MEDICARE (CAHABA GBA) MINUTES
March 2, 2015 RIC/RAC Meeting

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

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Karen Northcutt

MR. ASHMORE: I would like to welcome Suzanne Evans and Joy Fowler from Cahaba.

1. Follow up to Question #1 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: **Discuss at meeting.**

   Discussion at Meeting:

   MS. EVANS: Good morning. This continues to be a work in progress. Just a little side note. I'm sure you have seen that we have been awarded Jurisdiction J (JJ) . In the next couple of months we will be going through a transition, even though we still have the same responsibilities, Part A, Part B, for Alabama, Tennessee, and Georgia.

   Medicare, because of funding, you have to go through a transition, which means you'll probably see pretty much the same thing. Things won't change that much. But there might be a few little odds and ends that you'll see that will be different. We may change the processes. This is a good opportunity to identify things that may not work as well as we would like for them to work. And so you may see some things like that.

   That said, I would encourage you to watch the website. Because on the website it talks about JJ implementation. So anything that's due, any kind of activities that we do through the transition, you will see through that.

   Currently the date for Part A transition is June the 1st. And like I said, you should not see any kind of major delays upheld, anything like that, but it's just information.

   The other thing I want to share is we've had some management changes at Cahaba, people leaving, people being promoted, people coming from the outside to the inside. And so some of these things that we've talked about before that we would like to see changed, we're going to have to defer our answers today.

   One of those is process control. I know that's a big issue for you. We have two questions today on process control. So today we will have to defer those questions. And hopefully in the next couple of months, we'll have those kind of things worked out.

   But I do appreciate you putting it in writing because that helps us to forward it to management to say these are the things that our providers are seeing. So when you send me things like that, it is very helpful to have your concerns. And even though I can't answer your question today, I do take that and pass that on to management.

   So that said, for question number one, we are still in process with that. However, if you will watch the website, reimbursement is starting to put some articles under there. And you go to the claims tab and go down to overpayments, reimbursement. Talking about

some ideas that may help you answer some of these questions yourself. I'm not sure how good it answers the questions that you have. I may be tapping into some of you that send me frequent things to see if any of the information out there is helpful to you. That's what we want to do. So hopefully next time we'll have a better answer.

MR. ASHMORE: Do we have any questions on that?
(No response)

2. Follow up to Question #4 from November 3, 2014. Providers continue to have MAC and RAC denials which they are attempting to rebill as Part B which are rejected as past timely filing despite being appended with the W2. When can we expect Cahaba to be able to process these correctly?

Response: **Discuss at meeting.**

Discussion at Meeting:

MS. EVANS: W2 indicates that you are rebilling and no appeal is in process. It has nothing to do with the timeliness of the claim. According to the change request that came out following in 155F, the timely rules do apply. So you have to have it within a year from the date of service.

That said, I know your RAC claims are not a year from date of service. So until we get that figured out, you just need to send those to Peggy at AlaHA and she'll send them to me and we'll work on those for you. The W2 has nothing to do with the timeliness.

MR. ASHMORE: Any questions?

THE SPEAKER: I'm sure that you're sure about the W2, but as far as the RAC, what the ALJs have said is that it is one year from the date of most current denial.

MS. EVANS: And you may be right, but that's not what's in the change request. That's not what's in the manual, what's in the change request. But you may be very right. And that's why I'm saying, if you will send those to me, then we can help you get them fixed.

THE SPEAKER: Thank you, ma'am.

MS. EVANS: Absolutely. Hopefully there's not a thousand of them. I will have that, though.

MR. ASHMORE: Do we have any other questions?
(No response)

3. Follow up to Question #5 from November 3, 2014. Please provide status update with regards to provider outreach education with regards to Medicare not keeping the same DCN# when processing a RAC denial, recoupment and repayment.

Response: **Discuss at meeting.**

Discussion at Meeting:

MS. EVANS: Friday afternoon there was a FAQ put out on the website, and it had to do with this. I'll just read it to you if that's okay because you may not have seen this yet.

The providers requesting appeal using the Cahaba GBA Medicare Part A redetermination request form should use the document claim number (DCN) of the claim they are trying to appeal. If the claim has been adjusted, the original claim has been cancelled so the adjusted number should be used.

So anytime the claim has been cancelled, you cannot use that. You have to use the latest one. And I realize our smart form says original DCN, and I'm still working on that. I don't know why we can't all agree what original means.

But, again, we have a new person in appeals Part A, and she's still trying to get her feet wet. I hate to tell you, but it's really not the most important thing in her life right now. But we will keep picking at it.

THE SPEAKER: I will just say, just so everybody is clear on that, when you talk about you get a medical record request via the FISS and you have the first claim number which is the first, so it would be original. Remember, when you file your redetermination, don't use that one. Use the second one that you get, which is the DCN number that comes across with the denial in the FISS system. Because, otherwise, they're going to dismiss your appeal because you use the first claim number because that's what the form told you to do. But use the second one.

4. Follow up to Question #17. 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: **This is the one I just talked about that we are going to defer.**

5. 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.

   b) 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: **This is the other one that we are going to defer.**

6. Please provide an update on CMS settlement process including how the Round 2 (disagreement spreadsheet) process will work, i.e. when will it begin, who will manage the resolution of those claims on behalf of CMS, what will be the forum, etc.?

   Response: **Round 2 should begin shortly, and providers should go ahead and submit their Round 2 spreadsheets to CMS at MedicareAppealsSettlement@cms.hhs.gov.**

Any other questions they have regarding the process should be sent to the CMS team, as we have not received finalized technical directions from CMS that we are able to share at this time.

Discussion at Meeting:

THE SPEAKER: We already sent in the Round 2 with the Round 1. I would assume everybody had done that. So do we send it again?

MS. EVANS: I don't know that answer. I did not know that. So I will go back and find out. You sent them together?

THE SPEAKER: Yeah. You sent it back and said here's the ones we agree, here's the ones we disagree, here's your new updated agreement because you had to sign another agreement. So you signed the first one, assuming you sent it in October. You sent one in October. When you submitted the second one, you had to submit another agreement same contract, new signature date for the Round 2 disagreement ones to kind of, I guess, kick that process off again?

MS. EVANS: I would think that's appropriate, but I will find out for sure.

THE SPEAKER: They had an open door forum called last week about the Round 2. And a lot of people were confused when you submitted your Round 1 and you had the two separate spreadsheets. If there were cases that were added as eligible on the disagreement spreadsheet, you had to sign a new agreement and resubmit those. And I don't think people knew that you had to.

They did post updated instructions on the CMS. I think it's the appeals settlement website. So there are some very specific technical instructions out there. So if you're doing this settlement thing, you probably want to go out there and review those, because that might help answer some questions.

THE SPEAKER: The instructions got more and more specific. Because we have multiple hospitals. The first letter and the fourth letter, the instructions got better and better each letter of what to do.

MS. EVANS: I guess they figure out what they didn't tell you the first time. You know, it's a learning process.

THE SPEAKER: And this is all new.

MR. ASHMORE: Do we have any more questions?

(No response)

7. Please provide an update on Probe & Educate. What were the stats for Round 1? Has Round 2 been completed? When will Round 3 begin? What are the big differences between Round 1 and Round 2?

Response: **This probe was "Provider Specific". That being the case, letters were mailed to individual providers, rather than having overall results posted to the web site. CMS will handle the notification of overall results for Phase 1 and 2.**

January 30 – Deadline for completion of claim review
March 30 – Deadline for completion of provider education
We are currently awaiting further instruction from CMS as to how to proceed with additional review.

Difference between Phase 1 and 2 – There seems to be better understanding of the Rule. There were not as many questions and requests for educational calls during Phase 2. Fewer providers will move on for additional "provider specific" review. CMS will issue instructions as to how the Contractors are to proceed.

Discussion at Meeting

MS. FOWLER: Hello everyone. I provided you the answer there. We are continuing with provider education until the end of March, and at the end of March, that will be the end of Phase 2.

Now, we are currently working with CMS on how to proceed as we speak. We've had a couple of conference calls, information going back and forth as to how we're going to proceed. We should have an answer by the end of the month. At that point in time, you will find out how we will proceed.

THE SPEAKER: Have you sent all the Phase 2 letters out? Because we're missing one. So I'm going to have to search for it, I guess.

MS. FOWLER: Yeah. All the Phase 2 letters are out. We're just completing the provider education as requested. A lot of providers have not requested calls this time. If you request, the conference call is set up. If we don't hear from you, we assume that you understand and have no questions.

THE SPEAKER: Just a comment. If you are missing a letter, I just e-mailed the J10 and they were able to send it to me expeditiously. But from that, we were denied due to non-receipt of medical records. However, we provided the tracking numbers.

MS. FOWLER: Right. And we will attempt to trace those down for you. Yes. I'm aware of that.

MS. EVANS: Did you communicate that back that you had done that, that you had the tracking number and everything?

THE SPEAKER: Yes. And they found them both.

MS. EVANS: Oh, okay.

THE SPEAKER: Thanks.

MS. FOWLER: Yeah. Our unit keeps track of the communication going back and forth in that mailbox. And if you had had that issue - and I know several of you have - we will attempt to take that tracking number and locate those records. And we will reopen those claims.

MR. ASHMORE: Do we have any more questions?
(No response)

8. Medicare has AARP Medicare supplement listed as an active participant in the COBA program and you are listed in the Medicare CWF for all of our patients with this supplement. We have reviewed claims as far back as 2013 and even then they were not crossing over. The administrative cost of such a large number of paper claims is just continuing to go up. We have pulled a list of almost 1000 claims that are just for 2014 and all were paper. The 1st link below is the list of trading partners from the CMS website. This supplement is listed on page 7 with the ID# of 30002. Has there been any change with the local MAC that would have affected these being sent to UHC?

   This is the information that is linked into the patient's files with Medicare. The second link is the COB page for Medicare that discusses the COBA process.

   http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/ProviderServices/Downloads/COBA-Trading-Partners-April-30-2013.pdf

   http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Coordination-of-Benefits/Coordination-of-Benefits.html

   We have reached out to the payer (UHC) but have not received an answer yet.

   Response: **The Coordination of Benefits Agreement (COBA) Program establishes a nationally standard contract between CMS and other health insurance organizations that defines the criteria for transmitting enrollee eligibility data and Medicare adjudicated claim data. In 2006, CMS fully transferred the claims crossover functions from the individual MACs to a national claims crossover contractor, the Coordination of Benefits Contractor (COBC).**

Trading partners (i.e. AARP, UHC) generate an eligibility file to the COBC. For those benes listed on the eligibility file, the COBC will transfer claims to the trading partners.

Under the consolidated claims crossover process, trading partners execute national agreements called Coordination of Benefits Agreements (COBAs) with CMSs COBC. Through the COBA process, each COBA trading partner will send one national eligibility file that includes information for each Medicare bene that it insures to the COBC. COBC will transmit the bene files to the Common Working File (CWF) via a transaction ("Beneficiary Other Insurance (BOI)" file).

Through the COBC Medicare transmits outbound 837 Coordination of Benefits (COB) and Medigap claims to COB trading partners and Medigap plans (trading partners) on a post-adjudication basis.

Usually if a claim does not cross over, it is due to either eligibility or the type claims the trading partner chooses to receive or not receive.

Providers can get with trading partners to work it out or file a hard copy claim with the secondary insurer (i.e. UHC, AARP).

COBA: COBVA@EHMEDICARE.com or 1-800-999-1118 (M-F 9-5 EST)

Discussion at Meeting

MS. EVANS: This was a real learning experience for me, because I had not dealt with any of these crossover claims before. And then to try to find somebody who knew anything about it was a challenge. As late as this morning, I finished the response.

Basically if a claim doesn't crossover, it's either due to the eligibility or the type of claims the trading partner chooses to receive or not receive. And the trading partner is the AARPs, the UnitedHealthcare's, those people that are the secondary insurances. So there's something awry there.

The MACs don't handle that anymore. It goes through the coordination of benefits office. And I have numbers and things like that.

It's the trading partners that determine what kind of claims that they're going to look at. And I had an example from Infirmary, I believe. And when we looked at it, the type of claims that she was asking for, they were not accepting. So you will have to get back with your trading partner to figure out that.

MR. ASHMORE: Any other questions?

(No response)

9. Please go over initial findings for your prepayment review of kyphoplasty.

Response: **The Local Coverage Determination (LCD): Surgery: Vertebral Augmentation Procedures (VAPs) (L30062) has been in effect since 2009. Claims lacking a covered diagnosis per the LCD will be denied and providers should appeal with the clinical information supporting a covered diagnosis. Medical record documentation (e.g., progress notes, procedure notes) must also support the medical necessity of the VAP consistent with the indications as outlined in the LCD.**

Cahaba periodically reviews the effectiveness of LCD edits and bases potential policy updates/ changes on the results of this process. All LCD coverage updates are posted to Cahaba's web site.

Discussion at Meeting

MS. FOWLER: We do have a probe in progress right now. We have not reviewed all the claims. So I can't give you any results of that. But you will receive those results when that probe is completed.

When I answered this question, I answered it as related to the LCD. And then later on, I thought, well, you may be interested in the results of the probe, but that probe is still in progress.

THE SPEAKER: Just a suggestion. When you publish your findings of these reviews on your website, the more detail that can be provided, the better. I look at several different MAC websites, and they're all very different in the amount of detail they give for those denials. But I think it would really be helpful to the providers to have some specific examples or denial reasons. I mean, just to say it denied for lack of medical necessity doesn't tell you much.

MS. FOWLER: We'll give you detail on that. We're going to tell you what we find. We'll give you that detail.

THE SPEAKER: That would be great. Thank you.

THE SPEAKER: I'll make a quick comment about that too. You know, those are outpatient procedures, for the most part. And so the patients are usually not there for very long, which means the physician doesn't have a huge amount of time to document in that record usually.

So what we're finding is we're having to go to the physician's office to get a lot of that documentation to submit with the record request. So you may want to look at that, that you have to get that supporting documentation from the physician's office because it may not be in your outpatient procedural record.

MS. FOWLER: Right. And specific on this probe, we're looking at documentation of conservative treatment prior to the surgical procedure, which would be an indication of if the surgery was medically necessary or not. But those are the specifics we're looking for on this.

MR. ASHMORE: Any questions?

(No response)

10. Since all diagnosis codes have been removed from the LCDs for PT and OT how will Cahaba determine that medical necessity for the services has been met?

Response: **Cahaba monitors utilization of these services through data analysis to determine if further reviews will be necessary.**

Discussion at Meeting

MS. FOWLER: We do data analysis to look at utilization of services, and we compare providers. We do an analysis of providers who are PT, OT, ST providers. And we look at patterns, and that's the way we make decisions as to how we proceed with additional probes. And we also do the KX modifiers and look at services that are provided over that cap. So there are several different ways that we look at data. Even in an absence of a diagnosis code on the LCD, we can still see how the services are being utilized and how the claims are being billed, what diagnoses are coming in on the claims.

MR. ASHMORE: Any questions?

(No response)

11. Please explain the process of billing clinical trials.

Response:

BILLING CLINICAL TRIALS

I. General

- **a. Enter clinical trial and non-clinical trial services on separate line items when billing both types of services on the same claim.**
- **b. Items and services provided free-of-charge by research sponsors generally may not be billed to be paid by Medicare and providers are not required to submit the charge to Medicare.**
- **c. If it is necessary for a provider to show the items and services that are provided free-of-charge in order to receive payment for the covered routine costs (i.e. administration of a non-covered chemotherapeutic agent), providers are instructed to submit such charges as non-covered at the time of entry.**
- **d. For OPPS claims, provider must report a token charge for a "no cost" item in the covered charge field along with applicable HCPCS modifier, i.e. FB, appended to the procedure code that reports the service provided to furnish the "no cost" item, in instances when claims**

processing edits require that certain devices be billed with their associated procedures.

II. Clinical Trial Number

- **a. Effective for claims with DOS on or after 01.01.2014, it is mandatory to report a clinical trial number (8 digits) on claims for items/services provided in clinical trials/studies/registries, or under CED (Coverage of Evidence Development).**
- **b. This is the number assigned by the National Library of Medicine (NLM) Clinical Trials.gov website when there is a new study in the NLM Clinical Trials data base. The number is listed on each study's page, preceded by the letters "NCT".**
- **c. To bill the 8-digit clinical trial number, providers shall code Value Code 'D4' where the value code amount equals the 8-digit clinical trial number).**

III. Medical Record Documentation

- **a. Must include trial name, sponsor, and sponsor-assigned protocol number.**
- **b. This does not need to be submitted with the claim but must be provided if requested for medical review.**

IV. IP Clinical Trial Claims

- **a. V70.7 (examination of participant in clinical trial), in either the primary or secondary position.**
- **b. Condition Code 30 (qualifying clinical trial) – regardless of whether all services are related to the clinical trial or not.**
- **c. As HCPCS codes are not reported on IP claims, modifiers Q0/Q1 are not applicable.**

V. OP Clinical Trial Claims

- **a. V70.7 in primary or secondary position.**
- **b. Condition Code 30.**
- **c. Identify all lines that contain an investigational item/service with HCPCS modifier Q0.**
- **d. Identify all lines that contain routine services with HCPCS modifier Q1.**

VI. Q1 Modifier

- **a. Line specific.**
- **b. Must be used to identify items and services that constitute medically necessary routine patient care or treatment of complications arising from a Medicare beneficiary's participation in a Medicare-covered clinical trial.**
- **c. When billed in conjunction with V70.7, serves as the provider's attestation that the service meets the Medicare coverage criteria.**
- **d. Not appropriate:**
    - **i. For items and services that are provided solely to satisfy data collection and analysis needs that are not used in the clinical management of the patient.**

ii. For items or services that are not covered by Medicare by virtue of a statutory exclusion or lack of a benefit category.

Discussion at Meeting

MS. EVANS: I was a little curious about this and the next one because I wasn't sure exactly what you were needing from this since we didn't have any claim examples. So I just went through the manual and the different sources that we have and just documented the general billing clinical trials.

If you have any specific questions, if there was something that drove this question that I didn't touch, I'd be glad to listen.

MR. ASHMORE: Any questions?

(No response)

12. Please provide information on psych inpatient billing and reimbursement processes for voluntary, involuntary and court ordered admissions.

Response: **The facility must meet the requirements for medical necessity to be covered by Medicare. Medicare does not differentiate between voluntary, involuntary and court ordered admissions as long as it meets medical necessity.**

Here is how the psych benefits work:

- **If the patient is in a psychiatric hospital, type of provider XX4XXX: The beneficiary uses their regular 60 full 30 co 60 lifetime, they also use the 190 psych days available. They must have both Psych days and regular days available.**
- **If they are in a psychiatric facility within a hospital XXSXXX, they only use the regular benefits, 60 full 30 co and 60 lifetime.**

PSYCH INPATIENT BILLING AND REIMBURSEMENT PROCESSES FOR VOLUNTARY, INVOLUNTARY AND COURT ORDERED ADMISSIONS.

Claims Processing Manual 100-04 Chapter 3 190.10

I. General

a. TOB 11X
b. Correctly code diagnosis for principal diagnosis and up to 24 additional diagnosis
c. Correctly code one principal procedure and up to 24 additional procedures performed during stay
d. IPF distinct part must code source of admission code "D" on incoming transfers from the acute care area of the same hospital (to avoid overpayment of the ED adjustment when the acute area has billed or will be billing for covered services for the same IP admission)

e. **Other general requirements for processing Medicare Part A IP claims described in Chapter 25 of the manual apply).**

II. **Billing Period**
   a. **Submit on admit through discharge claim for the stay upon discharge.**
   b. **IPF's may interim bill in 60-day intervals.**
   c. **Final PPS payment based upon date of physical discharge or death, or date benefits exhausted.**
   d. **Can submit adjustment claims but late charge claims will not be allowed, i.e. adjustment claims must include all charges and services and must replace the earlier claim(s) instead of including only the additional charges and services.**
   e. **Patients fall below skilled level of care**
      i. **Submit TOB 112X with occurrence code 22 (date active care ended) and patient status code 30 (still a patient).**
      ii. **As appropriate, continue to submit subsequent interim TOB 117, with patient status code 30 and occ span codes that indentify payment liability (codes 76 or 77).**

III. **Benefits Exhaust**
   a. **Occurs when benefit exhausts and date benefits exhaust will substitute for the 'actual' discharge date.**
   b. **Claim paid based on the benefits exhaust date if present rather than the discharge date.**
   c. **Submit no pay (TOB 110) with patient status code of 30 every 60 days until patient is physically discharged.**
   d. **Last bill shall contain discharge patient status code.**
   e. **Don't need to continually adjust claims once benefits exhaust.**

IV. **ECT**
   a. **Revenue Code 0901.**
   b. **Service units: total # of treatments provided during IPF stay.**
   c. **Procedure code 94.27, procedure date is the date of the last ECT treatment the patient received during their IPF stay.**

V. **Misc**
   a. **OP services treated as IP services – subject to the 1-day payment window for OP bundling rules.**
   b. **Interrupted Stays – occ span code 74; from date = day of discharge from IPF; through date = last day patient was not present in IPF at MN.**
   c. **Grace Days – not applicable; last covered day is the date the bene is notified of provider's intent to bill (occ code 31).**
   d. **Ancillary Services – no special rules for billing IPF inpatient ancillary services.**
   e. **Psychiatric Benefit Application – 190 days applies only to freestanding psych hospitals, not distinct part units.**

Discussion at Meeting

MS. EVANS: Pretty much the same answer as the previous question. I talked to the people in claims, and the facility must meet the requirements for medical necessity to be covered by Medicare. Medicare does not differentiate between voluntary, involuntary, court ordered admissions as long as it meets medical necessity. So once again, the medical necessity needs to be met. Were there any specifics with this one?

THE SPEAKER: I have a question that kind of veers off from this a little bit. If the patient comes into an acute care facility, then it's converting into psych. We have nowhere to place them. And it looks like it will be mandatory that they be placed somewhere.

At that point, are we issuing a HINN at that point to that patient? Because they're no longer medically meeting acute care. They met, say, maybe initially if you had to clear them for something physical. So what would you do with that patient at that point?

MS. EVANS: How do you bill them?

THE SPEAKER: I mean, if they were there for an inpatient reason.

MS. EVANS: But you would bill them under the acute care number, not the psych number?

THE SPEAKER: Yeah, the acute care.

MS. EVANS: Let me write that down.

MS. FOWLER: Are you asking whether the patient should be issued a notice of noncoverage if he is waiting on placement in a psych facility and there is no bed available? Or is that your question?

THE SPEAKER: That would be the case. Or we may be waiting on guardian appointment for somebody to assign that patient over to get them into a psych facility. I mean, you have those issues. You're waiting on DHR to get involved. But the acute care reason is over.

MS. FOWLER: But you're holding them in the acute bed until you can get that resolved? I mean, based on what I know in my past experience working with that kind of situation, a notice of noncoverage would not do you much good anyway.

The only advice that I can give you is to make sure that documentation is crystal clear as to why that patient remains in that bed. And I think that from the medical review standpoint, we're going to look at all those things going on and take all that. If we pulled that for review, say maybe for DRG 885 or whatever, we would look at all those situations. Because those are things unique to psychiatric patients, and that is a whole different ball game.

THE SPEAKER: Because the concern was would all those days become provider liable days? We're not going to receive payment from that beneficiary or whoever is their guardian.

MS. FOWLER: Well, is the patient admitted for a medical issue initially, that turns out to be psychiatric issue?

THE SPEAKER: Yes.

MS. FOWLER: Well, if medical necessity is there for the admission, you would be paid that DRG category. You might have a couple of days lagging on the end, but you would still get the DRG, if that makes any sense.

THE SPEAKER: I think the question is more about protecting the beneficiaries' days and being accurate in what's provider liable.

MR. ASHMORE: Do we have any other questions?

(No response)

Additional Discussion at Meeting

MS. EVANS: If we don't have any further questions, I need to remind everybody that any kind of inquiry needs to come through Peggy at AlaHA. I have a lot of inquiries and I get a lot of e-mails. And unfortunately, some of you are probably the recipients of this, I have missed some because you're just sending me an e-mail.

The way we do it is if you send it to Peggy, she sends it to a particular mailbox. And that's a tracking mechanism. So that's how I track things, and I get notifications that they're there. And I have this process where I keep up with them all. And I will tell you that I've lost some. So I apologize up front, but I really need the inquiries to come through Peggy so that we can keep track of them.

And I don't mind people giving my name out. You all know that. But when I get an e-mail with a few questions asking me to call, I really cannot do that. If you have specific questions, perfect. But they really need to come through Peggy so that I don't lose them. Because I have a lot of inquiries between three states, and I'm the only one that does it, which is fine, I'm glad to do it. But I don't want to miss your things because I know you need your money, and I want you to have your money. We want you to have your money.

MS. CARSTENS: And everybody does have my e-mail; right? Because I'm the one that sends out the notices for the meeting. Okay.

THE SPEAKER: Do you have any information on when the new RAC contracts will be finalized? Nothing?

MS. FOWLER: I wish I did. I would like to know that myself.

MS. EVANS: If you hear, let us know.

MS. FOWLER: In closing, we have one more announcement. Most of you know that Dr. McKinney is no longer with Cahaba. Dr. Thomas Mitchell is the new medical director. His background is internal and emergency medicine. He was actively in practice before coming to Cahaba. And he has been transitioning into the role from his former job. I believe now he is full time with us and is getting his feet wet. And he's really good, and I think you'll be pleased. We are.

MR. ASHMORE: Any other questions?

(No response)

MR. ASHMORE: All right. Thank you, Suzanne and Joy, for coming today.