MEDICARE/CAHABA MINUTES
November 6, 2017 RIC/RAC Meeting

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

FACILITATORS PRESENT:
Ms. Karen Northcutt
Ms. Debbie Rubio

MS. RUBIO: We want to welcome from Cahaba - for the last time - Adrienne Nabors and Michelle Cope.

1. Follow up to Question #3 from July 17, 2017. Do you have a presentation developed for Lifetime Reserve Days you can send us?

   Response: **Not at this time, currently we can only refer you to the Claims Processing Manual on the CMS website.**

   References
   https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0663.pdf

   https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c05.pdf

   Discussion at meeting
   MS. NABORS: As we have discussed before, we know that Lifetime Reserve Days and the SM days issue when benefits are about to be exhausted do pose a problem for the provider community. Our claims department still works on those, because each scenario is very often different from claim to claim. At this time, all we can really offer you is going to the manual and presenting any concerns to us on any claims to us that we can best give. A lot of times, we can't give instructions even in the notes of the claim examiners that may work that claim through. We can't put all the notes in there of everything that they've done, because they may go through 25 or 30 steps just to get the claim back through CWF until it finalizes. Those steps are so tedious and so distinct for each individual claim; we have nothing that's just down there for that. And we do know a lot of times, those come into question with the SM dates, all suspended claims.

2. Follow up to Question #8 from July 17, 2017, regarding the update of 5243E. When will you start adjusting it on prior claims?

   Response: **Per Support Services the claims for Georgia and Tennessee were adjusted. They are confirming if the claims for Alabama were mass adjusted, I will advise Peggy once I hear from them.**

Discussion at meeting
MS. NABORS: Initially, upon reviewing this particular request, I pulled back the information from our support services team, and identified that they have processed all of Georgia and Tennessee claims. Alabama claims had gotten missed. As of November 3rd, all of the Alabama claims were pushed back through and now proceeding to the finalization.

3. Follow up to Question #11 from July 17, 2017. Have you received a response from your support services team regarding instructions for handling discharge dispositions when a patient is discharged and presents to another acute care facility within 72 hours or less, since the SE is listed as rescinded?

Response: **Information on the inpatient transfer policy is located in the "Medicare Claims Processing Manual" (100-04), Chapter 3. For questions concerning clarification on the proper usage of patient discharge status codes, providers should be utilizing the "UB-04 Manual" which is maintained by the National Uniform Billing Committee.**

Discussion at meeting
MS. NABORS: This is the information as received from the Medical Review Department.

MS. RUBIO: Several years ago, Medicare put out some transmittals that instruct hospitals that you may not know the patient went to another hospital, but Medicare does. They will halt your claim and let you know that. You can change that discharge disposition based on Medicare, what Medicare tells you. And you may want to add documentation of that into your medical record just so you'll have it. But per instruction from Medicare, you can change that disposition to what they know it to be. Those were really a long time ago, but I can find them, I think.

4. Hospital claims are rejecting for overlap with hospice election period. The hospice election period is prior to our DOS (sometimes years). The hospice agency (if still in business) is not cooperating with updating their claim with Medicare for the hospital claim to process. We've received 2 different answers from the Provider Call Center: 1) Bill claim with 07 condition code, to get claim processed; and 2) Email cahabafirequest@cahabagba.com with the details of the issue. We've submitted emails, and received no response. [GINQ #s: 5743531, 5774698 & 5704644; and an example can be provided if requested]. Please advise of another process or source the hospital can use to get claims processed.

Response: **The instructions you received from the Provider Contact Center are correct. Providers must submit their claim with the Condition Code 07. The provider then must submit their request to the cahabafirequest@cahabagba.com email for special handling if they experience an overlap issue. Please note these requests can take up to 90 days to be handled by the Claims department seniors. The claim seniors must first submit a written request to the other facility's Medicare contractor, asking them to correct their claim. In most cases multiple requests are submitted before receiving a response. If no response is received the examiners must escalate the request to CMS. CMS will then contact the contractor, once the examiner is notified of the update the provider's claim is then reprocessed/ released.**

The claims department is addressing a way to intermittently notify the provider of status as their request is being handled. Please note the cahabafirequest@cahabagba.com email address is for handling claims that are overlapping another facility's claim and that facility's claim is handled by another Medicare Administrative Contractor. This address should not be used for claims that denied for HMO, timely filing, finalized for payment, etc.

Discussion at meeting

MS. NABORS: The instructions you received from the Provider Contact Center are correct. Providers must submit their claim with the Condition Code 07. If your claim offsets another claim or if you have an overlap issue, the provider must then submit their claim to the Cahaba address listed for the overlap. That's for special handling. And those particular claims assignees will work those particular requests. The claims centers must then first submit that information. After they pull your request, they have to submit a request to the other contractor who's handing the other providers claims. They wait. If they don't receive a response, they then submit another request. If they don't receive a response, they then reach out to CMS. CMS repeats the same type thing. They contact the MAC as well. I don't know whether they submit more than once. Upon their resolution, they notify us, and then we do what needs to be done, either reprocess or release your claim.

This process can take up to 90 days, and in some cases, may take more, because we don't just go straight to CMS: hey, have the other MAC fix that claim. As a contractor, we're responsible for making sure that we do the reach out first. The claims department, though, does realize that you don't know that that work is happening on the back end. So they are working on a way to intermittently notify you of any of those requests that they get that are true overlaps to let you know at least a status. Hey, we got it. And we're working on it. That would at least give you confidence knowing that the claim overlap issue is being addressed.

Please make sure that the e-mail address is keyed correctly, because sometimes I say, Cahaba Fire, when it's actually CahabaF-Irequest@cahabagba.com. We do know that sometimes the address is keyed incorrectly, and if it is, of course, they won't get it. Also, we do want to make sure that every request that is sent to that address is related to an overlap issue or an issue where your claim is in conflict with another provider's claim. We saw some timely filing, some HMO, and when that mailbox gets full of claims like that, it takes them a while to get to the true issues that that mailbox is for.

5. Medicare is still paying primary on claims when their Eligibility information shows the patient is covered by a Medicare Advantage Plan. We would like to know why Medicare's processing system doesn't deny the claim for "other insurance coverage primary" in these cases. [examples have been sent in the past and new example sent to Adrienne Nabors 8-21-17.]

Response: **In reference to the LTCH claims pulling coinsurance or deductible for HMO information only claims, the Cahaba Support services team presently has submitted an inquiry to CMS as to why the LTCH facilities were not added. FISS is responsible for removing reimbursement from the claim when edit U5233 is returned from the CWF on the HMO informational claims. Utilization days are still applied which would not prevent coinsurance days and value code amounts from being applied on the claim. Please note providers must**

reference their remittance advice, as it will indicate if the patient is responsible for the coinsurance/ deductible amounts that are applied. If no Patient Responsibility is noted on the remittance the provider should not bill the patient even though monies are applied to the coinsurance/deductible.

We have included some general HMO coverage guidelines for your convenience.

10.2.2 – Exceptions to Requirement for MA plans to Cover FFS Benefits
The following circumstances are exceptions to the rule that MAOs must cover the costs of original Medicare benefits:

• Hospice: Original Medicare (rather than the MAO) will pay the hospice for the services received by an enrollee who has elected hospice while enrolled in the plan. For detailed information about services furnished to an enrollee who has elected hospice care, see section 10.4 below.

• Clinical trials: Original Medicare pays for the costs of routine services provided to an MA enrollee who joins a qualifying clinical trial. MA plans pay the enrollee the difference between original Medicare cost-sharing incurred for qualifying clinical trial items and services and the MA plan's in-network cost-sharing for the same category of items and services. For further information on coverage and payment of clinical trials in MA plans, see section 10.7 below.

• Inpatient stay during which MA enrollment begins: (42 CFR § 422.318) If a Medicare beneficiary is in an inpatient stay and his enrollment in an MA plan takes effect after the stay begins, but prior to discharge from that stay:

- **Original Medicare is responsible for the costs of that inpatient stay; and**
- **The beneficiary is responsible for payment of cost-sharing as required under original Medicare**

In addition to providing original Medicare benefits, the MAO also must furnish, arrange, or pay for supplemental benefits and prescription drug benefits covered under the plan.
CMS reviews and approves an MAO's coverage of benefits by ensuring compliance with requirements described in this manual, including those outlined in this chapter, chapter 8, "Payments to Medicare Advantage Organizations," and other applicable CMS guidance, such as that contained in the annual Call Letter.

NOTE: The term "cost-sharing" refers to co-payments, coinsurances and deductibles

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf

Discussion at meeting
MS. NABORS: In reference to the LTCH claims, pulling coinsurance and deductible for HMO information only claims, our support services team is still working on that. That ticket is still open. And they have presented a question to CMS. They presented a question to FISS, and FISS submitted that the claims are processing correctly when they do pull that information, and that

is because they're pulling days from the common working file. If they're pulling days and applying the cost sharing amounts, the claim must come back read that way, so that part is correct. But our support services team is reaching out to find out why that particular facility type was left off of the change request. That is still pending. Once we find out information, that information will be submitted to you all as the provider community.

In relation to those claims that are showing that, because I think the confusion was before do we bill the patient for that amount. When we pulled up that code, U5233, it shows no patient responsibility or provider responsibility. So Michelle and I came to the determination, even though we couldn't see an active REMAC, that remittances most likely will not indicate any patient responsibility. If there is no patient responsibility indicated, even though it shows that that applies to the coinsurance or deductible, the patient should not be a billed. And, unfortunately, we would have to say the provider community may have to pull together with their billers and posters to make sure that no patients are billed for that, because the HMO has actually processed the claim. And that's just the option that we came up with, to try and suggest to you all, because do understand that if it's showing the remittance, we think that the patient should be billed for it, but the patient shouldn't be in this case.

We did include regular normal HMO billing information because we do know that that can be confusing.

6. We continue to get denials for NCD 20.33 (ICD-10 PX 02UG3JZ; MitraClip Procedure). These have to be appealed, which delays reimbursement on these procedures. The issue is a coding requirement versus the language of the NCD. The NCD requires that the primary diagnosis be either I34.0 or I34.1. However, many of these patients have more than one diseased valve. Per our Coding Department, ICD-10 requires that a combination code be used when there is more than one valve documented. Specifically, these accounts are coded with I08.0 (rheumatic disorders of both mitral and aortic valves), I08.1 (rheumatic disorders of both mitral and tricuspid valves) or I08.3 (combined rheumatic disorders of mitral, aortic and tricuspid valves). Can Cahaba please review this issue and assist with getting the NCD updated to more accurately reflect ICD-10 coding requirements? [examples were provided]

Response: **We perceive your request as reasonable; however, Cahaba GBA has no control over NCDs. If you wish to request a reconsideration of a NCD please follow the instructions in Federal Register Vol 78 no 152 August 7, 2013 pages 48164 – 48169 (attached)**

Discussion at meeting

MS. NABORS: This information did come from Dr. Mitchell. And it is stated in the CMS manual anytime an NCD is in question or the provider community feels that there should be some other things taken into consideration, it does have to go through them. And we know for a fact that there was one NCD that is still constantly being changed, because the provider community is challenging it. So with this particular situation, the information being submitted to CMS is the best route to go.

7. We have numerous redeterminations denied and the rationale states that the medical records were not included with the appeal. However, each appeal was filed via Cahaba's InSite Portal and the medical records were uploaded at the same time that the appeal was filed. This has

caused a great deal of extra work on these claims and a significant delay in receipt of payment when the provider is not at fault. Is Cahaba aware of this issue and what steps have been taken to prevent this error from continuing to occur? [examples were provided]

Response: **Still awaiting response from appeals**

Discussion at meeting

MS. NABORS: We are still waiting on the response from the appeals department regarding this. There is one particular issue that I'm aware of. And I called it an issue, but it's just a modification that Cahaba made due to -- for medical records, where if the claim hit a 39700 or denied, 56900, if you all submitted those through InSite, those records are pulled, scanned in, so that they can be routed through a different system and routed correctly to MR. That is the only situation that I'm aware of; however, I didn't have an example that indicated that a denial for lack of medical records in this particular case. For the two reference numbers that I received, the first one indicated that it was dismissed. Well, the two GINQs that we received appeared as if they were part of this example; however, they weren't. The first one was never dismissed. We received the records. It was overturned straight through. It wasn't denied. It was denied for, I believe, medical necessity and then overturned for full processing.

The second GINQ that was in this one and I did get clarification from Peggy, because I saw that it was also referenced in question number six. And she indicated that it truly was the one from the provider. That one we noticed actually was dismissed, but it wasn't due to medical records. It was dismissed improperly due to the NCD issue that's listed above; however, that appeal was recently reopened and currently should be processing for payment, because the decision was just done on November 1st. So whoever that reference number belonged to should be noticing an adjustment forthcoming. If you all have an example of one that really truthfully dismissed for no medical records, and you have that reference number, we'll be more than happy to take it so we can see why InSite is indicating no records, and you received a dismissal for no records, but something was received, and we didn't have that in these particular examples.

8. If a patient receives care at a hospital on the same date of service as the beginning date of a hospice episode and the care is related to the hospice diagnosis, but the services were provided prior to hospice accepting the patient, can both the hospital and hospice receive payment from Medicare?

Response: **No**

For example, a patient presents in the morning to receive observation services and the decision is made to move the patient to hospice. The patient is discharged at 3:00 pm to home hospice care. The hospice nurse comes that evening and the hospice begins care at 6:00 pm.

Response: **All services on the initial hospice date are 'hospice' services and payment for external services is the responsibility of the hospice.**

Additionally, if both the hospital and the hospice can be paid by Medicare – what about patients who are enrolled in a Medicare Advantage plan? Would Medicare or the Medicare Advantage plan be responsible for the hospital care received prior to the start of hospice?

Response: **All services on the initial hospice date are 'hospice' services and payment for external services is the responsibility of the hospice.**

Discussion at meeting

AUDIENCE: Do you or medical review have a reference for that? And the reason why I ask is because we asked Palmetto the same question- they didn't send a representative to ask today, but since Medicare allows both claims to be paid on the same day - and their response was different. So, we're being told by a hospice provider that the answer should be yes, and so I talked to some other hospital providers, and our problem is always, no, it wasn't. But the hospice that I was dealing with insisted that they've gotten these paid before through Cahaba. And so that's why we asked the question, because we were wanting something definitive, preferably for the manual, because we couldn't find it in the manual. But now we got conflicting answers from Cahaba versus Palmetto.

MS. COPE: Are you billing with the condition code 07, since your service at that time is unrelated to the hospice? Now, that can get paid that way, because the service is truly unrelated, if they weren't at hospice at the time you saw them.

AUDIENCE: I guess that kind of turns the definition. To me, they are related. They just happen to occur before they started on hospice. The particular example I'm thinking about is, the reason why they're going on hospice is because of what they were treated for at our hospital. So it just happened that that visit was just an observation that ended that day. But I can't find anything definitive in the manual. And now, like I said, I've got conflicting answers from the two different MACS.

MS. COPE: I can see if you applied the 07, because at that time, it wasn't in hospice, so technically, the service wasn't related to the hospice. The outcome of that service resulted in them entered into hospice.

AUDIENCE: But the reason why the third part of the question is about Medicare and Medicare Advantage is because this is actually a Medicare Advantage enrollee, so the 07 won't make any difference to them. My thought would be that the Medicare Advantage would be responsible, because this service occurred before enrollment in hospice. So it's just that extra level of complexity there, because if the Medicare Advantage is responsible, then the 07 isn't going to matter. If we send it to Medicare, is Medicare truly responsible at that point?

MS. COPE: Well, the manual states that they are HMO hospice during the same time, Medicare should consider the claim. So it's something we'll have to look at and get more information. And also, it could be that the hospice workers are not updated at the time. It's a lot of different scenarios, so we can look more into that for you, Brian.

AUDIENCE: Okay. Thank you. Well, I can say the hospice record is on the file. They know. And it shows our date of service for the outpatient claims. So all that is updated. It's just trying to weed through who is responsible, Medicare, Medicare Advantage, and the hospice. And if it's something in the manual that we can point to, that's fine. But we talked to compliance and we're really uncomfortable using the 07, because it is related. And nothing in Medicare that we can see from the file is time driven. It just says that hospice started on this date. So if you can get something from the manual or just some clarification, that will be great.

MS. NABORS: Okay. We'll ask the Medical Review for a reference that they got this particular answer from, because we did get this answer specifically from them. And if you have that patient and maybe a claim number we can look at, if you'll send it to us, you can send that one directly to me, but please put on there in relation to question number eight, and me and Michelle will look and analyze and break it down and see what we can come up with. Because sometimes the dates do cross, but also we can actually present that to the Medical Review Department as well to say, hey, we got this situation. What are your thoughts here? And sometimes it revamps things a little bit, put it on a different track.

AUDIENCE: I can send you an HIC number, but we haven't submitted the claim to Medicare.

MS. NABORS: That's fine. If you just secure the e-mail and get it to us, or I can secure one and send it to you.

9. Will the "appropriate use" for specialty radiology services as proposed in the MPFS for 2018 affect the radiologists that are billing Part B for interpretations for hospital provided specialty services? [attachment was provided]

Response: **The changes will not be final until they are final – the ACR sent a letter 9/11/17 stating:**

This implements Section 218(b) of the PAMA 2014 which mandates use of appropriate use criteria (AUC) for advanced diagnostic imaging studies (ADIS). The 'ordering professional' for radiologists must consult qualified clinical decision support mechanisms (CDSMs). G codes would describe the CDSM. When the G code is used – all claims with the G-code will be paid in the first trial year 2018. CMS wants CDSM judgments to be binary 'approve or not approve'. The ACR wishes that the furnishing professional may consult AUC on behalf of the ordering professional. The ACR wishes to have input into qualified CDSMs.

Discussion at meeting

MS. NABORS: This answer did come from the Medical Review Department. I apologize for it being clinical.

MS. RUBIO: I'm making myself a note to read the Medicare Physician Fee Schedule final rule section about that. Haven't gotten to that one yet.

10. For Medicare outpatient claims with HCPCS code J9355 (Herceptin) units greater than 44, we are receiving reason code 7O001. We are applying the patient's weight in KG, but Medicare is still

not allowing the claim to process. We have rekeyed the claim, we have called it in and have resubmitted the claim (per Provider Call Center supervisor), but the claim still will not enter the system. Originally there was a diagnosis issue, but this was corrected early in the process. In the past there were not issues getting the claims to Medicare (example provided). What do we need to do to get these claims past this reason code? [examples provided]

Response: **Returned to Peggy – waiting for clarification**

Discussion at meeting

MS. NABORS: I actually reached out to Peggy and the provider on this one. We needed additional clarification. I submitted this to the claims department. And in Michelle and me reviewing and preparing everything for this meeting, we realized it was a little tad confusing. And the example that was submitted shows one claim finalized and paid and one claim returned to the provider due to an error in the seventh diagnosis. So we have the claims. We just don't see one. We're not going to be able to help, if we don't have it; however, we reached out to the provider so that we could contact the EDI department to verify what was going on. Because according to some information I show, it looks like this question or issue had been presented to them. We don't want to do rework. We want to get the information so that we can reach out to EDI and find out what's going on.

AUDIENCE: This is our claim. And we reached out to EDI, and EDI said, no, indeed, it was not their issue and that we needed to go back to customer service. I had to leave Friday, so I'm not sure what customer service has said in regards to this. After this meeting, I can show you the examples. We did not have issues with Herceptin for claims that were paid in the month of April and May. In June, we have a patient, and Herceptin is administered based upon the patient's weight. So it will be times where you will have more than 44 units administered. This particular patient had more than 44 units. The examples that you see where they were paid, those were the April and May examples. The claims that we can't even get to the cross over are for the month of June.

MS. COPE: When you say "cross over," it's not even coming into this? See, that's a front end rejection, so that's why we're referring you to EDI. So if the claim doesn't enter into FISS, we can't see it.

AUDIENCE: Well, EDI is insisting it is not their issue.

MS. COPE: Do you go through a clearinghouse?

AUDIENCE: Yes, we do.

MS. COPE: Because, see, that reason code is specific to FISS. Normally, if you're rejecting on the front end, you get a different type of error. So do you have that specific error that you're receiving?

AUDIENCE: No. This is the only one we're getting.

MS. COPE: And you're getting that from your clearinghouse?

AUDIENCE: Well, yes. It's up front.

MS. COPE: Yeah. So you might want to revisit the clearinghouse, because that reason code is specific to FISS. It's not a front end rejection.

MS. NABORS: There's no point in why they would be getting it in the first place.

MS. COPE: Because that's what their clearinghouse is giving them, but that's not the true rejection. If it's in FISS, you'll get that, because it has to spin for someone to review. If it's not even coming into the system, that's what we call a front end rejection. It should be a different error that should be received other than this.

AUDIENCE: Okay. Well, when I get back tomorrow, I'll probably be contacting one of you, if that's okay, so I can find out what's going on, because we've addressed this with EDI, and they said absolutely not.

MS. COPE: Yes. Because that reason code is normally when the claim hits FISS, but it's not even making it that far.

MS. NABORS: And I apologize.

AUDIENCE: I personally am the one who has been calling customer service and talking to these people and getting the GINQ number.

MS. NABORS: If you call customer service, if it's a front end rejection, they have nothing to see. Unfortunately, they can't help you. The only thing we can do is say contact your clearinghouse or contact EDI.

AUDIENCE: Finally, on 10/3, is when they finally said contact EDI.

MS. NABORS: And we apologize for that. And I will say in their defense to this reason code, whenever the provider presents us a reason code, we're thinking that the claim is present.

AUDIENCE: I'll show you what we're getting.

11. Providers are getting denials for the 6th month follow-up to the Lung Cancer Screening (G0297) that physicians are ordering based on findings from the first screening. Please provide guidance on how to bill the 6 month follow-up test? Should it be ordered and billed as a diagnostic test with CPT 71250 instead of as a screening? [see attached examples]

Response: **It would be dependent upon the reason for the encounter. If signs and symptoms are present, the indications would be the CT was for diagnostic purposes. In the**

absence of signs and symptoms, a screening would be appropriate with the policy indicating the coverage guidelines under the "Written Orders for Subsequent Annual Lung Cancer Screening with LDCT."

Indication: Lung cancer LDCT screening absence of signs or symptoms of lung cancer

Lung Cancer Screening with Low Dose Computed Tomography (LDCT) (210.14) Policy for subsequent LDCT:

Written Orders for Subsequent Annual Lung Cancer Screenings with LDCT
For subsequent annual lung cancer LDCT screenings, the beneficiary must receive a written order for lung cancer LDCT screening. The written order may be furnished during any appropriate visit with a physician (as defined in Section 1861(r)(1) of the Social Security Act) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in Section 1861(aa)(5) of the Social Security Act).
If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit before a subsequent annual lung cancer LDCT screening, the visit must meet all of the criteria described above for a counseling and shared decision making visit.

Discussion at meeting
MS. NABORS: The answer is from Medical Review Department and they provided information from the CMS manual.

MS. RUBIO: Okay. We are going to chime in on that. If your patient had an abnormal finding on that original screening, that, to me, is a sign or symptom, and that would be a diagnostic at that time, and your diagnostic code would be abnormal findings on an x-ray.

12. Can we bill for multiple episodes of CPR performed on a patient in the emergency room? The MUE value for CPT code 92950 is (2). For example, if CPR is performed at 1pm and the patient is stabilized, but then requires CPR again at 1:45pm. Can we bill for 2 units of 92950? Is there a certain time that should pass in between doing CPR before it is considered a separate episode? Or should we only bill for one unit no matter how many times CPR is performed while the patient is in the ED? Should additional units of 92950 be reported with modifier -76?

Response: **My take on this is per episode of care. If CPR is performed three times in the ED that is one episode of care. If CPR is performed in the ED and then later in the ICU that is two episodes of care.**

Discussion at meeting
MS. NABORS: This information was from the Medical Review Department.

AUDIENCE: We had asked the same question of Medicaid, and they had indicated that per NCCI, the quantity is two per day, so this is different. We wanted to make sure are the different guidelines being followed by Medicare?

MS. NABORS: Medicare is considering it in this manner; in other words, if you give the patient CPR in the emergency room department multiple times, they're considering that one episode, because the patient may not have been stable, per se. But if they go from the emergency room and then they go to ICU and it's administered again, those are two different episodes.

AUDIENCE: Yeah. This is the exact same question we asked Medicaid, and Medicaid was yes. NCCI/MUE allows a maximum quantity of two per date of service and no modifier as needed. So if it's NCCI, shouldn't it be the same? This is what we were trying to get at.

MS. NABORS: Okay. That's an addendum that we would need. If you could send just that piece to Peggy, so we can send it to the Medical Review Department. I don't want to chime in too deep on this, and also include what Medicare stated.

AUDIENCE: Okay. Thank you.

13. On appeal, how should we report the units for a drug that are over a date of service MUE value? For example (disregarding wastage), a patient receives 758mg of Fusilev (J0641, billed per 0.5mg). The MUE is 1200. Should we appeal with the 1516 units on one line? Or do we need to split the 1516 units with 1200 on one line and 316 units on another line with modifier -59? This question can be applied to any CPT code that is denied for date of service MUE.

Response: **On appeal, the drug would be billed on one line with the J code and the number of units administered (no modifier) even if it is over the set MUE value. If discarded/wasted drug is documented, add an additional line item with the J code and modifier JW for the total units discarded/wasted. This is the same as any other CPT code. As stated in the AHA, Coding Clinic for HCPCS, Second Quarter 2010, Page: 10, "The use of modifier 59 with any one J code should be uncommon and should not be routinely utilized to avoid MUEs."**

14. Will there be any changes to the escalation process in anticipation of Palmetto becoming the Jurisdiction J MAC? How will claims that are still pending escalated inquiry with Cahaba be handled after the MAC transition date?

Response: **Cahaba GBA will continue business as usual until the work is transitioned. Palmetto GBA will collaborate with ALAHA to understand the business needs of their members and the association executives to develop an escalation process.**

Discussion at meeting

MS. NABORS: All pending escalations at the time of the transition will be identified by Cahaba to ensure Palmetto prioritizes those escalations for resolution.

AUDIENCE: I just want to add to that if you were not at the workshop for the Palmetto transition, they did specifically also identify or address this and said that regardless of the scenario, they will be the owner on cutover.

15. How will claims (received, but not yet paid by Cahaba), reopenings or appeals (redeterminations) that are pending with Cahaba at the time of the MAC transition be handled? Will Cahaba continue to work all of these until completion or will some/all of these transition to Palmetto?

Response: **All pending or in progress work regardless of type of work (Provider Enrollment, Appeals, Credit Balance, Cost Reports, Claims, etc.) will transition to Palmetto GBA with the original date of receipt from Cahaba GBA. Palmetto GBA and Cahaba GBA will work together between now and the transition to monitor workloads so plans can be implemented to address any pending workloads.**

16. If a claim with a date of service prior to the MAC transition date needs to be corrected, reopened or appealed after the transition date, will this be handled by Cahaba or Palmetto? Will there be any special requirements for handling these requests?

Response: **After the transition date, all work will be processed by Palmetto GBA. See response to question 15.**

MS. RUBIO: Well, we definitely want to thank you for coming and being with us over the years. So thank you very much.

MS. NABORS: It has indeed been the pleasure of both Michelle and me to serve you in this capacity and even in the capacities that you aren't aware of - behind the scenes - that we work to try to handle or resolve any issues for you. We did encounter some of you that we met at the expos or even here on our way in today. We do thank you for your prayer and your concerns. We will be good. We will be good.