MEDICARE/CAHABA MINUTES
July 17, 2017 RIC/RAC Meeting

CAHABA REPRESENTATIVES PRESENT:
Ms. Adrienne Nabors
Ms. Michelle Cope
Dr. Thom Mitchell

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Debbie Rubio

MR. ASHMORE: This morning, we have Dr. Mitchell, Adrienne Nabors, and Michelle Cope from Cahaba for Medicare.

1. Follow-up to Question #1 from March 13, 2017. In March, you shared the improvements that have been made to the escalation process within Cahaba. Please provide an overview of the steps of the escalation process; the timeline of how many days in each step and what types of claims these apply; cover both suspended and non-suspended claims.

Response: **Cahaba is currently working with IT on this process; we have no date for the enhancements at this time.**

2. Follow-up from discussion for Question #1 at the March 13, 2017 meeting, in regards to altering claims. We're having such an issue with claims being changed internally at Cahaba. What is your audit process for who makes the changes and why the changes are being made?

Response: **We are processing the claims per the edits received from CMS, these edits advise the days must be listed as they have them on file.**

Discussion at meeting

MS. NABORS: After speaking with the claims department, we did confirm that in the past, this question has come generally with regards to days being changed on a claim, so I got the information based on thinking that this is probably related to that. In speaking with them, even though you submit your claims a certain way with days listed a certain way, when we submit the claim to CMS, CMS hits us back with what they have at that time and they want it keyed that way. So the claims department is following the process with how those claims should be keyed. Unfortunately, a provider may show 80/20 at the time that they submitted the claim, but once the claim actually hits the common working file, it may be something different. So our claims examiners have to process and key the claim according to what's listed in the common working file, and that's in alignment with the CMS guidelines.

AUDIENCE: This wasn't my question, but we had this issue before, and I had sent some examples to you previously. I don't understand how someone at Cahaba is changing lifetime reserve days to 83 or 84 days when there's no such thing as that many lifetime reserve days. So I don't see how CMS could be telling Cahaba to do that.

MS. NABORS: In terms of lifetime reserve?

AUDIENCE: Yes. I had sent some examples back right after the last meeting.

MS. NABORS: Okay. I'll do some research to try and pull those examples because I did forward the information that Peggy sent to us to the claims department, and that was the feedback we got from the claims department saying CMS wanted them actually keyed in that manner. I do understand what you're saying in terms of the days not being correct. It's actually probably how they have to lay it out in order to try and get your claim to process and finalized based on what hits they're getting from them on the edits, but we will recheck that information.

3. Follow-up from discussion for Question #1 at the March 13, 2017 meeting, in regards to Lifetime Days.

   A) We would like a Part A Educator from Cahaba to come and make a presentation/mini-workshop to provide education on Lifetime Reserve Days (LTR).

      Response: **We have notified our Provider Outreach and Education and Claim teams to see if/when they can develop a presentation for Lifetime Reserve Days. Once this has been developed we will notify Peggy.**

   B) Please confirm we're not in conflict with MLN Matters SE0663 if we bill LTR Days when we're not able to reach the patient.

      Response: **In order to confirm if they are in conflict with SE0663, we would need claim examples for review.**

Discussion at meeting

MS. NABORS: When we develop a presentation for Lifetime Reserve Days, we will notify Peggy and any questions that you have won't have to wait until the next meeting. You just forward that information to Peggy with any examples that you have so we can get that to them so they can do the, well, what about this and what about this? So they can try to get you better education on that information.

In terms of following the MLN, if you're noticing that there's something that you have a concern about, please go ahead and submit that information to Peggy, and we will forward that to claims so that they can compile it all together as a part of the examples for the presentation.

MS. COPE: Also there's a part in the manual publication 100-02, chapter 5, section 10.2 tells you when the beneficiary will be deemed not to use lifetime reserve days and section 20 when payment will be made for reserve days, so that's also a good resource.

AUDIENCE: I think on the part B, the concern from the last meeting was that we just wanted something in writing. Because there's nothing in the manual that specifically says what to do when the patient is unable to make that election, and they have no appointed representative; or in situations

where we just can't reach the patient. I know we had a patient that we tried for six months to reach. He was homeless basically, and he was in and out of shelters and community care organizations. We tried and tried and tried. I just don't know what additional information that I can provide to Cahaba other than just to say is there some kind of process whereby the hospital would say, okay, we've done everything we can do to try to reach this patient. Are we okay to bill lifetime reserve days?

MS. NABORS: I do agree with you, Brian. What it does for us from a claims standpoint, it helps us not have just a general question. It also helps us to present that information to CMS for their guidance on it; hey, here's an example of what we have. Can you give us some guidance on what to do when a patient is not reachable but the patient is not deceased? So it helps us easily glean information that we need and have something on file because we may find different stuff going on, on that particular one, so you're correct. It doesn't really help you, but it helps us to try to get better, clearer, concise information for you.

AUDIENCE: So you're really not wanting a GINQ number. You're wanting a narrative, say, here are the steps we took to try to reach this patient, and we're willing to bill the lifetime reserve days. Is that what you're saying?

MS. NABORS: That's what we want to try and help you get. So if you give me a GINQ number, that helps us get a preparation for you. It helps us get a claim. We get the claim. We use that as a guideline to give them the narrative as CMS, and they help us give something back for the provider community, some guidance.

AUDIENCE: Generally speaking, I wouldn't call Cahaba if I couldn't reach a beneficiary. I mean, I guess I could call and say, look, I need to get this to escalated process, can you give me an MCR number? Is that kind of the process? Or do you just want us to send you the DCN with a narrative about what's happening? I guess I'm trying to understand.

MS. NABORS: No. In a case like that, when you have a general question, we do not open up the escalations for general questions. In actuality, this one is not quite general because we've kind of had it mentioned before in a case like this. Just send that information. If you have a claim of the patient or the information from where, hey, I couldn't file this claim, but here's the Medicare date of service of the patient's claim we're trying to send, send that to Peggy. Peggy will get that to us. That's not an escalation, but it's one where we've got to get assistance in order to get more clarity because the manual gives instructions, but they don't tell you how to run down a beneficiary. We want some help from them to help guide the providers on that.

MS. COPE: Also, Brian, the manual states when the patient is running low on days, the facility is supposed to notify the patient at that time. Are you not doing that?

AUDIENCE: We do, but we have a lot of problems. This usually is an issue for our psych patients. You get to that gray area where does the patient even understand what you're telling them. Sometimes you can't communicate that to the patient, and oftentimes they're dropped off by the family and that's the last time you see a family member or anyone else. So that's kind of those difficult situations where the patient doesn't understand and they're in and out of mental facilities and there's

no family support or an appointed representative that even monitors the patient care, so that's where we need that clarification, I think.

MS. NABORS: And giving the information from the provider community helps us address it to CMS to say, hey, this is something you might want to pinpoint because this is a reality.

AUDIENCE: And just to clarify, we're really also talking about CMS is saying, the patient just has to tell you when they don't want to file. Just so we're all clear here, it's not that we're having to get permission to file. So I'm thinking that because this is such a rampant issue even just in Alabama, it might be something that you want to talk to CMS about putting guidance out to the patient in what goes to the patient so that we're also covered in directing that patient back to the materials that they get as a part of becoming a beneficiary of Medicare. So when you can point them back to that guidance, that is also helpful, and I don't know that there's a lot of coverage there. I haven't looked lately, but that might be something you could offer as a suggestion.

MS. NABORS: I do believe it is more general. So that actually is the twofold piece. Give clarity for the beneficiary, but we definitely want to help the provider community get their instruction as well for those beneficiaries who are not going to understand the information they have in print.

4. Follow-up to Question #7 at the March 13, 2017 meeting. In regards to the original answer to question #7 and additional discussion during the meeting, would a MOON notice be required to be mailed to a patient if the patient was discharged without receiving a MOON because the understanding at the time of discharge was the patient was inpatient?

Response: **The MOON must be delivered to a beneficiary who receives observation services as an outpatient for more than 24 hours, and must be delivered not later than 36 hours after observation services begin. The MOON must be delivered before 36 hours following initiation of observation services if the beneficiary is transferred, discharged, or admitted. The MOON may be delivered before a beneficiary receives 24 hours of observation services as an outpatient.**

The start time of observation services, for purposes of determining when more than 24 hours of observation services have been received, is the clock time observation services are initiated (furnished to the patient), as documented in the patient's medical record, in accordance with a physician's order. This follows the elapsed clock time, rather than the billed time, associated with the observation services.

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/CR9935-MOON-Instructions.pdf

5. Follow-up from discussion at the meeting for Question #7 at the March 13, 2017 meeting. If you have an inpatient-only procedure but there's no signed IP order, can we still bill as IP?

Response: **Now it can be billed as long as the admission order is obtained within three days of the surgery and while the patient is still hospitalized. (See MLN Matters Number: MM9097)**

Discussion at meeting

MS. NABORS: I'm sorry. It took me a while, but going back to question number five about the inpatient only procedure, that's what I was talking about when the inpatient only procedure is combined with an inpatient admission. Also remember the stays have to be continuous. You can't have an inpatient only procedure on an outpatient and the patient go home and then come back as an inpatient and combine it, but as long as it's a continuous stay it's the same thing that I talked about. So that's the MLN matters that had that April 2015 change of policy.

6. Follow-up to Question #9 at the March 13, 2017 meeting. Is there any rule that would prevent a hospital from billing a hospice patient if they do not schedule their care through the hospice (and therefore, the hospice is denying payment)? This occurs frequently in the emergency room. Can we bill the patient?

Response: **Medicare will not pay for the following services when hospice care is chosen:**

- **Hospice care furnished by a hospice other than the hospice designated by the individual (unless furnished under arrangement by the designated hospice)**
- **Any Medicare services related to treatment of the terminal prognosis for which hospice care was elected or are equivalent to hospice care, with the exception of: Care furnished by the designated hospice**
- **Care furnished by another hospice under arrangements made by the designated hospice.**
- **Care furnished by the individual's attending physician who is not an employee of the designated hospice or receiving compensation from the hospice under arrangement for those services.**
- **Room and board, unless it is for short-term inpatient care that you arrange**
- **Covered care in an emergency room, hospital, or other inpatient facility; outpatient services; or ambulance transportation, unless these services are either arranged by you or are unrelated to the terminal prognosis.**

Please Note: These questions are more appropriately addressed to your HHH MAC.

Discussion at meeting

DR. MITCHELL: I'd like to make just a brief comment. I practice emergency medicine so this is something that I'm infinitely familiar with. There's no question if the emergency department visit is related to a separate diagnosis from the hospice diagnosis. Classic example would be the patient with

end-stage cancer who falls and breaks a hip. Then that's billable to Medicare. But let me ask you a question. If a patient is in your facility and requests a service that is statutorily not covered by Medicare, I presume that you're able to bill them for that. Is that accurate presumption? So I think the answer to six would be the same.

7. Follow-up from Open Discussion at the March 13, 2017 meeting, per your request to submit this question so you can research it for us. Is there a rule regarding physician co-signature on nurse practitioner services rendered like in the emergency department before those services can be billed? Do they have to be countersigned by a physician?

Response: **If the Nurse Practitioner is working for a Physician/Physician group (Physician will bill for the service, rather than the NP), then the Physician must co-sign.**

If the NP is independent (NP will bill for the service), no co-signature required.

Discussion at meeting

DR. MITCHELL: It is hard for me to sit on my hands for some of these, but I would argue that if you're preparing documentation that's going to be reviewed, the physician must not only cosign the document, but the physician really needs to attest that they have seen the patient and agree with the nurse practitioner's assessment. That's really what it would require for the physician to bill us for the service, because remember, that's the issue is who has said I've provided this service, and I should be paid for it.

One sort of related note that's been a recent decision by CMS, if you use scribes, the scribes don't need to sign the chart but the physician clearly needs to attest that what the scribe documented is accurate and consistent with what they did related to that.

AUDIENCE: So if the nurse practitioner is employed by the hospital, working in the ED setting, not employed by the physician for hospital billing, who's billing for the technical services rendered, how does that play?

DR. MITCHELL: So just for clarification, you're not talking about the E&M codes. You're talking about the facility charges?

AUDIENCE: Facility fee. Now, the hospital will bill for the ED facility level when a nurse practitioner sees the patient. So that's just a little bit of a twist.

DR. MITCHELL: That is a little bit of a twist. Let me just go back to who's billing Medicare. I think if the hospital is billing Medicare for facility charges related to a nurse practitioner touching the beneficiary, I don't believe that would need to be cosigned. To bill the E&M code, if you're billing the E&M code from the doctor's perspective, then the attestation would be important.

AUDIENCE: Okay.

DR. MITCHELL: But if the nurse practitioner is billing with their own provider number that’s different.

AUDIENCE: No. So the hospital is billing for the technical, not billing for the nurse practitioner as a practitioner.

DR. MITCHELL: I don't have a problem with that. I think that is reasonable.

AUDIENCE: Okay. Thank you.

AUDIENCE: I just wanted to note that for a nurse practitioner, any kind of status order would have to be cosigned. An inpatient status order would have to be cosigned by a qualified physician with admitting privileges, and the same may be true for other services. Any service that requires a qualified practitioner to sign to bill the technical component, but particularly with inpatient admission orders, a nurse practitioner is not a qualified provider for payment purposes, and it's a condition of payment.

DR. MITCHELL: Good point. Thank you.

8. Follow-up from Open Discussion at the March 13, 2017 meeting, in regards to toenail debridement claims. Providers are continuing to get incorrect denials for Toenail debridement (CPT 11721) for medical necessity even though there are covered indications on the claim. Providers have to appeal these claims individually in order to get paid. GINQ 5512643 was provided to Adrienne & Michelle at the meeting and the provider also sent a follow up email to Michelle with additional examples of this continued issue through Peggy Carstens on May 18th (EI7924 /GINQ-5624382). Please provide a status on when Medicare will update their systems to process these claims correctly.

Response: **Medical Review advised for all claims that denied in error prior to the update of 5243E to be adjusted.**

Discussion at meeting

MS. NABORS: I do apologize. I did not get a date from the medical review team. That was an error on my part. I can go back and clarify with them when they notified, which would have been probably our support team to have those claims adjusted. I'm assuming, based on this information, it was also recent denials that you have, so I will go back and make sure, with our support team, that we confirm that those updates did go in and go in correctly.

AUDIENCE: So will we be getting some sort of notification when it would be adjusted, or will it come through Peggy? How will we know?

MS. NABORS: I notify Peggy from the GINQs that's listed in the question. I'll contact her back. I guess when I saw it I was like, okay, I sent it to medical review for a response. It didn't dawn on me, even after reviewing these answers, that I didn't have a date to confirm when they notified, whether it was something that they just notified them upon the questions or whether they had previously notified them and some claims may have gotten missed. So that's what I've got to correct.

AUDIENCE: Because it would be the past claims and the ongoing, right? Both needing to know when the ongoing ones will be fixed as well because this has not stopped.

MS. NABORS: Right. I'll notify Peggy of the dates.

AUDIENCE: Thank you.

9. The LCD for CT of Abdomen and Pelvis L34277 lists Abdominal or Pelvic Pain as an Indication, yet the list of diagnosis codes do not list the Abdominal Pain codes from R10.0-R10.9. Can you review the policy and add these diagnosis codes?

Response: **Your reconsideration request to the POE representative is not in a valid format. If you wish to request a formal language change in the policy you do need to follow the requirements.**
Among the requirements in requesting a LCD (or LCA) reconsideration are:
*** Requests must identify the language that the requestor wants added to or deleted from a LCD (or LCA).**
*** Requests must include a justification supported by new evidence, which may materially affect the LCD's (or LCA's) content or basis. The level of evidence required for LCD (or LCA) reconsideration is the same as required for new/revised LCD (or LCA) development…….**

The requirements can be found at:
http://www.cahabagba.com/part-b/medical-review/lcd-comment-and-reconsideration-processes-2/

Discussion at meeting

DR. MITCHELL: Yes. I would ask that you help us do that, however. At the bottom of the response is a link, and I think we have around 40 LCDs. We try to keep them current; however, the ICD-10 process really moves faster than we do, and this is true for NCDs and for LCDs. Well, for LCDs, in your jurisdiction, if this is a significant issue, then I would put together all the codes that you think should be in that LCD and why and submit it as the directions request in the reconsideration link. It helps us stay on top of it, and we look at these and we consider them. It's much like giving us a claim to have this coming from providers and it could come from your organization. I think there's an answer later where it says the Alabama Hospital Association is putting together a reconsideration request. That's a great idea because that way rather than being touched by 20 of you we get one request and hopefully we can consolidate it and put it through.

For the NCDs - the national coverage determinations - we don't own the NCDs; CMS does. But there's a very similar process for the NCDs, and it's not unusual for us to be touching CMS and saying, you know, we're finding this to be a problem with NCD. Will you consider redoing it, but there's also an entire legislative pathway for you to touch CMS and request that changes be made in the NCDs and why. This is a little bit easy. We often ask that you provide the language that you would like to see changed in the LCD. It sounds to me like really what you're requesting is that we add ICD-10 codes, and that's a pretty simple language.

10. Please advise if CMS has written policy regarding the coding of signs and symptoms ICD-10 codes to justify Medical Necessity of an ordered test or procedure that has an associated LCD or NCD. Coders are instructed to code the final determined-most definite Dx. and this often results in a rejected facility claim as final findings Dx is not a covered Dx per the NCD or LCD.

Example: Doctor orders a breast biopsy for a lump in the breast. Dx for lump in the breast N63 is a covered code per LCD-NCD and this is coded as a reason code…Final determination is often benign and this code is not a covered code per LCD-NCD. Our procedure CPT 19081 is then denied for not meeting medical necessity. Coders are reluctant to code the reason Dx other than as a reason code when final findings are documented.

We have this same issue with Diagnostic colonoscopy, pt. has rectal bleeding which is covered Dx per LCD but final finding Dx internal hemorrhoids is not. These are surgical examples however we have various tests (cat scans, duplex scans, etc.) that also have a covered reason Dx but not final Dx.

Are there any plans in the future for Cahaba to consider reason for visit codes listed on the claim for claim processing and to support medical necessity?

Response: **Cahaba for professional claims requests that physicians and/or coders representing the physicians (the physicians have responsibility for correct claims) use of 'reason for visit' coding rather than final diagnosis coding.**

The Centers for Medicare and Medicaid Services addresses the Patient Reason for Visit fields (Form Locator 70) in the Fiscal Intermediary Standard System (FISS) in the following MLN Matters Article. Please refer to –

MLN Matters® Number: MM9450
Related Change Request (CR) #: CR 9450
Related CR Release Date: December 31, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3435CP
Implementation Date: March 31, 2016

Discussion at meeting

MS. NABORS: The physicians have responsibility for the corrected claims if there's a need for it. See the listed change request and the MLN Matters that they're wanting you to refer to and the related other change requests that are also listed. There are several pieces to reflect on.

AUDIENCE: So does this apply for hospital billing also, the same logic for hospital billing? This says physician billing.

MS. NABORS: Yes. This is the information that's indicated for medical review.

AUDIENCE: So the reason for visit. Okay. Thank you.

11. How do hospitals handle discharge dispositions when a patient is discharged and presents to another acute care facility within 72 hours or less?

Response: **We have submitted this inquiry to our support services team and are still awaiting a response.**

MLN Matters® Number: SE0801 Rescinded	**Related Change Request (CR) #: N/A**
Related CR Release Date: N/A	**Effective Date: N/A**
Related CR Transmittal #: N/A	**Implementation Date: N/A**

Clarification of Patient Discharge Status Codes and Hospital Transfer Policies

Note: This article was rescinded on March 15, 2017. 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.

FL 17 - Patient Discharge Status
Required. (For all Part A inpatient, SNF, hospice, home health agency (HHA) and outpatient hospital services.) This code indicates the patient's discharge status as of the "Through" date of the billing period (FL 6).

Codes used for Medicare claims are available from Medicare contractors (*Not on our Website*). Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual (*There is a fee*). Will Cahaba consider subscribing? *Cahaba is reviewing this possibility.*

Discussion at meeting

MS. NABORS: We submitted this inquiry to our support services team because their information out there has been rescinded, and we're still awaiting a clear response. We wanted to confirm with them if our system is updated; if not, when it will be. In relation there were a couple of footnotes at the bottom, under codes used for Medicare. Claims are available for Medicare contractors. This information is not on our website, and there is an actual fee if you want to obtain the NUBC information. You did ask whether Cahaba would consider subscribing. We are reviewing the possibility of subscribing to that particular piece. It would only help us internally, but we will notify Peggy once we've received a response from our support services team regarding instructions on this since the SE is listed as rescinded.

12. Our hospital is considering the use of the Automated Breast Ultrasound (ABUS), which is to be used adjunct to mammography. The vendor suggests using CPT codes 76641 and 76642 to bill for this service. The aforementioned CPT codes represent 2D ultrasound, when the ABUS is 3D. There are

no specific examples to provide at this time as we have not purchased the equipment. Prior to purchasing equipment, we would like to determine the appropriate codes to bill for this service.

Response: **Automated Breast Ultrasound (ABUS) may be billed with a xxx99 (unspecified, not otherwise specified NOS, not otherwise classified NOC) code. Cahaba would expect that Automated Breast Ultrasound (ABUS) would be considered an integral part of and bundled (not separately paid) into the primary service.**

13. If a Psych patient seen in the Emergency Room has an order to admit to Psych but is being held in the acute care hospital for more than 1 day while waiting on a Psych bed - How should providers bill for the charges from the patient's initial presentation until the Psych bed is available?

Response: **If the patient is not being treated for medical problems, the days/charges are combined with the DRG billed for the Psych inpatient admission.**

Discussion at meeting

DR. MITCHELL: I would like to make a brief comment about this as well. The other piece to this, though, is to keep in mind if that psych patient has a blood alcohol level of 300 and you have to keep them for 24, 36 hours before they're accepted in the psych bed, then that's a medical reason. The same would be true of potassium of 2.9, things of that nature. So keep that in mind because those are medical reasons. Unfortunately, from my perspective as an ER physician, medical screening is not a medical reason, which is consistent with this answer, I think.

14. The injection of the spinal canal LCD L34291 states there must be documentation of therapeutic versus diagnostic injection in the procedure note, this seems appropriate for the transforaminal procedures, but does this documentation requirement also apply to the epidural injections? Does this policy also apply to selective nerve root block procedures since they are the same CPT codes as transforaminal?

Response: **LCD L34291 section 'Documentation Requirements' states:**
3. Procedure Note
A. History: A brief overview of the patient's pathology and responses to previous interventions, when applicable
B. Diagnostic versus therapeutic'
*** …, but does this documentation requirement also apply to the epidural injections?**
Answer: Yes
***……Does this policy also apply to selective nerve root block procedures since they are the same CPT codes as transforaminal?**
Answer: No. Selective nerve root block procedures whether cranial, spinal, or peripheral are not the same CPT codes as transforaminal.

Cahaba GBA retains the discretion to make individual claim determinations based on the medical necessity of the service(s) being provided to the beneficiary. Cahaba GBA does not speak for other agencies, departments, and entities of the federal

government such as DOJ, OIG, ZPIC, FPS contractor, RA (formerly and more recently known as the RAC), CERT, NCCI, special Supplemental Medical Review contractor (SMRC), and Medical Review Documentation Compliance and Technology Contractor or Documentation Compliance Contractor (DCC).

Discussion at meeting

DR. MITCHELL: So diagnostic versus therapeutic is a documentation issue. I think this is outside of my area of expertise. I don't do this, but my understanding is that if this is a new patient, for example, and it's a chronic back pain patient and the practitioner is saying, will nerve root ablation work? That is diagnostic. Let's say it works. It relieves 50 percent of their pain, and so we're not really sure whether we should proceed with ablation. So they do a second diagnostic, and maybe that works 75 percent of the time. But that's a documentation issue, and it would really only be a documentation issue upon review. Therapeutic is, you know, this really gave them an 80 percent relief of their pain for three months. We're going to proceed to nerve root ablation. My understanding is that selective nerve root block procedures -- be they cranial, spinal, or peripheral -- are not the same CPT codes as transforaminal. If I'm mistaken, please send me that documentation, and I'll be happy to look at that differently.

15. Please provide clarification on whether Cahaba requires NDC codes on all the drug codes submitted on a UB claim. If yes, providers need to get official notification on a workable effective date since this requires programming changes by providers that will take time.

Response: **Effective for claims with dates of service on and after July 1, 2009, hospitals billing for drugs/biologicals that have received FDA approval but which have not yet received product-specific drug/biological HCPCS codes will not only specify the NDC of the drug/biological, but will also specify the quantity of that drug/biological using the CTP segment in the ANSI X-12 837 I (in Loop 2410 LIN 03).**

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6330.pdf

If this required information is not present on the claim, the claims are returned to the provider for the required information.

Discussion at meeting

MS. NABORS: There's a link indicated with instruction. If this information is not present on the claim, the claims are returned back to the providers for that specific piece. We have to have that in order to appropriately price the claim according to the information we receive.

16. We would like to request a redetermination of LCD L34271 – Laboratory: B-type Natriuretic Peptide (BNP) Testing. The current policy, which dates from 2001-2005, does not cover monitoring the efficiency of treatment for CHF and tailoring the therapy for heart failure. [We are collecting supporting documentation to provide to you.]

Response: **A formal procedure has been provided to AlaHA to submit requests for determination.**

Discussion at meeting

DR. MITCHELL: And we are happy to look at that. Continuing to see just heart failure patients, I appreciate that concern.

MR. ASHMORE: Adrienne, I believe we had submitted the documentation, but you want us to put it through a more formal process, using the LCD redetermination e-mail address you gave us.

MS. NABORS: Yes.

AUDIENCE: So based on my understanding, does that mean that you're going to reprocess these claims and pay them if that is the appropriate diagnosis code? Is that what you're saying?

DR. MITCHELL: I don't think I said that. We will certainly consider it. I'd like to look at what gets submitted, and to be honest with you, I need to look at the literature that supports that or may not support that. I cannot make a decision at this time with respect to how much of a retrospective scope will be applied to those changes **if** we decide to make a change.

AUDIENCE: Do you have any overall opinion regarding this question. You know, we approached you before when we found the LCD that was way more narrow than the NCD. Can you just offer your opinion? We are going to comply and get Cahaba what is needed for this, but can you just give or render any sort of opinion regarding the BNP for current state of the state with monitoring the efficiency and tailoring that therapy?

DR. MITCHELL: This is something that I need to look into. For example, what we'll do is we'll go to the American College of Cardiology, and we'll look at their guidelines regarding monitoring congestive heart failure patients, and if those guidelines says, following BNPs as an outpatient is recommended, or if you submit those guidelines to us if you have them, that's really the kind of information that sways our decisions. Generally, my opinion doesn't bear much weight but professional body guidelines really do. I mean it's easy for me to wax about this a bit, but you know BNPs are a measure of atrial strain, which is a measure of the preload of the amount of volume coming into the heart, and so they were very useful in the management of acute congestive heart failure. And what we see is practitioners who order a BNP and act on it seven days later, and that's clearly not consistent with the LCD. Now, if the American College of Cardiology says that that practice is state of the art, then it will shift our position. But I really need to see how the professional organizations weigh in on that. I personally get it. There's a patient we used to take care of who had horrible congestive heart failure, and when her BNP was 300, she was tuned, and that's the best you could get it. So when she hit the door and her BNP was 1200, we knew we had something to do. So in that setting, following serial BNPs would be useful, but I really need to look and see what the American College of Cardiology's position is regarding outpatient BNPs, which is something I'm not familiar with. If you have those, please send them my way.

AUDIENCE: And I believe they have been sent to some cardiologists so they could give evidence based guidance and why they're using it because it's the most common thing and we're getting denied forever on those.

MR. ASHMORE: We have some of them, yes.

AUDIENCE: Yes. And then it just needs to be sent through to that e-mail address directly to you is what we're understanding. So we do have all of that. I think some physicians they've sent that?

MR. ASHMORE: Correct.

DR. MITCHELL: We'll look for it.

AUDIENCE: Thank you.

Additional discussion at meeting

AUDIENCE: I have a question related to the two midnight review. We received our final determination letter in May, and we haven't received a demand letter for the denied claims. I called KePro, and they said we might not actually receive one. Do you have any information on that, or do we need to call?

MS. NABORS: I would say that you contact the provider contact center. You said you received your final decision letter in May? Who did that decision letter come from?

AUDIENCE: KePro. They said they mailed the letter which was in May.

MS. NABORS: Just call in and make sure they did get the information.

AUDIENCE: Okay. Thank you.

MR. ASHMORE: Any other questions?

AUDIENCE: I just want to say on behalf of this group, Dr. Mitchell, we really appreciate you attending. Just the discussion with you, I mean, even if we don't resolve something, having that level of discussion with us really means a lot so we appreciate you coming. Thank you.

DR. MITCHELL: Thank you very much. I always learn something, so thank you.

MS. NABORS: Back in reference to the follow up question for number one, I did say I have a question that our claims manager, our higher up director, wanted me to propose to you all in relation to the escalations. She told me to ask you all in relation to us better getting a response out to the providers what would you all prefer. When you all contact the provider contact center you get a GINQ number. If after the 30 days you have not heard anything, you usually forward that GINQ number and information to Peggy, and she forwards it to Michelle and I and we pray real hard and we try to work miracles on your behalf. Occasionally we have to forward it on to the next altar of sacrifice so you can get some additional help. What she wants to know was when you do that first step of escalation and contacting the provider contact center, would you, in relation to your GINQ number, like having something automated to let you know about your claim? It would be something along the line of every

14 days you getting feedback, a pop up to the e-mail address that you all submit to us letting you know claim is in the review status with the claims department. Claim is still pending but working with an examiner.

I'm giving you just a hypothetical because this still is in the developmental phases. She wanted to know would that be acceptable in the provider community, or do you all still prefer to have physical one-on-one feedback. They're wanting to confirm if this is something that the provider community would accept and not complain or hit us really hard from an evaluation standpoint saying nobody ever called me back, but if you're getting automated feedback letting you know that this claim is being worked. It will let you know that we haven't forgotten about you but that we are working to get your claim resolved. Just letting you know you're not being ignored, but it's giving you something, a status.

AUDIENCE: For clarity, that would be in lieu of the person calling you back and you get the automated e-mail?

MS. NABORS: I'm going to use this very loosely. There are always going to be those one unique circumstances where a provider does have to be contacted back, but in the case where I need my claim priced, it hasn't gotten priced yet and it's been over 30 days, 45 days, and I ain't got my money yet. Something like that would not necessarily merit a call back, so it would be in lieu, but please accept my disclaimer. There are always going to be those unique circumstances where we may have to contact the provider back. We may find out that the system is about to blow up on a particular area, and we need to call you back and get even more information. So this would be in lieu of that, but we're not trying to cut off the community.

AUDIENCE: And it would only be a status update and not an answer, per se, if we had a particular question?

MS. NABORS: No. This would be only in reference to claims that are suspended that have had to be sent back to the claims department because they have been out there for an extended period of time. And this is my understanding from how they're working on it. If you are told, we haven't seen this before, we may have to contact you back, you may get a call back. However, if we've identified there is a problem, there also may be some sort of way to notify you of claims in a particular location without necessarily contacting you back but contacting you via the e-mail address you submit to us.

It's a fine line, but she wanted mainly to know is that something that you all would accept as a status. Hey, claim has moved out of suspense. It's now in CWF. Claim is finalized. Money should be expected soon. You know, if that's something you all would consider accepting.

AUDIENCE: Yes.

MS. NABORS: I will go back and give her that information. Again, it's still in a developmental phase, but she wanted me to find out from you all what was your general synopsis.

MR. ASHMORE: If we don't have any additional questions, I want to thank Dr. Mitchell, Adrienne, and Michelle for being here today.