MEDICARE (CAHABA GBA) MINUTES
March 13, 2017 RIC/RAC Meeting

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

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Karen Northcutt
Ms. Jennifer Bartlett

MR. ASHMORE: I want to welcome Adrienne Nabors and Michelle Cope from Cahaba today.

1. Follow up to Question #2 from November 7, 2016 RIC/RAC meeting.
Providers continue to have claims suspending for extended periods of time. This is particularly true for high dollar claims and inpatient claims where the Part A benefits have exhausted. Can Cahaba provide an update on addressing these suspended claims? Also, at the November 2016 RIC Meeting, Cahaba stated that the escalation process was being reengineered. Does Cahaba have update on changes to the escalation process?

Response: **Cahaba has processed 6.7 million claims in 2016 with 1.8 million of those claims coming from Alabama.**

Our responsibility to you is to respond quickly and with substance to your claims/inquiries. To do that we have been reducing any aged inventory, making sure our associates are trained fully, and making sure we have enough communication channels to meet your response expectations.

Reducing aged inventory:
From 1/3/2017 to present, Cahaba has reduced the number of suspended claims 30 days old or older from over 11,000 to approximately 1,100. During the same time frame, we have reduced Part A claim adjustments over 30 days to approximately 7,000. Through dedicating resources, hiring additional staff, hiring contractors, and implementing many automations we have made good progress but there is more progress to be made.

Fully trained associates:
We are continuously training our associates on general topics as well as more in-depth topics. Training for our associates also includes professionalism and tone programs, and we hope that you are seeing the benefits of our hard work to improve all of these requests you have made.

We extend that training to our customers as well through Cahaba learning events, our website, listserv emails, Open House events, and our Expo. Our Expo in Murphreesboro, Tennessee on April 19th will continue that trend with both general and more in-depth topics. We would appreciate your input on any additional topics where you see we need improvement to meet your expectations.

Response expectations:

Over the past few months, we have implemented 3 programs to have greater transparency and open communication with you to meet and exceed your expectations.

1. **Cahaba Open House. We have had 2 open house events in 2017 and the feedback has been very positive. In the open house each provider has the opportunity to sit face-to-face with an associate from a subject area (i.e. provider enrollment, claims) to discuss any issues they may be having. If the provider sends the information prior to the appointment, a resolution may be reached before the appointment and further education can be discussed. If the issue cannot be resolved in the face-to-face, we are committed to following back up with you until the issue is resolved.**
2. **The Claims Issue Log has transitioned to the Cahaba Help Log. We have opened this notification of issues up to more than just claims issues. This provides a resource to check prior to calling customer service for issue updates.**
3. **We are increasing the number of callbacks we make to you, closing the feedback loop on any inquiries which were made to Cahaba and a callback was expected.**

While we have made many improvements, we are not done. Over the next few months, you will see articles noting changes where *you asked* for changes and *we listened.* The articles detail the changes we have made to meet your needs. Continue to give us feedback and we will respond!

Discussion at Meeting

MS. NABORS: The Claims Issue Log that we have has turned into the Cahaba Help Log. We've opened this notification of issues up to more than just claims issues, such as system issues or anything that we have going on that may be causing your claims to perhaps suspend or for you to have an issue with your claims. So throughout our company, many additional resources will be updated in that particular log.

And we're also increasing the number of callbacks we make to you, closing the feedback loop on any inquiries which were made to Cahaba and a callback was expected. For instance, they weren't able to release the claim, they need more expertise, they may forward it to Michelle and I.

They may contact you and ask you for contact information such as an email, perhaps a direct number; preferably email in this particular case because what will happen is, is once they contact us and forward the claim to us, once we get it, we will acknowledge it by email saying we have your claim and we've released it or we have your claim and we have run from it and forwarded it to the claims department, one of the two. But this is just to help close the loop. And we would respond a little differently from our escalation process. We would respond saying we've done one of the two, and we'll either follow up with you once the claim has been released or we would tell you that the claim has been released and to just monitor the DDE and contact us back directly but to please receive that as your Provider Contact Center (PCC) callback.

So we're liaising with them as well to help make sure that the provider community is satisfied with getting a callback. Just a little different from our escalation process. This would be something we would receive directly from the PCC in assisting them with their workload.

AUDIENCE: I've noticed claims that are using lifetime or coinsurance days. We submit them with the appropriate number of days and value codes, and then the claim goes to suspense and the coinsurance lifetime reserve days have been changed. At any rate, I don't know how that change is happening. It's not changes we're making.

For example, I saw a claim of the lifetime reserve days of 83 days. We all know that can't be. And we know that no one on our side made that change. So can you tell us what's going on with those claims?

MS. NABORS: I can try and give you a general idea. Was this a regular claim? Was there any psych involvement?

AUDIENCE: No psych.

MS. NABORS: So this was a regular claim? That most likely happened because of hitting reason code 15202 or hitting SM days. That's one of the reason codes we're working extensively on. Your claim probably hit the days. It's possibly a partial payment claim, partial benefits where the benefits have exhausted one/two days or several days. And because of that, we're not trying to alter your claim, per se, but our specialist who's working those particular claims, they are working to try and get the claim to be accepted by the common working file with the days that are out there.

Again, because we are working on extensive training, trying to learn the habits of what CMS is actually asking for on that reason code, I can't tell you that you're doing something wrong. But I can tell you that we probably are making changes, but we're not trying to manipulate your claim illegally. We're trying to give the claim information to process - what CMS is expecting in order to do that.

However, you have a particular question on, hey, 83 shouldn't be doing this, send us an example so we can try and get you a clearer response.

AUDIENCE: I had sent one back originally, and I was told that you couldn't track who had made the change. But I can track within our system and see who made the changes, and, obviously, no one in our system has made the changes. And I have a second one that recently happened, and I have screen shots of how it looked between times. And we all know you cannot have 83 lifetime reserve days.

MS. NABORS: If you have the one with the screen prints that shows what it was at the time you sent it to us, we can look at the audit trail. The audit trail may be extensively long, but if we can at least get a rough range as to what may have done it and get with those claims seniors to find out what happened.

AUDIENCE: All right. I'll get it to Peggy.

MS. NORTHCUTT: And I think there are several other hospitals that I have talked to that are having that same problem. And it would be altered when it comes back, and they don't understand.

MS. NABORS: And that may be on our part. Maybe our senior claims examiners may need to add notes out there as to why they're doing what they're doing.

Again, I do know that one of our subject matter experts in that is a senior, and she is working to give it what it's asking for. But it would help the provider if we notate and say "The common working

file is going to list this is why we're making this change to see if this would work" or "This is working because of," again, so that you know that we're not trying to illegally alter your claim, we're just trying to help you receive payment based on what you submitted and based on why the common working file (CWF) is hitting back.

MS. NORTHCUTT: And I think that would be a wonderful education topic just on lifetime days and all the claim manipulation that goes with that. You know, that just is way over my head when you start looking at it too, and what the common working file has in their system, what you have in your system.

MS. NABORS: Along with what the claim is.

MS. NORTHCUTT: If everybody could meet in the middle somewhere.

MS. NABORS: And we are working on trying to get the helpful hints to see. But again, because of this reason code, we're trying to get a list of this is what we see providers are doing and this is what we see the common working file is asking for. But on part of them, we can determine what the provider is doing, but we can't determine why they're telling us what we're supposed to be doing. And I apologize. That's just one of those things where we're just really, really working on it.

MS. NORTHCUTT: And if you have it out there, just say, we're working on that. From my end, I'm working with people that are just getting beat to death by their CFOs and up there with their days in suspense, where is this money? So, back on this end it's in suspense, and that doesn't mean anything to anybody. So I think having something that we're working on this and this is the reason code, I think it would be very helpful for all that have to deal with it at the claims level on this side.

MS. NABORS: We'll work to get that information out there.

MS. NORTHCUTT: That would be great.

AUDIENCE: I have a question in regards to the lifetime reserves days. I have a patient that was in the hospital and didn't have any inpatient days left, so we wanted to use some of his lifetime reserve days. But I'm under the assumption that we're supposed to notify the patient and ask the patient if we can use the lifetime reserve days. But if you can't contact the patient to ask him about the lifetime reserve days, what do you do in that instance?

MS. NABORS: The patient is still living, but you're just not able to contact them?

AUDIENCE: Yes. It was a patient that was maybe on a psych unit or self-recovery unit. And the patient went home, we filed the claim, and it came back saying the patient was out of days. But we noticed that the patient does have some lifetime reserve days left, but I have no way of contacting that patient to ask the patient if we can use the lifetime reserve days. So what do we do in that instance?

MS. NABORS: They were on a psych unit or psych facility? Just the unit itself?

AUDIENCE: Just the unit itself.

MS. NABORS: We need to see that example. And the reason I say that is because I don't want to get the unit versus the facility mixed up. Because if they're in an actual psych facility and they have no full days and they have lifetime days, those days can't be used. Those would be benefits exhausted even though you can see lifetime days. They have to have regular days to equivocate in the same amount of the lifetime reserve days that you would be utilizing. But if this is the unit, we want to see that so we make sure we give you the accurate information.

AUDIENCE: So who do I contact? Is there a direct email or something? Because I'm having a lot of issues just like that. I can submit a claim with the coinsurance days on there, and they'll send it back in T status, but the information I submitted is gone.

MS. NABORS: With the information that we just found out on psych facilities and making sure that we direct them correctly, please send that example to Peggy so we can get it. Because that's the newest information we got on the days for psych facilities, we want to make sure that we direct you correctly.

AUDIENCE: But it's not necessarily a psych claim that it's doing it on.

MS. NABORS: That's why we want to make sure that we check it.

AUDIENCE: Okay. I'm sorry.

MS. COPE: In reference to your question, the manual does say you can use the days so long as the patient doesn't have anything in writing saying not to use them. But just keep in mind, they can come back and change their mind and say, well, I didn't tell her. So it's kind of tricky. But the manual did say so long as you don't have it in writing that they don't want to use it, you can use them.

AUDIENCE: Does what you said about trying to work this issue out with the CWF mean that you are working with whoever controls the edits in CWF to try to improve their process so that it's not causing these issues?

MS. NABORS: Right. Now what we're working on is trying to figure out what the problem is. We know that there is a small lack of education on that because of the changes that they made regarding SM days and the utilization of the days. Sometimes you need the revenue code 180, sometimes you need condition code 74, just trying to figure out the base for what's needed for a claim. And we're experiencing this pretty much on any partial benefits exhausted claims, where we're having to try and calculate the days to make sure that the provider has it calculated correctly.

So right now it's at an internal piece. But we are talking amongst each other saying we need to see what we can get from perhaps even another contractor as well as CMS to figure out if everybody else is having this problem, because we're noticing our system is hitting left and right for any claim that's hundreds of thousands and millions of dollars, if we get a no days, that's easy; but if we get partial days, those are challenging. And we're working on our internal education. But we have not closed up reaching out to everyone else to see what we can find out.

AUDIENCE: I need clarification on the lifetime reserve days used. Did you say we don't have to reach out to the patient for that verification or we do?

MS. NABORS: We do recommend that you reach out to the patient if you can get in touch with them. In the event you're not able to and the patient is still alive, you can use those days as long as the patient has not submitted something in writing stating do not use my days.

AUDIENCE: Okay. I just wanted to make sure.

AUDIENCE: If the patient is deceased, our payment was taken back at the end of 2016, and he still had all 60 lifetime reserve days after he died. I'm having the same problem with when it gets there, my lifetime reserve days are taken off even though I'm putting the correct code and all on. Is this something we can send hard copy to someone?

MS. NABORS: If you're having a claims issue, something of that sort, where you need detailed information on it, you can utilize the escalation process by sending it to Peggy.

AUDIENCE: Okay. Thank you.

MR. ASHMORE: Just to clarify the escalation process, when you send it to Peggy, she is the go-between between you and Cahaba. She'll send it on to Cahaba, and then they'll work the claim. But do not send any HIPAA-sensitive information.

MS. NABORS: All we need is the call reference number (GINQ) from the Provider Contact Center. If you do not have the GINQ from the Provider Contact Center, you can send the DCN/claim number to Peggy and she can forward that to us. But we found that most of these, unless they're new situations you can contact the Provider Contact Center on it so you would have a call reference number.

AUDIENCE: One time somebody told me that because our room rate was higher than the patient's copay on their lifetime reserve days, that Medicare was not allowing their system to process the claim using the lifetime reserve days. That was a while back, but I just thought I'd tell you that in case it might help.

MS. NABORS: I would have to see that.

AUDIENCE: Well, it was just a thought. Because somebody at Medicare is the one that told me that. Because it's been going on for a long time.

AUDIENCE: I remember that. It was someone in customer service that was saying that.

MS. NABORS: I myself am just nosey. I want to see that example so I can better understand.

AUDIENCE: It wasn't an example. It was the reason that our lifetime reserve days were not being paid. I'm just mentioning it. You were talking about revenue codes. That might be something to

look at. But because our room rate was higher than patient's copay for those days, the system would not allow the system to process those claims and use the patient's lifetime days.

MS. NABORS: Well, that would give her the education for myself on that.

AUDIENCE: How much is their room rate?

MS. NABORS: I don't know. That's why I'm saying that.

AUDIENCE: You could have a copay that would be more than a room rate or less than a room rate, depending upon how many days.

AUDIENCE: Well, if the room rate was $600 and your copay was $500, your room rate is more than your copay. So that was the example.

AUDIENCE: I want to make sure that we're following the last reference under MLN Matters SE0663, because it does talk about that we have an obligation to ask the patient if we can use their days and even if we went into those after the fact in hindsight. And I took it from the message that if we didn't notify the patients, we could just use them as long as they're not telling us that we can't use them.

MS. NABORS: Right.

AUDIENCE: And that's contrary to what this MLN is saying. So I just want to make sure that we're compliant. So would you look back at that and then reach back out to the hospitals so that we're all on the same page?

MS. COPE: Yes, ma'am.

MS. NABORS: But we do recommend definitely trying to do what you can to reach the patient.

AUDIENCE: The MLN Matters definitely says that you should reach out to the patient.

2. Follow up to Question #7 from November 7, 2016 RIC/RAC meeting.
If a patient is seen in the ED, and the physician writes an inpatient order but the patient has not been notified regarding their inpatient status, can the physician change the order to outpatient upon further review that it doesn't meet inpatient criteria without a condition code 44 being issued?

<u>Response:</u> If an inpatient order is written, a Condition Code 44 should be issued. Medicare Claims Processing Manual, Chapter 1, Section 50.3; Transmittal 299 CR 3444 released September 10, 2004; MLN Matters SE0622.

Discussion at Meeting

AUDIENCE: Okay. So you're saying that if a patient is admitted through the emergency room and they're inpatient when they leave the emergency room and they want to change it to observation, are you going to put a condition code 44 on there?

MS. NABORS: As indicated from the Medical Review department.

3. Follow up to Question #13 from November 7, 2016 RIC/RAC meeting.
Has CMS updated the system to accept a 940 revenue code without a CPT code?

Response: **The system has been updated to accept the revenue code 940 whether the CPT code is present or not.**

Discussion at Meeting

AUDIENCE: When we bill 940 revenue code and no CPT, it must be in the noncovered column in order for the claim to process.

MS. NABORS: So you're saying you're receiving denials or maybe the claim returned back to you?

AUDIENCE: Returns to the provider.

MS. NABORS: And you have recent claims that have done that, or was this prior to our possible update?

AUDIENCE: What date did this go in effect?

MS. NABORS: Unfortunately, I'm sorry, they didn't give me the date on that. But if you have just a quick example, I can check it and see if that's something that's required.

MS. COPE: It's not.

MS. NABORS: I mean, I know we've updated it. But to make sure, your date and the other date hadn't crossed each other.

AUDIENCE: Okay. Well, we'll attempt to do it currently and see what happens.

MS. NABORS: Okay. All right. And just let us know. Contact Peggy if you experience an issue, and we'll follow back up with the support.

MS. NORTHCUTT: And just to remind everybody what that means, 940 without a CPT is back to when we were talking about packaged services, bundled services, this goes back to when a physical therapist is going to do evaluation and a treatment on this observation patient, that would be considered an adjunct service for that observation. Sometimes the doc will say evaluate and treat. They

want them to be stable before they leave. They don't trust a nurse to walk them down the hall, so they want the PT to come.

So last year it kind of changed there to go ahead and bundle those unless you're going to actually have a full plan of care, a written plan of care, an order for that rehab service and all of the functional things that you have to have, HCPCS that you had to have on the bill. So this was going to be a way that you could show their revenue under 940 revenue code and not have any CPT codes. So, basically, you don't get paid for it, but you get credit for the service.

So just as a side note, that's what all that 940 means, to those that don't have to deal with that.

4. On October 1, 2016 diagnosis code R97.2 has been termed. It should be replaced by R97.20 or R97.21; however the National Coverage Determination (NCD) for PSA (84153) has not been updated with these new diagnosis codes causing invalid denials. NCD 190.31 should be updated with R97.20 and R97.21 as covered diagnosis. This is currently not on the issues log. [Example: GINQ# 5384789]

Response: **The National Coverage Determination was updated to reflect the new ICD-10 codes.**

https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/Downloads/manual201701_ICD10.pdf

Discussion at Meeting

MS. NABORS: The NCD was updated to reflect the new ICD-10 codes. So you should be able to actually submit those codes now that they have been added.

AUDIENCE: As of?

MS. NABORS: They were updated January of this year. Of course, it's the first of the year, you always have a few delays because of the holidays, they may have gone in a little late, but January 2017.

AUDIENCE: Okay. What if the claims are actually denied? Are you going to reprocess those claims now that it's been updated, or are we going to have to send in appeals?

MS. NABORS: Do you know what the denial reason code was?

AUDIENCE: Not medically necessary.

MS. COPE: Did it actually deny or reject it?

AUDIENCE: It denied.

MS. NABORS: With the code that begins with the 5?

AUDIENCE: Yes.

MS. COPE: They'd have to appeal it.

MS. NABORS: Unfortunately, we would need for you to do a redetermination for those.

AUDIENCE: But at this time now, it's past the time we filed them.

MS. NABORS: Past the time limit?

AUDIENCE: Right. Because this was back in October.

MS. NABORS: The appeal?

AUDIENCE: Correct.

MS. NABORS: The appeal timeliness can be waived based on the fact that we're giving you this information today at this meeting. If you just advise them that we got notification by Adrienne Nabors or Michelle Cope on this said date, those appeal reps will read that information for this particular instance here.

5. We have claims in RTP with Medicare with reason code 32402 it is not allowing HCPCS code Q9969 to be billed with revenue code 343. This is a correct revenue code. Can the edit be corrected?

Response: **Our Support Services team is still reviewing this issue.**

Discussion at Meeting

MS. NABORS: Okay. We did get notification from our support services department that this code has been updated as of last week.

6. Providers have been instructed to file "1XQ" claims for Medicare adjustment filed past 1 year from discharge. Guidance for filing has been followed for electronic claims submission but the claims are being held in the RTP file. We need resolution for MACs to process "Q" claims without RTPing when filed correctly.

Response: **It is appropriate for providers to submit their reopening adjustments using the XXQ instructions as noted in SE 1426. Please note that all XXQ adjustments are set to suspend to allow the MAC contractors to control their workload. This also allows the MAC's to review the adjustments to make sure all required parameters are present.**

This workload is monitored and released on a regular basis.

Discussion at Meeting

MS. NABORS: Initially, these particular codes that we used to review the reopenings to make sure that they're valid, they were returning back. But we tried to make sure we cleared all of those out,

and then we changed the codes so that they would suspend so that our workload could be managed. This helps us review everything to make sure all of your justification is there.

Peggy did send me examples, and I looked at all of them, and what I found on reviewing those was that the remarks were not keyed correctly. We do need you to look specifically at that information that is in the SE article. It gives you details regarding where your spaces should be. So I do believe where they had good cause, they may have had good cause with the underscores in there, but they didn't have a space where it needed to be. And that first line is read in the system, so it will return to you for any of those particular pieces. But those that I looked at, I found the justification in the remarks was incorrect, not just a simple space.

7. If a patient is placed in outpatient with observation services and later upgraded to an inpatient level of care, yet the order is not signed at prior to discharge, which of the following is the correct billing status? 1) Part B only or 2) Outpatient with observation since it is the only valid order on the chart.

Response: **It is number 2) Outpatient with observation since it is the only valid order on the chart.**

Discussion at Meeting

AUDIENCE: In that situation, if we decided to bill the outpatient with observation and the patient, of course, is out the door, would we have to mail that patient a MOON notice? Because they would have exceeded the 36 hours and would not have a MOON notice.

MS. NABORS: A what type of notice?

AUDIENCE: The Medicare Outpatient Observation Notice (MOON) that's required recently by CMS that was effective March 8th.

MS. NABORS: We'll need to get clarification for that. Because this response did come from the Medical Review department, we can find that out for you and clarify it. We want to get that answer from them.

AUDIENCE: Okay. And one additional question regarding that. If you have an inpatient-only procedure in the midst of all of this, is there any exception there when you don't have that order signed but it was an inpatient-only procedure?

MS. NABORS: We'll want to take that to them. We definitely want to present that to them and let Dr. Mitchell and them give us an answer on that response.

AUDIENCE: Thank you.

8. Will you please clarify the physician supervision requirements for Hyperbaric treatments for an on campus hospital wound care clinic? Must the supervising physician be in the department?

Response: **Per the Medical Review department, the supervising physician must be able to respond promptly to an emergency development with the hyperbaric treatment. Qualified Health Professionals (QHPs – including PAs/NPs) may also supervise HBOT. However, this type supervision may be outside of the QHP's "scope of practice", depending on the individual state license. In addition, individual Hospitals should have a credentialing process in place for any practitioner providing these services.**

9. 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.

Response: **Hospice patients may go to the emergency room to seek care for an injury or condition not related to their hospice diagnosis. For example, if a patient has a terminal diagnosis of cancer, but falls and breaks an arm, he may go to the ER for treatment of the broken arm. But if that same patient goes to the ER to seek treatment for cancer, then he revokes hospice service. Hospice care steps in when a cure is no longer realistic and the patient has decided he no longer wishes to pursue curative measures.**

Discussion at Meeting

AUDIENCE: Is that an automatic revocation? Because if the patient comes up for the second scenario, if they come in for their treatment but, yet, they haven't revoked their hospice and we notify them that they're there, if we don't have our form signed, we would expect the hospice to pay for their care. So are you saying that it's an automatic revocation? Because the family sometimes doesn't want to get rid of their hospice because they're trying to keep those other benefits but they're continuing to seek medical care for the hospice-related diagnoses.

MS. NABORS: We'll take that one back and confirm it. I understand what you're saying. We just want to make sure we get it correct.

AUDIENCE: It's just they come, and they don't want to revoke it, and sometimes we don't know that they have hospice, we couldn't do that revocation or whatever. That is when it becomes a problem. And hospice says that it didn't come through us, so they don't pay, and Medicare denies saying that it's hospice.

MS. NABORS: It is a possibility that there may be some sort of code that could be added on the claim to reflect that. But because these responses actually came from the Medical Review department, we want to take it back to the Medical Review department and get a good response for you.

AUDIENCE: There is a hospice condition code 07.

MS. COPE: That's only if it's unrelated to the terminal condition.

AUDIENCE: Right. But sometimes when we contact our hospice carrier, they'll tell us that the patient did not let them know, they did not approve the patient to go.

MS. NABORS: Right. I've seen that.

AUDIENCE: And so, therefore, they'll say at that point they're not covered under the hospice care, and we have to file it as a noncovered hospice. Even though it may be they come out there because they're dehydrated or something related to the cancer, the hospice will say that the family did not contact them they were coming to the emergency, therefore, they're saying they're not responsible.

MS. NABORS: And that puts you in a bad position because you're just trying to treat the patient. Families sometimes are emotional. They're not thinking that care must be handled through hospice. They're like I'm just treating my relative.

So we'll see if there is anything that can be done to help the provider community who's servicing the emergent care for that patient, and we'll get that answer back to you.

AUDIENCE: And in that instance, could we bill the patient?

MS. NABORS: I do not want to say that. Let me just get that information clarified first.

MS. COPE: We will refer you to your remittance advice. It will let you know when you can bill your patient. The Medicare remittance advice will let you know when you can bill your patient, or the EOB, explanation of benefits.

10. Can a student in PT/OT actually scribe the documentation of a visit if the therapist co-signs the documentation?

Response: **Yes. The student may scribe the documentation of the visit if the therapist co-signs the documentation for Part A. The therapist has to be present - "line of sight" for Part B.**

11. Outpatient rehabilitation has asked about having a glucometer in clinic for patients that are showing signs of low blood sugar. Can the therapists use the glucometer to test for blood sugar and then act on the result?

Response: **This type supervision may be outside of the "scope of practice" for a Therapist, depending on the individual state license.**

12. A) If a hospital uses a patient care area in their Imaging department as an overflow for their Emergency department, providing treatment using ED Physicians and staff, is it appropriate to bill an E&M level using a 450 revenue code? The area being used is down the hall from the ED, but it is not immediately contiguous.

Response: **Yes**

B) If it is allowed, are there any specific criteria for signage and/or notification to the patient?

Response: **No**

Discussion at Meeting

AUDIENCE: Good luck explaining that to the patient.

Additional Discussion at Meeting

AUDIENCE: We're having problems with ADRs from Cahaba. They're asking us, for the outpatient red flags, to list the physician's progress notes and nurses notes, et cetera. And when we don't send that information because we won't have it, that's a red flag, we're getting denied. Is there a way to get that? Are other people having denials based on that?

MS. NABORS: I would need to see a claim reason code example just so I could look at it more specifically. I don't like giving blanket information kind of blindly. It just helps me give you better information, accurate information.

MS. BARTLETT: These are strictly reference labs, nonpatient accounts that come to a reference lab or to them just for processing of the specimen that was collected in the doctor's office. Okay? So there's never going to be a progress note ever sent with a specimen to a facility to process that specimen. So there will only be the order, and there would only be a result that you get from running that test for the doctor. Because we're having that in some other areas in addition to Medicare.

MS. NABORS: When you say in some other areas, you mean some other payors?

MS. BARTLETT: Yes, we're seeing that elsewhere, but it's also happening with Medicare as well. There's never going to be a progress note, and they're being asked for something that's not going to exist.

MS. NABORS: And this may be something that we just really do need to take for Dr. Mitchell and the Medical Review team to just review and say, oh, hey, we may need to check into this, or him contacting CMS to see why this is happening.

AUDIENCE: Because we actually appealed it, and we got a denial of the appeal saying the information that was asked for wasn't provided. So then I called and talked to someone two separate occasions and told them I'm never going to have this information, and they're like, well, other people are getting paid so you must be doing something wrong. But I'm not.

MS. NABORS: I'm sorry. That's not the correct response. I can tell you that. So if you could just get some information to Peggy, we'll look into it for you.

AUDIENCE: It's always been my understanding that when you receive an ADR back from reference lab, that, at that point, you can go to the physician's office and request information from him, you add it with your information, you send it in, and you should receive payment.

AUDIENCE: We own several of our LLCs, and I can get the information from them. But like other facilities that are in another city, the larger institutes like Huntsville, I cannot get cooperation at all. So I'm still being punished for something I have no control over as a facility because I can't get their notes.

MS. NABORS: And I understand that. There may not be anything we can do, but let me take it back, and let's visit it and look it over.

AUDIENCE: You probably need to get your physician's advisor to help you with the process.

MS. NORTHCUTT: I think that we're going to continue to have this problem. Because Cahaba's local coverage determination is very clear that it's a point of a service test, that it is not for routine monitoring of congestive heart failure. And most cardiologists and many others that don't know that, you might have a diagnosis of CHF or chest pain, and it would cover and pay, when, in fact, it's not meeting the requirements and the indications for having a BNP. And so that's, thus, the complex review of the BNP claims.

And that's where, thus, they're having a huge denial rate, just from my knowledge, number one, because we don't have that progress note; but, number two, when you do have the progress note, they automatically see that the physician is monitoring the congestive heart failure treatment and for anybody that needs to go back and tell them it's not a covered service.

And the other part of the ADR that came out on that was that BNPs are routinely done in the emergency department and on observation patients. And when this 100 percent review came along, the entire claim stopped for review. So your ED and your observation claims are sitting out there now waiting to review whether that BNP was medically necessary.

The problem with that being billed with the emergency department on the observation is that we're going to go all the way back again and say, you know what, on those claims, that's the package service anyway, they're not going to pay us for the lab. So now we're under review on a package service. So we're looking for coverage. You're waiting on that. It might fail coverage when, in fact, that's going to deny. So the reference labs where you truly only get an order and you get a result, that's where you would actually lose money because those would pay separately.

It's not a preventative screening. You know, until Medicare passes that, it is not prevention. So you better have definitely osteopenia, osteoporosis, HIV, CHF Class 3.

You got all this other stuff you really got to have with vitamin D. I'm glad they did mine because I was a 13. I failed so miserably. I'm on 50,000 units twice a week. So I am glad my doctor went out of the way to screen me. But it is not a covered service.

So just make sure and look at your vitamin Ds out there. They're all reference lab. They're all coming from the checkup to see if your D is low and you haven't been out too much in the sun. So, you know, if you're 80, your D is probably low. But we need a diagnosis, just an FYI, of the office note.

AUDIENCE: Our facility has had some issues with toenail debridements, specifically 11721 failing medical necessity. It's a problem because we have covered indications on our claim, including in the system, a condition that's required. We've gone out and submitted some appeals, but I haven't seen it on the claim issue log.

I have an inquiry number for you, Adrienne. Hopefully, it's something that can be data corrected. It's requiring a lot of manual rework on our side.

MS. NABORS: What's that inquiry number?

AUDIENCE: GINQ 5512643.

MS. NABORS: We got it.

AUDIENCE: Thank you.

AUDIENCE: We've started noticing denials for mammography and tomosynthesis, and the denial says to call the FDA MQSA hotline. And when you call them, they tell you that it's a nationwide CMS issue with a file upload that was corrupted. They say that we are not an FDA-compliant facility anymore. So when you call them, they tell you to call William Ruiz with CMS. And he is never in the office, and you have to resubmit all of your data, and he will try to get your facility to the top of the list.

So do you know when this file upload will be corrected? Do we have to resubmit our claims, or will you re-adjudicate the claims? Because of automation of systems, a lot of these are going to patient responsibility, and we're getting a lot of upset patients.

MS. NABORS: And did I understand you to say that this is happening across CMS?

AUDIENCE: According to the FDA MQSA hotline, the people you talk with there, they said that it is a CMS issue and it is across country.

MS. NABORS: For a CMS issue, I'm not by any means trying to bow out, but I would actually want to refer you to CMS on that one.

AUDIENCE: They do refer you, but the gentleman they refer you to is never in the office. His name is William Ruiz.

MS. NABORS: Right. We've seen that on pretty much all CMS documentation. But there should be another way for you to contact CMS as well. We'll see if we can get you a contact. But we will also check to see, because if it's across the board, then it would be all MACs who are having that problem.

AUDIENCE: It's happened at three out of four facilities that perform that service for us.

MS. NABORS: We'll see what contact information we can at least get to you, if you'll give us your contact information, or you can get it to Peggy and just say the mammogram issue, can't get in touch with William Ruiz, and we'll pull something up and see what we can do for you.

AUDIENCE: All right. Thank you.

MS. NABORS: You're welcome.

MS. NORTHCUTT: Frank, could you just say one more time what the initial issue was that they said?

AUDIENCE: They're denying them saying that you're not an FDA-certified facility. So they want a copy of your certificate with that six-digit FDA number, and you have to resubmit that. And what we were told —— and I've only left messages for Mr. Ruiz —— is that you have to give him that information and he will try to move your facility to the top of the list. Well, if everybody in this room does it, nobody is ever at the top of the list. So anyway, it's causing denials.

AUDIENCE: 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?

MS. NABORS: We have no idea. But we can find out for you. Will you send just that question as you stated to us to Peggy? She'll get it to us, and we'll get you some definitive information. It won't be that we don't know.

AUDIENCE: Thank you.

MR. ASHMORE: All right that is all for now. I want to thank Adrienne and Michelle for being here today.