MEDICARE (CAHABA GBA) MINUTES
November 9, 2015 RIC/RAC Meeting

CAHABA GBA REPRESENTATIVES PRESENT:
Ms. Adrienne Nabors
Ms. Paula Motes

FACILITATORS PRESENT:
Ms. Jane Knight
Ms. Karen Northcutt

MS. KNIGHT: Our representatives from Cahaba with us today are Adrienne Nabors and Paula Motes. Suzanne Evans has moved on to another position with Cahaba, so she'll no longer be joining us, but Adrienne will.

I. Follow-up questions from July 13, 2015 RIC/RAC meeting:

1. Follow up to Question #2, which is a follow up from previous meetings.
   We are still having issues when sending medical records on CD. How can we provide Cahaba with a password so the CD may be encrypted? We are concerned that the encrypted CDs and passwords are not being matched up timely. Connolly has a generic email address where the provider can email the password and the tracking number for the CD. When the CD arrives in Connolly's mailroom, their staff can access the email on demand, open the disk in the appropriate password, and load the claims into their system.

   a) Can Cahaba set up a similar system?

   b) Or in the alternative, can we have a provider specific password that is used for any medical records submission? This would alleviate the cost of sending to FedEx packages for every medical records submission.

   Response: **Providers can send passwords to CDs sent with medical records to: NGSMailandDistribution-Indiana@anthem.com**

   Discussion at meeting

   MS. NABORS: Good Morning. The system that we do have set up is the actual e-mail address that providers can send their passwords for those CDs, and that is NGSMailandDistribution-Indiana@anthem.com.

   Cahaba does advise that you include the tracking number for your actual CD in the body and subject line of that e-mail when submitting it. That will make searching easier.

2. Follow up to Question #4.
   Hospice 07 Audits: We have hospice related claims that are denied on prepayment audit. After researching further, the hospital learns that the patient either: 1) revoked hospice coverage during the hospital admission; 2) or was admitted to hospice during the acute care inpatient hospital admission. Either scenario results in a one day benefit overlap. The hospital must then split the bill and submit a corrected claim to

Cahaba for the Medicare portion of the care. When our billing department contacts Cahaba, we are sometimes instructed to file a corrected claim only. However, when we file a corrected claim, it gets stuck in suspense because there has already been a denial from the prepayment audits. If we appeal, we still have to do a corrected claim because the original claim did not have the correct dates (though this generally does not affect payment), but the appeal does not seem to marry up with the corrected claim. As a result, the hospital has had claims dismissed for failure to submit a timely appeal. How do hospitals synchronize the appeal and the corrected claim so that the claim does not get hung up in suspense or dismissed?

Response: **Previously per CMS it was highly recommended that providers submit all corrections that need to be made prior to requesting an appeal. In the event they made a correction that caused their appeal to be untimely, they should submit the information showing where they made that correction and waiting on it to complete caused a delay in their request. It was also advised if the provider was close to their appeal timeliness they should go ahead and submit their appeal request the note the correction that needed to be made as well.**

Now that the Part A CER work is handled in appeals, they should submit their appeal request and note any additional corrections in their request at the same time. It does not require them completing two forms, but it will require them marking the changes and noting the reason why on within their submitted documentation.

Discussion at meeting

MS. NABORS: If you're nearing the time limit for your appeal, it is possible that we do recommend that you do submit the appeal in first, because that trumps the actual correction. You have a longer time to do a correction than you do to request an appeal. But you can request an appeal noting your correction within the request as well, submit your appeal supporting documentation. And in addition to that, note the correction that you're wanting to make by marking it -- circled or asterisk, noting it -- sometimes in your regular form, you may actually say, I want to request an appeal on the redetermination form.

But we do read the letter or additional comments that you may put on the page afterwards, just giving us specific instruction that you're appealing this but you're also submitting corrections with the corrected dates that you're needing to do or any other correction that you're wanting to do. That way the appeal and the clerical reopening correction will be done at the same time under the same event.

With all Part A MACs now going to the Medicare appeal system by the CMS, most of those for Part A are now handled under MACs system in appeals. So you will just be definitive in both. You will actually specify that you are doing an appeal, but you will also include in the notes that you are making a correction as well and note your corrections on that form that you're submitting with your actual documentation.

II. New questions

3. Why are some Medicare Notification claims paying with a copay due from a patient? [Example: GINQ # 4647462 and 4589637]

Response: **Discuss at meeting.**

Discussion at meeting

MS. NABORS: Even though this type of claim is submitted to Cahaba as a notification claim, in the event that a patient is having to utilize their coinsurances days, their system is set to pull the coinsurance amount even though the patient would not be responsible for that.

I apologize for not being able to give full confirmation, and I can submit that information to Peggy at AlaHA. We wanted to confirm that that amount should actually be written off by the providers. But that is how the common working file (CWF) has the system set up to process. So it pulls the amount that the patient would not be responsible for. It's just the only way it can calculate the coinsurance days appropriate for the patient.

AUDIENCE MEMBER: But these patients are not due to pay a copay because Medicare Advantage Plan is paying their claim. And so when the claim is paid by Medicare with a copay, it gives us a copay that's the patient's responsibility, we have no alternative but to post it that way. We don't bill the patient because they're not due to pay it. But when it comes in, you have to post it that way. And if they don't want it to be a patient's responsibility, then they need not to apply that copay.

MS. NABORS: I think it's the way the system is set up. However, again I do want to get confirmation, the write-off portion -- and I do agree with you. You're stating that it should actually specify, probably, provider responsibility instead of beneficiary responsibility. Being that it's coinsurance, there is a strong possibility it can't be. But I will submit that confirmation to Peggy. And I apologize for not having it at this time to verify how or assist at least possibly in how a provider would note that so that patients won't have to be responsible, but yet the providers won't have any trouble with their books.

AUDIENCE MEMBER: Okay.

4. Provider Customer Call Center representatives have advised our facility to wait 90 days from the date the claim was received or was placed in S-Status. If this is correct, this is a departure from the previous limitation of 60 days, and prior to that, 30 days. Per Cahaba online newsletter on Sept. 11 “Cahaba Part A Claims is experiencing high volumes of claims in suspense. Action is being taken by Cahaba to add staff to work on suspended claims. There is no action necessary on your part. We expect to see a reduction in these high volumes beginning within the next 60 days, with normalization occurring after that.”

a) Is there a definite timeframe on when this will normalize other than "within the next 60 days"?

b) Is this issue limited to certain types of claims? If so, which types of claims?

Response: **Per claims there is no definite time frame and all claim types are included.**

Discussion at meeting

MS. NABORS: The claims department is highly anticipating the turnaround for all claims processing to be at a more normal processing status by the first of December. And when I say the 1st, I mean the first of the month not a set date, but the first of the month of December.

AUDIENCE MEMBER: What do you consider normal?

MS. NABORS: The normal status is 30-day turnaround. I want to say 30- to 60-day because we do have a normal suspense. But I have been advised, it should be as close to 30 days, the normal CMS regulation.

5. How should we report the adjustment of gastric lap band via subcutaneous port using fluoroscopic guidance? There is no CPT code to describe this procedure, only a HCPCS S-code, S2083. Currently, we are only reporting CPT code 77002, but it has a status indicator of "N" and we end up with an edit stating only incidental services provided.

Response: **The coding advice in the AMA, Coding Clinic for HCPCS, First Quarter, Page: 7 is still current. This advice states, "Question 5: Is CPT code *17999, Unlisted procedure, skin, mucous membrane and subcutaneous tissue*, accurate for facility reporting of Lap Band adjustments performed at a facility under fluoroscopy, where the port is accessed subcutaneously (not intra-abdominally)?" The answer was, "As published in *Coding Clinic for HCPCS*, 2009, Volume 3, it would be inappropriate to report CPT code *17999, Unlisted procedure, skin, mucous membrane and subcutaneous tissue*. If fluoroscopic guidance is utilized, report CPT code *77002, Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)*. However, if fluoroscopic guidance is not utilized report an evaluation and management (E/M) service code."**

HCPCS 2015 Code : S2083 : Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline is assigned a Status Indicator 'N' - Payment is packaged into payment for other

services, including outliers. Therefore, there is no separate APC payment. Per Addendum D1.

Discussion at meeting

AUDIENCE MEMBER: Is 17999 being recommended? That is what it looks like. But, that was the question basically, because there's no CPT, where do we go from there? Because it's a lighted procedure that's being done. So I guess the question is are they looking at -- you know, you might not be able to answer that, but then what would be the alternate to S2083 for us to use?

MS. NABORS: So you're needing an alternate code for that S2083?

AUDIENCE MEMBER: That's correct.

MS. NABORS: I would have to get that information for you because the information we received only specified the 77002, and stated that the S2083 was inclusive.

AUDIENCE MEMBER: Yeah. Because we are using that, but it's not serving the purpose on it.

MS. NORTHCUTT: And I think the other part of that, if we use the 77002, it's an N status indicator as well. So you're basically billing a bill that has no payment.

AUDIENCE MEMBER: Right.

MS. NORTHCUTT: It's incident to services. And I did look at this again. Medicaid had a question about this as well as far as because they cover some S codes. But their main question to me was this normally should be done in a physician's office. So I think that we're getting kind of with should this actually be performed in an outpatient hospital setting; and if so, what circumstances would it be required to perform; and if it was required to perform, what CPT code would it be?

So I think the big take back would be is it medically necessary to do that in your facility, first off.

6. Should we add modifier -25 to an emergency room E&M level (99281-99291) in every situation where a separate procedure/test/service is performed that is reported with a CPT code? Or just for services that have a status indicator of "T" or "S"? For example, should we add modifier -25 to the E&M level when only reporting a laboratory test?

Response: **CMS cautions routine appending of Modifier -25 unless all the requirements for use are met. The OIG report, OEI-07-03-00470,**

November 2005 and other current references, including the Medicare Claims Processing Manual, Chapter 12, Section 40.1/Section 30.6.1; Transmittal A-00-40 with Change Request 5025, July 20, 2000; CMS, Medlearn Matters Number: MM5025 with Change Request 5028, revised November 1, 2012; 2015 CPT Professional Edition, E&M section; AMA, CPT Assistant, March 2012 Page: 4-7; AHA, Coding Clinic for HCPCS - Fourth Quarter 2013 Page: provide greater details on the use of Modifier 25.
Refer to the AMA, CPT Assistant, March 2012, Page: 4-7 which states, "Modifier 25 is used to indicate that the patient's condition required a significant, separately identifiable E/M service above and beyond that associated with another procedure or service being reported by the same physician on the same day. In addition, this separately identifiable E/M service must be separate from the usual preoperative and postoperative care associated with the procedure that was performed that same day, and be substantiated by documentation in the patient's record that satisfies the relevant criteria for the respective E/M service to be reported. The E/M service is generally unrelated to the procedure or service being provided but may, on occasion, be prompted by the symptom or condition for which the procedure and/or service was provided. Thus, different diagnoses are not required for the E/M services and the separate procedure or other service reported on the same date."

7. We have a male patient who has a history of right breast cancer that was diagnosed and treated 9 years ago. He receives a screening mammogram yearly. He has no new symptoms therefore his physician and the radiologist do not feel a diagnostic mammogram is needed. We are receiving a denial for the screening mammogram because the patient is a male. How should we bill this to receive payment?

Response: **Provider was contacted and issue addressed.**

Discussion at meeting

MS. NABORS: Medicare does not cover a screening mammography for men. However, Medicare does provide coverage for diagnostic mammograms for men and women who meet certain criteria.

AUDIENCE MEMBER: That advice is incorrect. There is unambiguous gender condition code 45 that you add to the claim for sex specific procedure. Because we do that occasionally for a patient that gets that same service.

MS. NABORS: But it does need to include the CPT code for diagnostic, not screening.

AUDIENCE MEMBER: I don't know about that. But I think that's incorrect, because we do have males that get screening mammograms.

MS. NABORS: I can give you the reference for the national coverage determination from the CMS website; that is, national coverage determination for mammograms 220.4. It does give the description of the diagnostic and screening. And also the MLN, national provider called CMS Events and Announcements, which was recently updated. I believe it is October it was updated that had the national breast cancer awareness month information out there, which does state on the website that Medicare does not cover it.

We do cover mammograms, but just not screening. They actually define screening mammography as a radiological procedure furnished to a woman without signs or symptoms of breast disease for the purpose of early detection of breast cancer. And it includes a physician's interpretation of the results of the procedure. A screening mammography has limitations as it must be at a minimum of two-view exposure of each breast. I don't disagree with the particular condition code. We just want to make sure that you utilize the appropriate procedure code.

AUDIENCE MEMBER: Well, these patients are post cancer, and it's a high risk screening, so we get paid for them using the condition code.

8. There have been numerous claim processing issues for Alabama hospitals and across the country with pacemaker insertion/replacement claims. We assume due to this, CMS announced at the first of September that they were delaying implementation of NCD 20.8.3. The announcement stated that all editing and decisions on coverage relative to CR 9078 will be made at the local Medicare Administrative Contractor (MAC) level until further CMS notice. What are Cahaba's coverage and claim reporting requirements for pacemaker insertions and replacements? For example, what ICD-10 diagnosis codes / procedure codes are required on the claim and is a KX modifier required? Will Cahaba be publishing any guidance concerning this? Additionally, the indication for the need of a pacemaker post node ablation is not listed as an indication and the patient would always be pacemaker dependent post procedure.

Response: **Per CMD:**

1. The announcement stated that all editing and decisions on coverage relative to CR 9078 will be made at the local Medicare Administrative Contractor (MAC) level until further CMS notice
   Response: **Correct**

2. What are Cahaba's coverage and claim reporting requirements for pacemaker insertions and replacements?

Response: **Although the CMS cancelled some edits related to pacemakers (PM) – they continued to cite the NCD pub 100-03 section 20.8.3 as unchanged and in effect. Cahaba continues to follow the NCD on PM.**

3. What ICD-10 diagnosis codes / procedure codes are required on the claim
   Response: **We do not wish to achieve this level of granularity at this time.**

4. Is a KX modifier required?
   Response: **No**

5. Will Cahaba be publishing any guidance concerning this?
   Response: **No**

6. The indication for the need of a pacemaker post node ablation is not listed as an indication and the patient would always be pacemaker dependent post procedure.
   Response: **We do not wish to achieve this level of granularity at this time.**

Discussion at meeting

AUDIENCE MEMBER: So basically does this mean that you can submit the claim with any diagnosis code without the KX modifier and it will be paid, but then if it's reviewed, Cahaba would expect you to have followed the guidelines in the NCD?

MS. NABORS: I would say that that would be appropriate.

9. Can you provide reimbursement information on CPT code 81313 (PCA3/KLK3 ANTIGEN)? According to CMS, this lab test should be priced by the MAC for 2015 using the gapfilling methodology.

Response: **This code was not priced at this time.**

Discussion at meeting

MS. NABORS: We're not able to provide the reimbursement information at this time. The CMDs did not set pricing on this code. Medical review would ask for office note to determine an allowance if billed. This will most likely be done via additional medical records request or the appeals process.

10. Based on discussion at the August Hospital Open Door Forum and verification by follow-up email to CMS ODF, the PO modifier that indicates outpatient services provided in an off-campus provider-based department of the hospital only applies to

outpatient items and services paid under OPPS. Therefore therapy services paid under the Medicare Physician's Fee Schedule (MPFS) and lab services when paid under the Clinical Laboratory Fee Schedule (CLFS) would not require the PO modifier when furnished in an off-campus provider-based department (PBD). Does Cahaba agree with this interpretation of the requirement?

Response: **Per CMD: The short answer is yes. There is no requirement; however, we believe the PO modifier was done mainly for data collection. By not using the PO modifier in the off-campus provider based setting, you/we are defeating the reason for the modifier.**

11. Can multi-layer compression dressings such as CPT code 29581 be billed in addition to wound care services or is this code only utilized for fractures and dislocations? If this code can be used in wound care would these dressings need to be applied by a physician or non-physician practitioner?

Response: **2015 CPT Coding Expert Manual, Section 29581 Instructional Notes state: (Do not report 29581 in conjunction with 29540, 29580, 29582, 36475, 36476, 36478, 36479). Includes Notes: Application of splinting and strapping to stabilize fracture or injury without restorative treatment; A replacement procedure.**

CPT code 97140 Should not be reported for any type of manual therapy provided during the same patient encounter in the same anatomic region where a multi-layer compression system is applied and CPT 97597 Should not be reported with casting/splinting/strapping (29580 or 29581) for the same anatomic area.

Refer to Medicare's Benefit Policy Manual, Publication 100-02, Chapter 15, Section 100: Surgical dressings are limited to primary and secondary dressings required for the treatment of a wound caused by, or treated by, a surgical procedure that has been performed by a physician or other health care professional to the extent permissible under State law. In addition, surgical dressings required after debridement of a wound are also covered, irrespective of the type of debridement, as long as the debridement was reasonable and necessary and was performed by a health care professional acting within the scope of his/her legal authority when performing this function. Surgical dressings are covered for as long as they are medically necessary.

Additional reference: National Correct Coding Initiative (NCCI) Policy Manual Hospital APC Version 19.2, Chapter IV, Part F, Sections 3 and 15; AMA, CPT Assistant, March 2015, Page: 10 and September 2012. Page: 16.

12. 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 QIOs assumed responsibility for the Two Midnight Probe and Educate process effective 10/1/15. To date, CMS has issued no formal instruction to the MACs regarding how the QIO is to proceed or addressing the appeals process.**

Discussion at meeting

MS. NORTHCUTT: I talked to Lois Durran at Cahaba, and it appeared to me that you would be taking on the first level after the QIO, or is that a true statement?

MS. MOTES: We think, but that has not been confirmed as of last week.

MS. NORTHCUTT: And they think. It has not been confirmed as of last week.

MS. MOTES: Yes.

AUDIENCE MEMBER: I just wanted to ask has anyone received any new Probe and Educate from KEPRO yet?

AUDIENCE MEMBER: Has anyone received any of the ADRs from the QIOs yet regarding the Probe and Educate starting October 1st?

MS. NORTHCUTT: Yea.

AUDIENCE MEMBER: We have one this summer. So it's outside of their window, I

don't know why they did a couple -- almost all of theirs has been DRG audits. But we have had one that fell within the window of two-midnights' effective date. So it was kind of weird, I thought that they were starting early, but I haven't heard anything else.

AUDIENCE MEMBER: Could someone please just tell me -- I had the impression that two midnights Probe and Educate was going to be three levels or be done by three different audits, which now we've done. Has that been extended? Are we going to continue with the Probe and Educate? I thought it was just a way to go look to the regular audit process at this point. Am I wrong?

MS. NABORS: We haven't received any information just yet.

AUDIENCE MEMBER: So we don't know.

MS. NABORS: No, ma'am.

AUDIENCE MEMBER: In the final OPPS rule, they talk about this. The Probe and Educate has been turned over to the QIO effective as of October 1st. And they will do education. They will review those claims through the end of the year, and then at the first of the year, they will continue to do so under the new non-ruling, two-midnight non-ruling, as Karen calls it. And then once they've educated hospitals, if a hospital continues to have issues with noncompliance beyond that, they may refer them to the RAC. But that's discussed in the final rule under this section about the two-midnight non-ruling.

13. When will the final implementation date be for the draft Drug Screening LCD? It appears to still state future on the draft policy.

Response: **The following LCDs are effective for services performed on or after 10/1/15:**

Local Coverage Determination (LCD): Pathology and Laboratory: Quantitative Drug Testing (L35920)
Local Coverage Determination (LCD): Pathology and Laboratory: Qualitative Drug Testing (L34501)

Discussion at meeting

MS. NORTHCUTT: I would advise everyone in this room to take a very hard and good look at these policies. Anyone that is doing drug testing for pain clinics referenced drug testing. And those drug tests that are coming out of your ED, I strongly suggest that. And I also suggest from a national level that you go to TRICARE. They also have a drug screening policy. And go to BlueCross for their medical policies as they have probably one of most stringent policies that are out there. So I can't urge you enough to get out there and get with

your lab to do that now. Thanks.

14. The CERT is not sending a review results letter (RRL). When we contact the CERT to get an initial determination, they are directing us to contact Cahaba customer service. They state that the MAC can see the information in their system. The CERT is very behind and sometimes takes 10 months to make an initial determination. However, the demand letter does not provide information on the clinical reason for the denial.

    a) How can hospitals get initial determination notification about CERT claims?

    b) If a hospital receives a demand letter, how do we get the clinical information in order to appeal?

    Response: **Facilities should be able to view the CERT rationale via the DDE. The rationale is located on page 4.**

    Discussion at meeting
    AUDIENCE MEMBER: What is the DDE? What is that?

    MS. NABORS: The DDE? What is the DDE? It stands for direct data entry, which is located in FISS, part of the hospital's claim system.

    AUDIENCE MEMBER: Thanks.

15. Our mail is suddenly going to an old physical address. (More than one hospital is having mail issues.) We are receiving a trickle of mail with handwritten addresses over written on the printed addresses. We have contacted customer service and were told to update our 855s. The 855s were updated and the PO Box has not changed.

    a) Why is an old physical address showing up?

    b) What address does Cahaba use for redetermination notices?

    c) What address does Cahaba use for demand letters?

    d) Who do hospitals contact at Cahaba about address changes/problems with misdirected provider mail?

Response: **Appeals has discussed this issue with NGS:**

When the appeal starts in MAS the claims come from FISS which has a provider NPI. We take that NPI and go out to NPPES and bring back all the provider details (including address). It's this address that is used in Correspondence unless the MAC changes it.

The MAC's have expressed some concern with the current address we get by saying the following:

"Level 1 Users require the Provider Remittance Address in order to assure correspondence created during the adjudication process are sent to the correct process. Modifying the default address to the Provider remittance address which is pulled from FISS for the Provider Remittance Address to ensure the address is automatically populated promoting better operational efficiencies."

This is need is being addressed and is currently pending implementation date (date is TBD).

Any issues with misdirected provider mail should start by calling the Provider Contact Center.

Discussion at meeting

MS. NABORS: Problems with the old physical address showing up, I would say that that has to be some sort of problem, that's why they referred you to the provider contact center, to make sure that there has not been an issue in terms of your provider demographics. Generally, if that's happening, it may be a keying problem or something like that. We definitely would need to be notified. We ask that the providers contact us.

What address does Cahaba use for redetermination notices? Cahaba uses the provider's remittance address in order to assure correspondence created during the adjudication process are sent to the correct address. And that would be the same for demand letters as well.

Who do hospitals contact? Of course, we would want you to contact any problems with your physical address, whether it be the old one populating or a change or something, whatever the problem is, we ask that you contact the provider contact center. Examples do assist us with helping to identify what the possible problem is.

AUDIENCE MEMBER: So call customer service? Is that what you're saying?

MS. NABORS: Yes.

AUDIENCE MEMBER: Because they say correct 855 and we did it a year ago. So now

all of a sudden, we're having these pop again. And we go in and it's correct in CMS's system, but it's going to different addresses. So somewhere along the way, it's changing.

MS. NABORS: If there is any way you can provide at least one example, send it via the provider contacts through customer service? And I will say ask them to have someone from provider enrollment contact you, because there could be a mismatch somewhere within your update. And we can just have that checked and confirmed for you.

AUDIENCE MEMBER: Okay. So there's not a direct contact? Suzanne used to tell us to copy her on those so that she could make sure we didn't just get the GINQ number and nothing ever happens.

MS. NABORS: If you contact our contact center, get a GINQ number and then turn around and contact me with that information with the GINQ number, something will happen. We ask that you do go through AlaHA.

AUDIENCE MEMBER: Thank you.

16. 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: Refer to a).

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

Discussion at meeting

MS. NABORS: Actually the response that we received for all of these was yes. Any of these situations could be considered for billing, actual proper billing, if it meets, of course, the medical necessity criteria. It would be appropriate.

AUDIENCE MEMBER: So you're saying if they're in an acute bed but we're treating them psych-wise and we have a psychiatrist following them, adjusting their medicines, the acute care facility can bill, because we don't have a psych bed for them as inpatient?

MS. NABORS: That's what we received, yes, ma'am.

AUDIENCE MEMBER: Okay. That doesn't exactly make sense. Because they have to meet the criteria for medical status to be in an inpatient bed or observation and then acute care setting. So I don't quite understand your answer of "yes."

MS. NABORS: Could you repeat the question?

MS. NORTHCUTT: Are you just going to keep them in an outpatient status?

MS. NABORS: Could you ask the question again?

AUDIENCE MEMBER: Okay. Let's go through a scenario. A patient comes into an ED. It doesn't matter whether that facility has an acute care psych or not, it's ED setting separate. It's not psych; its acute care. So you don't have a psych bed available. And what are you going to do with them? They don't meet acute care inpatient -- they don't meet obs. So you're just going to hang them out in the ED. You have to hire people to come and look after them. And I see it that we're just stuck with them in the ED setting. So I just want to make sure we're clear.

MS. NABORS: They did state yes, however, me and Paula, we would go get additional clarification on that to make sure that this is what they were actually saying.

AUDIENCE MEMBER: Okay. But that's my point. They would have to meet the inpatient criteria to be inpatient in an acute care setting or to be observation. And most often these patients do not is what we see.

MS. NABORS: We would definitely clarify that for you, and I'll submit that answer to Peggy so that she can send that out to you.

AUDIENCE MEMBER: Okay. Thank you.

MS. NABORS: Thank you.

17. If a hospital utilizes a company in the ED that supplies splints and braces/crutches and DME supplies that dispenses in the ED can the company bill for the supply or does the hospital bill? If burn garments are dispensed in an outpatient hospital clinic are these considered DME? Should the hospital send the patient to the DME for these items or can the hospital bill for these items?

Response: **July 2012 per CMD**

If a hospital supplies an orthotic or prosthetic for an outpatient such as a knee brace post operatively for an outpatient or an immobilizer in the emergency room, must the hospital bill the appropriate L HCPCS code on the hospital bill or can a DME company provide the brace/immobilizer to the patient and bill Medicare for it? We know the hospital would have to bill it on an inpatient to be included in the DRG if used while an inpatient. Also can the DME stock the supply at the hospital and not tell the patient they will receive a bill for this brace immobilizer?

Response: **Refer to your DME contractor.**

Discussion at meeting

MS. NABORS: Institutional providers bill their fiscal intermediaries for the prosthetics and orthotics devices and supplies. Generally, Medicare does not pay for durable medical equipment in a facility.

For a hospital outpatient durable medical equipment, bills go to the appropriate durable medical equipment center for that carrier.

This information can be found in the CMS Claims Processing Manual, publication 100-04, chapter 20. It does give you the specific information regarding billing the supplies for inpatient and outpatient setting.

18. If diagnostic tests are ordered per protocol (EKG for chest pain protocol, for example) at triage in the ED *prior to the patient being medically screened* by a physician or non physician practitioner and the patient leaves the ED prior to being medically screened, can the hospital bill for the diagnostic test?

Response: **CMS FAQ 2297**

Can hospitals bill Medicare for the lowest level ER visit for patients who check into the ER and are "triaged" through a limited evaluation by a nurse but leave the ER before seeing a physician?

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.

Discussion at meeting

MS. NORTHCUTT: Please take this one back to people in your facility.

19. During the second round of the Two Midnight probe and educate sampling our facility had accounts denied in error for timely receipt of records (the records were initially mailed). We resubmitted the records with proof of timely delivery and the denials were later reversed and assigned a new ICN number. During our probe and educate conference call we were told the claims were still considered denied as part of the sample because of the initial denial. We now have claims denied in the third round of probe and educate because of timely receipt of records. We resubmitted the records with proof of timely delivery and one denial was overturned and the other claims are processing.

The records for the claims denied in the third round of the probe and educate process were shipped in July to the new Indiana address.

The question, how can the facility avoid being penalized for the (probe and educate) claims denied in error?

Response: **The QIOs assumed responsibility for the Two Midnight Probe and Educate process effective 10/1/15. To date, CMS has issued no formal instruction to the MACs regarding how the QIO is to proceed or if previous audit results will be considered.**

Additional discussion at meeting

AUDIENCE MEMBER: I got one other question. Besides the vertebroplasty, are there any other prepaid audits that the MACs are proposing or are following right now?

MS. NABORS: Haven't been notified of any, but I will confirm that. And you wanted to know again?

AUDIENCE MEMBER: Prepaid audits -- I know that right now you're looking at the painful places, but if there's anything coming out of the pocket that we would know in advance.

MS. MOTES: Generally, these are listed on our website in the medical review section. If you select part A and the medical review, you should be able to get a list of current prepayment and post-pay audits that are underway.

AUDIENCE MEMBER: Thank you.

MS. KNIGHT: Well, thank you both so much for being with us. And we appreciate

you answering the questions. And Adrienne, if you'll send the follow-up to Peggy and then we'll get it out. We look forward to seeing you at our next RIC/RAC meeting.

MS. NABORS: Thank you. Someone did say that they wanted to know what I am. Suzanne went to medical review just recently, about three or four weeks ago. And prior to her leaving, I was brought on as an additional provider relations research specialist. Now, I am holding that title -- not alone, but I'm holding that title in her stead. So it will be me that you see in the future.

We do ask that you present any questions that you do have to Peggy. We will work very diligently to get you any answers. Might not always be the best for you, but we will get you everything that you need.

MS. KNIGHT: Thank you.

AUDIENCE MEMBER: So we would just follow our same routine that we always followed when we communicated with Suzanne?

MS. NABORS: Yes. And that's going through Peggy.

AUDIENCE MEMBERS: Okay. Thank you.

MS. MOTES: I'm the clinical educator and provider outreach and education for both part A and part B.

MS. KNIGHT: Thank you both for being with us.