DME MAC Changes

Here are some of the implications.

BY PAUL KESSELMAN, DPM

Recently, CMS has made two announcements concerning the future of DME Medicare Administrative Contractors (DME MAC). While to many these announcements appear "out of the blue", they actually were initiated several years ago. CMS has instituted them as cost-savings measures to reduce the number of DME MACs, similar to what has transpired over the last few years with all types of Medicare Administrative Contractors. This month's column will provide further insight into these announcements and how these will impact you as a DMEPOS supplier.

Currently, there are four DME MACs (see Figure 1 on page 40). These contractors provide a variety of services for those suppliers servicing beneficiaries living in each of the specified jurisdictional areas.

Several years ago, CMS began the process of reducing the number of MACs from well over a hundred to approximately 25. At the same time, new MACs were added to handle various new types of audits and higher level appeals. Some examples include ZPIC, CERT and RAC, none of which actually initially process or pay claims.

Currently, the function of the MAC (those contractors that providers are most familiar with) is to provide claims processing and first level appeals; and transferred other responsibilities (e.g. second level appeals, higher level post payment audits, etc.) to the aforementioned ZPIC, RACs, CERT, and other contractors. The MAC contractors also continue to provide providers with educational opportunities, LCDs, fee schedules, and other valuable services. However, the MACs all face increased scrutiny by CMS to increase their frequency and targets for audits on home health, skilled nursing, durable medical equipment, hospital services, as well as Part B medical services provided by all types of healthcare providers.

Increased pressure by CMS has often caused the contractors who pay providers to cut back on other services (education, customer service, etc.) and integrate more digital cost-saving measures. This includes expansion of self-service tools and provider portals (e.g. Connex, etc.) as cost-saving measures in order to remain profitable and compliant with their CMS contracts. Some carriers simply chose to propose unacceptable bids to CMS upon contract renewal or chose to withdraw from the marketplace.

CMS has hoped to save money by awarding fewer contractors to adjudicate Medicare claims, thereby leaving more revenue to pay for the healthcare of the ever-growing number of Medicare beneficiaries. The number of Part B Medicare contractors has significantly dwindled over the last few years. For example, NGS is now the single payer in New York State and New England. Previously, New York State had up to four separate payers, with NYC alone having two separate contractors.

Presently, there are four DME MAC contractors. As with regular Part B, CMS has been looking to reduce this number. In December 2015 and January 2016, CMS announced it would reduce the number of DME contractors to only those two contractors presently servicing the Southeast and Northwest, expanding them into other areas of the country. The Midwest contractor (currently NGS) and the Northeast contractor (currently NHIC), both of which are currently also Part B medical Medicare contractors, will be phased out of the DME contract market this spring. Those suppliers providing DME services to beneficiaries in the Midwest (DME MAC B) will be switched over to Cigna Government services (currently the Jurisdictional C Contractor). Those suppliers servicing the Northeast (DME MAC A) will be switched over to Noridian (the current DME Region D Contractor in the Northwest (see Figure 2 on page 42).

The implementation of this change was well hinted at in a governmental accounting office report to Congress released in April 2015, entitled "Medicare Administrative Contractors: CMS Should Consider Whether Alternative Approaches Could Enhance Contractor Performance."

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The implication for these changes are huge for both the personnel working at the "lame duck" contractors and for the supplier community. Those well-trained employees at the soon-to-be-phased-out contractors face uncertainty whether their employment will soon be terminated, or be provided with new opportunities and conditions of employment at another contractor. Those employees at the remaining contractors may also find themselves replaced by some personnel who are transferred in from the phased out contractors. In either case, those left at the DME contractors will likely face new challenges, taking on an ever- increased burden of responsibilities. Peripheral secondary contractors who provide other resources (e.g., IT, etc.) may also find their contracts terminated, resulting in the departure of well trained personnel who may refuse any mandated physical relocation requirements.

There also will be many changes for the supplier community, some of which may not be fully appreciated until the changeover is implemented. Some possibilities include a reduced number of staff personnel from whom to obtain education, reduced customer service representatives with whom to file and resolve complaints, and an increased requirement to utilize digital self-service tools (which often are cumbersome and difficult to maneuver). Another challenge faced by the supplier community is the loss of familiar contact personnel with whom the supplier community has established long-term relationships. These "cutting through the red tape" relationships are often difficult to establish. These issues are certainly not new to corporate America, yet remain under-appreciated by the average individual in small practice.

The single most tangible change faced by the supplier community may be in a larger number of audits that they may be subjected to. The remaining contractors may have a history of targeting specific DMEPOS-type claims than those MACs they are replacing. They will be faced with pressure from CMS to expand their auditing (both pre- and post-payment) practices.

Fewer auditors reviewing increased numbers of claims may result in increased frustration from suppliers, already burdened with a higher level of pre- and post-payment audit errors. With auditors having less time to review more claims, there is the potential for them to make more mis-

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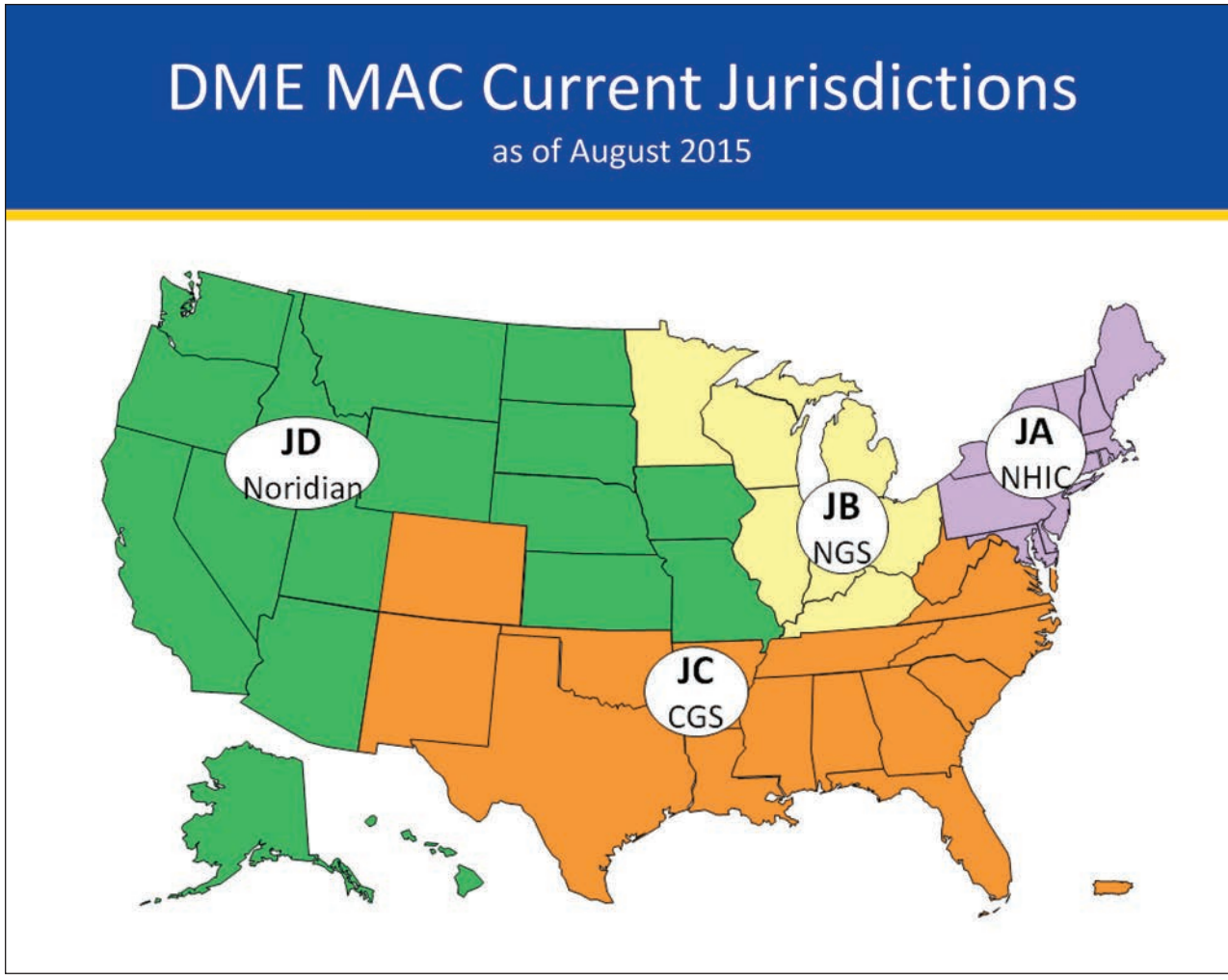

Figure 1: Current DME MAC Jurisdictional Map

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takes (especially with less experienced personnel), resulting in suppliers needing to appeal these faulty conclusions. Suppliers may face increased costs as the result of dedicating more non-revenue generating resources to appeal poor audit outcomes. Some suppliers may choose to reduce the provision of certain DMEPOS as net profitability decreases. This is no different for Part B Medicare for medical services (e.g., routine foot care services and audits), home health, etc.

While the implications for these changes are huge, the sky is far from falling. Fewer contractors may provide an opportunity for more uniform application of LCD policies. It could actually improve communications between professional associations having to deal with fewer carrier medical directors and fewer staff members who often contradict one another.

One final unanswered question is whether or not the contractors will retain their A, B, C and D letter status and be classified as DME MAC Jurisdictional A (Noridian), DME MAC Jurisdictional B (CGS), DME MAC Jurisdictional C (CGS), DME MAC Jurisdictional D (Noridian); or will they more simply be classified as DME MAC A (Noridian) and DME MAC B (CGS). Either choice may be difficult for some suppliers to comprehend. Perhaps CMS will not surprise us by adopting a different and even more confusing nomenclature.

Over the coming months, both phased-out and phased-in DME MACs will announce the implementation of these changes. Since this article was written in the first week of February, by April 2016 many of the unanswered questions may already be resolved. All suppliers should check a wide variety of free digital communication tools at their disposal. These include *PM News* and the *APMA News Blast*. Primarily, if you are not signed

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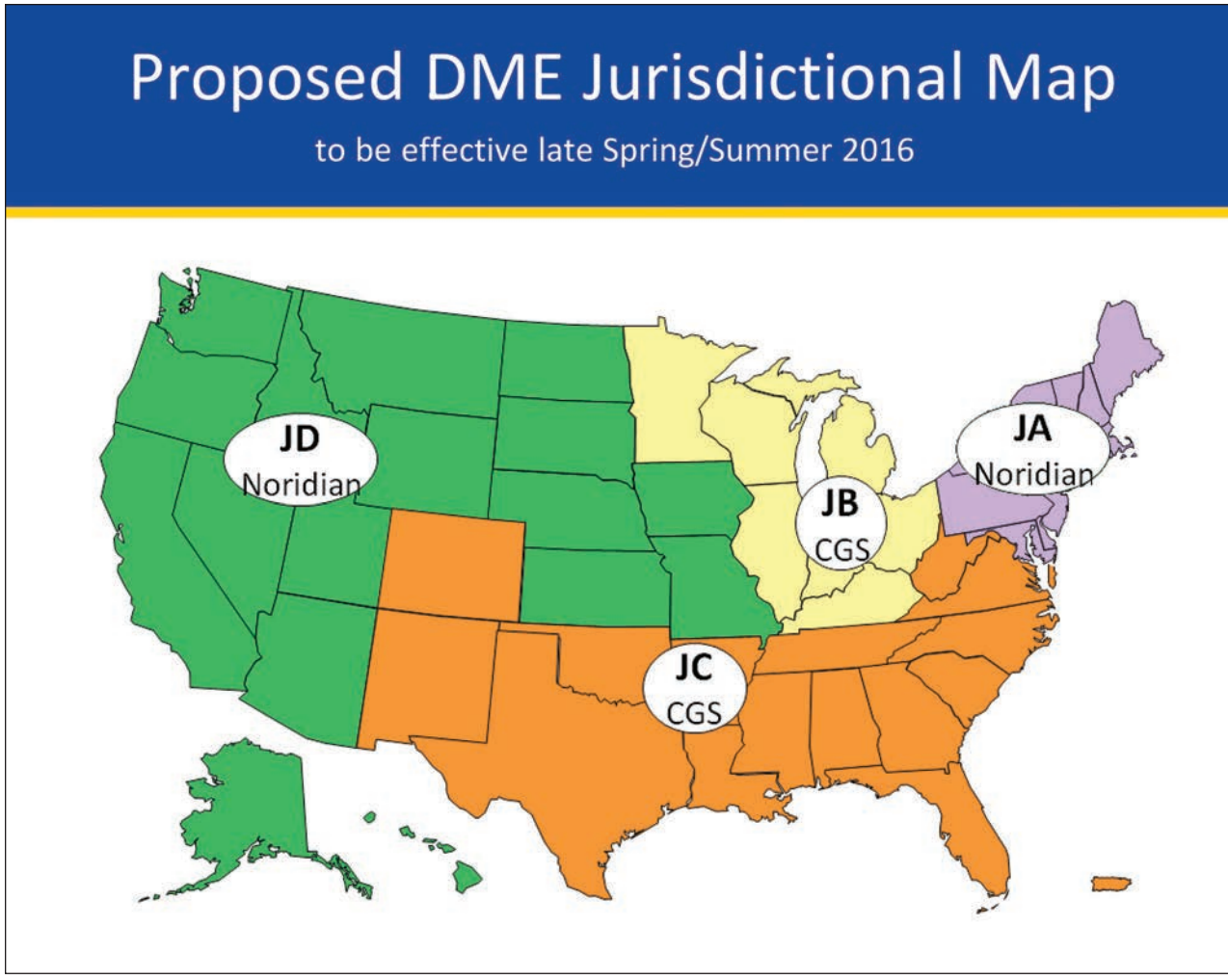

Figure 2: Proposed DME MAC Jurisdictional Map to be effective late Summer 2016.

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up for your current DME MAC website, I urge you to do so immediately, as they will provide the reader with up-to-date changes.

Post Script:

Shortly after this article was submitted for publication, a reliable source has provided further information regarding the future of the DME MAC Jurisdictional map. The following are some additional points of information, followed by the author's italicized commentary. This includes:

1) For at least the next five years each DME MAC will continue to operate with its own Carrier Medical Director, auditors, customer service reps, provider education etc. although the contracted entities will be different in Region A and B. After five years this may change. Thus JA will be Noridian, JB CGS, JC CGS, JD Noridian. *This plan seems to indicate some allowance for some transition on the part of CMS and the contractors. Nonetheless, personnel changes and physical location of where certain carrier functions are carried out are still uncertain. Also uncertain is what restrictions and allowances will be enforced on carrier staff.*

2) The DME MAC will always have 2 DME MAC. *This is to assure some competition amongst contractors for the DME MAC contracts. CMS would want this type of competition in order to reduce their contract allowance.*

3)Audits will be driven by utilization not simply by a carrier's current or past history. *This seems hard for the author to fathom as there are higher rates for certain DMEPOS providers, providing certain DMEPOS in only certain areas of any specific DME MAC. Yet all suppliers in an entire region seem to be targets of unrelenting pre and post payment audits for specific DMEPOS yet other suppliers in regions not currently with the soon-to-be-phased-out carriers are not. What the future will bring here is uncertain.*

4) *The author will be privy to much information over the coming weeks and months ahead. As was stated in the main body of the article, the reader must use digital resources to stay current with this ever-developing story.* **PM**

Dr. Kesselman is in private practice in NY. He is certified by the ABPS and is a founder of the Academy of Physicians in Wound Healing. He is also a member of the Medicare Provider Communications Advisory Committee for several Regional DME MACs (DMERCs). He is a noted expert on durable medical equipment (DME) for the podiatric profession, and an expert panelist for Codingline.com. He is a medical advisor and consultant to many medical manufacturers.