MEDICARE (CAHABA GBA) MINUTES
March 7, 2016 RIC/RAC Meeting

CAHABA GBA REPRESENTATIVES PRESENT:
Ms. Adrienne Nabors
Ms. Michelle Cope

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Karen Northcutt

MR. ASHMORE: Okay. Next up we have Adrienne Nabors and Michelle Cope here from Cahaba. Thank you for coming.

1. Follow up to Question #3 from November 9, 2015 RIC/RAC meeting.
Why are some Medicare Notification claims paying with a copay due from a patient?
[Example: GINQ # 4647462 and 4589637]

Response: **Awaiting Clarification from Support Services**

Discussion at meeting

MS. NABORS: We believe that those are actually possibly processing incorrectly. Our support services department did confirm that the CR8704 did go into effect and was implemented March of 2015. However, upon receiving the example that we had and further investigation, we've actually presented a question to FISS to confirm that that is actually probably an error.

We know that it's a system issue, but we don't know all of the specifications regarding that particular issue. Once we find out, we will get the answer to Peggy. We will also find out, for any providers who need to have their claims reprocessed, what instructions and what you will have to do in order to get those remittances corrected so that they don't reflect a beneficiary responsibility so the provider can submit their remittance correct to any other insurance or to the HMO.

MS. NORTHCUTT: What's the CR again?

MS. NABORS: The CR is CR8704. And that was from CMS where they implemented that information; you know, implemented that the coinsurance for the beneficiaries should not populate on the claim for notification claims when they're covered by an HMO.

And like, again, support services, upon reading that information and reviewing everything, they've determined that there's probably some error going on with that; but we don't know exactly what, if it was particular facilities didn't get updated or what may have happened.

We will get that information out to you as soon as we know what's going on and FISS lets us know.

2. Follow up to Question #12 from November 9, 2015 RIC/RAC meeting.
Please provide an update on the KEPRO (QIO) transition to performing the Two Midnight/Short Stay Audits to include the following:

a) Will KEPRO send a review results letter (RRL) like the RAC?

b) Will there be a Cahaba denial reason code set up that is specific to the QIO? If so, what is it?

c) Will Cahaba issue a demand letter if KEPRO denies the claim?

d) Will Cahaba be the Level 1 appeal reviewer for Two Midnight/Short Stay audits denied by KEPRO? If not, who will?

Response: The MACs are no longer responsible for the Two-Midnight / Short Stay Audits. Please direct all questions regarding this process to the QIO / KEPRO.

Discussion at meeting

AUDIENCE: When KEPRO issues a denial of payment for inpatient, the payment will have to be reversed. So this question is related to the payment. What will we see when KEPRO notifies Cahaba that it's been denied and there needs to be a payment transaction?

MS. NABORS: They advised us to still refer you to KEPRO. However, there is the possibility that what may happen if it has to be reversed, that Cahaba would actually probably make that adjustment.

AUDIENCE: So Cahaba hasn't made any changes to the system so that we can tell that that is a Two Midnight reversal similar to the RAC reversals that we were seeing when we had the M432s and 469s and things like that?

MS. NABORS: They haven't advised us as of yet; but if you would, afterwards, maybe give me that particular honed-in question, maybe we can find out more specifics on that, which I know they have the questions out here, but maybe we can at least direct you to see where that is in the QIO or with KEPRO.

AUDIENCE: Okay. Thank you.

3. Follow up to Question #16 from November 9, 2015 RIC/RAC meeting, which you were going to send us a clarifying answer.

A Medicare patient presents to the ER with conditions that meet criteria for acute IP psych but does not have a medical condition. The provider is not a Psych hospital and is just having to hold the patient for a long period of time while awaiting transfer to an Acute Inpatient Psych facility.

a) Does the provider continue to keep the patient in the ER in Outpatient status?

Response: Yes

b) Can the patient be changed to OP with “Observation” service?

Response: **Yes**

c) Do we admit them as an Inpatient in a hold bed while awaiting the transfer to an Acute Inpatient Psych facility?

Response: **Yes**

Please note any of the scenarios could be considered in the billing of claims as it may apply to prolonged services. Please reference the online publications below for guidelines.

Medicare Claims Processing Manual, Pub 100-04, Chapter 4, Section 290;
AMA, CPT Assistant, October 2015, Pages: 3, 4, 8;
AMA, CPT Assistant, August 2012, Page: 3-5;
AMA, CPT Assistant, July 2012, Pages: 10, 11, 14.
We have also included those guidelines for your reviewing.

AMA General Guidelines:

Hospital Observation Services are used for those patients designated or admitted as 'observation status' in a hospital. It is not necessary that they be located in an area designated as an observation area.

Codes were created in 1998 for Observation or Inpatient hospital care services (99234-99236) which are provided to patients admitted and discharged on the same date of service.

When a patient is admitted to the hospital from observation status on the same date, the physician should report only the initial hospital care code. The initial hospital care code reported by the admitting physician should include the services related to observation status he/she provided on the same date of inpatient admission.

Patients who are not subsequently admitted to the hospital, codes 99218-99220, 99224-99226 (observation care) should be reported.

Medicare Claims Processing Manual, Publication 100-04, Chapter 4, Section 290

290.1 - Observation Services Overview
(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)
Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Observation services are covered only when provided by the

order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.
Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

<u>Prolonged Services correct reporting</u>

CPT Assistant, October 2015 Page: 3,4,8

Evaluation and Management: Prolonged Services

Revisions and additions were made to the Evaluation and Management/Prolonged Services section of the *CPT® 2016* codebook to allow reporting of prolonged monitoring by clinical staff in the office or other outpatient setting that may or may not include face-to-face services by a physician or other qualified health care professional. These changes were the recommendations of an Evaluation and Management (E/M) Workgroup (Workgroup), which was created by the Editorial Panel Chair in answer to a request to identify and report monitoring services provided by nursing staff in an outpatient office or clinic setting. Recommendations by the Workgroup were subsequently approved by the Editorial Panel.

Prolonged Clinical Staff Services with Physician or Other Qualified Health Care Professional Supervision

A new subsection was added to the Prolonged Services section to identify prolonged clinical staff services in the office or outpatient setting. This subsection is specifically designed to address and report the practice expense of prolonged services provided by the clinical staff, which is differentiated from the practice expense incurred during physician or qualified health care professional work.

Codes 99415 and 99416 are reported when a prolonged E/M service is provided in the office or outpatient setting that involves prolonged clinical staff face-to-face time beyond the usual face-to-face time of the E/M service. Although the physician or qualified health care professional need not necessarily be face-to-face in the patient room when reporting codes 99415 and 99416, direct supervision of the clinical staff who are performing the face-to-face service is required which entails presence in the office suite allowing for availability to furnish assistance when needed. This service is reported in addition to the designated E/M service and any other services provided at the same session as E/M services.

Codes 99415 and 99416 are used to report the total duration of face-to-face time spent by clinical staff on a given date providing prolonged service in the office or other outpatient setting. For these codes, it is not required that the time spent by the physician or other qualified health care professional on that date be continuous.

Discussion at meeting

MS. NABORS: The answer is yes, as it was before.

We did do additional research to find out what specifics there were. The medical review department did actually say all of these scenarios are correct. Any of the claims can be submitted for these scenarios because it may happen, depending on which one you choose. You may not have each one each time; you may have just one. And we do know that there were some issues with facilities maybe having some cuts on the psych end so they're having to hold those. They said that the scenarios are all considered for billing claims. For any of those specific pieces, we have to refer you to the IOM, the Internet Only Manual, for billing instructions on how to bill for those specific services.

We did include guidelines. They have them noted here. But we also did include the breakdown of those guidelines from the AMA from Chapter 4 of the Claims Processing Manual, the Prolonged Services Correct Reporting Information, and then we did Prolonged Clinical Staff Services with Physician and Other Qualified Healthcare Professional Supervision.

So we just included that information to hopefully give you some sort of guide. Of course, we can't tell you how to bill, but we understood needing to assist you as best we could on how to bill these services for psych patients who don't have a bed just yet.

Just in general talking, not as Cahaba, but in just general discussion, we do realize that there are some risks for putting a patient in a regular bed if they have psych issues or something along that line because you don't want them with regular patients who are fine because depending on what's going on, you may prefer keeping them in the ER, they may have to stay in the ER. But any of these situations can be billed to Cahaba and would definitely, of course, be considered based on medical necessity and the appropriate diagnosis.

AUDIENCE: Well, the concern was that if they don't have a medical condition then basically, medical necessity won't be met if a patient gets admitted as an inpatient or an observation for medical reasons because you're just holding them for psych diagnosis. So how would they meet medical necessity criteria if we just change the status from ER to observation or ER to inpatient in an acute care facility?

MS. NABORS: That's one of those where the claim may actually deny up front, maybe not. But if it denied up front, upon review of the medical documentation and the medical records, they would be able to determine and approve or deny based on, hey, this person need psych care so they had to hold them. So thorough documentation in the medical record would probably facilitate or aid in that claim being considered.

But we didn't have any special instructions. The scenarios, even with just pulling everything, the only thing they had was just follow your regular billing instructions.

AUDIENCE: They won't meet criteria.

MS. NABORS: Probably not. I do agree that there's a possibility they won't because they're not sick.

AUDIENCE: They're not medically sick.

MS. NABORS: They're not medically sick. I would say, though, if you do have any type of a more detailed scenario where that may have happened, maybe give us that information where we maybe processed or denied that claim, or you have one that's about to be filed, if you could get that information to Peggy; or if you have it with you now, you could submit it to me, and we can say, hey, this is the case, what do we recommend, and we could give a better recommendation on that.

AUDIENCE: Doctors have a psych, you know, hospital, but a lot of people don't. This question being framed was for those hospitals that do not have a psych unit, period. So they would not meet medical necessity criteria for the medical reasons that they're being held because it's not medical; they're just waiting for a psych. And we all know how difficult that is. So they'd be getting dinged for something and getting denied for just holding those patients. So that was the question, actually.

MS. NABORS: You said there have been some that have been getting denied for that particular issue?

AUDIENCE: I would ask the hospitals that do not have a psych facility associated with their acute care.

MS. NABORS: I would highly suggest that if there's somebody who does, maybe we can help in that with having an example.

AUDIENCE: We posed the question. And we do have a behavioral health unit. Sometimes, because of capacity, we can't get that patient moved, but they can't go home either. So the question was if they're crossing that two midnights and they need to be in that facility and wait on that bed, can we bill inpatient? And what I'm hearing Cahaba say is yes.

MS. NABORS: That is correct.

MS. NORTHCUTT: And I think both facilities were reluctant to bill an inpatient for that nonmedical diagnosis for psychiatric conditions.

MS. NABORS: And my suggestion is definitely yes, based on the question, not only just Cahaba, but just hitting Google and checking that, we found that there were facilities across the board in the United States that were having issues with that because of the cuts. And I'm just talking about just from doing my own internal research just to check and say, hey, what suggestions do we have? And it was bill it and we're going to work with the records to try and make sure that we can get that covered according to CMS's guidelines.

AUDIENCE: So I've just got two things. One, we do have an acute inpatient psych facility at our facility. And we oftentimes do not have beds available, and so we do have patients that end up being admitted to our medical unit. And Medicare's focus is on the safety of the beneficiary in applying the inpatient criteria. So what we figure is if the physician is still documenting that the patient is actively suicidal, then that would cause harm to the beneficiary if they were released; and if they crossed that two midnights, it's appropriate for inpatient stay.

The second thing, though, we have a question about is if the patient went to the acute unit as an inpatient because we did not have a bed, but a bed became available and then they did not cross the second midnight, do we need to be in a situation where we apply Condition Code 44 and change it to observation, or should we leave that inpatient because at the time the patient was admitted to acute care, the expectation was that we would be waiting longer for a bed and it is a transfer from acute to psych so you're anticipating a longer than Two Midnight stay at the psych unit?

MS. NABORS: I would say submit it according to regular guidelines but making sure that that information is documented. That information would be reviewed to see, hey, they went from here to here, and then any corrections that they feel need to be made would be in the decision. You probably would be able to correct it if it's not billed accordingly, they would probably suggest, hey, it should have been billed this way or according to these guidelines. But I would still have to refer to the manual on that billing piece.

AUDIENCE: Okay. Because I mean, they wouldn't all be reviewed. We need to know as a facility how to handle that situation. You're not looking at the documentation on every account we review.

MS. NABORS: Then I would say just bill it according to the regular guidelines based on the information and the applicable codes that are needed for billing.

4. Follow up to Question #18 from November 9, 2015 RIC/RAC meeting.
If an EKG is ordered per protocol by a nurse at triage in the ED before being seen by a physician or NP and the patient leaves before being seen but after the EKG is performed can the hospital bill for the EKG? We realize we cannot bill for the visit but what about the diagnostic service.

Response: No. The limited service provided to such patients is not within a Medicare benefit category because it is not provided incident to a physician's service. Hospital outpatient therapeutic services and supplies (including visits) must be furnished incident to a physician's service and under the order of a physician or other practitioner practicing within the extent of the Act, the Code of Federal Regulations, and State law. Therapeutic services provided by a nurse in response to a standing order do not satisfy this requirement.

CMS FAQ 2297

Discussion at meeting

MS. NORTHCUTT: And just a side note on that one. We were talking about benefit categories before you came in. So that would be an example of it doesn't meet the benefit category of being incident to a physician's services, which means that the physician or nurse practitioner actually is treating the patient and ordered the test. So we were just talking earlier. I just thought, wow, there's a benefit category of incident to. So that's how far it can stretch around to get a service covered or noncovered.

5. Could we get clarification on some terminology regarding LCD L34300 Surgery: Vertebral Augmentation Procedures (VAP) specifically, the time required for conservative therapy before a

procedure as well is what is the definition and documentation requirements for debilitating pain?

Response: No time line for conservative management is specified in the LCD. However, documentation must indicate that conservative medical management has been tried and has failed.

Conservative management includes (but is not limited to) immobilization, analgesia, physical therapy, etc. Medical record documentation (progress notes, procedure notes) must support the medical necessity of the VAP consistent with the covered indications as outlined in the LCD. Documentation must clearly indicate that the patient has severe back pain. Additionally, in the case of non-malignant vertebral compression fractures (VCFs), documentation must indicate that conservative medical management has been tried and has failed, or why the patient meets the exceptions outlined in the 'Indications' section. Also, any functional limitation that the patient is experiencing secondary to VCF(s) should be described in the medical record.

Documentation would indicate that the pain is "debilitating" if there is evidence that the pain seriously affects strength or the ability to carry on with regular activities. This pain has a draining/exhausting/weakening effect.

Discussion at meeting

MS. CARSTENS: I have a question. You used VCF. And I put it in my minutes as vertebral compression fractures. Did I put that correct? What does VCF stand for?

MS. NABORS: That's what medical review said to me. We actually just have the vertebral augmentation procedures.

MS. NORTHCUTT: There's a VAP and a VCF.

MS. CARSTENS: Yeah. You were gone when I was putting this together. And I don't like to put acronyms without something. So I put that in. I just want to make sure that I did it correct.

MS. NABORS: The VAP is the vertebral augmentation procedures. The VCF I will get clarification on for you as to what that is. That's what medical review did.

MS. NORTHCUTT: And that's vertebral compression fracture. And that's the one we were talking about earlier that has a 50 percent error rate on the documentation in the record.

So that's kyphoplasty and vertebroplasty; basically, where you're putting cement in somebody's back because it's fractured for a debilitating reason. I had one that had a chicken house fall on them.

That is really, under these, not consistent with some of the nonmalignant vertebral augmentation procedures. So you really need to look at when this is really covered for some of these chronic people versus an acute condition that might be healed. Just a side note.

MS. NABORS: When I get these from medical review, I try not to mess with their terminology; however, in the future, I'll make sure I have those detailed out.

AUDIENCE: And in saying that, a lot of times we find that that documentation that's necessary to meet the conservative treatment and things such as that is not the physician's documentation that's actually doing the procedures, it's in the orthopedic physician who's been seeing the patient several weeks before they refer the patient over to the surgeon. So that's just something important for hospitals to note. Because when we submit our medical record request, we need to make sure we get that doctor's office documentation because that's where the support is.

The other thing is I think that sometimes we forget is that there can be an exception to conservative treatment. So if there's a reason why they didn't have an epidural because they're on chronic anticoagulation or because they're too debilitated to do therapy, that's okay. We don't have to make the patient do that stuff. But the doctor has to document it in there. So just keep that in mind too.

6. SNF Therapy Discharge Order Inquiry: If a physical therapy order is written for a Skilled Nursing Facility resident for 5 times a week for 8 weeks but the therapy services were discontinued before the end of 8 weeks, is a physician order (order for discontinuation of therapy) required to reflect the change in therapy? If an order for the discontinuation of therapy is required, is there specific guidance that we may reference?

   Response: **Yes, all skilled services that are billed to Medicare A must have physician involvement. Please reference the Internet Only Manual Chapter 1 for General billing Requirements.**

   https://www.cms.gov/Regulations-and- Guidance/Guidance/Manuals/Downloads/clm104c01.pdf

7. "Only patients for whom there has been prehospital notification based on triage information from prehospital caregivers, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response can be billed a trauma activation charge." – from the CMS Claims Processing Manual, Chapter 4, page 119. Can this also be read to include ANY prehospital caregivers since we know that trauma activation is called for major trauma patients brought in by private vehicle? We are hearing that hospitals across the country are billing for G0390 when all other criteria are met but the patient is brought in by private vehicle.

   Response: **We have no information on this scenario. We can only advise that providers adhere to Internet Only Manual instructions.**

8. We have noticed with our PAP claims for Medicare if we have a screening HCPCS such as G0123 with a high risk ICD-10 CM code such as Z77.9 Medicare is kicking these out in a T-status as invalid but per Medicare guidelines Z77.9 is appropriate with G0123. We have called Medicare

on the claims that have rejected so far and they have been put back in process but this seems to be a Medicare system issue. Have other facilities reported a similar issue?

Response: A claim example was needed to give a specific response to this question. However, we did research the most common reason code we encounter when processing Pap Smear claims.

The FISS reason code 32970 states for screening Pap smear claims submitted with the listed procedure codes. P3000, P3001, Q0091, G0123, G0124, G0143, G0144, G0145, G0147 OR G0148.

The appropriate diagnosis codes listed Z124, Z1272, Z1279, Z1289, must be present with the diagnosis code Z77.9.

Z9189 is required for dates of service equal to or greater than the ICD-10 parameters date.

Please note the diagnosis code Z77.9 is very generic whereas the others diagnoses are more specific to PAP Smears.

IOM 100-4, Chapter 18, Section 30 - Screening Pap Smears.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf

Discussion at meeting

MS. NABORS: At the time of submission of this information to Peggy, we did need a claims example to give us more specific information so we could do a better job researching it. We did give general information regarding the most common reason code that we get for the PAP smear claims. We did also include the Internet Only publication for Chapter 18 for any specific information that you need regarding the billing of PAP smears.

However, this morning, arriving at work, I did receive an example. It was submitted to me encrypted, and I had not received my encryption confirmation so that I could open it up prior to me having to leave to get here on time. But we will research that information, that claim example that was submitted to us, to give a better answer for this particular scenario and submit that information to the provider who sent it to us as well as to Peggy for any other providers who may need it.

9. How do we go about getting a redetermination of a NCD?

Response: Providers who would like to request an NCD reconsideration should follow the normal change request procedures on the CMS website. The link to that website is listed below.

https://www.cms.gov/Medicare/Coverage/DeterminationProcess/index.html?redirect=/DeterminationProcess/01_overview.asp#regs

Discussion at meeting

MS. NABORS: There is a process you can follow if you're wanting to dispute it or give them some information for reconsidering how it's worded or what criteria is needed for it.

10. If a patient is admitted to an acute care hospital for a medical condition by the physician as an inpatient, but then the patient is transferred to an acute care psych facility prior to two midnights, would that qualify for the transfer exception under the two midnight rule?

Response: The provider should direct this question to the QIO since the MAC's no longer handle the Two Midnight Short Stay Audits.

Discussion at meeting

AUDIENCE: But the QIOs are really backed up. And I think the question is whether you'll deny it is how do you want us to bill it on the front end? Do we drop it as a transfer or do we bill it as a discharge. It's not so much is are you going to deny it as an inpatient; that question was do we do it as a transfer DRG or not? How do you want us to bill it on the front end?

MS. NABORS: We don't have any information in terms of to how to bill.

AUDIENCE: Because if you transfer from acute care to acute care, it's a transfer, but if you transfer from acute care to a psych, is that different under Two Midnight?

MS. NABORS: They didn't give us any information on that. However, I'll be more than happy to present that question to them to see if they can give some specific information for it.

AUDIENCE: Okay. Thank you.

11. A) A patient presents to the ED with a serious medical condition and the inpatient admit order is written, but prior to the physical transfer of the patient to the floor/unit, the patient's conditions worsens such that the care is not available at the facility. Therefore a transfer to another hospital is required. Do we bill as inpatient with condition code 40 and a DC status of 02?

Response: Yes. The Medicare Claims Processing Manual, Pub 100-04, Chapter 3, Sections 20.1.2.4 and 40.2.4 states, "a discharge of a hospital inpatient is considered to be a transfer if the patient is admitted the same day to another hospital. A transfer between acute inpatient hospitals occurs when a patient is admitted to a hospital and is subsequently transferred from the hospital where the patient was admitted to another hospital for additional treatment once the patient's condition has stabilized or a diagnosis established." The intent of the physician was to admit the patient. Additional references: CMS, Medlearn Matters Number: SE0801 and SE0801, Revised November 17, 2015; CMS Medlearn Matters Number MM8231, Date: October 7, 2013.

B) A patient presents to the ED with a serious medical condition and the inpatient admit order is written, but prior to the physical transfer of the patient to the floor/unit, the patient's family requests a transfer to another facility. Do we bill as inpatient with condition code 40 and a DC status of 02 and or the family requests a transfer?

Response: **Yes. The intent of the physician was to admit. The discharge status code 02 states, "This patient discharge status code should be used when the patient is discharged or transferred to a short-term acute care hospital. Discharges or transfers to long-term care hospitals should be coded with Patient discharge status Code 63." The Medicare Claims Processing Manual, Pub 100-04, Chapter 3, Sections 20.1.2.4 and 40.2.4 gives another type example of a patient who leaves AMA and later was admitted to another facility. This is considered a transfer. This advice states, "patients who leave against medical advice (LAMA), but are admitted to another inpatient PPS hospital on the same day as they left, will be treated as transfers and the transfer payment policy will apply."**

Please reference Med Learn Matters Number SE0801.

12. Can the hospital bill for patients who receive CT Lung cancer screening services prior to receipt of the registry number and back fill the registry information once the number is received? There seems to only be one registry in the country and it is slow receiving a registration number. Timely filing issues will arise in February 2016.

Response: **Awaiting Clarification from CMS**

In reviewing the information in the Internet Only Manual (IOM) regarding the Screening for Lung Cancer, the information listed in CMS is open to interpretation. Per CMS the provider would submit the claim to the contractor for processing. The provider would also submit the information to the registry for them to have record of the services and to obtain a registry number. There is not anything that states a registry number is required for the claim to be submitted to the contractor; however, due to the open interpretation of the National Coverage Determination (NCD) we have contacted CMS for clarification and are awaiting additional response from them.

http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Lung-Cancer-Screening-Registries.html

Discussion at meeting

MS. NABORS: So I presented that particular question to CMS. They sent back the information that we have referenced for the Internet Only Manual. However, when I presented the question in this manner, is the registry number required for the biller to bill it to us, they are going to get back with me. Once they submit me that response, I will forward that information to Peggy so that she can get it out to the provider community.

MS. NORTHCUTT: So should they continue to hold the claim or wait for you or bill the claim? I guess on that timely filing, you know, the ones over a year old because would be backed up until February.

MS. NABORS: Well, I will say that for timely filing guidelines, if it's beyond your control, which needing a registry number from CMS and not getting it in a timely manner is something that does fall under that criteria, that timely filing would be waived as long as we do have the detailed information stating, my claim is late because I was late getting my registry number from CMS. And any documentation from CMS that you have to show where you had just gotten your registry number, we do recommend that that be included or noted on the notes page in the DDE when you submit your claim.

I can't really say hold those claims. However, if they submit us one and it's denied for the registry number, that would actually answer one of our questions, which is, is the registry number actually required. So I'm not saying file them, and I'm not saying hold them. But we did get a response from them. The first response came relatively quickly. I would say you could allow us at least another week to find out from them.

MS. NORTHCUTT: We might could gather you some updates. Try a to bill one out just to see.

MS. NABORS: Right. Just to see what happens.

MS. NORTHCUTT: Okay.

13. We have a lot of issues with suspended claims for our no-pay (type of bill 110) claims that are submitted per the A/B Rebill Process (1599-F). These 110 claims are required before providers can bill for the expanded list of Part B charges using bill type 121. Often the 110 claims are suspended for over 90 days and the only thing needed is for the claims to reject so that the 121 claim can be submitted. Also, the 110 claim will often go into T-status after it is being released from suspense and there's nothing to correct on the claim. Finally, we have received conflicting instructions on the use of Condition Code 21. Based on previous instructions from Cahaba (available on their website at: https://www.cahabagba.com/news/provider-reminder-ab-re-billing/), we have not been adding Condition Code 21. However, we have been told by customer service that the reason the claim is suspending is that Condition Code 21 is missing (adding condition code 21 did not make any difference – claims still suspended). Billers have been instructed not to add the Condition Code, but can Cahaba please clarify whether this code is required and also address the issues with the 110 bill types suspending.

Response: The A/B Rebill claims require either the value code M1 or condition code 21 when billing the A/B no pay claims. Your claim should not include both, but it does require either the M1 or Condition Code 21 in order to process correctly. Claims submitted with both the codes M1 and 21 will be suspended due to only one code being required.

Discussion at meeting

MS. NABORS: In addition to that, what we've noticed is that putting the Condition Code 21 on there when there was no M1, some of those claims are going through. Now, we have been advised that

they will suspend. Sometimes they will suspend for not having the required justification on the note section; some are hitting for 21 and the M1. However, if you have an example of one that is suspending where it has the 21 or the M1, then I would like to at least see a couple of those examples because we had not actually seen that in-house for suspended. But I was advised that they will suspend if both of those codes are present on the claim.

AUDIENCE: This is my question. So we never put both. We always just had the M1. And I'm trying to remember the exact definition of 21. But doesn't that make the patient responsible? Isn't that what the Condition Code 21 means, I think? So I don't understand why it would ever be applicable in this situation for the Condition Code 21 to be on there.

But it has improved as the backlog has been addressed. It's not as pressing as it once was. So I hope everyone else is seeing the same thing. But you're saying that 21 or M1 should be on the claim?

MS. NABORS: That was the information that the claims department did give me regarding that, that the 21 would work. We've applied 21 on them, and they actually went through and weren't suspended so that the providers could also go ahead and submit their actual outpatient claims that they were wanting to get submitted. But that's what they advised me of.

AUDIENCE: Can you confirm that, please? Because I talked with someone else and we discussed that since 21 makes the patient responsible, that it wouldn't be applicable to this process. So I would think that it should only be the M1.

And, again, we never added the 21. We had a little phase there where my billers got confused because of some information from customer service where they were adding that. But I stopped that. I said only the M1 because that follows the rules for Medicare. So could you clarify to make sure that's okay?

MS. NABORS: I sure will.

AUDIENCE: You saw the M1 on there. They just went through without suspending. Is that what you said? I know you said you saw ones with 21 on there. What about the M1?

MS. NABORS: Well, those that I've seen with the M1, if they were suspended, it was because the justification was not present. That was the only thing that we saw that would have caused that claim to suspend. Because we do have to have the notes for the justification present in addition to the M1 or 21.

AUDIENCE: Okay. I'll go back and check and see if we have any more that are suspending. If I do, I'll give those to Peggy to pass along to you.

MS. NABORS: Please do.

MS. NORTHCUTT: And that 21 is to make the beneficiary liable for that no-pay claim. So that probably wouldn't be the right ones in my head on this scenario.

MS. NABORS: We will clarify that.

AUDIENCE: When you clarify that, would you please give that information to Peggy?

MS. NABORS: Oh, yes, ma'am, I sure will.

14. Based on "NCD Rule 220.13" there is a Medicare edit and Medicare is denying for medical necessity on HCPCS 10022 *Fine needle aspiration w/imaging guidance* and 76942 *US Guidance for needle* placement if there is not a breast cancer diagnosis reported. The breast related ICD 10 Codes are C50011-C50929, D0500-D0592, D4860-D4862, D493, N63, R920- R928. These imaging guidance procedures are performed on various body areas, not just breast. Also if 76942 is on the claim with 10022, 76942 is packaged but Medicare denies both procedures with this edit. How can we get this edit revised to be correct? [*example attached*]

Response: Please review the Revision History for NCD 220.13 on the CMS website. The information provided when the question was submitted is no longer valid. The Reason Code logic was updated in the January 2016 release.

https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?clickon=search

Reason Code 59049 is hardcoded by FISS and implemented based on CMS instructions. Providers, who would like the NCD changed/updated, should follow the normal change request procedures on the CMS website.
https://www.cms.gov/Medicare/Coverage/DeterminationProcess/index.html?redirect=/DeterminationProcess/01_overview.asp#regs

If you have a claim example that processed after the January 2016 update, please submit that information to Peggy and we can research to see what may have occurred.

Additional discussion at meeting

AUDIENCE: I have a question about suspended claims. As I alluded to earlier, most of the claims we had suspended that were in that backlog were A/B rebills that we were trying to get through, but, we still have our typical suspended claims. And while I've noticed that there's been a drastic decrease in those A/B rebills that are suspended, our other claims that are suspended are still out there and haven't been worked yet. And a lot of those are back mid-2015 and third quarter 2015.

Do you have an update on when you expect to have the entire backlog caught up? Because I think the last thing I saw Cahaba was shooting for early March, and that's kind of where we are now. So again, the A/B rebill is better, but the older, especially our high dollar claims, are still kind of stuck out there.

MS. NABORS: We did receive an update. The website was updated to reflect that our claims department is on task for all claims that are backlogged being current by the end of March 2016. And they are currently on task based on the information that we've received from them.

AUDIENCE: Okay. So I have several that are out there that are still pending. What do I need to do? Do you want us just to wait until the end of March, just sit out there and then circle back around, or do you want me to keep sending those over? How do you want us to approach those?

MS. NABORS: Currently we are working our escalation list based on the escalations and inquires that we've received from the provider community. We're asking, if you would, allow us until the end of March for those that you've already submitted.

The reason we're asking for that is Michelle and I are working on getting those claims. Anything that we've seen that has really been holding and taking a while and taking an extensive long amount of time, we've been forwarding those directly to a specific group in Part A saying, hey, this one is still pending, can you please release it or at least give us what we need to tell the provider that is needed.

But if you have a specific list of claims that you're not seeing move, especially high dollar claims that are possibly affecting your facility in terms of financially, if you could compile those on a spreadsheet with the claim number, Medicare number of the patient, and date of service and submit that spreadsheet to Peggy, or submit the information, hey, I have an outstanding list that's over 30 days, submit that information to Peggy, and upon our acknowledgment email, submit that to us, that spreadsheet, we can get that listing honed in.

Because we are working a process to get that information to the claims department to help get those done, especially something that may be in a location that is extremely unique that we may not have quite seen. So if you're having a problem like that. However, we are working diligently to make sure that these claims are cleaned up for the providers.

AUDIENCE: Thank you. I'll get a spreadsheet together.

AUDIENCE: Last month CMS released a decision memo on left atrial appendage closure, and Cahaba currently has an LCD that says that they do not cover that. But the decision memo does cover it with, of course, a lot of criteria. But we have cardiologists wanting to do that procedure.

And I guess the basic question, two parts, is if we perform the procedure and submit the claims at this point, would they be denied or paid? And is Cahaba planning on updating their LCD now that there's a decision memo out?

MS. NABORS: What was that LCD again?

AUDIENCE: Well, the decision memo was CAG 00445N, and then the local coverage is L35889.

MS. NORTHCUTT: And I think that Cahaba had that as investigational. Then CMS has just put the decision memo out there under, as Frank said, a lot of criteria and evidence development. And you have too, again, registry. There's a lot that you have to do. And basically, this procedure helps with afib.

So, again, cardiology issue - If you haven't noted, the theme here today is cardiology. And I tried to go back too just to look, where I think that for a MAC, I researched that they have 90 days when there's a revision to an NCD or an NCD that's developed. I think they've got 90 days. But I think it's just in that 90-day period, if we were denied for doing it, we could appeal basically on CMS's new decision memo probably.

MS. NABORS: That is correct. You can appeal the NCD. However, I definitely will present the question to confirm as to whether we will be making any updates based on CMS's decision.

AUDIENCE: We had three claims to come up that were bariatric surgeries that this happened after we had submitted all the questions for today, and we have the claim numbers and the information on those. They've rejected for medical necessity when we believe that the medical necessity was met per the coverage determination. So are those claims that we can give to Peggy to send to you to look at?

We've tried to call on these claims to customer service, and customer service just basically tells us it just rejected for medical necessity. They can't tell us why, even though the coding is there on the claim and it met the requirements. So we don't know if it's just I-10 related or not. I know Medicare had another issue earlier on that was I-10 related. So we would like to get some clarification on those.

MS. NABORS: Okay. Yes, you can submit those to us. I take it you haven't tried the appeal process yet, have you?

AUDIENCE: Not yet. But they're meeting the LCD. And we had the exact same issue earlier on with a different medical claim, and it was I-10 related. So we feel like this is probably the same thing.

MS. NABORS: Okay. And do please present those to Peggy. And I take it that these are probably more recent claims?

AUDIENCE: Oh, yes.

MS. NABORS: I want to encourage you that in a situation like that, even if it is an ICD-10 Cahaba error where the code may not have been in, we still want to advise you to always submit a claim like that to appeals if it denies for medical necessity, you know, for the appeal rights. Because a lot of times if it is an issue, it will get caught on that end, and we don't want your time frame to run out, just in that event. But, yes, please send those to Peggy, and we can have those looked at that.

MS. COPE: I have a question for her. Is it one that the policy requires you to bill for one of the three groups when you're doing the surgery?

AUDIENCE: It was on those three.

MS. COPE: The reason why I ask, because there was a part of the policy that was going to be implemented in April. So the policy is correct for now if you're not billing within those three groups. It's not going to be implemented until April.

AUDIENCE: So you feel like it will be covered?

MS. COPE: It is denying correctly now until it's implemented in April.

AUDIENCE: So we've just got to rebill it?

MS. COPE: Exactly. Well, file an appeal now until it's implemented in April.

MS. NABORS: But just go ahead and send those to us just so we can make 100 percent sure. Not to second guess Michelle. Just so we can be sure for the example.

AUDIENCE: I just wanted to follow-up on the other NCD ICD-10 related denials that we're getting, especially for cancer drugs. There was a transmittal that said that all the NCDs with ICD-10 related issues that were incorrectly denied would be taken care of by the end of January, but some of them still keep denying. So we just wanted to see if there was any update as to when they would be resolved.

MS. NABORS: Please repeat that.

AUDIENCE: Okay. There were some ICD-10 related denials for NCDs especially. I think it was cytoxan at that point in time. There was some other drugs, cancer-related drugs. And there was a transmittal out there that said that those NCDs would be updated with all the relevant ICD-10s that would qualify for medical necessity. I just wanted to know where Cahaba/CMS is on that. Because we continue to get denials incorrectly.

MS. NABORS: Will you please submit an example to Peggy, just an example of the denials so we can have some coding to go on?

AUDIENCE: Is anybody else? I mean, I know it was Cytoxan at some point in time, but what else?

AUDIENCE: PET scan, but PET scan was fixed.

AUDIENCE: Yeah, PET scan was fixed, because that was one of the ones that got fixed. We had to appeal all of them, but then, yes, they're getting paid. It got fixed in November.

MS. NORTHCUTT: Brenda, I think there's a matter out there in March maybe, an update to an LCD. I didn't look at that one specifically, but I do know that it had some diagnosis-related issues. Yeah. So we can Google that and look it up maybe.

AUDIENCE: I think we have another question on the Q0.

AUDIENCE: For our cardiac patients who are receiving a pacemaker insertion that qualifies being logged on the ICD registry, there is some guidance from CMS that indicates you should report a Q0 for any patient logged on the registry. If you report a Q0, do they file the claim to the Medicare Advantage carrier?

So on the outpatient side, we're billing them to Medicare. Those adjudicate without an issue. However, the problem exists if the patient is made inpatient and is logged on the registry, you can't report a Q0 on an inpatient claim. So in my mind, we should then file the Medicare Advantage contractor as primary. There isn't direct guidance for an inpatient case with a Q0.

MS. NABORS: Thank you.

MS. NORTHCUTT: Not that I know of. I think once they're admitted, from an ICD standpoint, for those that will have to be a primary and secondary, the primary being in the register, there's no indication on the NCD that that's going to be required on an inpatient.

And again, the great draft policy that Cahaba just wrote for all things cardiac device related. I think it's the broadest that I've ever seen, and it goes into great detail. The only thing that I can say from reading it, what Cahaba can't do is tell you how to bill it. So that's got to come from CMS on the modifiers and what to do.

They can tell you the codes and the diagnosis codes, but how to bill it is not in the purview. I don't know how all that works with CMS. But in general, if they're admitted, I don't think that you would have a problem on the primary prevention.

MS. NABORS: And I'm sorry. I was stumped. He was looking at Karen. I was jotting it down just for my general information. Then he looked at me. I was like, oh.

MS. NORTHCUTT: No. It's just the weirdo thing. I've had a lot of defibrillator stuff, you know, whether they meet or not.

My uncle had one and didn't quite meet, but I was so happy. So that's when I'm mute, when the doctor is saying he really needed it and I say, okay, good, knowing, maybe, maybe not. But it's worked out wonderful for him.

MS. NABORS: And was your question generally the Q0, can it be on inpatient?

AUDIENCE: Well, the guidance from CMS requires the Q0 reported for those ICD registered patients, but that really only applies to outpatients. You can't report a Q0 modifier line on an inpatient claim. So there's kind of a lack of guidance on how to handle it. The assumption would be since you don't report a modifier line on an inpatient claim, that you bill the Medicare Advantage plan. I guess I wanted some confirmation that that was appropriate.

MS. NABORS: Got it. Thank you.

AUDIENCE: I'd like to refer back to question number two and the responses that the MACs are no longer responsible for the Two Midnight audit. And I understand that the KEPRO has posted on their website that all initial determinations will be referred to the MACs for appeals. So is that true? Is it not true? Who would we be making our appeals to on denials for the Two Midnight rule, 2D in particular?

Because KEPRO is saying that our appeals will go to the MACs. This answer alludes to the fact that the MACs kind of is hands-off of the Two Midnight rule. So who will our appeals go to?

MS. NABORS: And I understand you're asking that question based on what KEPRO has stated. From my understanding, your appeals would still go to them.

AUDIENCE: And not the MAC? Because they're saying the MACs will do the appeals. And that's what we've always done - any denial that we've ever experienced, our first determination would go back to our MAC. And KEPRO is saying that it will go to the MAC.

MS. NABORS: Let me take this specific one back to the medical review department, and I'll get that answer to Peggy to get to you.

AUDIENCE: Okay. And the second part that I wanted to know is has KEPRO not given any determination for the jurisdiction that Cahaba is over? You know, in response to the recent audits, do you have results? Where do the hospitals rank in your jurisdiction?

MS. NABORS: Okay. I'll get both of those for you.

MS. NORTHCUTT: I think it goes back to that payment question too. This whole process, these are Medicare claims and auditors denying it, the same way that Cert would deny it or Cahaba would deny it through your MAC prepayment review process. So we need to know that the Medicare claims are going to follow the same redetermination process that they normally follow in addition to the other things that KEPRO is allowing, which is an educational phone call required for facilities that have a major concern and then optional for facilities that have a moderate or minor concern.

But, again, I think what we're asking is, is it going to follow the regular Medicare redetermination process, which would be that Cahaba will handle the payment adjudication and then we would have a redetermination reconsideration, an ALJ, and so forth.

MS. NABORS: Got it. Thank you.

AUDIENCE: I had another question come in related to short stays. So if we had a patient that came in and was direct admitted to one of our facilities from a smaller hospital that was not under the same ownership, they were direct admitted to cardiology and met at the heliport and brought directly into the cath lab, patient immediately started coding and they got them back, they started working on them, coded again and eventually died, never made it out of the cath lab.

Now, obviously, it was a direct admit from one smaller facility to a larger facility, but the doctor didn't stop during those two codes and write the order to admit or sign the order before he died and was discharged. So would that be something that we would need to self deny or you just put that through as an inpatient, because clearly the intent was to make that patient an inpatient, though it didn't follow the technical details of the requirement.

MS. NABORS: Due to the details in that question, if you can submit that just like you explained it to me to Peggy, that's one I definitely would have to send to them because that's really detailed.

AUDIENCE: Okay. Thank you.

MS. NORTHCUTT: Hey, Claire, did you try the CA modifier that they expired prior to the formal admission, inpatient admission?

AUDIENCE: No. They just emailed it to me.

MS. NORTHCUTT: Yeah. There is a modifier for expired patients - it's one of those weirdo things. There are certain procedures. Because, obviously, I didn't know if they had an inpatient

procedure to match it or it just was a cath or what was denying. So there might be something that you can actually modify. I'm not sure. But that's another route.

AUDIENCE: So if you put them in as an inpatient, you couldn't put a modifier, right?

MS. NORTHCUTT: No. No. If you didn't have the orders and they died prior to the order being written. Is that what I'm hearing?

AUDIENCE: Yes. I got you. All right. Thank you.

MS. NABORS: I do want to introduce Michelle Cope. Michelle Cope is my teammate for the PRS with Cahaba. She joined November of 2015 and has completed training. So you will see emails from her and myself with the PRS. So anything that you have, still continue to follow the normal process in sending it to Peggy. But I just want you to be familiar with her; that I'm not by myself anymore, but I do have Michelle here with me. Y'all have a wonderful day.

MR. ASHMORE: Thank you. Thank you, Adrienne and Michelle.