**MEDICARE (CAHABA GBA) MINUTES**
**November 7, 2016 RIC/RAC Meeting**

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

**FACILITATORS PRESENT:**
**Mr. Wesley Ashmore**
**Ms. Karen Northcutt**

MR. ASHMORE: Good morning. I'd like to welcome from Cahaba this morning Adrienne Nabors, Michelle Cope, and Dr. Mitchell.

1. Follow up to Question #1 from July 18, 2016 RIC/RAC meeting.
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:** **If the system was updated as it was supposed to be. Per Change Request if the condition code 04 is present then coinsurance should not apply.**
**If the claims are adjusted and the coinsurance value codes 08, 09, 10, and/or 11 and their corresponding amounts are removed, they should process without the coinsurance based on the changes made in Change Request (CR) 8704. Business requirements were not present in the CR 8704 for the MACs to mass adjust claims previously processed with coinsurance amounts on these claims, so the providers must adjust the claims if they need to have the coinsurance amount removed.**

**Test adjustments were processed to confirm that the coinsurance amount will be removed. To date those claims were still processing.**

**Discussion at meeting**

MS. NABORS: I did receive an additional response this morning from our support services. I was specifically asked for the amount of providers that were affected if you were long-term care facilities. You can let me know or contact Peggy, if you need to.

Based on the information that they sent to us, if you were having that problem with the coinsurance applying, were you having that problem with more than just Cahaba? So if you're a long-term care facility and you were having the coinsurance issue and if you're having it with Cahaba, if you're having it with any other MACs, we want to know.

From our understanding, we believe that it has been reported that some long-term care facilities are having the coinsurance applied, but it's been across the MACs. And they were trying to get that information together so we could better assist with resolving the problem.

MR. ASHMORE: Thank you, Adrienne.

2. Follow up to Question #5 from July 18, 2016 RIC/RAC meeting.
Providers are continuing to experience claims suspending beyond 60 days, particularly high dollar claims. At the July RIC/RAC meeting, Cahaba stated that the backlog would be caught up by the end of the quarter (September 2016). Does Cahaba have an update on the status of the suspended claims backlog? Does Cahaba anticipate decreasing the suspense timeframe for high dollar claims?

**Response:** **Cahaba is dedicated to process all suspended claims and claim adjustments as quickly as possible within Medicare's rules and regulations. If the claim submitted does not have any inconsistencies in data elements and follows Medicare rules and regulations, an electronic claim should be adjudicated within 14-16 days and a paper claim within 30-32 days.**

**We track suspended claims and claim adjustments (type of bill ending in 7, 8, or a letter) separately. At the beginning of 2016 we had over 17,000 suspended claims aged over 30 days. At the end of March we had driven that volume down to approximately 4,000 and we continue to keep that volume over 30 days to less than 4,000. As of the end of October, we were at 3,700 suspended claims over the age of 30 days, and 21% of the 3700 were in the 30-34 day age grouping. We continue to drive that volume down as low as we can without sacrificing quality.**

**For claim adjustments, we are currently in the middle of an inventory reduction plan. We have 40,000 adjustments over the age of 30 days and have hired and trained 14 Part A dedicated associates to assist our current staff and help reduce that inventory by the end of 2016. We are reducing them predominately in age order.**

**While reducing the current inventory is only half of our responsibility to you, our customers, the other responsibility is to meet your expectations and keep the inventories under control from this point forward. We have already put safeguards in place to keep the inventory below acceptable levels once it has normalized.**

**Also, while you did not specifically ask about our escalation process, we see it as an area where we can improve and we are currently reengineering the process. Please watch for more information regarding the reengineered process over the next couple of months.**

**Discussion at meeting**

MS NABORS: This information was given from our higher parts at Cahaba, but I do want to make an addition. The staff that has come in that's helping to work the adjustments, they are the bomb, and they're doing very well.

We've noticed with one of the main particular claims that are high dollars are the SM days location claims. Michelle and I have worked diligently and are still working with the seniors from the claims department to receive those parameters as CMS has made some drastic changes for those claims.

I have a bible that has SM days in it, and those passages of scripture no longer work. And we have been informed that condition codes and certain other things are required on those claims. Any of them that have to do with where a patient was in the facility and their benefits are going to be partially exhausted. That's where a lot of the higher dollar claims are stuck and they have to be manually touched. And we are working to try and diligently locate and identify what the provider needs to add to gather that information so we can help educate the provider community so that those claims can become cleaner as well as do what we can to help them go through the system as fast as they can. But they are intense.

We have worked and worked and worked. I put in 20 hours on one claim that came in through a congressional, and she laughed at me for weeks on end. She just finalized. It took over two months. Because every time it went back to CMS, it came back.

I just wanted to give you that information so you can understand that it's not that we don't want to do it, we get hit back every time. And most of the time it looks like it's repeating itself with the same type of verbiage that it hit for the first time. So we are working on those. We noticed that that's a lot of the volume in terms of large amounts.

So please, if you'll continue to be patient. We are working to get the information from our seniors so we can glean and help the provider community in getting those claims released.

AUDIENCE: You were talking about the bible. When did that change that you were not informed ahead of time?

MS. NABORS: A part of that would have been that I'm no longer an actual claims examiner. Michelle's and my experience is being used in helping with the reduction of this inventory, but we're not 100 percent sure when the required condition codes are needed. If the patient is not using lifetime reserve days, that they still have to have a certain condition code on there.

All of those changes we think came out within at least the past year. And I wouldn't have been informed, because at that time I had taken on the PRS responsibilities and just had started really seeing SM days hit as frequently as it is.

But we will get that information. Until then we can't say the provider is doing this wrong. We can't tell because we're trying to glean as much info as we can.

AUDIENCE: You said that there's going to be an escalation process. But in the meantime, if we have claims that are sitting and that are more than a year old, what do we do right now?

MS. NABORS: Continue to send it to us. And we're doing our best to push those. I can't say to the top. We're pushing them and we're pushing them. And those that we can work, Michelle and I are working them.

AUDIENCE: So we send it to you directly?

MS. NABORS: You send it to Peggy. Because we do have to make sure that they are properly tracked. Get that information to Peggy. We're getting that information to claims. Some of them never reach claims because if we can work it, we can.

SM days is just the one particular issue that we know we are just at a loss for. However, we are working on getting that documentation so we can mentally train and prepare ourselves.

AUDIENCE: All right. Thank you.

MS. NABORS: You're welcome.

AUDIENCE: So what are SM days?

MS. NABORS: SM days is a location that you will see most of the time on the DDE. It's a location that most claims will hit when they're hitting because the patient's days are hitting close, partially exhausted, may not have been calculated right, may not have been put in right. It's just one of those days that we don't like.

AUDIENCE: It's just annual. That's what it means, annual.

AUDIENCE: Sometimes the claims are billed out of order if the patient comes from one hospital to another. Could those kind of claims also be causing this issue?

MS. NABORS: They can be causing the issue, but they probably, most likely, will not hit that particular location. They'll hit for out of sequence, a different edit.

3. Follow up to Question #9 from July 18, 2016 RIC/RAC meeting.
a) Medicare overpaying claims when secondary – unable to determine how they calculated payments. How do we get them to correct them?

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

c) Do we bill a patient for deductibles and coinsurance when Medicare is the secondary payor or do we adjust these?

**Response:** **This information was from one particular provider and I have submitted that information to them via email. If any other providers have experienced this issue, please submit those claim examples to me so our support services team can research.**

**Discussion at meeting**

MS. NABORS: This question was asked previously, and I did give the response at that time; however, we did receive another addendum to that one.

This information came from one particular provider, the examples that we needed. I submitted that to our support service department. There was a very large summation that did come back. I forwarded that information to that particular provider. However, if someone else does have this same issue, we definitely need the specifics for our support team to review so we can get your specific issue covered.

AUDIENCE: That was us. And I got your response. Thank you very much.

MS. NABORS: Great. And did that clarify everything for you?

AUDIENCE: It just doesn't make sense.

MS. NABORS: Okay.

AUDIENCE: No. The explanation made sense. It's just that sometimes we don't understand. The 835 transactions that come in, we have to post them the way they come in.

MS. NABORS: Okay.

AUDIENCE: And it puts these balances on the accounts because of the contractuals that come in with them. We think they're maybe not reading the primary insurance information correctly. But you told me you had some other examples that you were following up on.

MS. NABORS: Well, the remaining two claims, our support service team is still checking on those.

AUDIENCE: Thank you. I appreciate you doing that. It's complicated.

MS. NABORS: Our pleasure.

4. Follow up to Question #11 from July 18, 2016 RIC/RAC meeting.
As a follow up and clarification - Does the industry standard of one month apply to monitoring of long term therapeutic meds, such as Coumadin, in hospital outpatient setting?

**Response:** **Yes. Coumadin is rapidly being replaced by the various NOACs which do not require laboratory monitoring.**

**Discussion at meeting**

DR. MITCHELL: I will comment a little bit more regarding this. I think that if an order comes through and it says monitor the prothrombin time for the next six months, then that order would be effective for six months. So I think there is some flexibility in particular in that circumstance, which is chronic monitoring.

Did you hear that response in the back?

AUDIENCE: No.

DR. MITCHELL: What I said was in the circumstance where something is chronically being monitored with the example given being a prothrombin time for somebody that's on Coumadin, they're likely to have their prothrombin time checked for the rest of their life. I think if the order says monitor prothrombin time monthly for the next six months, then that order would be effective for six months. I

don't think monitor prothrombin time for the rest of their life would really work, but I think if there's a definite duration, it certainly should work.

The good news is, well, not so good for emergency medicine folks, but is that much of the Coumadin treatment or the anticoagulation is now being transitioned to these oral agents.

**5.** Follow up to Questions #15 from July 18, 2016 RIC/RAC meeting.
Please provide status on the expected explanation/analysis as to what was going on from your financial department on "indemnification adjustment" on claims from 2010.

**Response:** **Our support team is still researching this issue.**

**Discussion at meeting**

MS. NABORS: We've had several TDL change requests that have been going in which has been pulling them for different researches, but I did get a response from them that they are still checking on this and working on it.

As soon as we get the response, I will make sure I get it to Peggy to get it to the community.

6. Follow up to Question #16 from July 18, 2016 RIC/RAC meeting.
Any further consideration to use 96416 code for prolonged infusions?

**Response:** **Per our Medical Director**

**The providers are correct. $27.37 does not even cover the cost of the equipment, as well as preparing and connecting an infusion. These are individually priced. This has been discussed with the Medical Review team to make the reimbursement more equitable based on the device and length of the infusion and any other parameter as directed in the CMS direction. Our medical review team is working on getting this particular code to develop for medical records.**

**Discussion at meeting**

MS. NABORS: At this time, if that particular procedure code does not pay enough, you will be required to file an appeal and submit supporting documentation. They're working on generating an ADR for medical records so that you won't have to do that. But in the meantime, if you want that to be reconsidered, please send in an appeal with the supporting documentation.

AUDIENCE: Do you know when the ADR will go into effect? Because we have numerous claims that are being paid with the $27.

MS. NABORS: No, ma'am, we don't know when the ADR will go in because our support team does have to develop that. They have received the permission from the medical review department to go ahead and proceed with that, but it does take time to get that generated, to get that code to pull it; and then, also, if there is a code change, they would have to work on revising that as well.

AUDIENCE: So until then, we just need to appeal and send records with each and every one of our folks that have to have the pump?

MS. NABORS: Yes, ma'am, unfortunately, we would need for you to do that in order to have that considered at the better pricing.

AUDIENCE: That's a huge volume that we have.

AUDIENCE: It is. Especially for all of our chemo patients that have to be on this pump.

AUDIENCE: So I'm just confused. We would still bill the unlisted infusion, and then an ADR would come. But right now you bill unlisted code and then appeal?

AUDIENCE: We get paid the $27 and then have to do an appeal with records?

DR. MITCHELL: I'd like to just ask what do you think is the most recent turnaround time where that's happened? I mean, has that happened in the last 30 days?

AUDIENCE: Oh, yes, sir. Yes, sir.

DR. MITCHELL: Let me work on this. Because I agree with you. The $30 reimbursement is not reasonable.

MS. NORTHCUTT: And I do want to say on the physician fee schedule, not to get confused with OPPS Medicare, but they have a beautiful G code, G0498, that was developed. It has chemotherapy extended IV infusion with pump. And it goes for both the pump and for giving the infusion.

But I diligently searched in the final rule trying to find out if this code was paid under outpatient OPPS. I could not find any indication that they would be covering this G code. So that might be something. If you've got any pull, I'll give you the transmittal. But it's a beautiful perfect G code, but it doesn't have any money attached to it in the Addendum B. So you get zero if you go with this G code right now. So at least get your 30 bucks on the unlisted code.

AUDIENCE: Hopefully you'll be able to do something for us.

AUDIENCE: I'm just curious, and this may be too general of a question to be answered, but if you're doing chemo and you're being paid just the $27 and then you go through the appeal process, if you get a favorable determination, what kind of payment adjustment are we looking at? Is that too general?

DR. MITCHELL: No. It's a very reasonable question. The honest answer is I don't know. It's a good question. And I honestly do not know.

We have asked that that rate be adjusted. And Adrienne and I will try to learn what the holdup is. Because we asked that it be adjusted a while back.

AUDIENCE: Karen, weren't we going from like a $250 payment down to a $27 payment?

MS. NORTHCUTT: Yes that's correct.

7. Follow up to Additional Discussion from July 18, 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?

**Response:** **Yes-but the patient must be informed of the decision regarding the bed status. Please reference: MLN Matters Number: SE0622**

**Discussion at meeting**

MS. NORTHCUTT: I just have one clarification on that. Can a physician change their own status after they reviewed it without the UR committee being involved? Because we have a lot of that, where the physician may change the order from inpatient back to outpatient, and then we haven't followed condition code 44 because we have not informed the UR committee or the patient.

So in general, the attending doctor has their hands tied if we follow the transmittal that we have to have the UR committee involved to tell the doctor that he can change the order and then we have to run and tell the patient too.

I think the conflict is that in order to convert an inpatient back to an outpatient, there's no outpatient if the condition code 44 process is not followed. I guess that's kind of where we are now. Can a doctor, without UR committee involvement, change the status for their own patient without getting everybody involved; and at the end of the day, would that be an outpatient, not an inpatient? Which happens a whole lot.

AUDIENCE: That wasn't really the question. The question was if a patient is seen in the ED, if the patient remains in the ED, the ED physician writes an order to admit to inpatient, but then, before any services have been provided, the doctor changes his mind while that patient is still in the ED, can the doctor change that order without a condition code 44? And so I think that was the initial question that he answered.

MS. NORTHCUTT: Oh, okay. That was not answered last time. Okay.

DR. MITCHELL: I practice emergency medicine, so I'm probably the culprit of your question. I believe that the answer is yes. I may be stepping into something that I don't particularly understand very well, but the process within your hospital is really your business regarding the involvement of the UR process. But I think, from our perspective, particularly if there has not been any significant action taken on that order, it could certainly be changed. We allow doctors to change their minds.

AUDIENCE: But I guess it comes down to was the patient informed and consented. That's what it's coming down to. But that is one of the condition code 44 requirements. So that's the conflict, I guess.

DR. MITCHELL: So the 44 requirement is that the UR committee be involved?

MS. NORTHCUTT: Yes. And they still have to be there, of course. So I think that's the question. Again, CMS is confused with what really goes on in a hospital. Because that tells the doctor they can't make a decision about their own patient without people up in your business, number one. And number two, if they never left the ED and have never reached an inpatient bed and you change them back to out, would they be going to obs in that scenario?

AUDIENCE: Only if they meet criteria.

AUDIENCE: Karen, I just want to point out, on that question, I think the key here is in the first line: But the patient has not been notified yet of their inpatient status. So that's what we were talking about. The patient has never even been notified and the doctor changes his mind.

DR. MITCHELL: I think that's something we're going to need to discuss and learn a little bit more and then get back with you.

MS. NORTHCUTT: So you're saying, Jennifer, that the patient has never known they're inpatient to begin with. Okay. So they're just in the ED?

AUDIENCE: Correct.

MS. NORTHCUTT: An order is written for inpatient, but they are not notified because they don't…

AUDIENCE: They don't know any better, that they are ED or inpatient.

MS. NORTHCUTT: Okay.

DR. MITCHELL: We will learn more about this and will share what we learn with you.

8. Follow up to Additional Discussion from July 18, 2016 RIC/RAC meeting.
As a follow up, just want to clarify if a registered polysomnography tech is required to perform the sleep lab studies and procedures.

**<u>Response:</u> Per our Medical Review department please reference the Local Coverage Determination (LCD): Medicine: Home Sleep Testing (HST) (L36745). The Physician and Technician Requirements are listed in this LCD.**

9. How should the facility bill for a patient who has Medicare, authenticated inpatient order for procedure on the Addendum E inpatient only list scheduled in the ambulatory setting but the procedure is cancelled due to an abnormal finding?

**Response:** **If the patient presented in the pre-admit area prior to the planned inpatient only procedure, the primary diagnosis would be the reason for the encounter, followed by a canceled surgery (ICD-10-CM diagnosis code from the Z53.XX category). These codes should be followed by the condition (abnormal finding) that caused the cancelation (if applicable). Since the formal admission had not occurred, the encounter appears to be outpatient at this point. The planned INPATIENT procedure code would not be submitted. A procedure (CPT) or ICD- 9 procedure code would not be assigned since it was not performed.**

**Refer to Medicare Claims Processing Manual, Chp 4, Section 180.7; Transmittal 2386**

**Discussion at meeting**

AUDIENCE: At what point would the procedure be coded and the modifier of 73 or 74 be added for the cancelled procedure, the 73 being I think before anesthesia, the 74 being after anesthesia; so if the patient actually makes it to the OR and then the procedure is cancelled, then would the surgery code be billed?

DR. MITCHELL: Was the surgery performed?

AUDIENCE: No. Cancelled.

DR. MITCHELL: I am not a coder, as you know. But I think, generally speaking, if the surgery is not performed, you're not able to code for the surgery.

AUDIENCE: In this case, we're saying that it won't meet inpatient criteria since it was cancelled; hence, it needs to be billed as outpatient, correct? That's what we were talking about. Because if it's outpatient, you could code the CPT code with a 73 modifier that says it was cancelled prior to anesthesia being administered.

MS. NABORS: Right.

AUDIENCE: So that is what I guess we were trying to find out, is that now that it has been deemed not inpatient but outpatient, can you code the procedure, CPT, with the relevant modifier depending on when it was cancelled?

MS. NABORS: Yes, I have seen that happen. Is it an inpatient-only procedure?

AUDIENCE: Yes. Yes.

MS. NABORS: I'm sorry. Okay. It's an inpatient-only procedure being submitted, you're saying you want to put that, but the services are now changed to outpatient?

AUDIENCE: Outpatient, correct.

MS. NABORS: If it's an inpatient-only procedure, it won't process on an outpatient claim even with the modifier.

AUDIENCE: Yes, that's right.

MS. NABORS: Okay.

MS. NORTHCUTT: Did they get another outpatient order after that. If it says we've got an authenticated inpatient order for the procedure, are they changing that?

AUDIENCE: But even if they change the order, you can't bill the inpatient only procedure on an outpatient claim.

MS. NORTHCUTT: Well, I know.

AUDIENCE: The procedure itself is inpatient-only; hence, you cannot bill it, is what we're understanding, right?

MS. NORTHCUTT: Right. It won't go through.

AUDIENCE: Did we resolve it? I have the same question. If you have a patient that comes in and they go to surgery, you put them to sleep and then decide to cancel the surgery for whatever reason, then they usually go home. There's no reason to keep them as an inpatient. So if you bill it with a 73 or a 74 modifier, they're going to deny because it's an inpatient-only procedure.

MS. NABORS: That's correct.

AUDIENCE: So what do you want us to do, bill them as an outpatient? Because it's not going to be a two midnight stay. I guess I'm not stating the question correctly.

MS. NABORS: No, I'm understanding the question that you're asking. And I apologize. I didn't quite get that interpretation until you said inpatient/ outpatient. I do know that the inpatient-only claim procedure can't go on an outpatient claim.

And I have seen those particular services through my experience with appeals where the particular claim did have that. It had the inpatient-only procedure on there. And our thoughts were this actually denied correctly. However, there was a resolution to that back then. I need to get the newer resolution to that. And what we'll do is find out how should the providers bill.

So basically what it boils down to, like you said, they had the service rendered, the service got cancelled because they weren't able to do that. It's no longer inpatient. But you should be compensated for those services up to that point: the prep, the getting them back to their room. You can't just say, well, wake up on your own and go home. You know, you have to be compensated. And for that, we will find the clarity on how that particular type of service should be billed.

At one time, my experience was the entire claim denied because that primary procedure was not billed. I will have to get the clarification for you that particular situation. It may be that that line denies and everything else is paid or there may be additional instruction for the type code or how the provider should bill it. And I will get that information for you and get that to Peggy.

MS. CARSTENS: Karen, someone thought maybe we had covered this previously in detail. Do you remember seeing this at a previous meeting?

MS. NORTHCUTT: Yes. It's been several years.

AUDIENCE: I was just going to say every detail, every scenario you are talking about, you detailed it out in a question previously. I can't remember when, but I have the reference on my desk actually.

MS. NORTHCUTT: And we've got an index, so we can send it to you through Peggy, too, on that outline scenario. Because I know that a lot of them were denying then and people were having to appeal just to try to see what to do with this patient. And then some left them as inpatient. And in Medicare world, it is allowable, although, you know, I think it will be picked up immediately as a one-day stay or as zero-day stay as an inpatient claim to be audited on the other side. (*See the November 2014 minutes, question # 16.)*

DR. MITCHELL: And I think just as an aside, one of the interesting things from my perspective of working as a CMS contractor is that CMS is a lot like an aircraft carrier in that it maneuvers very slowly. And the inpatient-only list is a list that we communicate a lot with CMS about. Because as you are aware, in the last ten years, a number of procedures which are on the inpatient-only list are now being safely done in the outpatient setting. And that's an area where we communicate regularly with CMS. And I would anticipate that there may be changes in that list, as would be clinically appropriate.

10. On several occasions lately, patients are refusing to pay their portion upfront, stating that they called Medicare, and the Medicare rep advised them to never pay upfront and that they should always just wait until they received a bill from the hospital. Have Medicare representatives been instructed to tell patients this? And if so, why? The hospitals have every right to encourage upfront payments with good faith estimates.

    **<u>Response:</u> Medicare representatives have informed patients they do not have to pay their deductible and coinsurance amounts upfront. Generally, this information is specific to the patient's deductible at the beginning of the year. We advise the patients to not pay their deductible because in most cases the provider who is billing for the deductible is not the provider who is assigned the deductible when the claims process and finalize. When this happens the patient's have an extremely hard time receiving a refund from the provider and usually have to pay the assigned provider out of pocket and wait for their reimbursement due to it not being refunded in a timely manner.**

    **Please note there are some specific guidelines for Part A facilities regarding collecting coinsurance for Inpatient and Skilled Nursing Facility services. We have included the link below for your review. See Publication 100-04, Chapter 1, §60.3, See §60.3.1 in the same chapter for specific information on limitations on collecting funds from beneficiaries in SNF Part A stays.**

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf

**Discussion at meeting**

MS. NABORS: I actually would like to make a correction on this one. I had my own experience in there from where I used to work in PCC. And that's been some time ago. And I apologize. When I worked in PCC, as a provider contact center, we took beneficiary calls. That has not been so in years. We only take provider calls in the provider contact center.

So if this has been a recent occurrence where you're noticing that the beneficiaries are not paying, then this would be a question that should be better posed to Social Security. They are the ones who take beneficiary inquiries and call and advise them regarding their information and their benefits. We don't do that at Cahaba because we don't take any beneficiary calls.

That being said, I will give you our past information which is what we've seen from a behavior. With the deductible, we did advise the patient not to pay their deductible up-front and Social Security I'm sure probably still does.

The reason we did that is because if there was a deductible involved it could involve several Part B providers. If a deductible was involved for our patient Part B services, they went to see their doctor that morning, they went to also have their other tests done, they went to see several doctors during that day, the primary doctor says you owe the deductible, they paid their primary doctor.

But the primary doctor doesn't get his claim in before the other doctor does. Dr. Fred will not promptly reimburse that beneficiary, who is on a limited income, back their money and their deductible, so they end up having to pay out-of-pocket, write in to Cahaba or to Social Security to try and get that claim readjusted so we can manually take that money back so that the moneys can then be turned over to the right provider.

Because of that experience with deductibles, we do advise and have advised the beneficiaries to not pay that up front.

As for coinsurance, there are specific rules for the skilled nursing facilities, inpatient services where CMS does advise that there are certain criteria for billing the coinsurance up front. Providers can ask; however, services cannot be refused if the beneficiary doesn't.

And I will say there are many beneficiaries who say I want to wait until I get my Medicare summary notice before I pay you because I paid this doctor before and it took you four months to give me my money back so I could pay this doctor over here. And we know how the Medicare beneficiary community is. They don't want their credit messed up, they don't want to have any bad issues and bad experiences.

So that being said, this is a question for Social Security. But with this history, I can pretty much speak that they are possibly advising them not to do so. I know for the deductible, because it's very confusing for them to get their records and stuff straight and the providers do not promptly refund as they promptly take that money.

For coinsurance, they can bill, but they can't refuse the services if the beneficiary decides,no, I want to wait.

MS. COPE: And also, for Part B, they have the entire year to meet the deductible. So that's why we don't encourage they pay it up front.

11. Based on the information below, does the LCD (L34281) Radiology: PET for Myocardial Perfusion Imaging restrict coverage based on the NCD 220.6.1? In these cases, the PET scan must be considered necessary to determine what intervention is required.

**Medicare Program Integrity Manual Chapter 13**
13.5 - Content of an LCD (Rev. 473, Issued: 06-21-13, Effective: 01-15-13, Implementation: 01-15-13)
Contractors shall ensure that LCDs are developed for items or services only within their jurisdiction. The LCD shall be clear, concise, properly formatted and not restrict or conflict with NCDs or coverage provisions in interpretive manuals. If an NCD or coverage provision in an interpretive manual states that a given item is "covered for diagnoses/conditions A, B and C," contractors should not use that as a basis to develop LCD to cover only "diagnoses/conditions A, B and C." When an NCD or coverage provision in an interpretive manual does not exclude coverage for other diagnoses/conditions, contractors shall allow for individual consideration unless the LCD supports automatic denial for some or all of those other diagnoses/conditions.

**National Coverage Determinations Manual**
**Chapter 1, Part 4 (Sections 200 – 310.1) Coverage Determinations**
220.6.1 - PET for Perfusion of the Heart (Various Effective Dates) (Rev. 120; Issued: 05-06-10; Effective Date: 04-03-09; Implementation Date: 1030-09) 1. Rubidium 82 (Effective March 14, 1995) Effective for services performed on or after March 14, 1995, PET scans performed at rest or with pharmacological stress used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease using the FDA-approved radiopharmaceutical Rubidium 82 (Rb 82) are covered, provided the requirements below are met: o The PET scan, whether at rest alone, or rest with stress, is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT); or o The PET scan, whether at rest alone or rest with stress, is used following a SPECT that was found to be inconclusive. In these cases, the PET scan must have been considered necessary in order to determine what medical or surgical intervention is required to treat the patient. (For purposes of this requirement, an inconclusive test is a test(s) whose results are equivocal, technically uninterpretable, or discordant with a patient's other clinical data and must be documented in the beneficiary's file.) ***(NCD does not specify)***

**LCD L34281**
**Coverage Indications, Limitations, and/or Medical Necessity**
***Indications***
Positron emission tomography (PET) is considered medically necessary for the following cardiac indications:\

1. Evaluation of coronary artery disease via myocardial perfusion imaging (MPI):
PET scans using rubidium-82 (Rb-82) or N-13 ammonia done at rest or with pharmacological stress are considered medically necessary for non-invasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease, provided such scans meet either one of the two following criteria:

A. The PET scan is used in place of, but not in addition to, a single photon emission computed tomography (SPECT), in persons with conditions that may cause attenuation problems with

SPECT: e.g. obesity - BMI greater than 40, large breasts, breast implants, mastectomy, chest wall deformity, pleural or pericardial effusion; or

B. The PET scan is used following an inconclusive SPECT scan (i.e., the results of the SPECT are equivocal, technically uninterpretable, or discordant with a patient's other clinical data).

**Response:** **Since we retired the cardiac PET L34281– questions related to the policy details in the Local Coverage Determination (LCD) no longer apply. The Centers for Medicare and Medicaid Services (CMS) does allow the MACs to 'fill in' the whitespace that is not addressed in the National Coverage Determinations (NCD) with LCDs (taken through the proper process).**

**For question regarding clarification of the NCD 220.6.1 –CMS has asked the MACs not to clarify coverage in interpretive manuals (of which the NCD is one) as the language in the manuals 'says what it says and means what it says'.**

**Discussion at meeting**

DR. MITCHELL: The short answer is I don't think so. I think the language in the NCD and the LCD are very similar.

And basically, what both say is that if a single photon emission computed tomography test is done for myocardial ischemia, that a PET scan should not also be performed on that patient unless it's medically necessary. If your SPECT scan is equivocal or is not interpretable because of body habitus, then it certainly makes sense to do a PET scan, again, saving the beneficiary an invasive cardiac procedure.

But that simply needs to be in the chart, that the practitioner looked at the SPECT scan or looked at the results, that the results were equivocal, and that it's clinically indicated to do a PET scan.

And that's my interpretation of both the NCD and the LCD.

AUDIENCE: I actually have two parts to my question. One is in the NCD, it doesn't list all the specifics it does in the LCD. And I think that's where some of our cardiac physicians are concerned. If you follow the NCD, it almost makes it their discretion if they want one versus the other, the PET versus the SPECT. In the LCD, it lists specific things that the patient has to meet.

The other part of my question is to your response that says that since we retired L34281, it's not retired according to your website this morning; it is still active. And I just wanted to make sure is it retired or is it not retired?

DR. MITCHELL: It is not. You are correct. It is not retired.

Correct me if I'm mistaken. I think that within the LCD, if a practitioner says I'd like to do a PET scan, we're not talking about doing a SPECT scan and a PET scan, but they're at their discretion. I don't interpret the LCD as interfering with that. Am I mistaken?

AUDIENCE: Well, I think what they're reading is that it versus with conditions that may cause attenuation and it lists those examples. So I think before, in their minds, they were thinking they could do one or the other basically at their discretion. And now the LCD specifically says if there's attenuation problems, and it lists some of those examples. I'm sure it's not inclusive. But anyway, I think that's where their confusion is, and I'm just trying to get resolution for them.

MS. NORTHCUTT: And I think, too, from the NCD and I think as far as the cardiologists are concerned, they say the PET scan whether it rests alone or with stress is performed in place of but not in addition to a SPECT or that in the cases where the SPECT scan could be considered necessary in order to determine what medical or surgical intervention is required.

But I think that what threw cardiologists off is it's either the PET or the SPECT. They like the PET better, and they think it prevents a lot of unnecessary interventions. But in the LCD, they feel like, of course, just like you said, that you would do it only in place of a SPECT if you had attenuation problems with the SPECT.

You know, we got down to what are large breasts in this LCD. And a lot of the conversation centered on does the documentation support large breasts, and, therefore, what do you have to have in your document. Then it got on to further and further down the road of can you do a PET instead of a SPECT for cardio.

AUDIENCE: And also with that is an inconclusive SPECT. Is that from a week ago, a month ago, when they came last year for their study. If it was inconclusive then, is it going to be inconclusive now? That was also their question is how far back you consider. If they already know that that's going to be the result of that study because of prior studies, can they just move straight to the PET.

DR. MITCHELL: Yes. I think in response to this conversation, we'll go back and look at the language. Because my interpretation of this is that whether the practitioner does a PET or a SPECT is their clinical decision. Really, what I think this was trying to address is both. And there really is no clinical indication for doing both unless the initial test is equivocal.

Now, you know, if they had an equivocal SPECT a year ago and they've lost 50 pounds. But if they had an equivocal study a year ago, then I would save the trust fund the money and go directly to the PET.

MS. NORTHCUTT: So you think they can do a PET to begin with and just skip the SPECT altogether?

DR. MITCHELL: You know, let me go back and let us massage the language, because that is really the intent.

MS. NORTHCUTT: Okay.

DR. MITCHELL: Good. Thank you.

MS. NORTHCUTT: Thank you.

****Follow-up:** Cahaba retired the LCD with an effective date of November 1, 2016.

12. Is an individual psychiatric session required as a component of PHP program or can group sessions cover the requirement if performed multiple times during the day. If the group sessions suffice can they be performed by the same provider /therapist if the sessions represent different topics?

**Response:** **From the Medical Review team: Items and services that can be included as part of the structured, multimodal active treatment program, include:**

1. **-Individual or group psychotherapy with physicians, psychologists, or other mental health professionals authorized or licensed by the State in which they practice (e.g., licensed clinical social workers, clinical nurse specialists, certified alcohol and drug counselors);**
2. **-Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy, if required, must be a component of the physicians treatment plan for the individual;**
3. **-Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients;**
4. **-Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes (subject to limitations specified in 42 CFR 410.29);**
5. **-Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals;**
6. **-Family counseling services for which the primary purpose is the treatment of the patient's condition;**
7. **-Patient training and education, to the extent the training and educational activities are closely and clearly related to the individuals care and treatment of his/her diagnosed psychiatric condition; and**
8. **-Medically necessary diagnostic services related to mental health treatment.**

**Please see:**
**Local Coverage Determination (LCD):**
**Medicine: Partial Hospitalization Programs (L34309)**

13. For the new rehab rules for billing under the comprehensive APC can the hospital just not bill at all for the rehab service instead of billing with a 940 revenue code?

**Response:** **Per the Claims Department: Please reference the links below for instructions regarding the new rehab rules.**

**https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9661.pdf**
**https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9658.pdf**

**https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf**

**30.1 (pg 29), 80.4 (pg 90), 80.7 (pg 91)**

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

**10.2.3**

**Discussion at meeting**

MS. NORTHCUTT: And I did want to say one of the issues here from an outpatient billing perspective is the 940 revenue code requires a CPT or an HCPCS code when billing outpatient. And what is happening is that that edit would have to be removed because you're supposed to bill that revenue code without a CPT HCPCS code.

So I think that's one of the questions here is can we bill it or can we just not bill the rehab at all under those scenarios. And I can probably send you an example. Would that help?

MS. NABORS: Yes, please.

MS. NORTHCUTT: Okay. I can.

AUDIENCE: So we are billing with the 940 revenue codes, and all claims are rejected. They're returned. So we need a way out of this.

MS. NABORS: I'm sorry. Could you repeat that question?

AUDIENCE: So we are billing these services that are not traditional rehab. We're doing an evaluation, and providing some therapy to the patient who's just staying overnight. And so we stopped using the functional codes and billing with the 420, 430 revenue codes with CPT, and we've replaced everything and used the 940 as directed. However, our claims are all returned.

MS. NABORS: I do need those claims examples. That will help us better isolate and hone down on what's going on.

MS. NORTHCUTT: I was just wondering if CMS is aware of this. I knew that was going to be a hard fix when that came out from CMS to bill that and just don't bill any codes. I don't think they thought that all the way through because all edit systems in the world require one.

MS. NABORS: And what we can do is when we have the claim examples, we can forward that information to our support team who can, in turn, pose a question to CMS or AT FISS, depending what's going on. It's probably one of those issues where we may have to have dual inquiries, one to CMS and then any repairs to FISS if that's needed at the time. So examples will definitely help us on that one.

AUDIENCE: All right.

14. If the MUE for respiratory nebulizer treatment is 2 and the hospital performs more than two can the hospital just bill the two treatment and not the others?

**Response:** **All units of service provided to the patient should be billed.**

**Discussion at meeting**

MS. NABORS: All services that are rendered in a particular facility, whether outpatient or inpatient, should be billed.

DR. MITCHELL: I need to ask you a question about this. So is this relevant if the patient is an inpatient? Is this question relevant?

MS. NORTHCUTT: No.

AUDIENCE: No.

MR. ASHMORE. Okay. So this would only be relevant in the outpatient or observation status?

MS. NORTHCUTT: That's correct, yes. Unless they did a whole lot of breathing treatments in the ED, you know, if they stayed around long enough.

DR. MITCHELL: Well, many of you may know that CMS doesn't use InterQual, but hospitals do, and InterQual's requirement is three in the emergency department.

MS. NORTHCUTT: And whoever wrote the MUE edits made it two, and so we get paid for zero. So if you bill more than two, they will pay you zero amount because you over extended the MUE. So I think that was the question, can the hospital take the hit for doing three and only bill two or is that going to be giving away a third treatment that you're not going to get paid zero for to begin with if you do three.

So this is just convoluted all day long. That's the real question, if the hospital can just not bill for that third treatment and get paid for the two they rightly deserve.

MS. NABORS: But if the provider is billing those services and they render, as you say, three, which is maybe InterQual's limit but not CMS's, if they rendered those three and they're billing those three, are they being completely denied?

MS. NORTHCUTT: Yes. It's a date-of-service edit. So if you have more than two on one day, they deny that whole service.

MS. NABORS: And they're denying that they're excessive in the MUE?

MS. NORTHCUTT: Yes.

MS. NABORS: It depends on what's going on. But are these being appealed in any form or fashion?

AUDIENCE: That's really the issue. I mean, appealing a claim takes time and effort, and, therefore, cost.

MS. NABORS: It does.

AUDIENCE: So if you could bill two, get paid for two, you'd be a lot better off than billing for three, getting denied, having to turn around, appeal, then get paid for three. I mean it's just the economy of scale. You're much better off if you can just bill the MUE and get some payment rather than having to either bill three and get no payment or bill three, appeal, and go through all the cost of trying to get one more paid.

MS. NABORS: However, I have to say, unfortunately, the provider community in some cases - in quite a few cases - may have to appeal in order to get the notice of CMS to perhaps revisit a particular issue in this case. This is something that we can't call attention to them as being a habit if the medical review department doesn't happen to see any come in. Yes, it does cost, it's inconvenient, but if in the end the result is met to help the provider community by calling attention to CMS, that may be a route that you may want to try in order for us to get the attention of them and get that information submitted to them.

DR. MITCHELL: Two things. I agree with Adrienne. Having said that, I will give you the contact for who owns MUE. And as an organization, I would lobby that the MUE in that case, number one, not be completely denied if they exceed the MUE; and then, number two, I would lobby that the MUE be extended to five or six. Because I take care of patients who are on the brink of being intubated, and we give them continuous treatments in the emergency department for a couple of hours and on occasion avoid that morbidity.

So I think the MUE program is an excellent program. I think in some areas they've made mistakes.

AUDIENCE: How can we know if this is a CMS issue or it's a system issue? How do you verify that CMS says deny all three units if you go more than two or if it's just not programmed correctly in the system?

DR. MITCHELL: That's a good question. You know, I may have too much faith in the system. MUEs are something that I think works. The answer to your question is that we'd have to take a claim and we'd have to walk it through and see if it was denied due to the MUE.

MS. NABORS: And that's what my response was going to be. We need some examples to help us to get guidance on what we're seeing. As I said before, true, if I'm only going to get reimbursed five dollars, you know, on a $100 claim, then it is not worth it. But if there should be some compensation for it, at least notify us.

We, as Cahaba, can't help the provider community if we don't know of the problem. At least we can get some sort of guidance out. Because if Dr. Mitchell or the medical review team receives hundreds upon hundreds upon hundreds for one MUE, they're going to say, wait a minute, what's going on. They can gather that data, present that information, and do as Dr. Mitchell says, hey, we might want to relook at this because this is overwhelming us.

And you don't want to have to do it. It's a lot of work, but it does help out. Claim example to determine initially what's going on does help us hone down as to whether it's system or whether it's actually something that CMS instituted.

DR. MITCHELL: I've written down on my to-do list to email the physician that owns the MUE list and verify, number one, that what I think I've learned is accurate; number two, that they're all being denied, which that's not clinically reasonable; and to lobby that if the MUE is in fact two, that that be increased.

It is hard for me to imagine beneficiaries getting excessive nebulizer treatments in an outpatient setting. So that is something that we'll pursue. And I would encourage the Alabama Hospital Association to do the same.

AUDIENCE: Well, we all know that we're dependent on systems that somebody has programmed. And a lot of times they just need to be tweaked, and they're only as good as the people who input those edits. I was just bringing that up because a lot of times that seems to be the issue.

DR. MITCHELL: I agree with you. And you've heard this many times. One of the things I've learned is if we start with a claim that's been denied and we walk it through the claims system, we see which edits it hits.

And you are absolutely correct. Sometimes there's an edit that was loaded in there X number of years ago and it's no longer appropriate. Often, it's unintended consequences. It's we thought we fixed something and we didn't.

AUDIENCE: Thanks.

DR. MITCHELL: So that is why we ask for claims. And it's not because we're trying to create more work for you.

AUDIENCE: This is just kind of a rule of order here. It seems to me that instead of us having to do a lot of work for something that we already have identified as a problem, and I appreciate you, sir, being here, but that's not necessarily going to be the case every time, that we should be able to, I don't know, sign a proclamation or something that says we all have this same problem, here, please take care of it. You know, please look into the problem instead of us having to prove the problem to you individually.

I just think that there should be another avenue when it is something that is like a show of hands. I think everybody in this room could probably raise their hand and say, yes, we're having that problem.

MS. NABORS: And in cases such as these, you can actually contact CMS directly stating that. I mean, even Peggy could submit that information.

AUDIENCE: I'm just an individual. I'm saying as a group.

MS. NABORS: Right. I do agree. But unfortunately, in order for us to help a client, we have to have one or two examples to say.

But if Peggy sends that to Michelle and I and she says, hey, provider just contacted me, they're blowing me up, these claims are not paying, here's two examples below, this is the summary and scenario of what's going on, we get that information, we pull up the information.

Because being at the level that Dr. Mitchell is, he can't see the claim information. But we do screen prints for them, we submit that information to them, and we say, hey, Dr. Mitchell, this is what the provider community is telling us is going on.

Because he is the one who has the direct contact, closer contact with CMS. He can get the information. If nothing else, he can tell us how to direct you guys. Hey, we got it, we're looking at it, we're checking into it. And then he goes from there.

So, no, every provider doesn't have to send us an example. I just need one.

AUDIENCE: Okay. So if I am the one that presents the question, could I not also come prepared with two examples, and then I, as representative who asked the question, hand you the two examples, and everybody in this room agreed that, yes, we're also having the same problem?

MS. NABORS: Yes.

AUDIENCE: And that would do the same thing? Without everybody having to submit their claims?

MS. NABORS: Yes. And when we say send us an example, we by no means want everybody in this room to send us an example. Because I'm going to send back a hollering no saying unh—unh.

No. We only need one to two examples. And we would actually say present this information stating this is affecting the entire Alabama provider community, and submit that information going from there.

But like I said, we do need examples, for one thing, such as this young lady said here. We want to make sure that there is not a system issue. We want to check the systems to make sure that the MUE edits are in correctly. Upon going through that, we want to go further and further. And then, at that time, upon doing our research and checking everything, we send a nice, clean document to Dr. Mitchell and say, Dr. Mitchell, help. And when that information comes back from him, we submit it out to Peggy and we say, hey, get this out to your community.

But in addition to that, we contract for other providers as well. We get it with our provider outreach and education, and we get that information to them as well by adding those things to the web page, to the server and going from there. So this is the type of information we need. If it affects the community as a whole, that's one of the first things we want in the sentence. Good morning, Adrienne, this is affecting everybody in Alabama, here you go. That's how we can help you. We can at least do that.

AUDIENCE: But my thing is you guys already have that type of data to go out and do the data mining.

MS. NABORS: Okay. When you say we, are you talking about the two of us or are you talking about Cahaba?

AUDIENCE: Cahaba. Cahaba has the data. Because what I'm thinking is we need to go back to our facilities, pull the data. But you guys actually have that data already.

MS. NABORS: The information that I'm speaking saying that we can do, I'm talking about the two of us. I'm not talking about Cahaba. Because to have a report pulled and to contact them and say, hey, can you pull the report to do this, to do this, and tell them this, I may miss something. I may miss a parameter or something. But when I have an example, I know exactly what I'm looking for and I can say it looks like this under these type of fields affecting all of these type of providers from this state and they're hitting this edit. That information is coming directly from me. And I can get it to Dr. Mitchell faster, Michelle and I, than waiting on someone to pull data affecting our providers.

Once we get all of the information, then, if there needs to be some sort of correction or CMS gives us some sort of directive, then at that time we can do it. We want to move fast.

15. Should a written description of the diagnosis be placed on the order or will an ICD-10 code suffice on the order?

**Response:** **It is best practice to include the narrative. If the ICD-10 code only is used, documentation in the medical record must support the use of the code.**

16. Can an inpatient claim be billed with a 636 revenue code for drugs if they are not billing clotting factors or do they have to bill drugs on an inpatient claim with a 250 revenue code?

**Response:** **No.**

**Drugs on inpatient claims are billed with revenue code 250. In certain circumstances (blood clotting factors), additional payment is allowed with revenue code 636.**

**Please reference the Medicare Claims Processing Manual, Pub 100-04, Chapter 3, Inpatient Part A Hospital, Section 20.7.3**

**Medicare Claims Processing, Transmittal 2332 with Change Request 7553, Date: October 28, 2011.**

**Additional discussion at meeting**

AUDIENCE: In regard to bariatric claims, basic claims, I know that I recently worked with Michelle, and she got a lot of claims fixed for us. We've gone through the process of explaining those. We've now heard from several other providers that they were having the same issue. And that issue is now recurring at Brookwood Baptist.

Is there any update on getting that fixed? Because I really, really believe it's just an edit issue. I don't believe that it's actually not meeting the requirements of the coverage article. Do you have an update on that?

DR. MITCHELL: On October 1st, there were a substantial number of ICD-10 codes that were added to many of the NCDs, including bariatric procedures. We cross our fingers because we hope that many of those repairs fix the issues that you have been having. I think if you continue to have difficulty with claims that have been submitted after 10/1, work with us and let us try to figure it out.

AUDIENCE: Okay. So for the claims that were before 10/1, can we still send those to Michelle and Adrienne and have those adjusted?

MS. NABORS: Right now we would advise that providers would still have to appeal for those particular services, unfortunately.

AUDIENCE: Is there anyone else having trouble with their bariatric claims? Is anyone else having those rejections? I know UAB had that problem. I know Mobile had that problem. It's a lot of claims and a lot of appeals.

You know, a 60-day turnaround on those appeals for something that really is medically necessary, there's really nothing wrong with that claim, it's just an issue with the ICD-10 procedure code, it just happens to fall on that claim.

If that's the only option, then it's the obvious thing we've got to do. But if we can just say, hey, here's the line that's saying here's everything before 10/1, we know there's an issue, let's just get those adjusted, I think that would be a lot easier for the provider community and also for the medical review not to get all of these appeals to come in for something that truly is payable.

MS. NABORS: Brian, we want to look at your claims again and check those and a few from the others, I think I saw two other hands that went up regarding that. We want to look at them and see what adjustment we could possibly do to avoid the appeal process, if we can. Let me give my disclaimer because we might not can. But let's see what we can do. I don't want you chopping my head off saying Adrienne said it. But let's see what we can do and look at the affected providers and see what's going on. This may be one of those situations where we need to reevaluate and maybe go higher. But let's see what we can do. And we can also make sure we check all of our systems and make sure everything is working right.

AUDIENCE: Okay. Thank you. And I'll get those to you.

And another question, we've had a real issue with the automated reopening process, getting those claims when we file the automated reopening to get them to go through. They always kick into T status. Do you have any updates on that? And I wonder if any of the other providers are having the same issues that we are having?

MS. NABORS: Yes, sir, that's been updated. I worked on that project myself. We did have those particular claims. Those edits are now suspending instead of returning.

That was something you called to our attention. Because we don't see every single edit that comes in. We've had the edit fixed. They now suspend. And they are supposed to suspend per the narrative because that's how we work them because they come in without paper electronically.

That has been corrected. You may still see some out there, but they are being worked. I just trained the staff on how to work those particular claims just the week before last, and they are making progress with getting them done. It may take a little bit of time because we did have to have the

reporting pulled to pull those claims for the department that will actually be moving those claims to finalization for you guys.

AUDIENCE: Okay.

MS. NABORS: And that's for every provider.

AUDIENCE: So if we have one that's in T status now, should we just F9 it back, will it suspend, or should we send those to Peggy?

MS. NABORS: Send those to Peggy just to make sure. Because when they come back, they're going to still probably show T. We know that if they were already T'd, they're not pulled and assigned to that location automatically. Any newer claims after the update went in will go to the new location. Send them on.

AUDIENCE: All right. Thank you.

MS. NABORS: You're welcome.

MR. ASHMORE: I want to thank Dr. Mitchell, Adrienne, and Michelle for being here today.