CGS Administrators, LLC.

Moderator: Tammy Tucci
February 8, 2012
2:00 p.m. ET

Operator: Goof afternoon. My name is (Melissa), and I will be your conference operator today. At this time, I would like to welcome everyone to the J15 CGS Part A Ask the Contractor Teleconference.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Tammy Tucci, you may begin your conference.

Tammy Tucci: Thank you, (Melissa).

Good afternoon and welcome to the CGS J15 Part A Ask the Contractor Teleconference for Ohio and Kentucky Part A Providers and Jurisdiction 15. My name is Tammy Tucci of Jurisdiction 15 Provider Outreach and Education team, and I will be your facilitator for today's call.

I'm joined today by a team of experts from across our Medicare organization. Together, we will be providing you with Medicare information and taking your J15-related questions once we get to the question and answer portion of today's call.

In our usual format, we are going to start with some J15 Part A news and reminders for you. Then we will address some of your pre-submitted

questions. And finally, we will move on to the open question and answer portion of the call.

So let's begin with the J15 Part A news and reminders. I wanted to begin by pointing out that the claims processing issue log which is updated weekly has some new issues that were added to the log this week.

The first is affecting Part A providers as a system release, incorrectly affected the release of information or RI field of the payer I.D. And claims are auto populating a value of N instead of a value of Y for the RI field of the payer I.D.

This is causing claims to deny incorrectly with reason code 31313. I know where I've received several calls about this issue so I did want to let you know this has been added to the log.

The update which was posted for February the 3rd, on Friday, was that a system – a scheduled system fix is ongoing. For those claims returned to provider or RTPed, providers may correct the RI field of the claim by changing the N to a Y and pressing F9 to return the claim.

Another issue that was added to the log on Friday as well is an issue that's been identified with Version 5010 National Drug Code, Revenue Code 0636. The Fiscal Intermediary Shared System maintainer is dropping the quantity and qualifier on Version 5010 claims submitted with an NDC Revenue Code 0636.

This is causing the claim to return to provider with reason code 32511. And the status on this issue is this issue has been reported to the Fiscal Intermediary Shared System maintainer and it's in research. Please continue to check the log for information regarding a scheduled date for the fix or possible work around if we do receive one.

The next information I want to give you is concerning the Common Working File Dark Day which is scheduled for February 18th, 2012. On Saturday, February the 18th, the Common Working File Great Lakes, Keystone and Southeast Hosts will be conducting a history purge.

Due to the anticipated duration of this activity and to ensure the completion of weekly processing and scheduled data center maintenance, there will be a Common Working File Dark Day at the CWF Great Lakes, Keystone and Southeast Hosts only on Saturday, February the 18th. What that means is there will be no access to the Health Insurance Master Record or HIMR query, which is usually available until noon on Saturdays.

The next update is concerning direct data entry eligibility information. There is an option issue that's currently occurring. CGS is aware of a DDE function key issue that is currently affecting all DDE users.

Users can select Option 10 Inquiry Menu to access eligibility information and view the first and second pages. However, the Option PS 8 to view additional pages of eligibility information is currently not functioning properly.

This problem has been reported to the FISS maintainer. All DDE users are encouraged to use either ELGA or Eligibility A or HIQA, Health Insurance Query Access, to view eligibility information until the issue is resolved.

A fix has been identified and is currently being tested with an expected production date of February the 2nd. CGS appreciates your patience and will furnish additional updates regarding this issue as new information becomes available. So it's in test and hopefully has been a successful fix.

Now we're going to move away from the update and go into your pre-submitted questions and their answers. And I'd like to thank everyone for submitting those forms in. I do apologize, normally there is a link on the Web site as well on the (ask) page and that link wasn't established this time. But we will have that in the future as well as the form so you have two options for submitting your questions.

The first question received was "Please clarify if lovenex and heparin injections are classified as self-administered. We would also like to know if CGS considers all injections administered subcutaneously to be self-administered medication."

This response came from medical affairs. The provider is referred to the CGS Web site to view the article on self-administered drug coverage. The link for the article that is being referenced is www.cgsmedicare.com/kyb, as in boy, /coverage/fad, or fad, /index.html.

And just so you know, I'm sure you couldn't write it down fast enough. That will be in the minute for this call. This will access the process whereby a drug is determined self-administered and the list of drugs that are considered to be self-administered.

Applicability is described in the following manner on the CGS Web site. This process applies to injectable drugs, uses in and outpatient setting for Medicare beneficiaries for reasonable and necessary indications whether or not the site of service for an IP or an infinite to a physician service and that the drug is reasonable and necessary.

Generic or otherwise equivalent drugs with separate J codes may be treated separately or as one drug. The decision is made based on how the Medicare population, as a whole, uses the drug, not how an individual patient or physician may choose to use a particular drug. This process is also defined in the CMS IOM publication 100-2 Medicare Benefit Policy Manual, Chapter 15 Section 50.2 determining self administration of drug or biological.

The term "administered" refers only to the physical process by which the drug enters the patient's body. Injectable drugs, including intravenously administered drugs, are typically eligible for inclusion under the "Incident To" benefit.

With limited exceptions, other routes for administration including but not limited to all drugs, suppositories and topical medication are considered to be usually self-administered by the patient.

The next question we received was "Please give additional guidance on coverage for J3488 or Reclast. We previously had a set of guidelines from NGS under an LCD on what diagnosis codes met the medical necessity guidelines for this medication. I have not found any CGS guidelines for this medication."

CGS does not currently have an LCD for Reclast. And CGS is not prescriptive with regard to Reclast or J3488 and recommends the provider follow FDA guidelines for it's use.

The next question received concerns LCDs. "CGS developed LCDs and articles for the provider region you service. There's no LCD that I can find for PET scan listed on your Web site. And CGS is referring me to CR6632 for coverage and billing guidance.

LCDs provide total coverage and billing guidelines for the provider that is required by you, the payer, and do identify covered and non-covered CPT HCPCS code. My issue is per CR 6632 PET scans are covered for solid tumors and myeloma.

It also says all other solid tumors are covered for initial staging and (NGS) gave explicit direction in their article for a diagnosis for a pulmonary solitary nodule to use ICD-9 code 518.89. We are billing a claim with the correct code 793.11 but it is being denied for medical necessity.

There are no specific codes listed in CR-6632, so how is CGS editing claims for PET scans? Will CGS provide it clear guidelines required by a UR payer like NGS did for a PET scan?

And this response also came from our medical affairs department who makes the determination on whether we will or will not have an LCD.

CGS considers a PET scan and CD to provide language that is specific for the indications and limitations for coverage and LCD is not necessary. The radiology literature and NIH clearing house guidelines which can be found at www.guidelines.gov indicate that a high resolution CT without contrast is the first step if CXR is not helpful, for example no previous films or change. PET is only used when the HRCT is indeterminate.

The next received was we have several – we have had several claims reject line items that were reported on the claim with the current code 32 end date with a GA modifier indicating the patient signed an ABN for those services

and PGS denied provider liable under (Cart) code CO-50 with (RISEN) codes 5H-164 and 5H-161 is the (system issue).

As per change request 6563 which was implemented April 5th, 2010, Medicare systems will now deny institutional claims submitted with modifier GA as a beneficiary liability rather then subjecting them to possible medical review and the beneficiary will have the right to appeal this determination. The line denial is 32454.

The next question we received was, "When we built the PET scans in a clinical trial we always appended the top modifier Q-0 to the PET scan HCPCS code, 78816 only and not to the contrast HCPCS code. Recently we received line item denials for the contrast not having the Q-0 modifier appended to it. Can you please confirm the Q-0 is required on both codes?"

And the answer is yes, that is correct.

The next question, "Can you please tell us what exactly you want us to do when we have to file corrective claims for adding modifiers on the HCPCS that was originally left off in error, whether it be a modifier AY-59-Q0 et cetera?"

Providers should submit an XX-7 adjustment type of bill with the condition code D-9. D-9 is used if adding a modifier to change liability and there is no change to the covered charge amount. Please keep in mind if you are deleting lines in direct data entry, to delete an entire revenue code line you must tab to the line and type zeroes over the top of the revenue code line to be deleted, or type D in the first position.

Then press home to go to the page number field, press enter and the line will then be deleted. Next add up the individual line items and correct the total charge amount on revenue code lines 0001. It's very important to follow these instructions that are also detailed in your direct data entry manual.

Once these changes are complete press F9 to update, enter the claim into the DDE system for reprocessing and payment consideration.

Next question we've received, "We have been instructed in the past that when a patient refuses to give us accident information that we would be able to file a claim to Medicare as primary with condition code 0-8 which would deny the claim as the patient's responsibility and a letter from CMS would also be sent to the patient informing them of such.

Recently we have had several claims with condition code 8 reported and CGS paid the claim. The accident code on the claims we were filing with condition code 08 was 01 from (premises) medical. Is this a system issue? Please advise.

I called the PCC on 1261, 2011 who did not know why the claim paid and gave me a reference number. I still have had no resolution on my claim. What should I do for my claim that paid an error?"

Ask for the CMS IOM publication 100-5 chapter five section 30.2. Condition code 08 should be used when a beneficiary will not provide other insurance information. The use of condition code 08 on the claim flags the COBC or coordination of benefit contractor for development of the other insurance information.

Do not include accident occurrence codes or value codes with condition codes 08. Enter all available information and remarks including the refusal to cooperate. Submit the claim as Medicare primary. Where condition code 08 is reported the contractor rejects the claim. COBC receives an automatic trigger from the common working file for claims filed with the condition code 08 and developed with the beneficiary.

We will need to review a claim example in order to determine the processing accuracy of this specific claim.

The next question we received, "We have tried to file a corrective claim for charges that were charged in error on an account that was over the one year timely filing guidelines. We knew it was going to be a timely filing denial, however, we had to report this to Medicare due to a charge error. The claim RTP'd on the date and we had to resend in a pre-opening request form and that

we could no longer adjust claims that were over the one-year timely filing requirement.

I did that on 11-25-11 and to date CGS has not processed my request or taken back their payment. How long does this process take?"

There is a specific timeline for processing a reopening request. Depending on the number of requests received the processing may be longer at some time then other times. There has been a large increase in the number of items sent for re-determination and for re-opening and there is currently a backlog too to this increase.

The next we received was, "We need a clear explanation on all of the claims we have in RTP for (RISEN) code 30928. This is not something we experienced with NGS and I checked your FAQs on your Web site and understand they could be out there for 75 days.

I'm not sure what is needing to be updated at the common working file that would take 75 days. And so we recently called the provider contact center on this again to better understand."

As per CMS IOM publication 100-5 Medicare secondary payer manual chapter five section 60.1.3.2.1B, as in boy, cost avoidance savings may not duplicate savings reported as full or partial recoveries and may not be shown where Medicare ultimately makes primary payment. CMS prefers cost avoidance savings only after 75 days have left.

Claims appearing on (remits) and status and location RB-7516 are not finalized. They must remain in RB-7516 up to 75 days to become final and please note that it's up to 75 days. That is not a guarantee of 75 days.

Adjusting claims before they are final and that would be RB-9997 or PB-9997 will receive the (RISEN) code 30928. Post day claims can be closed through to contact center by requesting an action request be processed if and when the term date of the MSP record is prior to the date of service of the claim. The coordination of benefits contractor should be contacted to delete or term any inappropriate MSP records.

If Medicare is in fact secondary submit an adjustment. The claim must sit for 75 days and that's again up to 75 days. If adjusting to make Medicare primary indicate in remarks that the services are not related to an open workers comp liability no file or (black line) record, then contact the provider contact center and have an action request sent to assure that this claim can be finalized and that the adjustment can process through.

The next question we received was, "We recently filed several re-determination for CGS and did not include the XX-7 adjustment type of bill copy of the UBO-4 with the re-determination request which is a requirement with CGS on any appeal.

We have prepared our corrected claim and sent it back in to CGS without the re-determination request and it was again returned because one line item denial for NCD, LCD or medical review denials with (inaudible) codes 55A-00/54-NCD and 44A-003 to name a few was not reported on the UBO form and the covered and non-covered column of the corrective claim.

I could not find any specific guidelines on your Web site regarding this. I contacted the provider contact center and got confirmation that the re-determination request that are sent in for medical review denials must show the line item as covered and non-covered on the adjustment claims.

However for other appeal reasons like 51-MUE and 52-MUE where there was a charge error we did not have to pull all those out into non-covered. We could attach the corrective claim using the XX-7 adjustment type of bill which (RISEN) code D1 and of course the original DCN.

This is also something new for us as well. Can these items be put in your Web site so we can be informed on how CGS wants us to handle these types of situations? Are providers required to submit an adjusted UBO-4 with their appeal even if there are no changes to be made?"

Providers do not need to show the items as both covered and non-covered on the adjustment for NCD, LCD denials. If the provider is sending in an adjustment bill-in for an item that they feel should be paid they will move the

specific line item from the non-covered column to the covered column. They should not move all items to the covered column but only the ones they are requesting a review.

In fact if they don't send an adjustment bill the appeals team will review their requested item only and make a decision. The appeals department does not need an adjustment bill to adjust the claim. Providers are not required to submit an adjustment UBO-4 if there are no changes. It is better if they don't.

If they do send one in the appeals department has to address it. If there is a charge denial or MUE that they are requesting an appeal they can move this item to the covered column if they are sending an adjustment bill. Most of the MUE denials are bundled services but not all. If the MUE is a bundled item, a review must be performed to assure that the provider actually ordered and provided the number of units billed.

In most cases, the provider has billed more units than they have ordered and were provided to the patient. Here again, they do need to send in an adjustment bill. The appeals team can review and adjust accordingly all types of denials.

On the adjustment form, the provider should not move everything from non-covered, from the non-covered column to the covered column. However, if the provider does see this, appeals will not look at what they have moved, only what they have requested an appeal on. They must specify what they are requesting the appeals for.

If the provider has not requested an item on the reconsideration or redetermination appeal request, then the appeals team does not have authority to review that item. Providers also need to make sure they complete all fields on the redetermination request form especially the field that requires the provider number in order to speed up the processing of redeterminations.

The next question received was (Cart Code C050) is used on a lot of line item denials. However, when you look up the line item denial on (inaudible), the reason codes are different. And per the PCC, not all claims that come across on the Medicare remittance set by with (Cart Code C050) require a

redetermination. The PCC stated that for true medical review denials, they will require a redetermination request. All other could have adjusted claims that are filed.

Can CGS put a list of the medical review denial codes on their Web site identifying that this recent code they require a redetermination for. This will save the provider's time and filing unnecessary redetermination requests, and CGS desk time on processing paperwork. So far, I have confirmed with the PCC that the following codes do require a redetermination request to be filed – 55A00, 54MCD, and 55A03.

If there are more medical review codes, can you please list them on your Web site? The other (inaudible) reason codes filing under (Cart Code CC050) that do not require a redetermination are C, 7C812 and 7C212.

There is currently an article out on the CGS Web site and it will also be posted in these minutes that tells you when – how to directly determine whether to appeal (inaudible), or to submit a clerical error request.

Determining to appeal, the providers can appeal a claim or claim line that received a full or partial medical denial. If a claim or line item is medically denied of status and location is PB, as in boy, 9997. And the provider has medical evidence that the service should be covered by Medicare, an appeal may be submitted by using the redetermination request form.

When determining whether to adjust, claims that are processed and paid or rejected status and location, P as in Paul, B as in Boy, 9997 or/are B as in boy, 9997, and our postage to the Medicare history and the common working file can be adjusted. If a historical record of a claim says NCWS, an adjustment transaction must be proceed to update a historical record. These adjustments may be made through a direct data entry or through vendor software.

It is important to note, if the claim was partially denied such as the claim contains a medically denied line, the adjustment cannot be made through DDE unless the system will, in fact, allow it because you are changing something that is not a denied line. Please refer to the instructions that are (spoken)

about in a few moments and we will talk about them for submitting a clerical error reopening request.

Now, when you submit an online adjustment, providers can do so using bill type again X67, and this will allow you to correct things such as the number of in-patient days, claims coding, adding additional charges, the blood deductable, servicing hospital, in-patient cash deductible of more than $1, DRG, discharge status in a CGS hospital, the outlier payment amount, or as we spoke about earlier, to add a modifier.

Please note that as adjustment for the – that the hospital initiates the results and it changed to a higher weighted DRG, the Medicare contractor edits the adjustment request to assure it was submitted within 60 days of the date of the remittance for the claim to be adjusted. If it is, the Medicare contractor processes to claim repayment.

If the remittance date is more than 60 days prior to the receipt date of the adjustment request and result and it changed to a lower weighted DRG, the Medicare contractor processes the claim for repayment and forwards it to the common working file.

Now, this is speaking specifically to adjustments on claims that have medically denied line. If a lined item on the claim is medically denied, which again is status and location, D as in dog, B as in boy, 9997. And the provider has medical evidence that they feel should allow that particular denied line to be covered by Medicare, an appeal is going to have to be filed using the redetermination request form.

But if there is a medically denied lined item on a claim and the provider need to adjust the claim to make a change to something other than the denied lined item, the provider may key the adjustment and the system with the appropriate condition code that describe the change on the claim. Once adjusted, the claim will go to (inaudible) status and location to be reviewed by the claims department before it will continue processing.

Now, when do you need to submit a clerical error reopening request form? CMS defines clerical error including minor errors or emissions as human or

mechanical errors on the part of the party or the contractor, such as mathematical or computational errors, transposed procedure or diagnostic codes, accurate – inaccurate, rather, data entry, (misapplication of a C) schedule, computer error, a denial of claim as duplicate which the party believes were incorrectly identified as duplicate, incorrect data items such as the provider number, use of a modifier or date of service.

If there is a medically denied lined item on the claim and the system will not allow you to make an online adjustment, in this instance the provider should submit a hard copy adjustment with the clerical error reopening request form.

Now, note, clerical error or minor errors are limited to errors in form and content and that omissions do not include failure to bill for certain items and services. A contractor shall not grant a reopening to add items and services that were not previously billed with exception of a few limited items that cannot be filed on a claim alone, such as G0369, G0370, G0371, and G0374. Third-party payer errors do not constitute clerical errors either.

One more piece of this whole process, of course, is the use of this condition code change code. You need to understand when you should use the particular code. There is a chart listed in this article. I'm not going to through them all, but it mainly deals with the use of the condition code D9, because I know a lot of providers have been using that to make adjustment changes to their claims, and sometimes as we understand, that is the correct code to use.

Important to know, when you use the D9 claim change reason code on an adjustment claim, to reflect any other changes to be made to a claim that was already processed, it is used to report an adjustment to a claim when an original claim was rejected from Medicare secondary payer but Medicare is in fact primary. Additionally, it can be used when the original claim was processed an MSP or conditional claim and change needs to be made to the claim such as a change in MSP value code amount.

If an adjusted claim is an RTB status, TB9997, it is important to verify that the D9 code is being used correctly. If the D9 is the best code to use, the claim will need to include remarks, indicating the reason for this adjustment.

If remarks are not submitted on the claim, the Medicare contractor will return the claim back to the provider using reason code 37541.

Please note the Medicare contractor must suspend for investigation, all adjustment requests with claim change reason codes D4, D8 and D9. Providers that consistently use D9 will be investigated, if a pattern of abuse is evident, they will be reported to the Office of Inspector General. So that's the reason why providers have been cautioned not to use D9 unless it, in fact, appropriate. But of course, there are times when if it's the most appropriate code to use when making a change to your claim.

The next question we received is is there an update on the process for obtaining fifth DD2 access for new staff. I had completed the application and faxed them on 10/2711. In January, I checked the status again with the EDI and they confirmed they had them and they were being sent to the next level.

I did get a call from another department about a week later stating that they are backlogged and will process my request. When I asked for a timeframe, she could not give me one. As of today, my senior employees still do not have access to (inaudible) or DDE. If this process going to get any better in the near future? It has now been three months and still no access.

There is backlog in the department that handles those applications for new set ups. A specific time is not able to be given, again. It's just like the claims processing. There is a timeline but it (inaudible) depending on the amount of requests. But currently, we have been told that it's taking at least 30 days or more for a new set up to be processed.

The next question we received was I received an adjusted claim on 1/31/12 due to a RAC complex review denial that have remark code N432. To date, I have not received the demand letter. Since the check is due within 30 days to avoid interest, when should I expect to receive the demand letter in order to have the payment mailed to you in time? Will all RAC denials use a specific remark code N342. Have you considered allowing the specific (rack) coordinator and the facility to receive all of the demand letters?

And this was actually sent through the area that is handling the RAC demand letters. In reference to when should they –should this provider expect this particular demand letter – excuse me – they said that they would need to actually have the specific claim information to give you an exact date. I guess in reference to telling you when that particular one was mailed, but that can be achieved. The provider is advised to call the provider contact center with that specific claim information to get the status of that demand letter.

The next question was wanting to know whether the remark code would be the same for all denials from the (RAC) and all (RAC) denials will contain the specific remark code N, as in "Nancy", 432.

The next question was asking whether or not we would be allowing for the use of the specific rack coordinator in your facility to receive all of your demand letters. We do have a limitation with (High Glass) as to where it pools. (High Glass) sent the demand letters based on the physical address that we have in our system. And so, of course, that would be who you have in that physical address and what that address is.

It is the same process that we use for other demands such as a (Mac) demand, a (ZTech) demand, cert or medical review demand. These overpayments for (RAC) are not going to be handled any differently.

So the only option you have, of course, would be manipulating the physical address field that's in your provider file which you can do by contacting provider enrollment with your provider, making a change to your form to change that particular information.

The next question was regarding billing for insulin as a self-administered drug. When insulin is given by medical staff in the ER or outpatient setting by any valid administration including IV, are there any circumstances under which the hospital may bill for the administration of the insulin.

For example, the patient is unable to self-administer the insulin due to adverse medical or medical conditions such as a diabetic coma, dementia, et cetera. We understand this is not the norm but it does occur with enough frequency to try to clarify the procedure the hospital should be following.

Also, insulin is not listed as a SAD or self-administered drug on the Part B list on your Web site, unless I have overlooked it somehow. Please comment on insulin as a self-administered drug. And again, this was referred to the medical affairs area and their statement was that insulin, as a self-administered drug, is not reimbursed by Medicare. Emergency usage – uses, IN, IV, and subcu administration by a health care professional are bundled into the facility reimbursement, OPPS reimbursement or under the DRG.

OK. So now that we have gone over your Medicare updates and we have talked about all of the pre-submitted questions, and as you see, we've received a lot of them. So thank you, we can now move to the open questions from the attendees for today's call.

So, Melissa, if you can, I'd like to open the lines for questions and answers from the attendees.

Operator: At this time I would like to remind everyone, in order to ask a question, press star then the number one on your telephone keypad. We'll pause for a moment to compile the Q&A roster.

Your first question comes from the line of (Bobby D'Amato). Your line is now open.

Female: Thank you. I'm new to the (BO4) billing, and our clearing house, we've got numerous issues with our Part 8, we're an FQ8(c). The most current issue has become field locator 14, 16, and 17. On the 2012 requirements, field locator 17 is a required field. But according to our software vendor, they will not – 14 and 16 populates the members, 99 in them.

We want to know if we submit our form electronically with 99 in field locator 14 and 16 in order to populate field locator 17, will it be denied? Because we don't want to submit everything on your UBO4s and have them all kicked back.

Female: And you're talking about the way that your groups and segments are setup?

Female: Yes. Well, I guess it could be considered that it's basically the format from our software vendor. Their UB format required if I choose field 17 on our UBO4 which is the status field, it automatically populates 14 and 16 with a number 99 in it. So we're just questioning if we should proceed or not.

Female: Well, I would definitely go back to your clearing house because those fields, the field locators 14 and 16 are actual fields that have numbers where it would be correct for entering into them and 99 would not be 1.

Female: OK, good.

Female: So I don't know that that would make it process correctly. Of course, I would have to look at a claim example to see what would happen to it. But obviously that they need to get the leaves and segment setup to go accordingly to the field that they need to go into in reference to the UDO4, so I definitely would go back to visit with them and make sure that they would have that setup correctly because obviously whatever you key and go then to that, that they transmit over to us, needs to be in the right leaf and segment process correctly.

Female: Fair enough. I have one other question. We – again on our FQH(c), we built to Part A CGS, Jason's team, that's the transition, and my CFO is questioning me because we got our first remit yesterday and on the remittance advice, the remittance advice has listed Part B that it shows our type of bill as a 770 and 771, et cetera, which is applicable to the UBO4 billing.

Female: Right.

Female: Is this the correct – we would see Part B on our Part FQH(c) EOB from CGF?

Female: I can't – I don't know what you're seeing on the remittance. But whenever it's coming through, however you're submitting it through when it processes through the system, you're submitting it through on a UBO4 claim form or a 1500 claim form?

Female: UBO4.

Female: Right. If it's saying – I'm not sure where you're seeing the reference to Part B on the remittance, I have to maybe look at that but it – you know, Part A does have Part B services in it. So I don't know if it's referencing something to do with the Part B and Part B services because that – you know, you determine Part B would not be in her to render Part A.

But of course, if you put it on that UBO4, it's going to the Part A system and I consider you correctly that FQH(c) is a Part A facility and your type of bill is correct, that you're using.

Female: Fair enough. Thank you so much. I appreciate your help.

Female: No problem, bye.

Operator: Your next question comes from the line of (Vicky Howard). Your line is now open.

(Vicky Howard): OK, actually we had taxes soon to be covered but for some reason it must have gotten missed. We're having trouble in the past, we've always billed our physical therapy separate for our Medicare patients. And now they are kicking out online, saying that they need to be bundled with everything else that the patient had done during that month.

Female: What provider type are you?

Female: Critical access hospital.

Female: OK. So you're a hospital and you're saying that you typically billed…?

Female: Prior to changeover, we would always have to bill our physical therapy Medicare claims separately. And now Medicare is kicking them out, saying that if the patient had anything else done during that month, that all is to be – all under the same claim. And we did – something changed that we're not aware of.

Female: Well, normally, with your critical access claims, how do you normally submit those as far as the timeline? Are you doing a monthly billing with them or…?

Female: Yes.

Female: OK. But you're pulling out the therapy, the physical therapy separately?

Female: Right. They have always been billed separately in the past.

Female: Is there a reason why you guys have done it that are you following a regulation that tells you, you had to do it that way?

Female: Previously, that is how Medicare always wanted it that had to be separate. And then if the patient had anything else done during that same months that was to be billed separately apart from the physical therapy.

Female: OK. I have to look at the claim to see why – what recent codes you're hitting. And I'll be honest, I'm not as familiar off the top of my head with critical access regulations. I don't want to speak (inaudible) with you but I can actually look at that.

You faxed it on that particular phone line?

Female: Looks like we just faxed in. It said we faxed in a letter, we didn't have a form so it looks like she just faxed in a letter to the J-15 Part A as the contactor.

Female: OK.

Female: But I do have a reason code for the denial for the physical therapies.

Female: OK.

Female: It's 38105.

Female: What fax number? Can you tell me what fax number you faxed it to?

Female: Sure, 803-935-0140.

Female: And it was faxed in…?

Female: January 31st.

Female: OK. I will see if I can go back to them and see what occurred and where it went to and then I'll make sure it's – it may have been forward to someone to respond to you.

Female: (inaudible)

Female: It didn't come to me because I know that I handled the actuals.

Female: Because also like along with the physical therapies, prior to the change, our mammogram screenings always had to be billed individually also. And now they are kicking out, saying if the patient had anything else done on that same date of service as their mammogram screening, it all have to be done together.

Female: OK. Since sorting the payment, is it referencing the payment window?

Female: It's not even processing the mammogram claim, it's kicking it out online, saying it stuck against something else for an overlapping date of service.

Female: OK. You all have to look at that and see. The claims example will have to be looked at. Now, did you call – have you called the provider contact center?

Female: Yes. Actually, we've called twice. We were given a reference number and told that someone from tier two would be calling us back and we haven't heard anything.

Female: OK, what is the reference number?

Female: 2359554.

Female: OK. OK, thank you.

Female: Wait a minute, we have one more.

Female: All right.

Female: I just wondered on the remittance vouchers now that our take home drugs are not showing up in the non-covered column. Is there a reason why?

Female: When you say take home drugs…?

Female: The 637 self-administered drug is also administered.

Female: Right. Let me see if I can find that particular article and I will read it to you.

Female: OK.

Female: I'll find it and it's also out on the Web site as well but I'll go ahead and read it to you because you're not the first person to ask me about that.

Female: OK.

Female: And it is the – the title on the Web site is instruction on billing for non-covered items or services and it says CGF has discovered that many (inaudible) and private providers are billing for self-administered pharmacy or other services for which they're seeking a denial, these items are not being denied, holding the beneficiary liable.

To prevent this from occurring, providers should bill non-covered statutorically excluded services in the following manner. Submit the revenue codes for which you seek denial, use the hex six code 89270 and append the GY modifier and submit your charges as non-covered. It gives you a specific example of how to go about doing that.

The hex six code 89270 is by definition for a non-covered item or service. However, in order to assign liability to the beneficiary, the GY modifier must be appended to the hex six code or the provider will be held liable. The above instruction was initially issued per change request 3115 dated April 2nd, 2004.

Female: So if you need the GY, it's what it boils down to.

Female: OK.

Female: We need the GY, that's what it boils down to.

Female: Yes, Ma'am. I gave you wrong answer but the short answer is you need the GY.

Female: OK.

Female: (inaudible)

Operator: Your last question comes from the line of (Erica Fletcher), your line is now open.

(Erica Fletcher): Yes. High, Candy. We're having some problems where our claims are stalling in a E7555 location and we're being told that we need to wait 30 days and then just F-9 the claims. These are kicking for NSP files that are open to liability, no fault, but the services are not related and our claims are rejecting an error, and in the past, the claims would tee. We were able to put on a D-9 and put that the services were not related to the open MSP file and indicate the specific dates.

We've got claims out there from July 27th that shows that, you know it went to this location but are still not moving.

Female: Right.

Female: It's well more than the 75 days.

Female: Right. If you have one of those, if you have a claim that has gotten into that status and location, you can all in on that especially if it's a situation where there's something that's an error or something to do with the, you know, common working file. These are mainly, you know, the MSP claims. And an action request is going to have to be sent in order to get the process moving for those.

Female: OK, we have called and we have been given a call reference ID number. And I mean similar to the situation I e-mailed too the other day on, we've gotten no response back yet on those. We're not getting the return phone calls.

Female: And that's probably happening is the reason why you're having and got no return phone calls because they're waiting on claims to respond to them. That's what they're doing with these.

I know that a lot of these are super backed up, and so they're trying work through them. But with the PCC, when they send an action request over to the claims department, they have to wait for the claim department to make the decision or make, you know, the action on it which may be why you haven't gotten the callback on that particular one.

But we do encourage the providers, of course, if you have something that sat out out there in any of status for, you know – or any status where it's just sitting, it's not finalized for 30 days, you know, give a call, let us know. And that's what you need to do is ask for an action request.

So many times, they just need to be touched by the claims department. They're sitting in a bucket waiting to move.

And so and of course, depending upon how many claims are sitting in that bucket will determine how long it takes to get them processed through, which is why there isn't – I can't pull a time line out of my head to tell you.

I know that would make you feel better just for you to know for how long should I worry about waiting, but of course, if you're seeing it 30 days come – call on it. If another 30 days come, definitely call back on it again as well.

And that's why we like those tracking numbers, so that we have it in the system where we can see that you – an action request was sent, what data was sent on and we can, you know, keep elevating up with the claims department to make sure that we get movement on those.

Female: What is being done about – you've mentioned numerous times that the reason that things aren't getting done is because of this backlog. What is being done by CGS to decrease some of this backlog because we're being told 10 days and we should, you know, our claims should move, check back. We checked back – no action, no activity, no comments, no anything, you know, no call back.

And just so you know, at least ten times, ten different things today, you said that there's a backlog. What is being done to correct that because as a provider, you know, our claims aren't getting paid. We need that money.

Female: Absolutely. We definitely do understand that. There is – there are processes that are in place – actually even with – just so you know with the appeals back clogs for instance, there is a plan and process that had to be filed with CMS because with the appeals, there is an actual CMS metric for how fast they've have to process through. So there is a process in place for those.

With the claims as well, many of the claims systems are backed up due to the fee schedule updates that are still being processed through. And some of the buckets where some of these claim are being held like the SMREPJ if you had any that got into that bucket.

That's where the mass adjustments for being held. So a lot of those got backed up. So they're having to go through and work those. But there is a process and that can include as much as people having to work overtime on weekends to try and process these things. But there is – there is a plan in place and action that is being taken to get those done.

Female: And is interest going to be paid to the providers for these claims that are being held up for essentially no valid reason other lack of staff or lack of knowledge or whatever the case is? (Inaudible).

Female: Not to my – nothing has been mentioned to us in reference to educate on that that's going to occur, so I would say no.

Female: (Inaudible).

Female: Unless they tell me different.

Female: There are timeframes for claims processing on what is, you know, a clean claim. There's timeframes to process for appeals and none of those timeframes seem to be being followed.

Female: Agreed. I agree with you that – I know that there is definitely a severe appeals backlog at this point. That's not a denial on that.

And I will say, some of it is also just the difference on what would go on an appeal versus what would go on in a clerical error reopening request. There

has been a lot of differences and we're trying – that's where we're trying to educate and get ahead in that to – because appeals is getting a lot of things that shouldn't come to them, that needs to go somewhere else and so then they're having to respond to those as well.

So some of that is taking – adding some time there. But, you know, it's a learning curve. So we understand that as well.

Female: Thank you.

Female: Sure.

Operator: Your next question comes from the line of (Rebecca Leigh). Your line is now open.

(Rebecca Leigh): Hello. We, right now are required to access the (DBE) system to retrieve the 201 report data. And this section is not user-friendly whatsoever and it's definitely not printer-friendly, eco-friendly and we were wondering if CGS is working to update the process for providers?

Female: We did note that that was a difference, a change when you guys came over and we have referred that up to the department who handles that and that is certainly something that is being considered.

I haven't heard of any particular change that's coming through with that, but we did give all that feedback to them as well. So it's been noted – I don't know, you know, what's happening in this particular year as what was planned within that budget. What could happen for the next year within that budget could be something different.

(Rebecca Leigh): And I have another. When we submit our records for the redetermination, are – do you know if those records are being scanned first or reviewed first, because often times in order to draw attention to important sections on our records, we use tags or highlight certain sections and it appears based on some of the review results that the sections that we are trying to draw attention to are being overlooked.

Female: I think the process when everything comes in is of written – I believe it's all scanned into the system and that's the way they access it. I believe – I would have to double check with appeals to see, but I'm pretty sure everything is scanned into our system because that's how the provider contact center can verify that an appeal has been received is that it's been scanned in. And that goes into a system to give it the date and have the clock start on it.

(Rebecca Leigh): OK. So do you have any recommendation then on how we can better try to, you know, bring your eyes to look at the spots we are trying to get you to look at? Since it not, you know – what we're doing now is not working.

Female: (Charles), you look at records – I mean what – would there be anything particular that you would want to tell the providers to do if – in an instance where it's getting a scanned in to the system?

Male: Yes, I tell people instead of highlighting to underline it – in that way it will still show up after being scanned.

(Rebecca Leigh): OK. OK. And actually, I have another question. On the A35 remittance file, we previously received accurate information regarding the payer that Medicare has crossed over to. And currently and for some time the payer names are not being submitted with the file data.

And this is actually being confirmed by our clearing house vendor that the data is not contained on the A35 file. This data is used by the providers to verify the payer matches the supplemental payer that we have on file with our – within our records.

So if a payer that Medicare has crossed to differs from our records, can we notify the beneficiary and assist in having this information updated?

Female: You're saying that you're not seeing it on the remittance?

(Rebecca Leigh): Right.

Female: Or you're seeing it inaccurately?

(Rebecca Leigh): We're not seeing it. So if we're not seeing it then we're not sure, you know where it is accurately being sent to the correct supplementary plan.

Female: So you're wanting to know if there is way for us to update that or I guess I don't understand what you are asking about notifying the beneficiary.

(Rebecca Leigh): It's that – I mean is that something that's being worked on now, but – that you know, it's that something that you guys in Medicare are not seeing the correct information so they're not reporting the information. I mean (inaudible) to come over on the files that where it would say specifically cross over to the specific supplemental insurance.

Female: OK. I'm not aware there – of a particular issue. But I would to take a look and see, have you reported the issue and got any feedback on that?

(Rebecca Leigh): We took it out with our clearing house because we assumed that that was something that was not crossing over in their system. But they informed us that it's not coming over in the 835 remittance file.

Female: OK. I have to – I'll have to look and see. I'll check with the department that handles that and see if there's something that has been verified as some type of an issue and then I'll make sure that that goes in the minutes as well.

(Rebecca Leigh): OK. And to note on the provider who called in and asked the question about the physical therapy being billed – having to be billed separately, we actually assume the same issue where we've, you know, in the past have billed the physical therapy separate from other out patient services and we're seeing the same thing where they're coming back and they're denying saying that it's overlapping.

The only – I mean from what we can see because we (inaudible) to suggest in the reference to some of those they can't give us a definitive answer. The only thing that we've been able to do to try to prevent the overlapping is by looking at the physical therapy claim to see if it's really been the whole month of treatment or if it's just, you know, from the fourth to the 15th. And we've been adjusting the physical therapy bill that way.

(Rebecca Leigh): But – therapy is happening through the critical access hospital.

Female: Well, we're not a critical access hospital. I mean this is just happening. It sounds like this would be happening across the board because if we're having issues with it as well.

(Rebecca Leigh): What type of provider are you? Are you a hospital or a school nursing…?

Female: We're a hospital.

(Rebecca Leigh): OK. So your hospital and you guys are doing outpatient physical therapy as well?

Female: Right. Right.

(Rebecca Leigh): And that's overlapping with…

Female: Other outpatient claims.

(Rebecca Leigh): OK. OK. Yes, I'll look at that and maybe we'll see if there's some type of a system issue going on with that.

Female: OK. OK.

(Rebecca Leigh): Thank you.

Female: Sure.

Operator: Your next question comes from the line of (Kaye Jolly). Your line is now open.

(Kaye Jolly): Hey (inaudible). I'm still confused. I'm the one who actually submitted the question on the (LCD) about the PET scans.

Female: OK.

(Kaye Jolly): You made the comment that there's no need for an (LCD) in your explanation. How are you all editing – I mean, the (NCB) or the transmittal that you're

referring me to does not have codes. You have to be editing me on a diagnosis code. So where are these codes coming from?

Female: Dr. (Paley), are you still there?

(Paley): I'm here.

Female: OK.

(Paley): These are codes that are specific for the conditions listed in the (NCB). And they're all in the (ICD9) coding book. The question you're really asking is that why aren't we covering for a more of a non-specific, you know – it's not a diagnosis. It's a lump or nodule.

(Kaye Jolly): Yes, sir.

(Paley): And the – and I thought it was – I provided sufficient explanation in that. That is not, you know, for the PET scan itself, that's not a first line staging modality of diagnostics. Your high resolution CT scans are really what the radiological societies – radiological guidelines say should be used for first line if the chest x-ray isn't providing you sufficient information.

And I didn't do this in isolation either. I also asked other contract medical directors across the country including a pulmonologist. And I won't mention names or anything like that. And Dr. (Oaks) and I are also on the same page on this.

In that it would be anticipated that the PET scan would be indicated, would a higher resolution CT scan not provide you with information you need or you just don't go straight to diagnosis. You know – and having been in the clinical world for many years, you know, in terms of diagnostics, if you got a suspicious enough chest x-ray or CT scan, you don't waste any time, you just get a biopsy.

Well, PET scans really are paid for for known diagnosis or what's called highly suspicious. But we don't have really a mechanism in place to do what you would call like a pre-authorization or pre-certification for a PET scan

upfront before it's done by taking a look at that situation that might be where the patient is highly suspicious.

So, you know, right now – and we've talked about this, if there was a way to adjudicate that up on the front end. And at this time it's if you got that situation, you go ahead and do the PET scan and submit it. I would put, and the indication for that in a narrative box on the claim. If the claim gets denied then I would appeal it. And it should be paid on appeal. But that's where we were with that and I understand what you're saying and…

Female: (Let's say basically, sir), then you're telling me that I cannot bill anything unless that patients has a cancer diagnosis. So from us as a facility up front trying to verify medical necessity, we could possibly be giving a patient an invalid (ABN) because Medicare says it is covered if it's not necessarily a cancer diagnosis.

Male: The PET scan (NCD), I want you to go back and read it real carefully.

Female: OK.

Male: There's specificity, we have – we have – we do have some – I don't know. (I've got) some additional information that I will share with (Tammy) to put out too, because we've written – we've written an article on this. I don't know if we got that posted on (inaudible).

Female: I cannot find anything, sir, on your Web site, you know, concerning PET scans, in fact have called the, you know, the line and it's actually been referred to – at the line to a research specialist because I was – I just don't understand this. So.

Male: Well, you know, that's a good point. I'll talk with Dr. (Oaks). We'll get together on this. We'll put our heads together and we should publish an article regarding that and…

Female: I wish you would, (NGS) did and that's where I'm coming at with the pulmonary nodule and, of course, they're old article.

Male: We're not…

Female: I mean, (that code) has been changed.

Male: I thought I was pretty clear that the (inaudible).

Female: (inaudible) that 51889 that I referenced in my question.

Male: I thought I was pretty clear on how we can do (change) that particular diagnosis.

Female: (inaudible) keep them updated. So, you know, I just didn't understand how you all were editing on something or denying me on a code when I don't find any codes listed.

Male: Non-specific kind of indications such as a pulmonary nodule.

Female: Yes, sir.

Male: As I've said, the standards of care and guidelines from the radiological associations across the country and from the national clearing house guidelines have indicated that PET scan is not the first line type of diagnostic tool to use.

Female: (Thank you).

Male: And they have indicated that the first line, of course, is a chest x-ray. These pulmonary nodules are pretty distinct actually.

Female: Yes, sir.

Male: But, you know, the – you don't always get everything on a chest x-ray certainly and then the high resolution CT scan.

Female: Right.

Male: And, you know, we've talked about that as if, you know, if a provider does that kind of diagnostics and you do a high resolution CT scan (inaudible) you

would anticipate that within a certain period of time, within 30 to 60 days you might consider doing a PET scan in addition to that.

And usually you would think that would be probably be in a matter of days instead of weeks. But, you know, not all people are going to show up to the clinic when you think they might especially if they work and they travel and they live in the rural areas and so on and so forth.

So I don't know that we have – we have that opportunity to take a look, you know, and through the claim system, do an adjudication that if you had a high resolution CT of the chest performed within 30 to 60 days prior to PET scan, we would consider that an indication that this was the next step.

But I don't know that we can do that in the claims processing system right now. But I'm really pretty firm on this. I really think that this needs to follow with I would consider to be the appropriate diagnostic guidelines that really can recognize – they are recognized nationally. So those are what we are defaulting to.

Female: OK. So you all are going to publish an article though?

Male: We will.

Female: OK.

Male: We will. We will discuss that and we'll get it out. I can't tell you exactly what timeframe.

Female: OK.

Male: But as soon as we have come up with a synthesis of opinion we will put that – post that as soon as we can.

Female: That would be very helpful, sir. Thank you.

Male: OK. Thank you.

Operator: Again, if you would like to ask a question, press star then the number one on your telephone keypad. Your next question comes from the line of (Stephanie Delayne). Your line is now open.

(Stephanie Delayne): Hi. This is (Stephanie) and I have (Lisa Defarme) here with me and she had a comment on one of the questions that came out.

(Lisa Defarme): We were, the provider that mentioned that they were flagging information in the record, we looked – from an appeal standpoint – we look at every piece of documentation that is sent to us. I mean, everything gets looked at and considered with that decision.

Female: Thank you, (Lisa).

Operator: And there are no further questions at this time.

Female: OK. Well, I want to thank everybody for joining us today. And remind you that we're going to be posting a transcript of today's (inaudible) call. It's going to contain all of your questions and answers on it as well as the references that we've had.

So, we will have that out on the Web site and, of course, anything that we needed to – the one provider that had sent a question and I didn't receive it, I will go back and check on that, see if we can get some claim examples on what's happening with those overlapping claims to assure that there isn't an issue going on.

Thank you again for attending and remind you, of course, that we do have another ask the contractor call that will be coming up on May the 10th. It's also going to be at 2PM Eastern Standard Time. The call in number and password are available on the Web site and will be included in your minutes as well.

And I just wanted to open the line now to (Melissa) to do the polling questions.

Operator: And, ladies and gentlemen, if you would stay on the line, we would like to conduct a brief survey. Once the questions and responses are read, we do ask that you choose the appropriate response using your telephone keypad.

Your first question is the (CGS) Medicare representatives were prepared for the teleconference. Please press one for very satisfied, two for satisfied, three for neutral, four for dissatisfied or five for very dissatisfied. We'll pause for a brief moment to compile the polling results.

Your second question is the (CGS) Medicare representatives were knowledgeable about the subject matter. Again, press one for very satisfied, two for satisfied, three for neutral, four for dissatisfied or five for very dissatisfied. We'll pause once again for a brief moment to compile the (polling) results.

Ladies and gentlemen, this concludes this survey. I would now like to turn the call over to the presenters for closing remarks.

Female: I just want to thank everybody again for attending and I hope that we will have you participate and submitting your questions ahead of time for the call as well as bringing them to the call and we'll see you – talk with you in May. Thank you very much and have a great day.

Operator: Ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

END