a certified diabetic educator. It can be either done individually or in a group setting. That training is billed to the part of the local carrier, but a number of diabetic patients have had training in that setting and they would just need to have – the documentation.

Female: OK. Because most of our clients that come in here, most of them, well, not most of them, all of them, we train them on the usage of the meter. I guess because there are different meters? I guess what I'm trying to say is, most of the physicians here don't – I don't think they give training on the usage of glucometers.

(Robert Hoover): Unfortunately, the requirement for beneficiary education and training is in the National Policy. We just mirrored that requirement in our Local Coverage Determination. So, it is one of the things that we'll be looking for in our review.

Female: OK. So, when the patient comes in here, we need to ask them if they've been trained?

Ronja Roland: Yes.

Female: Another question I had. You spoke of the KS and KX modifiers. We use the KX modifier when we have documentation even if the client is non-insulin?

Ronja Roland: No. The correct instructions, the KX, just the definition is that the specific documentation is on file. However, for this particular policy, it is used for those patients that are insulin treated.

Female: OK. What if someone that's non-insulin treated and the doctor request them to test two or more times a day because of their fluctuating sugars?

Ronja Roland: I'm sorry. Could you repeat that for me?

Female: We have clients that come in here. They're non-insulin dependent clients, but the doctor writes on the order that they need to test two times a day, four times a day because of fluctuating sugars.

Ronja Roland: Then they're still considered non-insulin at this point. They would fall under the over utilization guidelines and then as I mentioned, it's also located in the LCD, you would need to make sure you have the specific documentation if they are going above Medicare's parameters for non-insulin patients.

Female: OK. My question is, we still use the KF modifier and extend the dates for 1 month?

Ronja Roland: Yes. If they are not insulin dependent patients or not being treated with insulin then you would use the KF as I'm saying, modifier.

Female: OK.

Ronja Roland: OK? Thank you.

Operator: Thank you. We'll take our next question. Please go ahead, caller.

Female: Hello.

Ronja Roland: Go ahead with your question.

Female: OK. I'm on a modifier problem too. It seems to be that it's the norm for today. I've come across some problems I'm having. I'd usually had been using previously NU, the KS or KX and then a KL modifier and those claims aren't going through.

Then I changed it to a KH modifier instead of the KL. I'm just wondering, do I need those three modifiers or can it go with just the NU and the KS?

Ronja Roland: OK. Let me ask you this because you're saying – are these supplies being sent by mail order?

Female: Yes.

Ronja Roland: KL is the only modifier. KH is a totally different modifier that does not apply to diabetic supplies.

Female: OK.

Ronja Roland: The KL is the appropriate modifier if they're being shipped or being sent by mail order ...

Female: OK.

Ronja Roland: ... because again, that will apply the 9.5% reduction.

Female: Or maybe that's what it is, the placement codes.

Ronja Roland: That should be it. Originally, we were told that it did not matter,

Female: Great. Thank you so much.

Ronja Roland: Thank you. And also, if anyone happens to disconnect from the call before today, the minutes from this call will also be posted on our Web site no later than 10 days. So you can also go back out to the Web site under the ACT link and you can actually go out and read the minutes or the transcript from this call. So we'll go and take our next question.

Operator: All right. Thank you. We'll move on now. The line is open, caller. Please go ahead.

Female: I have a situation where the doctor ordered insulin. He said the patient's on insulin three times a day which would be a low frequency tester. However, the patient is testing three times a day that tells us they're not using insulin.

Do we have to get new documentation every 6 months because essentially, the patient is a high-frequency tester really? So they're not using insulin. Or do we go by what the doctor ordered?

Ronja Roland: (Carol Bradley), if you are there, if you don't mind to respond to the question?

(Carol Bradley): They're not getting insulin.

Female: Right. we have a order from the – a form from the doctor, ordering, saying that the patient is on insulin, testing three times a day which would make them a low frequency tester, right?

(Carol Bradley): Well, it would make them a normal frequency because ...

Female: Right. Normal frequency.

(Carol Bradley): ... you get three tests a day.

Female: Right. So we would not need new documentation every 6 months but the patient is not compliant. They're testing three times a day but they're not – they're telling us that they're not using insulin. They're not on insulin. So, do we now have to get new documentation every 6 months on the patient?

Because they're actually acting – they're actually acting like a patient who's not on insulin even though the doctor says they should be on insulin has ordered insulin for them.

(Carol Bradley): So you think the doctors' order that the patient's just not taking it?

Female: Yes, because the – I mean the patient, when we talked to the patient, they don't want the insulin. They are not getting insulin from us and they're saying that they're not using insulin, but they are getting enough strips and lancets to test three times a day which would you know say, we're not on insulin. We make them a high frequency tester or you would have to get repeat documentation every 6 months.

(Carol Bradley): And you're really not sure – you have log to show that they are testing at that frequency?

Female: Yes, we do.

(Carol Bradley): Well, I think I would probably try to get that clarified if ... the patient insists that they're not on insulin, then I think the safest thing to do is to protect yourself ... is to get those logs. Or else, if the patient just sign an ABN, to say that you know that the – you don't have enough information to show that they qualified a test more than once a day.

Female: OK. All right. Thank you. Thank you, Carol.

Operator: Thank you. We'll take our next question now. Your line is open, caller.

Male: Yes. I had a question about the physician's documentation for over utilizers and this is more of a suggestion. Do you suggest that we get copies of the patient's chart for every over utilizer or just a statement from the doctor that says, I do have this information documented in my charts?

(Robert Hoover): It's Dr. (Hoover). We can't require that you get that information. I mean the policy says you know to have an available upon request, I would suggest in this environment where the office of inspector general is looking at more claims, the sort of contractors looking at more claims, and the contractors are looking at more claims.

It would be wise to get the documentation and this would apply to anything, just not even just diabetic supplies but anything. I would try to get as much of that documentation as you can up front from the physician's office.

Male: In a part from the – there's a 1-page statement from CMS directed to the doctors in terms of what need to be documented. Have there been – is there any further clarification in terms of examples or types or anything that we can include in our request to these physicians?

(Robert Hoover): No. other than the – you know the dear physician letters that we put out and I would suggest using those types of documents and that resource page for medical review that Ronja gave out earlier, there isn't anything to my knowledge in addition that's out there.

We're certainly working on trying to do as much physician education as possible, recognizing that as the DME MAC contractor, we're not funded for that type of physician education. But we will

certainly try to help you in any way we can in providing information like those dear physician letters.

Male: OK. Thank you.

Ronja Roland: Thank you.

Operator: We'll take our next question now. Your line is open caller, go ahead.

Male: Hi. I was wondering. With regards to the written order by the physician, is the RX itself considered part of a medical record?

Ronja Roland: You're asking about the detailed written order or your dispensing order?

Male: The detailed written order, signed and dated by the physician. Is that part of the medical record?

Ronja Roland: Yes, it is.

Male: So, if the medical record, if the physician actually indicated a statement of why the patient needs to test more frequently than CMS's guidelines, would that be sufficient?

Carol Bradley: Ronja, in chapter 3, it says that a physician's order is not sufficient.

Ronja Roland: Thank you, Carol

Male: So, that that statement or the statement from the physician in his or her handwriting of why the patient needs to test more frequently than CMS's guidelines is not sufficient?

(Robert Hoover): Not just the documentation on the order itself. We're going to be looking for information directly from the patient's you know contemporaneous office notes or patient visits for support.

Male: Would the note that patient understands and knows how to is been trained on the glucometer be sufficient on that document, on the delivery order or the dispensing order? So if the doctor said the patient has been trained and understands how to use the glucometer?

Ronja Roland: Just a moment.

(Robert Hoover): This is Dr. (Hoover) again. I think if I'm understanding your question, you're talking about incorporating into your detailed written order this statement and information about medical necessity and all of that into one kind of unified document. Is that sort of your question?

Male: Well, I've had it both ways. I've had the doctors indicate that the patient needs to test five times a day because of some little diabetic reason and I've also had them say that the patient has been trained on the monitor.

(Robert Hoover): Right. I mean in general and we see it in the policy and at several places in our supplier manual you know supplier generated forms are – while we take those into account where we're doing medical review, they are way, way down on our list of things that we used to determine medical necessity.

Ideally, it should be something in the – in the patient's chart, related to a visit or documenting that they are aware of how to use that device. Those kind of one size fits all forms where you're trying to document their medical necessity and so forth on that one form in general is not something that I have seen and again in my experience that really supports the information we're looking for.

Again if you go back to sort of the 80,000-foot level about patients who are over-utilizing I mean what we look for in the medical record is some recognition that one, the physician has asked the patient to test a certain number of times a day. And why they're asking them to do that in very specific terms.

Most patients, and in particular patients that are non-insulin treated, again the review that we're doing here is primarily related to non-insulin treated patients because the medical literature doesn't support routine testing in this group of patients. So if you've got a patient that's not being treated with insulin that the physician is wanting them to test four times a day, aside from the fact that there is no support for that in the literature they better have a pretty darn good, specific reason for why they're doing that.

And you know that's going to take more than just you know a check-off box on a form to convince me that, that testing frequency is appropriate.

Male: OK.

Female: Thank you.

Operator: Thank you, we'll take our next question now.

Female: Hello?

Female: Go ahead with your question.

Female: We are a DME inside of a retail pharmacy and so our office is a little away from the pharmacy and sometimes we butt heads with the pharmacists about the whole supplying of the glucose

testing supplies where they want to do one thing and we're telling them no it is supposed to be done this way.

Is there another teleconference or some other online tutorial that I can give the pharmacist because I have printed memos, I have highlighted, I have printed the rules, the supplier manual, I have did everything I can to show them this is how to do it. And I don't know – my next step you know would be to you know let them hear it or see it on the actual computer. Is there anything else that you all are going to be doing?

Female: We will not have another ACT dedicated just to glucose monitors anytime soon. However, we probably will have Webinars scheduled strictly for billing for diabetic supplies. I don't have a specific date. I know it is not scheduled for March but it may be in the coming months after that.

So I do strongly encourage you to go back to the Web site under the education link or the calendar of events and just to keep posted as to when that particular Webinar will be held. Again there will be a transcript of this call so feel free to go back out and print that.

And again the link regarding the pre-payment edit reviews that information that's a great site to reference, as well as, you can print the materials from that, as well.

Female: OK, thank you.

Female: Thank you.

Operator: We'll move on now. Caller your line is open.

Male: Yes, I had two questions. One, I've got a patient that tests tests three times a day, records show that the doctor wants four times. We've determined that overutilization is not warranted.

However, we're in an audit situation. What you know we ship three records show the doctor wants testing four even though there is an Rx for three.

(Robert Hoover): This is Dr. Hoover, let me clarify you have an order from the physician that says test three times a day?

Male: Correct.

(Robert Hoover): OK and where are you getting the four times a day?

Male: From the patient's record, the doctor's progress notes show the patient to test four times a day.

(Robert Hoover): What do you have in terms of the patient log and that type of thing? What is the patient actually testing?

Male: We don't have the log in our possession.

(Robert Hoover): I think in that situation you're probably I mean you've got your order for three times a day ideally what you would do very tactfully is contact the physician or his nurse and say that you have a discrepancy between what the physician has documented in the patient's record that you've been provided and what he wrote on the order and see if you can get clarification.

Male: And my second question concerns how to best demonstrate evidence of the patient being trained on the glucometer. I was under the impression that you know according to the LCD you just have to have evidence of the training and what we do is when we confirm the strip renewal that the patient has nearly exhausted the diabetic testing supplies we have the patient confirm that he or she has received training on the glucometer.

(Robert Hoover): I mean the national policy that we're dealing with is pretty specific about you know information in the physician's record that the patient is competent to use the device. And so I think you know an attestation from the beneficiary is not something we're going to be able to accept.

Male: Because that's not what the LCD you know the LCD doesn't say you know it has to be in the physician's notes. We had it up a second ago you know and I think from other jurisdictions they indicated that that would be sufficient.

(Robert Hoover): And I understand you know the medical directors have had a number of conversations about this you know I try to be as flexible as possible within the bounds of you know a national coverage determination. But just like you guys that get audited by us we get audited by others including CMS and the Office of Inspector General and the Cert Contractor and those folks.

And so at least in jurisdiction C we have gone back and tried to make our education as consistent with what we have in the national coverage determination as long as it doesn't conflict with the LCD.

Male: Thank you.

Operator: Thank you we'll move on to our next question now.

Male: Hi, I have a couple of questions. The same similar situation where I've been shipping a patient for about 3 years regularly every 90 days, all of a sudden out of the blue I get a denial, I call customer service, and I'm told that another company has jumped in the middle of our last shipping window and we're not getting paid.

How do I – what do I do to show that I've been shipping this person for the last 3 years and somebody has jumped into the middle of our – of my last shipping window?

Female: The one thing we can advise you as a provider is you do have appeal rights. You know at that point if you have documentation of where you've spoken to the beneficiary and you know they stated that their supply has been exhausted they want to receive their supplies from you, you could submit that in the appeals process.

Do remember the beneficiary can change providers as they choose. It is beneficiary choice.

Male: Yes, yes but when I obviously when I made the last shipment I did call the patient and we went over the exhaustion of the supplies and we went over, of course, that we were going to re-ship them. What happened in the middle I don't know.

Female: Yes and like I said you know unfortunately there is no way of identifying the denial because this is a specific denial. You can contact customer service and again you can pursue the appeals process for that.

Male: So a written – in the appeal process a written statement of what the conversation was between the patient and the supplier that is sufficient?

Female: One thing I do also want to remind you based on the Program Integrity Manual remember you cannot contact the beneficiary any sooner than 7 days prior to your delivery shipping date.

Male: Yes.

Female: And again that's to make sure that items – that they still need those and again to confirm any modifications to that order.

Male: Or potentially modifications to who they're getting their supplies from.

Male: Correct, well that is for me a given. I mean we don't – I mean we make those calls. The problem is that again another company for X reasons you know some of these patients they – I've found that they receive supplies from many suppliers so it's my responsibility to somehow find that out. Is that correct?

Female: That is correct.

Male: OK and the only way I have right now and this is very important the only way I have right now is I am getting the authorization from the patient, shipping, and then getting the denial of the payment. That's the only way I have of knowing right. Is that correct?

Female: You can also do a three-way call with the beneficiary to the customer service number. Not 1-800-MEDICARE but you can do a three-way call with the patient to the provider line to verify same or similar or if something has been shipped or if they have received supplies within that time frame before you ship.

Male: OK, is there any resource today that exists similar to benefits verification? Is there anything available to see if someone is getting supplies from another company?

Female: Currently because of the category that the glucose monitors fall in you cannot check that through the automated system or the IVR. So because of like I said the payment category that they fall in you would still – the one option would be to go through a three-way call with the beneficiary on the line through the provider line.

Male: That would be as part of the appeal process after I get the denial?

Female: No, no, no the appeal, again, the appeal comes after you have received the denial. The three-way call can occur prior to you shipping those items.

Male: You're telling me before I ship every single one of my patients to make a three-way call to Medicare.

Female: That's an option you have. We're not saying it's ...

Male: Oh.

Female: That's an option that you have in order to verify that they have or have not received supplies.

Male: OK. Is there any practical tool being developed to be able to verify if another company is shipping this type of supplies?

Female: No. As I mentioned currently because of the payment category it falls into, the only option to verify that prior to providing the items would be a three way call with the beneficiary.

Male: OK. Very good. One more question on the proof of delivery, we use the post office. I heard something to the effect that the proof of delivery must be signed by the patient, is that correct?

Female: If not the patient, it has to be an authorized representative for that patient. And if it someone other than that patient, they need to clearly identify who they are in relation to that beneficiary.

Male: OK so if the post office simply leaves the box at the, in their mailbox and walks away and sends me a proof of delivery, that is not sufficient?

Female: No, that is not sufficient.

Male: That's just not ...

Female: ... I think we clarified that they don't have to sign for delivery if its shipped or mailed as long as they show – as long as they can have the tracking sheet that shows it was delivered and the address and you know their invoice and tracking sheet match up.

Because didn't we retract that?

Male: Yes.

Female: Yes, I'm sorry.

Female: We retracted that.

Female: Yes. I do apologize for that.

Male: With delivery services, I mean it just has to be very clear you know that we can tie that specific beneficiary to that specific address to that specific package.

Male: OK.

Male: And you know we recognize that some of the commercial delivery services UPS and the postal service you know that there's not always a beneficiary signature there but we have to be able to tie to like I say a specific address and specific supplies that are delivered.

And that's not only for diabetic supplies. That's a general rule for proof of delivery. We see a very similar issue and its one that is you know results in denials for things like enteral supplies for patients in SNFs where the enteral supplies delivered in bulk to a SNF and then its doled out to patients and we get billed for a specific patient but the SNF or the supplier isn't able to identify for us which supplies went to which beneficiary.

And that violates the proof of delivery too. We have to be able to show a specific beneficiary received a specific quantity of supplies on a specific date.

Male: OK. No problem. One more thing if possible. On the doctors medical records proving how many times, stating how many times a patient test and why they test, if there is over utilization, is there a specific verbiage that – is it published anyway or can you suggest something because there ...

Male: No, just ...

Male: ... because there is a lot of doctors out there.

Male: Well I understand that there are a lot of doctors out there and there are a lot of situations that cause patients to need to test more frequently. I mean there are you know patients that are running along very stable testing you know twice a day, three days a week that are insulin treated and they suddenly get bronchitis or pneumonia and that throws their blood sugars out of whack and so they have to test more frequently for a period of time.

There are patients with COPD that have an excerebration and get put on steroids and that's throws their blood sugars. I mean there are any number of situations that would cause a patient to have to test more frequently. Although typically that more frequently testing is only for a very limited period of time.

You know it may be that it could be non-insulin treated patient that's switching to insulin that would potentially be a case where you know somebody might need to test more frequently for a short period of time.

So as far as specific you know buzz words or verbiage that could be documented, no. Its – you know there is a myriad of conditions that would cause that.

Male: OK. Thank you very much.

Female: Thank you.

Operator: Thank you. We'll take our next question now.

Female: Hi. I have more of a comment actually than a question. And someone alluded to this before. We get very good cooperation from our physicians when we need additional documentation. And they generally do a very good job documenting comorbidities, real solid reasons why someone might be monitoring more than generally expected based on their treatment modality.

However, doctors do not typically put in their notes patients have been testing three times a day or patients continue to test twice a day. And this is you know where we feel as providers we have no control over the way in which a physician documents yet we are responsible when that documentation is not exactly as it should be or could be.

I am a nurse and I think documentation for a diabetes visit should contain those things including their recent blood sugars, the A-1cs, so on and so forth. But I really feel there has to be greater emphasis on the physicians because they're part of this and you know are sometimes 3,000 miles away from the patient we're shipping to.

When there does come a time that we need that additional documentation our claim may be denied because the doctor didn't document as well as he should. And I think that's an unfair burden on the provider when we are proving that we followed his order. We had a valid refill request. We have tracking. We have delivery confirmation. We have the log, whatever.

But the physicians are really very, very poor at that. And I think there needs to be a lot more intervention with the physician because again you know the physical responsibility falls on us when we can't get paid for supplies that we shipped out. And we have to trust that someone else is doing their part accurately.

Dr. (Heybryant): This is Dr. (Heybryant) I understand your concern unfortunately that isn't something that the DEM Max have control over. It's really related to statute and the requirement that the person billing for the service is responsible for ensuring that the service that they're billing is reasonable and necessary.

There's not a good solution to the dilemma that you raised other than you know trying to get as much documentation on the front end as you can to assure yourself that medical necessity has been met.

You know the problem that you describe is not a new one. I hear it every time I go out and do a speaking engagement and I sympathize with you to a certain extent and that's why we do try to do as much physician education as we can within the bounds of you know what we're funded to do.

You know I know would suggest you use the Dear Physician letters that we have there on our Web site and hopefully that will help.

Female: Well we do, we get great cooperation. Its just they're notes are really lacking. And I think if a physician is billing Medicare for a patient office visit with the ICD-9 code of diabetes and he's getting paid to treat diabetes, he or she should also be held responsible for proper documentation.

And you know if they're getting paid to treat that condition their documentation should be have to be adequate. And indeed if they're going to order diabetes supplies, their note needs to why they're ordering what they're ordering and also document that the patient really is doing what they said.

Otherwise I don't want to be billing for it. And you know I just think we need a little assistance on that side because we really have limited control. And I do spend a lot of time with nurses, medical assistants, when I call these physicians' offices and you know they're very willing to hear the information but I can't tell you it'll translate to a change in physician behavior.

Ronja Roland: And that's a very good point. And we do thank you. I apologize as our time is up. So operator that was our very last question. And we want to take the moment again to thank everyone for your questions, comments, and for participating in today's call. Have a great day.

Operator: Thank you. That does conclude today's conference. We appreciate your participation and hope that you have a good day.

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