MEDICARE (CAHABA GBA) MINUTES
July 18, 2016 RIC/RAC Meeting

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

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Debbie Rubio

MR. ASHMORE: With us today from Cahaba we have Adrienne Nabors and Michelle Cope.

I. Follow-up from March 7, 2016 RIC/RAC meeting:

1. Follow up to Question #1.
Did you get clarification from support services on why some Medicare Notification claims are paying with a copay due from a patient? Did you also find out for providers that need to have their claims reprocessed, what instructions are needed to get those remittances corrected so they can be submitted correct to coinsurance?

Response: **We have resubmitted this inquiry to our support services department, as we are showing services where the coinsurance should not apply still applying upon finalizing in FISS. We will submit this information to Peggy as soon as we know what is causing this to happen.**

Discussion at meeting

MS. NABORS: We have found that not only some of the HMO claims, but that some of the preventative services that should not generate a copay or coinsurance is still doing so. It is possible that they will have to pose this question to FISS.

That being said, it may take a while for a response. We are waiting for support to get back with us to find out who further they'll have to get with; and once that's done, then we will get the answer back to you. I will submit that information to Peggy upon receipt and confirmation from them.

2. Follow up to Question #8.
Were you able to research the example that was provided regarding the billing of PAP Smears?

Response: **The claims department required an example in order to provide a more detailed explanation. The example was requested, but was not received by the submission of this information to Peggy.**

Discussion at meeting

MS. NABORS: The claims department is in need of an actual example or claim, DCN, Medicare number, date of service, in order for us to confirm what is actually going on with the PAP smear claims. Because last time, when I pulled the information submitted to me, all I had was the reason code information, and that's why we had the response we had last time. In order to clarify the issue you are seeing with PAP smears, a claim example, 1, 2, would greatly be appreciated so we can actually make sure we advise you correctly.

3. Follow up to Question #12.
Did you get a response from CMS for the question if the cancer registry number is required before provider is able to bill?

Response: **Yes, Per the Centers for Clinical Standards and Quality (CCSQ), the registry number is not a requirement when submitting claims for Low Dose Computed Tomography (LDCT).**

Discussion at meeting

MS. NABORS: Yes, we did receive confirmation from CMS. We went to them for this one because there wasn't anything on the website that indicated that it was required at the time of filing the claim. It just stated that it was required.

They did contact me back. It's not required in order to bill. But of course, per CMS standards, you do want to make sure that that is obtained and kept in the actual records.

4. Follow up to Question #13.
Did you get any clarification on suspended claims for our no-pay (type of bill 110) claims that are submitted per the A/B Rebill Process (1599-F) and use of Condition Code 21 or M1?

Response: **Per CMS the Occurrence Code M1 should be presented on all Part A claims when submitting them for denial in order to bill their A/B claims.**

"The hospital would indicate Provider Liability period on the Part A claim by including the Occurrence Span Code "M1" and the inpatient admission Dates of Service.

The hospital could then submit an inpatient claim for payment under Part B on a Type of Bill (TOB) 12X for inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status."
I have included the link below as additional instruction is listed.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1333.pdf

Discussion at meeting

MS. NABORS: Yes. Upon looking back at the original question and the information that you wanted clarified was should Condition Code 21 be utilized on those claims. I would say no. According to SE-1333, M1 is what should actually be submitted along with the inpatient admission dates of service. But the 21 should not be because these actual services should be submitted stating provider responsibility, not patient responsibility, which is what the Condition Code 21 will generate.

We did include the MLN Matters link in the documentation for your additional review. But Condition Code 21 definitely should not be submitted, according to the instruction from CMS.

II. New questions

5. Providers are continuing to experience issues with claims hitting "suspense" status. During the last RIC/RAC meeting it was announced that Cahaba was expecting to be caught up with the backlog by end of March 2016. Please provide an update on the status of suspended claim resolution.

Response: **Response will be given at the meeting.**

Discussion at meeting

MS. NABORS: Right now we've been advised that there are currently 10 to 15 percent claims remaining in process from the heightened volume when we increased those escalations on claims that you have that are suspended that began at the beginning of this year when we started really honing in on those claims. Cahaba has revised their strategy to process the remaining claims through adjudication and are working diligently to process them in the next several weeks.

Our analysis identified several providers, and we did this through checking through the claims. For instance, at the expo, we had one provider who inquired and said, hey, we've got several providers, you're paying everybody but this one group, we get it kind of sporadic.

In our looking at some of those claims, what we found is each of those claims for this one provider have to be manually touched. That's what slows down a lot of processing of some of the claims, when they hit complex edits. And you have a group of people who are familiar with them, but those complex edits do take lots of time and extensive research to get them through to finalization. It's not just hit a button and it goes through. It's hitting a button, adding codes, adding condition codes. So with these complex type claims, it does take longer.

Well, with Cahaba noticing that and noticing that that seems to be some of the claims that are left over, they've revised their strategy. So they've identified several providers which make up a large majority of those outstanding inventory. We're going to be working on those claims and working on those providers' claims through adjudication until all of the claims that are over 30 days are finalized through the system and processed for all providers, regardless of whether that group has a large amount of claims that have hit complex. The ones who have a small group of claims that have hit complex are going to be included as well. You know, they're revising their strategy to hit it from a provider number scope, but they're still working to get all of the claims released for all providers.

AUDIENCE: Is there just some sort of ETA? When will it be done? Like two months, three months?

MS. NABORS: They didn't give me a time frame in terms of months. They're saying over the next several weeks. Because it's months, I would say our hope is to at least have that 10 to 15 percent drastically reduced by the end of this quarter.

It does take a long time. S/M days is one of those that are very challenging for us. In the working of those particular claims that are hidden S/M days, we're noticing that there are some things that we need to educate the provider community on as well. But each of those claims are specifically different and there are a lot of claims in that particular location. And we bump into that most commonly when the patient has been in the facility for an extended amount of time and they have run out of days and their benefits are about to be exhausted. Calculations, sitting down manually to do that,

it is possible for a claims examiner to sit on a claim like that, and it can take hours to work one claim through to finalization.

So when you have claims like that, even if you have just a couple of hundred, it takes a while to do that. That's just one example of those reason codes or suspended locations that we've noticed that claims are in, definitely with the inpatient and with the skilled nursing inpatient claims.

6. With the release of CR9603 which requires the JW modifier for billing drug waste be assigned by the hospital could you offer guidance for the following:

   a) Can the hospital bill for only the amount of the drug given and not the waste?

   Response: **Yes, until January 2017.**

   Initially the provider community would have been required to add the JW modifier to their claims for the disposed drug and biologicals effective July 2016, however, CMS has updated the effective date of CR 9603 to January 1, 2017.

   https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9603.pdf

   Link to the Instructions on submitting the JW modifier
   https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf

   Discussion at meeting

MS. NABORS: For part A, yes. You can bill just for the amount of drug given and not the waste, but that is only until January of 2017.

This actual change request was slated to go into effect July. However, CMS did make a recent update, and it will go into effect January 1st of 2017 but will most likely be implemented January 3rd of 2017. With New Year's Day and the holiday, you'll see a slight delay in that system implementation.

We've included links for your review for detailed instructions on the utilization of the JW modifier.

AUDIENCE: That was the intent, was when the JW modifier goes into effect, mandatory, right? We wanted to know if we could bill the amount that we gave versus the amount that we gave and the wastage. So what you're saying is that we have to bill for both and have two lines?

MS. NABORS: You will beginning the first of the year. You do not have to at this time.

   b) If the drug is wasted in the pharmacy (when mixed) and not by a nurse in the department the documentation usually is not located in the patient medical record of the waste. If requested for review, can the hospital supply documentation maintained in the pharmacy and not the patient medical record?

Response: **No, the wasted drug information must be documented in the patient medical record in the event the medical records are needed to support medical necessity. This places emphasis on the need for the pharmacy department to be actively involved in the quality of documentation in the medical record and participation in quality improvement initiatives of the hospital.**

7. Effective January 2016, the MUE value for CPT code 94640 (Airway Inhalation Treatment) was changed from ten to two units. The past instruction for reporting units of 94640 from the CMS NCCI panel stated:

*"Your inquiry requests clarification about the units of service that may be reported for this CPT code **94640** on a single date of service. A provider may report only one (1) unit of service (UOS) for a professionals (e.g., respiratory therapist) visit to provide services reported as CPT code **94640** even if those services require more than one inhalation treatment (e.g., multiple medications) at that encounter. The professional does not have to provide continuous face-to-face service during the entire treatment time but may initiate the inhalation treatment and return to continue or complete it.* ***If the professional completes the inhalation service(s) and terminates the patient encounter but returns later that day to initiate additional inhalation treatment(s) reportable as CPT code 94640 an additional UOS of CPT code 94640 may be reported for this subsequent patient encounter."***

This instruction was confirmed by Cahaba at the November 2014 RIC/RAC meeting. With the update to only 2 MUE units, does this change how we should report each separate patient encounter for an inhalation treatment provided on the same date of service? Do we continue to use modifier -76 for each additional treatment?

Response: **Inhalation Treatment**
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Coding Update: Code 94640
For the *Current Procedural Terminology (CPT) 2016* code set, code 94640 will be editorially revised to clarify that this is a bundled code representing both diagnostic and therapeutic services. The Coding Brief in the March 2014 *CPT Assistant* entitled "Pulmonary Diagnostic Testing and Therapies" addressed the previous reporting mechanism for code 94640. This coding update reflects the 2016 changes associated with this code. Note that the underlined code descriptor for code 94640 indicates the revisions and/or changes in the code descriptor.

94640
Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, Nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device.

Code 94640 describes the use of equipment for nebulization of medication, which may include bronchodilators, mucolytics, antibiotics, and other medications. Nebulization of medication may be done for diagnostic or therapeutic purposes, and can be done in the inpatient or outpatient setting. Thus, code 94640 is reported when the nebulization is performed for therapeutic and/or diagnostic purposes. *Modifier 76, Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional*, should be appended to code 94640 when reporting more than one inhalation treatment performed on the same date of service.

Code 94640 cannot be reported in conjunction with codes 94644 or 94645 (continuous inhalation treatments, first hour and additional hour). In addition, parenthetical references will be added for the 2016 CPT code set to indicate that code 94640 should not be used in conjunction with post-bronchodilator testing, which is reported with codes *94060, Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration*; *94070, Bronchospasm provocation evaluation, multiple spirometric determinations, as in code 94010, with administered agents (eg, antigen[s], cold air, methacholine)*; and *94400, Breathing response to CO2 (CO2 response curve)*. However, code 94640 may be reported in conjunction with codes *94667, Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/ or evaluation* and *94668 subsequent, which describe the use of manipulation of the chest wall to facilitate the clearance of secretions initial demonstration and/or evaluation and subsequent demonstration and/or evaluation*.

Discussion at meeting

MS. NABORS: Again, we've included some information. I won't be reading all of it. I'm going to try to make sure I hit the highlights.

It does stipulate a couple of codes, 94644 and 94645, that cannot be used and reported in conjunction with 94640. But it does appear that that particular code can be used, as with any code, in the event that you do receive a rejection such as a medical denial because you filed too many. We do request if you're going over the allowed amount that can be billed, submit it as a redetermination with supporting documentation.

MS. RUBIO: And I did want to point out that like she said, that MUE is a date of service edit.

MS. NABORS: It is.

MS. RUBIO: So if you report over two of those codes for a date of service, it will reject and deny. And that's whether you put a modifier 76 on there or any other modifier. So if you report more than two a day, you will get a denial and, like she said, you would have to do an appeal redetermination to get that paid. We are seeing a lot of denials for multiple units of that code.

MS. NABORS: My definite suggestion is to please include all of your medical records to keep from having a delay. Medical records are not required for a redetermination according to CMS, but they

are required in order to complete the appeal. So my recommendation is to make sure that you send those records to support it right when you submit your redetermination. You won't have a delay for anyone requesting medical records. With our parlay facilities, most of the time the requester is not the person that gets the letter requested for records. So it is my suggestion, to keep any of your redeterminations from delaying, is to submit medical records with your request unless, of course, it was one of those large redeterminations where you sent in a thousand pages and those records are in-house on file, because they can pull those, or maybe records for the RAC. But anything such as this, please submit it in.

8. Medicare making duplicate payments in old accounts (4-6 years). How to report on Credit Balance report? How to report in column 11 – sending check or corrected claim and we are not doing either?

   Response: **If the provider is sending in a check they would put "C" in column 11. If the provider is not sending a check or a claim correction then they would put an "A" in column 11. This will let us know that a claim adjustment is needed.**

9. a) Medicare overpaying claims when secondary – unable to determine how they calculated payments. How do we get them to correct them?

   Response: **Our support services department needs specific claim numbers or Medicare numbers and the date of service of the MSP claims in question; they will also need a copy of the primary insurer's EOB. With this information they can only determine if the claim processed correctly based on what the provider submitted.**

   Please note, if the provider submitted the MSP information incorrectly - they will not be able to determine that without a copy of the primary payer's EOB.

   *****Any examples presented on Monday will be brought back for review. *****

   Discussion at meeting

   MS. NABORS: We need to actually be able to look at the claim to see what happened. We want to confirm that the provider inputted their information correctly. We want to identify and make sure that there was not a change-up in the screens in FISS, something that would cause this error. They're not able to answer it on the blanket question that we have. They actually do need a specific claim example. When we get that, we will definitely look at it and review it to see if we can identify what's happening.

   AUDIENCE: That was actually a question from someone at our group. And she was not able to be here, but I've emailed her. So I'm going to try to get those for you before you leave.

MS. NABORS: Okay. And if not, if you get it to Peggy, Michelle and I will definitely get it to support for them to confirm.

b) There is no other payment info on the remittance (they are not showing primary payments, etc.). They are just not processing correctly.

Response: **Since this doesn't appear to be related to MSP, examples are definitely needed for this issue. The support team is not able to tell what happened to claims with the provider saying 'they are just not processing correctly'. The more information the provider can give us will help assist us in getting to the bottom of the issue.**

Discussion at meeting

MS. NABORS: Again, it really does help us if we can see the information, mainly the actual claim, what was keyed and the explanation of benefits from the primary insurance.

MS. CARSTENS: And I just need to clarify that AlaHA cannot receive claims with PHI. So if you have something and you need to send it, you need to send it directly to Adrienne in a secure email.

MS. COPE: And if you happen to have contact at the Provider Contact Center as well, if you have that claim reference number or a GINQ number, shoot that in an email to us, and we can pull the information from the Contact Center's documentation.

And if you're sending your MSP claims electronically, we're going based on what you keyed on the claim. So if you feel that you made an error, you can complete our MSP adjustment form and include the EOB, and we'll relook at it that way as well.

10. When a physician's office calls to schedule a diagnostic service at a hospital and a hospital faxes back a confirmation of the request back to the office, would that suffice for an order for the test or would there have to be verbal orders taken at the hospital which required countersignature of the ordering physician or would the physician office have to fax or electronically submit a written order with the original request?

Signature Guidelines posted by Cahaba May 2, 2012 for Part A reference the section below:

> The Medicare Benefit Policy Manual Chapter 15 Section 80.6 states no signature is required on orders for clinical diagnostic tests paid on the basis of the clinical laboratory fee schedule, the physician fee schedule or for physician pathology services. ***A NOTE is listed in this section that states unless specified, these sections are not applicable in a hospital setting.***

Response: **In a hospital setting, a signed order – or clear documentation by the physician of the intent to order must be present.**

11. How long are orders both written and verbal valid from the time they are originally submitted? For example, an order for future lab work for monitoring a specific treatment plan.

Response: **Per the medical director: This question is usually asked with relation to labs and written prescriptions (when can they be filled based on the date of the prescription) and also applies to other orders. The industry standard is one month. There can be rare exceptions – In patients with chronic conditions it could be longer and in patients with acute conditions it would/should be shorter. These exceptions would require narrative description (why?) in the clinical record.**

12. We understand that hospitals should not report a subcutaneous injection (CPT code 96372) when Insulin is given in the outpatient setting since Insulin is a self-administered drug for Medicare. At one time, Dr. McKinney told us it would also **not** be appropriate to report the administration of Insulin – regardless of the route by which it is given – including IV push / IV infusion. Is this still the case since patients would never self-inject Insulin by IV route?

Response: **Per the medical director: Please reference the Local Coverage Article:**

Self-Administered Drug Exclusion List - JJ MAC (A52700)

A. Route of administration: Absent evidence to the contrary, presume:
   - **i. Drugs delivered intravenously are not usually self-administered by the patient.**
   - **ii. Drugs delivered by intramuscular injection are not usually self-administered by the patient. Cahaba GBA may consider the depth and nature of the particular intramuscular injection in applying this presumption. The use of the particular drug, along with the acuity of the condition and frequency of administration, will be considered.**
   - **iii. Drugs delivered by subcutaneous injection are self-administered by the patient. The use of the particular drug, along with the acuity of the condition and frequency of administration, will be considered.**

Discussion at meeting

MS. RUBIO: The question is we know that insulin is a self-administered drug. So does that mean that you can bill for the infusion if you give insulin by IV infusion?

MS. NABORS: I would say yes. And, of course, if it was one of those cases where it was denied, then because he states that Cahaba may consider, meaning that if it hit for denial or rejection, I would submit that for redetermination with the medical records. It's just one of those cases where it would have to be looked at by the medical review department.

13. We are receiving denials for HCPCS code A9521 (Ceretec) which is a pharmaceutical required for the performance of a diagnostic test. Can you determine if this is a FISS problem or a NCCI problem? If this is a NCCI issue, can you assist in the correction of this problem?

Response: **Cahaba received a claim example from the provider, upon reviewing this claim in FISS; it shows this procedure was submitted as a non-covered charge. If the provider has a claim example where Medicare denied the charge, we ask that you submit it for review.**

Discussion at meeting

MS. NABORS: So what we would like is for anyone who had this, or whoever submitted the question, if you have one where it was denied and it wasn't submitted as non-covered, please submit that to us so we can review and confirm whether it was an NCCI or a FISS issue. But with it being submitted non-covered, we weren't able to make that determination.

14. For LCD L34252 Drugs and Biologicals: Colony Stimulating Factors, two diagnosis codes to support HCPCS code J2505 Pegfilgrastim, 6mg (Neulasta) are Z41.8 Encounter for other procedures for purposes other than remedying health state and Z51.89 encounter for other specified aftercare. Could you explain the appropriate use of these diagnosis codes? Are they to be used for the prevention of infection for patients receiving chemotherapy? Can they also be used for mobilization of peripheral stem cells?

Response: **The usual statement is 'the physicians in our clinic are only giving the pegfilgrastim (Neulasta) for infection prevention and no other reason'. We (the contractor medical directors and medical policy staff) are happy to work with you to possibly make the LCD somewhat less restrictive; however your use of the language 'for infection prevention and no other reason' falls into the category of preventive services. Pegfilgrastim is not a legislated preventive service – these can be found at the URL:**

https://www.medicare.gov/coverage/preventive-and-screening-services.html

Screening and preventive services that do not have a legislated exception are not covered by Medicare. If the patient has one of the narrative indications noted in the LCD, we would expect you to try to use the most appropriate diagnosis to go with / 'mirror' the indication.

Discussion at meeting

MS. RUBIO: I do want to point out that in the LCD, the indications for Neulasta says that it is for decreasing the incidence of infection. So that's not very far from saying preventing infection. But when you're giving a myelosuppressive anticancer drug associated with the clinically significant incidents of febrile neutropenia, which is when you would give Neulasta. So if the wording is to say prevention of infection, you might want to have them say decrease the incidence of infection, which is exactly from the policy, and maybe that will help get your claims paid.

15. Providers are experiencing issues with claims from 2010 wherein there is recoupment of payments that are being reprocessed with a lower amount with an "indemnification

adjustment" on most of the line items (CAS code OA-121). Cahaba customer service is advising the provider that this was due to a mass adjustment to resolve an issue on the Medicare Cost Report (per the remark "FP 22080"). Please provide clarification regarding what this means to the provider and the relationship between the cost report and these account level adjustments. [example was provided]

Response: **Our financial department is reviewing the submitted examples with support services, they have not yet submitted an explanation, but it is forthcoming and will be submitted to Peggy.**

Discussion at meeting

MS. NABORS: We went by advice from the financial area that this actually should not be affecting many providers. However, our support services department is reviewing the information that I received from Peggy. We had a particular provider that submitted this information. They are currently reviewing it. Once we have our analysis as to what was going on, I will submit that information to the provider and, of course, copy Peggy on that information as well.

16. MLN Matters Article SE1609 instructed providers on the billing of prolonged drug infusions. The article states that CPT or HCPCS codes should be reported to describe and account for the costs associated with the services provided by the physician or hospital staff while the patient is in the office or outpatient hospital. The drug administration code should also account for the cost of the equipment. To prepare and connect an infusion, a nurse must connect, program and prime the pump; educate the patient/family on the use of the pump; and be on call for any pump/infusion issues. Additionally the hospital bears the cost of purchasing the ambulatory infusion pumps. CPT code 96416 already describes these types of services for prolonged chemotherapy infusions of more than 8 hours. The Medicare unadjusted payment rate for CPT 96416 is $280.27 which we believe is an appropriate amount to cover the amount of work and costs associated with this service. Cahaba has posted instructions to use CPT 96549, unlisted chemo procedure, for prolonged infusion services which has an unadjusted payment rate of $30.87. This payment is inadequate to cover the hospital's costs for this service. In light of this information, would Cahaba please reconsider this instruction?

Response: **The procedure code 96549 is an unlisted chemotherapy service – when used for administration and pump Cahaba does individual consideration in determining the payment as there are many different options.**

Cahaba has published the article listed below to aid in answering your questions. The article is at the URL:
http://www.cahabagba.com/news/prolonged-drug-biological-infusions-started-incident-physicians-service-using-external-pump-2/

Discussion at meeting

MS. RUBIO: Since I wrote this question, I promised I would summarize it.

Medicare released a special education article, SE-1609, about the billing of prolonged drug infusions. And it says that when you bill that, it's to include the cost of the drug administration and also any education and any equipment such as the pump itself, in that. And they said that the Medicare administrative contractors could provide instructions on which code to use.

Now, normally, that service would be billed with CPT code 96416, which pays around $280. But Cahaba posted instructions to use a miscellaneous or an unlisted procedure code, CPT 96549, which, on addendum B, pays a rate of $30.87. And that amount of reimbursement is really not enough to cover a hospital's cost for a prolonged infusion service, the patient teaching, and the pump.

MS. NABORS: I would agree.

MS. RUBIO: So we wondered if Cahaba would reconsider that.

MS. NABORS: And our answer to that would be, yes, but based on a review. The procedure code 96549 is an unlisted chemotherapy service - when used for administration and pump, Cahaba does individual consideration in determining the payment, as there are many different options.

They did include a link, and this did come from the medical director. But my suggestion is submit it in as a redetermination with the supporting documentation for what you were doing because they're actually specifying that they make individual determinations.

MS. RUBIO: Do you mean they can pay different amounts for that 96549, or are they going to pay that $30?

MS. NABORS: It will probably be reviewed on a case by case to possibly pay more than the $30.87 because they're saying there are other options. But I would submit that in. However, if you have anything or any instance where we show that it paid that $30 or even perhaps less and those particular services were rendered for this particular or the previous code, then if you could just send us at least one example of it so we can send it to the director and say, hey, please look at this. Because I fully understood what you were saying on this particular question.

MS. RUBIO: Yes. And I mean, that would be a lot of redeterminations for a hospital that has a cancer center and performs this service a lot. So I don't know if the hospitals might could write the medical director or get you some examples of this is the cost that we put in, this is what the pump costs.

MS. NABORS: I would say if we could at least have one or two examples with the labeling of the cost along with the documentation of the services rendered, if those could be submitted to me, we'll get those to the medical director so that they could perhaps re-review their decision regarding this particular code or at least give a more specific direction if there's some other code that should be utilized instead.

MS. RUBIO: Right. I mean, because we didn't see anything wrong with the original code that described that service.

MS. NABORS: I understand.

AUDIENCE: Yes. My question was just what if we go ahead and continue to bill the CPT code 96416?

MS. NABORS: That's the original code that was submitted?

AUDIENCE: Yes.

AUDIENCE: In Cahaba's article that they put out, they said that we could not bill it. And we've been holding our claims waiting to hear what you had to say. And we have like 75 patients currently.

MS. NABORS: So you haven't received any type of rejection?

AUDIENCE: We have not billed them. We've been holding this waiting, because you just put this article out in May. So we've been holding our claims.

MS. NABORS: So they're saying to utilize the 96549 on their instruction. Has anyone billed 96549 and received the lower payment?

AUDIENCE: We have not.

AUDIENCE: I mean, we can submit one in. I can submit one.

MS. NABORS: Well, in order for us to get an example, we definitely would need someone to submit it in.

AUDIENCE: We can submit one.

MS. NABORS: At least submit it so we can see how it processes and what happens.

AUDIENCE: We'll submit one in, and then I'll let you know how it processes.

AUDIENCE: And mostly because it's not correct coding.

AUDIENCE: No, it's not. Because you use an unlisted procedure when there's not a code that you can use. And the code that you can use is because it is greater than eight hours. You're doing chemotherapy. That's why you would use the original one that we're talking about. And they're asking us to code it with a CPT code that's not valid or that's not appropriate.

MS. NABORS: In this particular case, especially with this response coming from the medical director, usually, when they give me a response, I stick with their definite script; however, that doesn't mean that we can't submit information for them to definitely look at and say, whoops, we may have made a change or, whoops, we need to go this way or, oh, we're correct but maybe we need to do this.

AUDIENCE: I'm just saying from a coding perspective, it's very hard to bill something that, to me, doesn't have the correct CPT code on it.

MS. NABORS: I definitely agree. But we have to have something to submit to them. And it would be better in claim form. Even with medical record documentation, we still would like something in the claim form so that they can look at it and they can see not just the medical record, but how it hit in the system. So that's my recommendation for at least one claim so that we can get that to them. We'll definitely get it to them for review.

AUDIENCE: Is the 96416 being used for incident-to services? Because I just pulled up the article. And it says, under the incident-to benefit, the physician must incur the cost of the drug. The allowance for CPT code 96549 will be considered all inclusive for the chemotherapy administration and the pump. Therefore, no other administration, pump charge, set up, or disconnect charges will be allowed. Provider should not report CPT code 96416, supplies, or pump codes.

And that's coming from that special edition you actually published on our website, SE 1609.

MS. RUBIO: It is an incident-to service.

AUDIENCE: Okay.

MS. NABORS: I think an example would probably really help us. So the lady who said that they were going to submit one in, please do so we can see how it goes through the system.

And like I said, we will definitely present it to them as a question that was asked along with saying that the provider community feels that it's inappropriate coding and have them relook at it.

MS. RUBIO: Right. And it is inappropriate coding. Of course, you can code like your payor tells you to, which in this case would be Cahaba. But the main thing is it's inappropriate reimbursement. I mean, it's not enough reimbursement to cover the cost.

The original article from Medicare seemed to be more about that you could not bill separately for the pump under DME, if you'll go back and look at the original SE article. Evidently some people were trying to bill for the service, bill for the infusion, and bill for the pump. And I understand that was a little bit too much billing.

MS. NABORS: Right.

MS. RUBIO: But for the hospital that has to incur the cost of the pump, has to put the time into initiating and adjusting that infusion, and then patient education and all of that, $30 for that whole complete service is just not enough to cover their cost.

MS. NABORS: Got it.

AUDIENCE: May I make suggestion that along with the example, that you bring up that many people in this room had a concern that it was expressed greatly that $30 does not cover? Because, you know, an example was fine. But really, the issue is very, very straightforward.

MS. NABORS: Okay. I really understand what you're saying. We just wanted to be able to have something to present to them besides a medical record showing that.

When I read the question, I was like huh, even though I didn't prepare that answer for this particular one. And when I got the response back, I did say, huh? But again, being that it came from the medical director. So believe you me, it won't be belittled. It will be the entire group there plus the folks who were not there, they're saying, hey, $30.87 for this little piece. I think it also may actually go down to what Debbie was saying, was because of previous billing of the DME along with the two separate billers, that the hospital may have just not gotten reviewed probably with regards to this particular code. And I can send that to them, and I will. But in this particular case, so that I can make sure that your issue is thoroughly reviewed, having just one particular claim on file and showing them what the system is pulling as a reimbursement just seems to have a little bit more back.

Additional discussion at meeting

AUDIENCE: I actually have a question about an old issue, but I was asked to bring it to the meeting, and it's concerning condition code 44 in the ED.

If a patient is seen in the ED, and the physician writes an inpatient order before the patient has received an important message or are notified regarding their status that they're being placed inpatient, can that physician change the order to outpatient at that time without a condition code 44 being issued? If the order has been put in the chart, entered electronically, but the patient has not signed an important message being notified that they're inpatient, can they change that without going through the UR Committee?

MS. NABORS: If you can get that question to me in more detail. I think I need to take that one back to make sure. I want to make sure I get you accurate information on that one.

AUDIENCE: Okay.

AUDIENCE: Scott Crawford, Revenue Cycle Director at Medical West in Birmingham.

I wanted to go back to suspense accounts. I know you hit on that earlier. But we've got a scenario, and I just want to make sure I get some clarification on it. We had an inpatient account in January of 2015 that we submitted with the wrong date of death. It sat in suspense for over 12 months and did not move to T status. When it finally moved to T status greater than 12 months, we filed a new claim, and it denied for timely filing.

I wondered if you could provide some clarification on that. Because we've got a couple of accounts right now that have been sitting in suspense for approaching 12 months. And if they could get to T status and we could correct them, we probably won't run into that issue. But this was, you know, a fairly large inpatient account. I wondered if you could clarify that for us.

MS. NABORS: Have you submitted that question to Peggy for the claim to be T'd back to you?

AUDIENCE: Yeah, I believe so. Yes.

MS. NABORS: Do you have a rough idea of when?

AUDIENCE: I don't.

MS. NABORS: Because if it was nearing 12 months, it is a strong possibility it may have been done prior to myself and Michelle joining the team, and we have certain accesses that our predecessor did not based on our experience with Cahaba. Because if you want a claim returned back to you, we can do that very, very quickly.

AUDIENCE: Well, that's interesting.

MS. NABORS: And upon that definitely getting it returned to you, we've also recently educated and made sure that the claims team was educated that if a claim exceeds timeliness. A lot of times when you're working a claim and you're working a very complex issue, you hit all these edits, and you get so glad and good that you get all of the edits worked, and you're like, yes. And we get into SC 9000 and sometimes we forget to take that one last look at that last edit, that 39011, and forget to put the timeliness override in there.

AUDIENCE: Okay.

MS. NABORS: They have been educated upon the expo, after the expo was done, to make sure that they override and bypass timely filing on claims that have been in this system for that long.

AUDIENCE: Okay.

MS. NABORS: We apologize for that getting overlooked, but we did make sure that we got that information to the claims department.

In the event, for the one that you had that was in suspense, you had it T'd back, you made your correction, when it came back, it denied for timely filing, if you submit that one to Peggy as well, Michelle and I will look at that. We can have that bypassed for you as well.

AUDIENCE: Great. Okay. Thank you.

MS. COPE: If you have a claim that T'd out, just add remarks before you send it back, and they have also been made aware to review the remarks on the page. And again, you can put something to the fact that we had it in suspense for a long period of time, and they will override it that way as well.

MS. NABORS: However, please do not request that your claims be sent back to you so that you can add justification.

There is a provider who asked that question at the expo. And because we've been recently working on some things and getting prepared for this, I have not submitted the response back to her yet. There was a provider, Part A, who was having that done. Because the claims had been in suspense for so long, she was requesting that they were T'd back to her so she could add justification.

Justification is only for you sending in your claim late and you're wanting to justify why that is happening. Please don't do that. If your claim hits for timely filing because it was in suspense for an inappropriate amount of time, please submit that request to Peggy. She will get it to Michelle and I, and we will take care of that for you. Don't do that. Please don't do that.

MR. ASHMORE: Any other questions?

AUDIENCE: I have a quick question regarding a Wisconsin Physicians Service (WPS) LCD. We just wanted to clarify if a registered polysomnography tech is required to perform the sleep lab studies and procedures.

And I've sent this information up through the chain and finally got the response back to follow your LCDs. So I'm just trying to clarify if we're following the Wisconsin LCD or the Cahaba LCD, which doesn't exist on that particular one.

MS. NABORS: You said this is for sleep?

AUDIENCE: Yes, for sleep studies.

MS. NABORS: If you could see us afterwards, we could get that LCD. We'll check that for you.

AUDIENCE: I just had one more thing to add to that about the LCD question. I called Cahaba and got my return calls. And the response that was received was that you cannot tell me if we are supposed to use this LCD or not but if we are denied, we can appeal. So my last question was what am I supposed to put in the appeal, and I haven't heard a response back since May. And this is for LCD L34535. And it's under the Wisconsin Physician Service Insurance Corporation.

MS. NABORS: We're going to research it under the CMS website to look for one for Cahaba. In the event we don't find one, we will go higher.

AUDIENCE: Thank you.

MR. ASHMORE: Okay. If we don't have anything else, that wraps it up for Cahaba. So I want to thank Adrienne and Michelle for coming today. Thank you.