MEDICARE (CAHABA GBA) MINUTES
July 13, 2015 RIC/RAC Meeting

CAHABA GBA REPRESENTATIVES PRESENT:
Ms. Suzanne Evans
Ms. Joy Fowler

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Karen Northcutt

MR. ASHMORE: We're going to go ahead and start with Cahaba. We have Suzanne Evans and Joy Fowler joining us. We'll start with the follow-up/deferred questions from the March 2, 2015 RIC/RAC meeting.

1. Follow up to Question #1, which was a follow up from November 3, 2014.

Is there any update regarding dedicating and training resources other than customer service to answer questions regarding RAC and MAC interest payments being applied to relevant claims?

Response: **With the award of Jurisdiction J (JJ) A/B Medicare Administrative Contractor (A/B MAC) to Cahaba, Cahaba has entered into a subcontracting arrangement with National Government Services (NGS) to provider limited services for the JJ contract. NGS will subcontract Audit & Reimbursement, MSP and Non-MSP Overpayments and basic mailroom functions. In some instances, depending on your business needs, you may be in contact with NGS associates as they relate to Audit & Reimbursement and Overpayments.**

Provider Contact Seniors have been trained to research these type of inquiries. Providers will contact the PCC and these inquiries will be sent to these seniors.

http://www.cahabagba.com/news/new-mailing-addresses-jurisdiction-j-part-providers-effective-june-1-2015/

http://www.cahabagba.com/part-a/claims/overpayments/

Discussion at meeting:

MS. EVANS: I'm sure you are aware that we have had a transition at Cahaba. We are now JJ instead of J10. And with that transition, we have subcontracted with the NGS, National Government Services. So they're doing the audit and reimbursement work now.

We have a process, and we are still learning the process. I'll be honest with you, as with any transition, you're going to hit a few bumps. You're going to think of something you didn't address.

But what happens is the seniors in the provider contact center have been trained to do this functionality. So you will call the PCC. You will give them your issues. And they will send it to the senior, and she will research it, and you will get a phone call either from the senior, if there are questions, or from the PCC RIC. Now, I can't tell you what the

turn-around is because we're still trying to work out some of those kinks, but they are actively working on that.

I'm also going to be trained to do that. So, hopefully, I will be able to help get those turned around quicker, but, you know, that's HIGLAS Part A. So this will kind of be a learning experience for me.

There were some questions about the mailing addresses now for JJ. And I have added that link in there for the mailing addresses. You notice it goes to Indianapolis, and that is correct. So that's where the mailroom functionality is, one of the things that our government is subcontracting, and they will be coming out of there. And if you see an Indianapolis address, that's correct.

Before the reimbursement people left, they put some education information out on the website on overpayments and withholdings. So I added that link there also so that you can look at that information as well. So that's where we are with that currently.

Does anybody have any questions about that?

AUDIENCE MEMBER: Thank you. On the NGS that are handling the parts for the audit and reimbursement, the letters that we've been getting, the letterhead has changed and all of that. And we're unable to find some of the patients because the information is not in the CMS provider portal. And when we call, it depends on which rep we get if we're able to get our patient control number or not.

One will tell us, no, I'm not able to give you any information, so we can't find the patient in our system, because it gives us the last four of the beneficiary number and the claim number. And then when I call back and get another rep, they'll give me the control number. Is that something that's going to be looked into?

MS. EVANS: Yes. When they tell you they can't give it to you on the first level, you need to tell them you want to be sent to the second level. Okay? So if the person answering the phone says, I can't help you with that, then you say, I need this to be referred to second level. Those are the people that are in the system. The first level people can do a minimal amount, but they can't get into data warehouse and the things that they need to get into to do that. So if they can't get that for you, then you need to ask them to escalate it to the second level.

AUDIENCE MEMBER: Thank you.

MS. NORTHCUTT: Would they call you back?

MS. EVANS: They should call you back.

AUDIENCE MEMBER: But you don't know the time frame that it's going to be.

MS. EVANS: Right now we don't know the time frame. It's probably pretty slow right now, I'll be honest with you. But it should speed up once we integrate more people into it. So the different units can help. Like if you send in a written correspondence, they're

learning to do it as well. So we're trying to attack it on several different levels so that we can turn these things over.

2. Follow up to Question #4, which was a follow up from November 3, 2014 and was deferred by Cahaba at the March meeting.

   We are still having issues when sending medical records on CD. How can we provide Cahaba with a password so the CD may be encrypted? We are concerned that the encrypted CDs and passwords are not being matched up timely. Connolly has a generic email address where the provider can email the password and the tracking number for the CD. When the CD arrives in Connolly's mailroom, their staff can access the email on demand, open the disk in the appropriate password, and load the claims into their system.

   a) Can Cahaba set up a similar system?

   b) Or in the alternative, can we have a provider specific password that is used for any medical records submission? This would alleviate the cost of sending to FedEx packages for every medical records submission.

   Response: **Will discuss at meeting.**

   Discussion at meeting:

MS. EVANS: I'm going to be honest with you. The response I got did not answer the question. So I have sent it back up again this morning before I left, and as soon as I get a response I'll send it to Peggy, and she can send it out to you. But there is a process; they just haven't shared that with me yet.

3. Follow up to Question #5, which was deferred by Cahaba at the March meeting.

   a) This question relates to ADRs for MAC audits. We are submitting medical records (some via ES MD, some via CD) timely, but are still getting a denial for failure to submit medical records. When we contacted Cahaba customer service, we are told that the medical record was never received despite the fact that we have a tracking number or the transmission number. Because we need to get paid, we resubmit the medical records. If that particular claim is paid and approved, there is no issue. However, we are running into the following situation which I will outline below:
   - one of the medical records is received and denied on the merits by the Cahaba reviewer
   - we begin our normal appeal process
   - we receive a Level I dismissal, however we have either not sent the Level I in yet or the Level I dismissal is dated before we sent the Level I appeal

We contacted customer service to find out how we could get a dismissal before we had submitted the appeal and yet were still well within the Level I appeal timeframe. We learned that the second set of medical records was found in the interim and sent to the appeals department. Because there was already a denial on the merits, the appeals department is treating the second set of medical records as our Level I appeal. Our "appeal" is being dismissed on the technicality of failure to submit a signed appeal document. We find ourselves in a Catch-22 situation because if we don't submit a second set of records, we cannot get paid. However, if we submit a second set of records, we run the risk of losing our Level I appeal. Please advise.

Further, the "redetermination dismissal" letter states that we may request that Cahaba vacate the dismissal by demonstrating good and sufficient cause for failing to address all the items listed in the dismissal. In an attempt to get the dismissal vacated, we have contacted Cahaba, explained the situation, and asked them to look at our actual Level I appeal. Our staff has been told that Cahaba will/cannot vacate the decision and that we must appeal to the QIC. This results in a huge delay in payment. Who can help us get the claim decision vacated?

Response: **Appeals Manager has educated the specialists on the issue of dismissing incorrectly. Additionally the transition of the mailroom should help as well. Manager has communicated with the PCC that these issues of vacating and correction should be sent to Appeals for correction and vacation of the appeal, if applicable.**

Discussion at meeting:

MS. EVANS: The records that were being sent for ADRs were getting sent to the wrong bucket. And they were sent to an appeals bucket as opposed to the MR bucket. And we've hopefully gotten that fixed. We have talked with the appeals manager. She has done education for her associates. And that should be resolved.

If you continue to have those issues, if you'll just shoot me an e-mail and let me know, but we hopefully have that issue resolved.

And with the vacation and everything, there was another part of it: How do we know how to vacate things. That should have been resolved too.

MR. ASHMORE: Okay. We'll start with our new questions.

4. We are getting mixed messages with the hospice denials. After filing a level one appeal, we follow up on the appeal within 65 days. When we call to find out the status of the level one appeal, one Cahaba representative will say that no formal appeal is needed and that the Provider only needs to file a corrected claim. Another Cahaba representative will say that an appeal is needed and will send the appeal back to the appeals department. Which is the correct action: appeal or re-file a corrected claim? *[an example was attached and also reference GINQ-355359 / GINQ-4355416]*

Response:

100-04 Chapter 11/ 50

Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and which are furnished during a hospice election period, may be billed by the rendering provider using professional or institutional claims for non-hospice Medicare payment. On professional claims, these services are coded with the GW modifier "service not related to the hospice patient's terminal condition." On institutional claims, these services are coded with condition code 07 "Treatment of Non-terminal Condition for Hospice." Contractors process services coded with the GW modifier or condition code 07 in the normal manner for coverage and payment determinations. See the related chapter of the Medicare Claims Processing Manual chapter for the type of service involved (i.e., Chapter 12 for physician services) for billing instructions. If warranted, contractors may conduct prepayment development or postpayment review to validate that services billed with the GW modifier or condition code 07 are not related to the patient's terminal condition.

Discussion at meeting:

MS. EVANS: I have put in there the information from the manual; and it says on institutional claims, these services are coded with condition codes 07, treatment of non-terminal condition for hospice. And that's the way they need to be processed. And we will educate the PCC on this as well.

5. We have a lot of claims that were affected by retroactive drug pricing changes from the April 2015 update and the article from CMS (MM 9097) states (see below) that "Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files." Do you know what process we should use to "resubmit" these claims? This April 2015 update affected almost 800 claims here and I want to make sure we have the process correct.

> c. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalOutpatientPPS/index.html on the CMS

website. Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files.

Response: **Per Support Services: provider should submit adjustments. If they file a new claim it will reject as a duplicate.**

Discussion at meeting:
AUDIENCE MEMBER: Not a reopening?

MS. EVANS: No.

AUDIENCE MEMBER: This is the reason for my question. Because they're all medical reviewed, you know, some of them are already past time they're claiming. And there's something wrong with the claim. There's nothing that we're actually changing on it, just the payment rate change. And that's when you do payment.

So I was worried because so often we send something in and it's returned back and it's not the correct avenue. Reopening seemed to be better if I could get it to fit into management, from making one of my calls, since I put the question on here. So I just send an adjustment claim in; I don't send it to reopen?

MS. EVANS: That's what support told me to have you do.

AUDIENCE MEMBER: Okay.

MS. EVANS: Do you want to do one and let me know how it turns out?

AUDIENCE MEMBER: Okay. I will.

MS. EVANS: Okay. And then we can report that back to Peggy, if it works.

6. Inpatient is discharged from our facility to Home/Home Healthcare. Eight months later we review and find that there is no claim for Home Health, so we change the Discharge Disposition from Home/Home Healthcare to Home/Self Care and refile the claim. Three months later we discover that there is now a claim from a home health agency, but the date of service is seven days from their discharge from our facility.

   a) We changed the Discharge Disposition back to Home/Home Healthcare and added a CC43. Is this correct?

Response: **The correct assignment is 01, Home/Home Self Care with Condition Code 43 (Continuing care not provided within prescribed post discharge window). The home health was outside the post discharge payment window. Please refer to the Centers for Medicare and Medicaid Services (CMS), to Medlearn Matters Number:**

SE0801 Revised, March 2014 and the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual, Patient Discharge Status for additional guidance.

b) At what point post discharge from our facility is the distinction between self care and home healthcare?

Response: **This is dependent upon the documentation at the time of discharge for the home care needs, or if there are new developments within the 3-day post discharge window. The discharge status documentation should be updated if the discharge status changes within the 3-day post discharge window. Use of applicable CWF reason codes or condition codes 42 or 43 may be appropriate.**

c) Is there a difference in our facility's payment from Medicare between a Discharge Disposition of Home/Home Healthcare with CC43 and Home/Self Care?

Response: **Yes. This is dependent upon the inpatient discharge status code as it applies to the post discharge payment window. Additional information is available in the NUBC, UB-04 Manual and CMS Medlearn Matters Number: SE0801, Page: 9. This further specifies Medicare's Post Acute Care Transfer Policy (42 CFR 412.4) based on claim's with Patient discharge status Codes 02, 03, 05, 06, 62, 63, and 65.**

Discussion at meeting:

MS. FOWLER: Hello. Okay. I'm not a coder. The coders do report to me. I'm manager Part A. And so there were several coding questions included, and I referred all the questions that you sent to our coders, and I'm bringing back those answers to you. So I can only give you a limited amount of information on this, because I am not a coder.

7. CR 9097 allows the bundling of an inpatient-only procedure performed on an outpatient basis into an ensuing inpatient admission under the 3-day window rule.

a) Does the new rule mean that if the physician failed to write an inpatient admission order prior to a known, scheduled inpatient-only procedure, that it is now acceptable to write the inpatient order after the inpatient-only procedure when the only reason for inpatient admission is based on the performance of the inpatient-only procedure (that is, there is no expectation of a 2-midnight stay after the order)?

Response: **If the patient is admitted for an IP only procedure, the admission status should be "Inpatient" from the time of admission. Cahaba would expect to see a Physician's order for admission at the time the patient presents for the IP only procedure. If a patient is admitted for what is thought to be an OP procedure, circumstances change, and an IP procedure is performed, the order for IP admission**

can be written at that time.

b) What is the principal diagnosis if the order is written after the procedure is performed – the reason for the surgery or a post-surgical reason?

Response: **According to coding rules, the principal diagnosis is - "That condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." The admitting diagnosis and the principal diagnosis are not necessarily the same. Generally, the "admitting diagnosis" identifies the patient's condition based on the presenting signs and symptoms. The principal diagnosis, however, is based on this admission information and the findings from all related diagnostic testing.**

Discussion at meeting:

MS. FOWLER: To answer Part A, there's just no good way to ask the questions, is there, to make them understandable, because sometimes I sit and read these and I think, well, let me break that down. Let me do a one, two, three out of that.

Well, when we look at these records and we see all kinds of different things going on. There's just so many different scenarios that are put forth in front of the clinical people on the Part A side that we try to look at the entire record and try to make a decision based on what happened with this and why was that order not written at a particular time and can we infer any of this information.

We try to do the best we can, because there are so, so many different scenarios we see in this. So, there are times that if orders are not there, if we see a progress note and we can infer that that was the physician's intent, then we'll go with it. You know, we try to do that the best way we can. And sometimes it's hard.

MS. FOWLER: Okay. For Part B, you have the answer there, it's just the coding rule. That's the answer to the question.

AUDIENCE MEMBER: If a patient is in obs and gets admitted, what was the diagnosis that caused that patient to go inpatient? And I think that's what they're asking.

MS. FOWLER: Did their fever spike to 101? Did they have unexpected bleeding? That would be the cause for admission.

AUDIENCE MEMBER: Right. But in this case, they're asking where you changed it because they changed the procedure to an inpatient-only procedure.

MS. FOWLER: Oh.

AUDIENCE MEMBER: So does that rule apply or do you stick with your diagnosis in the first place?

MS. FOWLER: Well, if they changed the procedure, if they went in with the intent of an outpatient procedure and something happened and they had to do a more extensive procedure that is an inpatient-only procedure, then the physician would write the order at that time. I mean, if he performed an inpatient-only procedure, then we're going to release it and we're not going to review if the patient is an inpatient.

AUDIENCE MEMBER: Regardless of what the diagnosis is?

MS. FOWLER: Yes.

AUDIENCE MEMBER: Even if the diagnosis supported the outpatient and not the inpatient-only procedure?

MS. FOWLER: Right. If it turned into an inpatient-only procedure, we get that claim and the coder determines it to have been an inpatient-only procedure, then we're going to release the claim. And we're not going to pick you apart on the diagnosis or anything like that.

Did that answer your question? It did? Okay. It's hard. There are a lot of different scenarios we see. We just try to do the best we can to sit in your seat and try to make a decision.

8. Is genicular neurotomy a covered service? It is uncertain if this procedure would be coded as CPT 64640 or 64999, but regardless of the code selection, is genicular neurotomy covered by Medicare? If it is a covered service, what is the correct CPT code to use?

   Response: **Per CMD:**

   Cahaba GBA considers genicular neurotomy as investigational – not yet proven effective based on review of available literature using standard strength of evidence guidelines.

   Discussion at meeting:
   MS. EVANS: So right now we're not paying for it regardless of the code.

9. A Neulasta Delivery Kit is placed on a patient following chemotherapy. Per the vendor factsheet, a Healthcare provider activates and applies the On-body Injector to the patient. Three minutes after activation, the needle inserts the cannula subcutaneously. Approximately 27 hours after the On-body Injector is activated and applied to the patient, Neulasta will be delivered subcutaneously over approximately 45 minutes.

a) Is the drug from the kit reported with the same HCPCS as Neulasta given by regular injection?

Response: **There is no information available at this time.**

b. Is it acceptable to charge for the injection?

Response: **If delivered by or under the supervision of a qualified health professional.**

c. What is the correct date of service to report the drug and/or injection – the day the kit is placed or the day the injection occurs?

Response: **The date the injection was administered.**

Discussion at meeting:
AUDIENCE MEMBER: Have you seen the new Neulasta delivery kit?

MS. NORTHCUTT: Yes. A lot of facilities are using this new Neulasta kit.

AUDIENCE MEMBER: I don't think it's working out too well, though.

MS. NORTHCUTT: What we're looking for is the correct date of service when it's injected. Because they place it, but it actually self-injects later. But, the injection does not occur at the facility. So people are trying to bill for the injection but the patient is not there while it's injecting. So would it be when they actually attach the kit or when it injects; or at least we hope it injects. Assuming it injected, the patient would not be there at the facility at that time.

MS. FOWLER: Right. I understand the dilemma there. But I don't think she found any information to even address that, so I would say let's just put a hold on that one for a bit, because I don't know. I wouldn't know how to answer them.

MS. NORTHCUTT: Go tell your drug rep that we still don't know the answer.

10. Are there any updates on billing for Lung Cancer Screening?

Response: **No new information available. Please see -**

http://www.cancer.gov/news-events/cancer-currents-blog/2015/medicare-lung-cancer- screening

Discussion at meeting:
AUDIENCE MEMBER: They do address that in the proposed OPPS rule, and they are

creating a G code. But that G code is not finalized. So it looks like it will be with that final rule before we actually are able to go for lung cancer screening with low dose CT.

MS. FOWLER: That just came out last week, didn't it?

MS. NORTHCUTT: Yes. The proposed G code is GXXX2. So we got some numbers that are missing until it is finalized.

11. Under Two Midnight, would there ever be a situation where a patient would stay in observation after they cross the 2 midnight threshold? If so, please provide an example of when this would be appropriate.

Response: **Patients who receive continued diagnostic and/or therapeutic treatments for a 2 midnight period of time should be billed as IP. We do not have an example of the above scenario.**

Discussion at meeting:

MS. FOWLER: That's really all I know to tell you. At this point, we're not pulling the observation claims that stay over 48 hours.

And I think this came up last time we were here too. We're looking at inpatient claims, but there will come a point in time where those claims will be pulled. But, if a patient is receiving continued diagnostic and therapeutic treatment over a two-midnight period of time, the intent is for that claim to be inpatient.

AUDIENCE MEMBER: I do have a question. And this was not my question. If the patient comes in, let's say, Friday night for the low risk chest pain and that's really been ruled out and consult cardiology, who has 24 hours to come see the patient; they come Saturday and they order a new scan for the next day. They're crossing two midnights, but you really ruled out an MI and this is now a very low risk case. So they're staying greater than two midnights. Or there just may be a delay in the patient's care or you just may be waiting on the tests that are being done, but no one is going to come back at that hour to read it, say, if it's seven or eight o'clock that night. So does the patient need to be admitted if there is some sort of delay?

MS. FOWLER: If we look at that record and we see a clear delay in the provision of diagnostic and therapeutic services, we would deny it. It would have to be billed like a 12X bill type, if it were billed as inpatient. Because if there is delay in any sort of service that the patient needs, past that second midnight, we would see that delay, we would deny it, and the facility would have to bill it onto a 12X at that time.

AUDIENCE MEMBER: So what period, then, are you able to claim observation services on this one?

MS. FOWLER: Well, on this, anything less than two midnights. If legitimately that patient is being treated and receiving timely diagnostic and therapeutic services for two midnights, then it can be billed as inpatient. But, if there is a delay in diagnostic services or a procedure, and we see this on the weekends a lot, then we would deny that, and the facility would have to bill under 12X bill type.

MS. NORTHCUTT: I think the other part of that would be with the proposed changes to the two-midnight rule.

MS. FOWLER: Right.

MS. NORTHCUTT: That's where it's going to get into if the physician thinks it's going to be some adverse effect because they're not going to get their new med and they're scared to let them go, then we're going to be back in the same dilemma that we were before the two-midnight rule.

MS. FOWLER: You will be. If the MACs continue to do this. But as you know, we take direction from CMS. And as they change the way they think about things and as they get feedback from providers and from the AMA and all these people who may have input, they kind of change the way they feel about things.

Not knowing what's going to happen with the proposed rule, my inclination is to say that whether the MACs do the first level or another entity does the first level, that they're going to be in the same boat we're in. They're going to have to look at the documentation in the record and look at what the physician says and see how clearly he documents the patient's treatment and the risks.

The physician's documentation is going to be key and always, really, has been in all of this, you know. It's really going to be the same thing. Whether we do the review or another entity does it, the documentation from the facility is going to be the key element to convince the reviewer of that necessity.

AUDIENCE MEMBER: So you're saying in that circumstance, that it's not appropriate to leave them in observation because they cross the second midnight?

MS. FOWLER: No. That's not really what I said. I said if there's a delay in the diagnostic and therapeutic services and we see that delay, inpatient admission is not appropriate. We would not pay that. It would have to billed on a 12X bill time. If there's a delay, no, you should not admit the patient.

AUDIENCE MEMBER: Here's my thoughts on this. If the care is not medically necessary and it's due to delay, I agree that inpatient isn't appropriate. And I think the question then becomes is it appropriate to continue to bill for the observation hours at that time because observation has medically necessary requirements also.

MS. FOWLER: I agree.

AUDIENCE MEMBER: And my thought, my personal opinion, is that it probably isn't necessary to continue to bill obs, because the care does not meet the CMS manual definition of what observation is.

Now, you can't let the patient go home. You're waiting on things. They're in an outpatient status. So they would remain outpatient. And then your decision is to whether to bill for observation hours. If you've already met the observation composite requirements, it's not going to change your payment. But just for issue of medical necessity, consider whether you should even continue to bill obs hours at that time.

MS. FOWLER: And sometimes this has everything to do with individual education inside your facility. Making sure that the medical staff really understands what's going on with this. And I know you have to deal with this pretty frequently. It just goes back to education on how all this is supposed to work.

AUDIENCE MEMBER: At any point on patients like the ones we're discussing, is it appropriate to issue an ABN? If they're going to continue in the hospital and we can't get any, I guess, cooperation from the medical staff in an area where they won't give you a discharge, but the medical necessity may not be strong enough to support inpatient or observation at this point, but the patient continues to stay.

MS. FOWLER: Yes. I would say yes. I mean, the ABN is still out there and it can be used.

12. If two infusions are given at separate encounters in one day (one infusion in the morning, patient goes home and returns for another infusion that afternoon), should hospitals bill two initial infusion codes, one with a modifier to indicate a separate encounter, or one initial infusion code and one subsequent infusion code?

Response: **The 2015 CPT Coding Expert Manual, Section 96360-96371, Instructional Notes and the AMA, CPT Assistant, February 2009, Page: 17 to 21 give guidance on reporting of two initial infusions that occurred at separate encounters. Instructions regarding the appropriate code assignment with applicable modifier application as it applies to the second initial dose are provided in the AMA, CPT Assistant, February 2009, Page: 17 to 21.**

Please note that for 2015, the second separate encounter modifier would be assigned from one of the new subsets for modifier 59. See Medicare Claims Processing Manual, Publication 100-04, Transmittal 1422 with Change Request 8863; Date: August 15, 2014 and CMS, Medlearn Matters Number: MM8863, SE1503, effective date: January 1, 2015. Additional guidance from CMS regarding the use of these modifiers will be forthcoming in a gradual, controlled fashion.

See the information below from the American Medical Association (AMA), Current Procedural Terminology (CPT) Assistant, February 2009, Pages: 17 to 21:

> **Question: Would it be appropriate to report two initial infusions (code 96365) with modifier 59 appended to represent the second dose in the following circumstance? A patient was seen in the outpatient center for drug infusion. The physician ordered antibiotic drug infusion every 12 hours, with the first antibiotic infusion followed by an antifungal drug infusion. The patient received the infusion at 8:00 AM and was permitted to leave the center. The patient then returned later in the day to receive the second infusion at 8:00 PM.**
>
> **Answer: It is appropriate to append modifier *59, Distinct Procedural Service,* to the second initial service, whether it is for a second encounter on the same date of service or second site per protocol. In this circumstance, the second initial service is reported because the patient left the center and upon returning, another initial infusion is administered. It is recommended that you provide medical documentation based on payer policy regarding the use of the same "initial" infusion code on the same date of service with modifier 59 appended.**

Discussion at meeting:

MS. FOWLER: All right. You have read this answer. We have had no clear education from CMS, really, on the new subsets for modifying 59. These are just coding rules here until we get some clear education on CMS's direction. And I think it will be very carefully planned and orchestrated. Because there's a lot of controversy and a lot of question about this.

If there's anything that I can take back to our coder, I will; but she's waiting just as you are.

Additional discussion at meeting:

AUDIENCE MEMBER: I have a general question. I think all hospitals that have infusion centers would be faced with this. And I'm looking for some direction, advice maybe, for the patient. So we run into, occasionally, a physician is ordering off-label drug use for a patient. We have that discussion with the physician and the patient to say Medicare doesn't cover drugs that are off label. There is no policy giving us direction.

So we inform the patient, have them sign an ABN. We ask them to pay upfront as a self-pay. So we do this because billing can be a challenge as to what modifier to put on the bill, because we don't want to get paid.

So I had a scenario that happened where the patient got a couple of treatments. We went through this scenario. And then the patient must have been from another state, because we got a phone call, a patient advocate from a hospital in another state who said, why did you not bill Medicare? We were unfairly treating this patient by asking them to pay

and not billing Medicare.

The patient was getting further treatment at this other hospital in another state for the same drug, and they were billing Medicare.

So it's a real challenge for patients to understand this concept. Is there anything that we can do to advise the patient to give them another avenue? You know, they can appeal? The hospital is not going to appeal, because we got paid by the patient.

So do you have any suggestions or advice in that? And, really, I'm looking on the patient's behalf.

MS. FOWLER: The bene can also appeal. The bene can write a letter, but we have to have the medical record with that letter. So they would have to get all the information and send it in. And it would be reviewed by medical review. If the bene appeals it is likely one of our CMDs would look at it.

AUDIENCE MEMBER: So our bill, the hospital bill, we reflected the drug, we used a GX modifier, and we were denied.

MS. FOWLER: Okay.

AUDIENCE MEMBER: So if the patient did appeal it definitely would be reviewed? It wouldn't just automatically be a payment?

MS. FOWLER: No. If a bene sends in an appeal, we're going to look at it.

AUDIENCE MEMBER: Okay. Then that's what I need. That's the advice I need.

MS. FOWLER: If it's chemotherapeutic drug, it should go to one of the CMDs. We've had this happen before.

AUDIENCE MEMBER: Okay. All right. Thank you.

MS. EVANS: And the other thing is you could bill it and get a denial and then appeal it. The facility could appeal it.

AUDIENCE MEMBER: Is there any recourse, besides provider liable, when a patient comes in and they're perhaps an observation and we get a verbal order from the attending to change it to inpatient, then the patient goes bad and expires before the order is signed. And it doesn't happen often, but it's happened a couple times.

Is there any recourse other than billing provider liable because we don't have a signed inpatient order on the chart before the patient expires?

MS. FOWLER: We're not supposed to be looking at ones where the patient expires. If it's coded with discharge status 20, we exempt the claim. We do not look at those.

MS. FOWLER: So you would have to send me an example. And we're not looking at any outpatients right now. You know, when things change on down the road, depending on what happens with the posts rule, we may be looking at pulling some of these other types of claims; but, if the discharge's position is 20, we're supposed to exempt that claim and not review it.

If you can send an example, I'll be glad to look in the claim and see. E-mail it to Suzanne, she can get it to me, and I'll be glad to look at it. Because we should have exempted that. We'd never look at the record. We exempt it if they expire.

AUDIENCE MEMBER: Well, would require the physician's signature on a verbal order for an inpatient admission - a physician never signed it and then the patient expires, is that okay?

MS. FOWLER: Well, I mean he should update the record when the patient is discharged. We would never look at that record. We would never pull that record, because the patient expired. But, yes, you still have the responsibility to have your records updated internally. But we would never pull that record to look at it.

AUDIENCE MEMBER: Hi. I was wondering about delays in treatment. If you have a patient who the physician has determined doesn't have a safe discharge, there is not a safe discharge place for them to go, and they documented this. Let's say the daughter lives in another state and knows momma's in the hospital and really is not working on that and there's no one to sign them into a SNF or whatever. How is that looked at from your standpoint? And I know it's never happened to anybody else.

MS. FOWLER: Yes. Technically speaking, a social issue we would not take into consideration as far as making a determination is concerned.

AUDIENCE MEMBER: So it would be denied?

MS. FOWLER: I would probably take a really good, hard look, and I have not seen a record like this, with that sort of thing going on that has been brought to my attention. But I would take a really good, hard look at it. But as an overall statement, I would say, yes, it would be denied.

MR. ASHMORE: Do we have any more questions for Cahaba? Okay. Thank you Suzanne and Joy for coming today.