PALMETTO MINUTES
March 19, 2018 RIC/RAC Meeting

PALMETTO REPRESENTATIVES PRESENT:
Ms. Marlene Frierson
Ms. April Gause
Ms. Christie Dunagan
Ms. Paula Motes

FACILITATORS PRESENT:
Ms. Karen Northcutt
Ms. Becky Miller

MS. MILLER: We have our new Palmetto GBA with us. So we're excited that you could come. Marlene Frierson and April Gause. And they're going to show us a presentation first. Hopefully that will kind of explain some of our new transactions and issues and policies and procedures. And then we can present questions to them that you will see in your packet. They will provide us answers after the presentation for those questions, and then we'll open up for some quick Q&A from them if time permits.

MS. FRIERSON: Good morning everybody. I'm Marlene Frierson with Palmetto GBA, provider outreach and education. And we are going to just go through some updates you and hopefully you will get some answers to some of the questions you may have since we are your new Medicare Administrative Contractor. It shouldn't take long to go through these slides.

SLIDE PRESENTATION:

(pg. 2) MS. FRIERSON: First thing, disclaimer. Just so that you'll know, any information in the presentation was current as of March 2nd, 2018. So any changes that you may want to see or that came about after the presentation you can find on our website at www.palmettogba.com. Instead of PalmettoGBA.com/JMA, use PalmettoGBA.com/JJA for Jurisdiction J. It's going to be JJA for you guys to get direct to your jurisdiction. So that's a shortcut for you.

(pg. 3) All right. We're going to give you just a quick test. This is Paul Metto. And you'll get it after a little while. A lot of people used to say you're with Paulmetto. So we developed a character, and Paul is our representative here. So Paul is going to give you a quick little pretest. If you can go to this website for me. It's at surveymonkey.com/r/bywqmarymaryguide. It's just a few little questions. It's not bad, I promise. This way, instead of doing evaluations, we do pre and post-tests whenever we give any updates. And Paul Metto is going to be very nice to you, I promise. I should have brought some Jeopardy music.

All right. Is everyone about ready?

AUDIENCE: Got four out of five.

MS. FRIERSON: You got four out of five. Well, hopefully you'll know five out of five by the time I'm done.

AUDIENCE: We were debating about the fifth one.

(pg. 5) I'm going to go ahead with the updates. The first one I'm going to do for you is audit and reimbursement. I'm going to give you some updates and also some contact information. For Jurisdiction J, we operate with two distinct audit shops. We have the one for JJ which would be you guys and, of course, the contract we held previously JM, Jurisdiction M, which is South Carolina, North Carolina, Virginia and West Virginia. Basically we're using our internal quality control measures to make sure that we receive and provide this information for you. We have standardized policies and procedures between both. But they're going to have two distinct audit shops when it comes to the different contracts.

(pg. 6) For your audit and reimbursement organization contacts, we have a new director, Vincent Bresovic. He is the auditor reimbursement (A/R) director. Scott Neely, which some people may already be familiar with, he is the manager for IQC and training. Cecile Huggins is your supervisor over appeals. And Deborah Scott is your supervisor for reopenings. And in order to reach them by email, basically you would take a name like Scott Neely and it would be scott.neely@palmettogba.com. These folks will be your contacts for your audits and reimbursement. And you don't have the slides now, but these slides will be provided for you so you can get to the URL's and the different contact information.

(pgs. 7-8) For your audit information request, to accomplish the goal of establishing accurate interim rates, cost and visit information, we requested, of course, from providers. Processing time varies depending on the fiscal year end. Cycle processing is usually accomplished within forty-five days of receipt of provider's information. Regardless of whether reviews indicate a lump sum payment due to provider or to the Medicare program, each review is stamped with a receipt date and processed in the order in which it is received. With the large volume of information that Palmetto GBA receives, it is very important that agencies provide their provider number on every piece of correspondence that is sent in to Palmetto GBA. So we just wanted to remind you, if you will, please indicate your provider numbers on any correspondence that you send to us. And for audit and reimbursement, we just want to remind the provider community that the notice of program reimbursement, your NPR letters, and a copy of the finalized cost report are sent via email unless there is an overpayment. In the case of an overpayment, NPR letter, the overpayment letter and a copy of the finalized cost report is sent through certified mail.

(pg. 9-10) As you already know, Medicare requires all certified institutional providers to submit an annual cost report to the Medicare Administrative Contractor. If a provider does not submit their cost report timely, Medicare payments are suspended and a penalty is assessed. Payment suspension will be released only after the cost report has been accepted. So we want to just remind you the best practice here is to send in that cost report early. You have thirty days. But if you go ahead and submit it early, you can utilize it in thirty days. In case there's a problem while they're trying to accept the cost report, you still have time to submit any necessary corrections. And please note that any updates, tips for filing Medicare cost reports are available on our website. These updates and tips encourage filing early, submitting files in electronic format and minimizing the amount of paper that is submitted. If they're not using eServices, then you will be mailing that cost report to us at Palmetto GBA, Attention: Cost report acceptance. That mail code is going to be AG-390, P.O. Box 100307, Columbia, South Carolina 29202-3307. If you're using a courier service, you will need to mail that to our Camden office. The mail code will still be AG-390, 2300 Springdale Drive, Building 1, Camden, South Carolina 29020-1728. If you're doing checks only, please submit that to Palmetto GBA, JJA Checks, P.O. Box 100312, Columbia, South Carolina 29202-3312.

(pgs. 11-14) For any cost report or reopenings and appeals, it is the same address which I gave out, the P.O. Box 100307. Now, for cost report appeals, you can send emails, and that address is up there for you. Prrb@fssappeals.com. For credit balance reporting, now, that's a different address. And that one can be sent either courier or certified mail or regular mail to the attention of credit balance reporting. The mail code is going to be AG-340, P.O. Box 100308, Columbia, South Carolina 29202-3308. And for any overpayments, if you're sending checks, they ask that you send that to the attention of Medicare Finance, P.O. Box 100312, Columbia, South Carolina, 29202-3312. And you can also fax your reports to 803-870-0147. Any provider inquiries can be directed to our Provider Contact Center at 877-567-7271. And you can always call them and ask for any of this information as far as addresses. And these addresses are also out on our website under contact us. I know it's a lot. If you go to the website, it will also show you where to submit and what you need to submit for certain rebuttals. If you're submitting an appeal or an electronic payment, you can find that on our website as well.

(pgs. 15-17) Now, you're going to hear us talk quite a bit about eServices. That is our secure portal. That's the easiest way for you to find your information and submit information. In order to register for eServices, you just go to our eServices portal. You will receive a lot of this information through eServices. And, again, it's an easy delivery system for you. In managing your information with eServices, you can check eligibility, claim status, submit your cost reports, respond to your additional documentation requests (ADRs), and submit first level redeterminations through our eServices portal.

(pg. 18-19) If you're not registered, you can sign up at www.palmettogba.com/eservices. To participate in eServices you just have to have an Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA. If you already submit claims electronically, you do not have to submit a new EDI enrollment agreement. And we just wanted to make note that only one provider administrator per provider transaction access number (PTAN) or NPI combination performs the registration process. But please register. In order to register, you just need your PTAN, NPI, tax ID number and the amount of your last Medicare payment received. The provider administrator grants permission to additional users related to their PTAN/NPI combination. Billing services and clearinghouses should contact their provider clients to gain access to the system. Just keep in mind that backup administrators will have access to all information functions by default. Any time you suspect misuse or need to change someone's role, please contact Palmetto GBA immediately.

(pg. 20) Now, one of the key reasons you want to sign up for eServices is for the Medicare beneficiary identifier (MBI) lookup tool. We're going to talk about the MBI, the new Medicare number program in a bit. So in order for you to access eligibility information electronically, you must be signed up with eServices. It's going to provide a mechanism to access the MBI without disrupting any work flow.

(pg. 21-24) Now, the MBI is the new Medicare card program, and it's going to be the Medicare beneficiary identifier. It's going to replace the SSN based health insurance claim number, the HICN as we know it, on the new Medicare cards for Medicare transactions, for billing, eligibility status and claim status. The primary goal is to decrease Medicare beneficiary vulnerability to identity theft by removing the SSN based health insurance claim number from the Medicare ID cards and replacing the HICN with a new Medicare beneficiary identifier. And this is all legislated by MACRA, and it mandates that the SSN be removed from the Medicare cards by April 2019. Beginning April 2018, new MBI cards will start to be issued in phases by geographic location. CMS is going to use an MBI generator and use initial enumeration and generate a unique MBI for Medicare beneficiaries. New unique MBI's will be generated for Medicare beneficiaries whose identity has also been compromised. And it's going to

change the format of the number as you know it now with the HICN. The new number is going to be non-intelligent. The key positions of two, five, eight and nine will always be alphabetic.

(pgs. 25-39) CMS is going to use that initial MBI enumeration, it's going to be sixty million active and ninety million deceased and archived beneficiaries are going to receive MBI's. So I still haven't quite figured out that rationale but other than timely filing. But yes, you heard me correctly. They're issuing to archived and deceased beneficiaries as well. They're going to start mailing these cards in April 2018. In the mailing they're going to get a new card and a letter explaining to them to start using the cards immediately and to destroy the old cards. Distribution will be randomized by geographic location, and all existing cards should be replaced by April 2019, the statutory deadline. By January 1st, 2020, only the new card will be usable. Railroad Retirement Board will issue new cards to RRB beneficiaries as well. Now, from April 2018 through December 31, 2019 is their transition period. And they're going to allow the beneficiaries and the providers to use either the HICN or the MBI. But we encourage you now to go ahead and prepare for the MBI format and make those changes in your system. And you can find that on the new Medicare card web page. It will give you the specifications for the new cards or new ID's. CMS is planning to actively monitor the transition and adjustment to the new MBI's to ensure adoption so Medicare operations aren't interrupted and everyone is ready to use only the MBI's by January 2020. But, again, during the transition period, you can use either the MBI or the HICN. Beginning October 2018 to the end of transition period when a valid and active HICN is submitted on Medicare fee for service claims, they're going to return both the HICN and MBI on the remittance advice. You can find the MBI where the changed HICN currently is located. For Medicaid and supplemental insurers, CMS is going to give the Medicaid state agencies and supplemental insurers MBI's for Medicaid eligible people. So they're going to receive new Medicare cards as well. During the transition period, CMS will process and transmit Medicare crossover claims with either the HICN or the MBI. So, again, during the transition period, you can use either the HICN or the MBI again.

Now, for Railroad Retirement Board (RRB) beneficiaries we encourage everyone to identify who these beneficiaries are because you will no longer be able to look at the HICN and tell that it is an RRB beneficiary or what type of benefits they have because the numbers are going to be unique to the beneficiary. So you may want to program your system so you can identify RRB beneficiaries so that you can submit those claims to the correct specialty Medicare contractor.

Private payers for non-Medicare business. Private payers will not have to use MBI. CMS will continue to use supplemental insurer's unique numbers to identify those customers. After the transition period, supplemental insurers must use the MBI for any Medicare transactions where they would have used the HICN. And, again, we just encourage you to sign up for eServices now because in a case where a patient will not have their Medicare card in the provider's office, you will be able to use a lookup tool. But it will only be housed in the secure portal which is going to be eServices for Palmetto GBA. There are a few exceptions after the transition period where you will continue to use the HICN, that will be for appeals and adjustments. So HICN can be used indefinitely for certain systems like the drug data processing system, the risk assessment processing system, encounter data system for all records not limited to just adjustments. Any incoming information such as MSP information, any inquiries, medical documentation requests, you can continue to use the HICN there.

Incoming premium payments. If a beneficiary still doesn't have their MBI and you don't have access to it, there's a transition period. You can still use the HICN. If the claim - let's assume it starts October 2018 and it spans past the January deadline of 2020 - you can still use the HICN. Any outgoing

reports and then there are other reports that's incoming, you will be able to use the HICN there as well. So those are a few exceptions.

What we encourage you to do is to go ahead and get ready now for the MBI making sure that your billing vendors are making changes. What are they doing to prepare? And, again, you can find the MBI format specifications on the website. The best thing to do is get the beneficiaries to verify their addresses because the cards are going to be mailed to the address that's on the record. If they need to change that address, they need to do it now because those cards will start being mailed April 1 of this year. You can sign up for weekly MLN newsletters for up-to-date information. And there is a dedicated page on CMS.gov where they have different products, different resources for you to use. You can even order if you'd like posters to hang up in your offices letting them know that new cards are coming. There are also different job aids, and they even have some in different languages. So they're really trying to spread the word. I don't know if you've seen the commercials, but they are trying to prepare beneficiaries that new cards are coming. The main milestone they need to be concerned with now is that they are starting to mail those cards beginning next month, April 1st, 2018. And you must be prepared to no longer accept the HICN by January 2020.

(pg. 40-49) From Palmetto GBA's perspective, we just want to discuss with you some of our interactive tools. We encourage you to bookmark certain websites. The shortcut is www.palmettogba.com/jja. That will take you directly to A. The same with JJB for Part B. You can always go just to palmettogba.com and select whichever line of business you'd like to get the shortcut. Now, in order to stay current with Medicare and Palmetto GBA updates, you should be registered and make sure your user profile is up to date. If you're not registered, just simply click register now. Complete the fields and click the register button at the bottom of the page. Be sure to follow the instructions when you receive the confirmation email to finalize your registration. By using eServices and some of our web services you can also find out your enrollment application status because we have a lookup tool. So CMS makes notifications to Palmetto GBA of all new certified provider approvals which is called the tie-in notice. Upon receipt of the tie-in notice, Palmetto GBA will update all necessary systems with your information. The processing time at the set of tie-in notice is approximately twenty-one days. The provider enrollment application status lookup tool as beneficiary will show you where you are in the process any time you make any changes or submit new applications to us. We also have an ADR response calculator. If you've received an ADR, you have exactly forty-five days from the date of the letter to submit supporting documentation. If we do not receive that information by four to six days, your claim will be denied for lack of response. The ADR calculator will help you determine the days to return the requested documentation. We also have a charge denial rate (CDR) calculator. Remittance advices will reflect the decision made on any reviewed claims for denial rate and restricts the percentage of claims that payer is denied within a certain period of time. This often overlooked percentage offers a tangible numeric insight into the overall effectiveness of revenue cycle management. Use the calculator to determine your charge denial rate. Interpreting denial rates can be compared to golf scores. The lower the score, the better. Low denial rates means profitable streams of cash flow.

We also have an appeals decision tool out there. This tool allows you to click on a series of questions to determine if your claim can be appealed or not. We have the appeals calculator that allows you to select a level of appeal, enter the date of the initial determination notice, remittance advice and it will provide the date of the request, the date that we must receive in order for you to still have your appeal rights. There's a neat little appeals and clerical error reopening module that provides guidance

concerning a redetermination request, correcting incomplete or invalid submissions, correcting claims with medically denied lines and any clerical error reopenings. So we have a tool to kind of give you some hints.

Now, this tool may be your best friend, the claims payment issues log. This is a list of the current system related claims payment and processing issues. These issues have been reported to CMS and/or FISS, the Fiscal Intermediary Standard System. Please check often for updates before contacting the PCC. The PCC can direct you there as well. The issues are identified by stand-alone articles and will be updated as needed. So it will tell you if there's an error that's discovered or an issue, it will tell you if any action is required by you or what will needs to be done in order to get those claims sent back through the system.

(pgs. 50-62) Everyone's favorite topic. The comprehensive error rate testing. So for CERT, some things to think about when improving a CERT error rate include coming up with a process to track the various denials you are receiving or to any trends or areas in which your staff may need additional education. Are there errors that are often repeated, are signature dates an issue for you? If so, you may want to consider adding a signature at the station log when you submit your medical records or if it can even be in the process in which the CERT additional documentation requests are being handled within your facility and therefore not submitting all required and necessary documentation to the CERT contractor. Sometimes analyzing the various denials will help you see areas of weakness which can be improved upon. As a reminder, if you did forget to submit any documentation to the CERT contract, go ahead and submit it. If you end up receiving a medical necessity denial but you do not agree, we ask you consider submitting a CERT redetermination request form.

CERT tips are provided weekly on our website, and the tips are based on actual data analysis and frequent provider inquiries. The comprehensive error rate testing initiative and error rate reduction is in the forefront of Palmetto GBA's educational efforts. The table before you is our national numbers from 2017. For the overall fiscal year of 2017, the Medicare FISS program improper payment rate was 9.51% representing about 36.21 billion in improper payments compared to the fiscal year 2016 improper payment rate of 11% with 41.08 billion in improper payments. So, see, it did go down. The national improper payment amount for Part A is 18.24 billion dollars and 11.31 percent. The reporting period for this improper payment rate is for July 1, 2015 through June 30, 2016. We continue to strive for even further improvement through educational efforts. We ask that you continue as well. Makes us all look good.

All right. So the CERT contractor, they're going to check to see that providers are billing correctly and contractors are paying correctly. They select and review claims, assign categories, calculate an error rate and provide education to change behaviors. They are responsible to identify improper payments, submit claims adjustments when errors are identified. If no error is identified, no action is taken. Please respond to any audit specific questions you may have such as the rationale for identifying potential improper payments.

As far as the MAC, our responsibility is to perform any claim adjustments based on the CERT review if an improper payment is identified, issue demand letters for overpayments generated for improper payments. Just a reminder, demand letters will be sent to your physical address. Handle administrative concerns such as time frames for payment and recovery and redeterminations. Now, we have information on the website. Once you get to your proper line of business, if you will just go under topics and select CERT, it will bring up specific information for you. Now, with A/B MAC CERT Task Force, it is a joint effort with the Medicare Administrative Contractors and the CERT contractor. We

communicate national issues of concern regarding improper payments to the Medicare program. We work together to educate Medicare providers on numerous topics affecting most providers. We share the goal of reducing a national improper payment rate as measured by the Comprehensive Error Rate Testing Program. Education is intended to complement ongoing CMS, the Medicare Learning Network and the MAC's individual error reduction activities within its jurisdiction. Palmetto GBA has designated task force members on the task force and shares the certain task force education material as it becomes available.

The goals of the CERT A/B MAC Outreach and Education Task Force is to ensure consistent communication and education to reduce the Medicare Part A and Part B error rates. And you can find this information at the MLN network and also the MLN provider compliance webpage. CMS has a webpage dedicated to education developed by the task force, and they work closely ordering and referring insufficient documentation issues. Note in viewing this material requires you to have or create an account on a CMS Medicare Learning Network. So if you haven't registered, please do so.

The primary goal of the Provider Outreach and Education Program (POEP) is to reduce the comprehensive error rate by giving Medicare providers the timely and accurate information it needs to understand the Medicare program, be informed about changes and correctly bill. POEP is driven by educating providers and their staffs about the fundamentals of the Medicare program, national and local policies and procedures, new medical initiatives, significant changes to the Medicare program, issues identified through analysis or such mechanism as provided inquiries, claim submission errors, medical review data, CERT data and the recovery auditor data. Our Provider Outreach and Education Program assists providers to understand the fundamentals, significant changes in new initiatives under the Medicare program. This includes national and local policies, procedures and issues identified through data analysis. Our goal is reduce and correct billing and payments and at the same time ensure that the patients are receiving the correct level of care they need. Now, we offer education supervisors through a variety of methods including teleconferences, online webcasts, web based training, videos and face-to-face education.

Now I can give my voice a little rest here. We're going to let Ms. April Gause talk to you for a little while about the new program of the Targeted Probe and Educate (TPE) and that process.

(pgs. 63-65) MS. GAUSE: Good morning. Some of you may have participated in our TPE/ACT teleconferences and are somewhat familiar with this new process we are implementing under CMS direction. CMS took into account previous success with the PCR Home Health and Hospice demonstration. And what we saw as that program progressed was an increased acceptance because the one-on-one education provided by the clinical team led to a decrease in denials. The denial rate went from 40 percent to 80 percent in turn leading to a decrease in appeals. On CMS' website, you can find change requests and articles for this regulation by following these links. On Palmetto GBA's website we have tons of articles, transcripts and question and answers from previous teleconferences about TPE and other information out there. So please venture out. Look on our website. You can gain some insight on this program.

(pgs. 66-69) Unlike previous reviews, this review focuses on specific providers and suppliers and not all. Previous edits looked at all and you were compared with your neighbors down the street and staying on edit due to what they were doing. With this process, we're looking at twenty to forty claims with progression depending on your compliance. Compliance can be met in any round with the charge denial rate less than 20 percent or a claim denial rate with zero to one being minor; two to five is

considered major. In other MAC's, their charge denial rate is at 15 percent. Once you're off, you're good for a year depending on the data analysis and if we see any spikes and patterns.

Your point of contact. This person is very important, and it needs to be someone who can affect change and assemble your team together. This is crucial because we place calls during these reviews. And they're called the inter-probe calls. This is your chance to submit anything that may be missing before your final review. So if you're missing an order or history and physical or a date, you can provide or submit that information within three days of the call, in turn preventing a denial and decreasing your error rate. So please make sure your point of contact has the medical records for the ADR's that were requested. Begin 2018 with your own TPE. Make sure your encounters include a relevant history, assessment, impressions, plan of care, past and present diagnosis to treat and consult an M.D., your patients response to the treatments. Make sure your treatment plans are consistent, and maintain accurate records. Document during or soon after the encounters.

(pgs. 70-71) These are current edits that we have in place. You can also look at your NCD's and your LCD's and, again, go to Palmetto GBA website for articles or education for any of these services to make sure you're within the guidelines. Being proactive is always better than reactive.

(pg. 72) Wondering how do I stay off edits? These are the data analytics that we use to determine who goes on edit. Are you registered for eServices? If not, please do so. And we have a migration tool up there for Cahaba InSite users because you'll find these tabs up under there, tools for self-audit, eCompare, eReview, eCBR, eUtilization and eAudit. And they're very important and helpful in enabling you to stay off edit.

(pgs. 73-76) For you eCompare Smart Edit, this is informational only. You receive a smart edit when a review flag sets on a claim for provider identified as an outlying. Your claim will continue to process. Please perform a self-audit to make sure you're following the guidelines for billing that particular code. And this is what that page looks like. And you see a link up there for eCBR if we have one for that code that you're billing for and all your line status information, your eServices review. This is also there to assist you with self-auditing and increase awareness of how your data is being used. In addition to our CBR education provided by mail, we have eCBR's. Currently on our website in the eServices portal you'll find an eCBR on the EMM code 99201 through 205, 99211 through 215, and 99221 through 223, chiro services, drugs of abuse and non-cancer length of stays for hospice providers.

(pg. 77-83) Under your eUtilization tab, there are two functions. And all it requires is your NPI for drill down for service specific services provided and the number rendered. And up under the rendering tab, same thing. Enter your NPI and you'll get a drill down for all your PTAN's and their utilization for that NPI. And, again, these are all resources available to help you be proactive in monitoring yourself. And this is what those screens look like. That's where you're ordering, referring. And that's where you're rendering. In one area you're able to see all your CERT information, your MAC med review information and your MAC appeals. And all of this is up under your eAudit tab. Here you can find out what your CID numbers are. You know, from CERT you usually don't hear much from them, and that's a good thing because that means everything went fine. But here you can come up there and check exactly how your review went and if there were any amounts paid incorrectly. You can also check your appeal status. And all of this will be found up under this tab, eAudit. And that's what the screen looks like. You see where we have the MAC medical review status. Click down at the bottom. And if you go there also it will pull up all of your CERT and your MAC medical review and appeals. Up here you can find your granular error per line.

(pg. 84) TPE resources. Remember, respond quickly to any requests that you get. Don't ignore or misplace them. Be proactive. Develop and utilize a check list or audit tracking tool to ensure compliance when responding to your ADR's. Make sure your address is correct.

(pgs. 85-89) Documentation tips. Some of this stuff may seem, you know, a little common sense, but often during our med review process we find a lot of this information missing, which in turn can lead to a denial. So make sure your providers are putting the correct beneficiaries, your correct dates of service, valid orders for your medication and dosage/frequency/route, your date of the orders and legible signatures. And we will make a signature log. We need to be able to see why your patient needs the services that you're supplying, everything for the reviewer to see a complete picture because we're not there with the patient. So these records have to be complete for us to make a determination. More is always better than less. If you aren't following recommended steps with prescribing, please let us know why. If your patient has any contraindications to any recommended therapy, provide that within your documentation and that can prevent a denial, too. Off table use in anti-cancer chemotherapy regimen. Same thing. Make sure your documentation is all there and CMS has a change request 6191. You can also go into the IOM and it will provide a lot of useful information about your cancer regimens.

(pg. 90) And there's Paul. We encourage you to be familiar with our website. There's tons of information up there. Find out about upcoming educational events. We have YouTube videos up under Palmetto GBA education. And there you can find a lot of useful information. We're also on Twitter and Facebook. So you can follow Paul and find out where we're going to be next. And we really encourage you to use those websites, too.

MS. FRIERSON: All right. Well, thank you everyone. Anytime you want to submit education requests, you can do so. If you need to speak with a speaker or clinical consultant like April, you just go to our website and select the education request form. Submit that to us, and we will comply. I hope this information has been beneficial to you. And if you will do the post survey for us, we would appreciate that. So I think someone said they had four out of five earlier. I hope you get five out of five. Just take a couple minutes for that and then we'll go through the questions and answers that were submitted to us and then see if we can receive any questions from the floor.

While you guys are finishing that up, I'm going to introduce two new team members for Palmetto GBA, but I don't think they're new to you guys. I have Ms. Christie Dunagan that has joined our provider outreach team and Ms. Paula Motes. Paula is clinical as well as April, and Christie is a senior provider representative like myself. So we're glad to be here in attendance with you.

Okay. Did you get five out of five this time?

AUDIENCE: I'm not done yet.

MS. FRIERSON: Oh, not done yet. Okay. You guys have to get five out of five.

AUDIENCE: There's more questions this time. I got the five right, but now there's more questions.

MS. FRIERSON: Oh. All right, then.

MS. MILLER: Okay. Now we'll go through the presubmitted questions, I can read them and then let you respond.

MS. FRIERSON: That's fine.

1. Hospital claims are rejecting for overlap with hospice election period. The hospice election period is prior to our DOS (sometimes years). The hospice agency (if still in business) is not cooperating with updating their claim with Medicare for the hospital claim to process. We've received two different answers from Cahaba provider call center: 1) bill claim with 07 condition code to get claim processed; and 2) email cahabafirequest@cahabagba.com with the details of the issue. We've submitted emails to Cahaba with no resolution on the rejections. Please provide guidance on the process that hospitals can use to get claims processed with Palmetto in this situation.

Response and Discussion at meeting

MS. FRIERSON: Yes. In this situation, you would receive the claim denial code C7010 unless the hospital billed the claim using a condition code 07. Also, the hospital primary diagnosis cannot be the same as the hospice primary diagnosis. You can find additional information on this on our website at Palmettogba.com/jmhhh/learningeducation under claim submission error help. You will just select the denial reason code. In this case, it would be the C7010. If the same diagnosis is being used by both providers and the hospice billed their claim first, then the hospital claim will not get paid initially. Normally on an overlap, whoever bills first usually is the only one paid for the claim. The only option left for the hospital would be to use the billing dispute form provided, which is under palmettogba.com/jmhhh/forms. And if you go under the forms, you will find a Provider Contact Center billing dispute resolution request form. Now, what we've found is that in digging into this a little deeper, what happens is for hospice, any claims that are submitted, if there's any election periods out there, if it finds that a notice of election is on file and does not have a revocation date, that hospice election form is going to take precedence. Okay. So you would use a condition code 07 if it's not a related diagnosis. And there is a check list out there, okay, for you. But you're going to have to provide a lot of documentation to kind of prove that the condition is not related. But we pretty much ask that you work together. The hospice should be working with you.

AUDIENCE: I think that's kind of part of the issue right there.

MS. FRIERSON: Well, let me say we're looking to start a -- I don't want to say coalition. But we're trying to start a work group where we can get the hospital associations and the hospice associations to work together since we do have the home health and hospice contract as well. And that way maybe we can eliminate some of these problems. Okay.

AUDIENCE: We've had this issue, and the problem we had is the hospice was no longer in business. They had closed. They never closed out that notification election. So our claim overlapped. We couldn't call the hospice provider to find out what their treating diagnosis was. All we know is we submit the claim to Medicare and it got kicked out. So if there's no hospice to call, there's no one to work with and there's no additional information, what do we do in those situations?

MS. FRIERSON: In that case, you would need to go and complete that billing dispute form so that you can provide those details. And then they'll work with you from there. They'll probably ask you for some additional documentation. But in that case, there isn't a hospice to work with. So we'll just have to start with that billing dispute form.

AUDIENCE: Okay.

2. Under the new Palmetto LCD # L34427 and L34428, will we be able to bill for CPT 29580 (unna boot) when performed in our Wound Care Center for patients with cellulitis and lower extremity ulcers? Can we also report CPT 29580 along with debridement services if done during the same encounter? Under Cahaba's LCD L34290 we were instructed to bill unna boot as a supply item, not a procedure.

Response and Discussion at meeting

MS. FRIERSON: Okay. For this one, our local coverage determination for policy L34427, occupational therapy, does not cover CPT 29580. The LCD L34428 outpatient physical therapy does. So the CPT 29580, it should not be reported with debridement service and that application of the Unna boot will be considered a placement of the bandage for the debridement service. The supplies for the placement of the Unna boot can be billed as a supply item.

MS. NORTHCUTT: So nothing has changed. So don't get excited.

3. Please provide guidance on how to bill claims for Medicare Advantage (MA) enrollees when services are involved in a data registry.

   A) An example would be implantable cardioverter-defibrillator procedures with rejection code U5233. Do we need the clinical trial information if we are only entering the patient into a data registry? Where would we get this information? Should we append the Q0 modifier to the procedure, add dx code Z00.6, and split bill the services as described in CMS Claims Processing Manual Chapter 32, Section 69.9? Would labs, drugs, supplies, etc. used for the procedure be billed to Medicare or the MA?

   B) Is it appropriate to bill traditional Medicare for claims where the services are reported to a data registry (indicated by modifier Q0), eg. Implanting cardiac defibrillators for **primary prevention** (NCD 20.4)? There were prior CMS transmittals directing providers to bill traditional Medicare for these services then a revised transmittal to bill the MA when the services are for secondary prevention. But there is no guidance to bill the MA when the services are for primary prevention of cardiac arrest.

Response and Discussion at meeting

MS. FRIERSON: Okay. I'm going to have to break this down into sections. Okay. So IOM Claims Processing Manual 100-04, Chapter 32, Section 69.9 provides guidance on billing and processing fee for service claims for covered clinical trial services furnished to managed care enrollees. The clinical trial

coding requirements for managed care enrollee claims are the same as those for regular Medicare fee for service claims. However, for beneficiaries enrolled in a managed care plan, institutional providers must not bill outpatient clinical trial services and non-clinical trial services on the same claim. If covered outpatient services unrelated to the clinical trial are rendered during the same day stay, the provider must split bill so that only the clinical trial services are contained on a single claim and billed as fee for service. This allows a Medicare claims processing system to not apply deductible when the patient is found to be in a managed care plan. Any outpatient services unrelated to the clinical trial should be billed to the managed care plan. So IOM 100-04, Chapter 32, Section 69.6 gives you the requirements for billing routine costs of clinical trials, providing guidance on diagnosis codes, modifiers, et cetera. Part A, for the example that was provided, if clinical trial information is required, this is a number assigned by the National Library of Medicine clinicaltrials.gov website. This number is listed on each specific study's page. IOM 100-04, Chapter 32, Section 69.2 states, Effective for claims with date of service on or after January 1, 2014, it is mandatory to report a clinical trial number on claims for items/ services provided in clinical trials/studies/registries or under CED. For all lines that contain an investigational item or service with the HCPCS modifier of Q0, for all lines that contain a routine service, the HCPCS modifier of Q1, ICD-10 diagnosis code Z00.6 in either the primary or secondary position and the condition code 30 regardless of whether all services are related to the clinical trial or not.

Now, you can find this information IOM 100-04, Chapter 32, Section 69.6 which provides information on which HCPCS modifiers, et cetera, needs to be used on those claims. Clinical trials covered under the Clinical Trial National Coverage Determination 310.1 -- and you can find that in your NCD manual. It states that original Medicare covers the routine costs of qualifying clinical trials for all Medicare enrollees including those enrolled in Medicare Advantage plans as well as reasonable and necessary items and services used to diagnose and treat complications arising from participating in qualifying clinical trials. All other original Medicare rules will apply.

And for Part B of this question, Decision Memo for Implantable Defibrillators (CAG-00157R3). It states that CMS will reimburse for primary prevention and the qualifying requirements for Category B IDE devices and clinical trials. Guidance for providers submitting claims for B IDE devices must follow the instructions in 100-04, Chapter 32, Section 68.4 and also 69.6 which we've already referenced. This section provides appropriate modifiers, revenue codes and other required information such as Category B IDE numbers, et cetera, as necessary to bill for the Category B IDE devices and routine costs eligible for payment under Medicare. That CMS coverage Decision Memo for primary prevention requires data be entered in the National Cardiovascular Data Registry, ICD registry.

And you can also reference the IOM 100-04, Chapter 32, Section 270.2. It requires that patients receiving a defibrillator for primary prevention be enrolled in a qualifying data collection system and the provider to use modifier Q0 to identify those patients whose data is being submitted. The instructions provided are written from the perspective for primary prevention and further explains that Q0 modifier may be appended to claims for secondary prevention.

AUDIENCE: Yeah. Okay. Currently we're appending the Q0 because it's required. But we don't do clinical trials. So why would we need to put a clinical trial number on there? You read a lot of information, but I'm not sure it really answered the person's question.

MS. FRIERSON: Okay. Which part?

AUDIENCE: The part that said the clinical trial information, if we're only entering the patient into the data registry. So more than likely they're not doing clinical trials either. They're just entering the data because we have to let Medicare know that we're doing this procedure.

MS. FRIERSON: Right. Okay. So that's under B. So you still would enter the information in the ICD registry. That's the one you're speaking of, right?

AUDIENCE: Well, we're reporting it to Medicare under Q0.

MS. FRIERSON: Right. And so you put it there, right, and then it tells you that the patient is enrolled in this data collection system. You use the Q0 as we've identified and that data is being submitted. Okay. And then basically in that IOM, it made it seem as if it's written from the perspective of primary prevention and not secondary. So those would be the steps in the IOM for you to submit your claim after you entered it into that data registry in order to receive your primary -- as stating it's for primary prevention. Does that make sense? No.

AUDIENCE: It would take us all day to read it.

MS. NORTHCUTT: Are you really asking from the Q0 perspective, would you just bill traditional fee for service Medicare?

AUDIENCE: Right.

MS. NORTHCUTT: -- because they're in a registry versus the managed care really or the Advantage program because they're in a registry I think is kind of the question.

AUDIENCE: Well, currently we bill with the Q0. We do have claims returning. And our biller has to go in and put some other information in. But we don't report a clinical trial number. So that's what I'm confused about. If it's saying in the manual we have to add additional information to the bill.

MS. FRIERSON: No. But you are reporting them in that National Cardiovascular Data Registry, correct?

AUDIENCE: Correct. And there is a number associated with it that I found.

MS. FRIERSON: That's fine. You still would use the Q0 modifier. So it is going into a data collection system.

AUDIENCE: Right.

MS. FRIERSON: I'm sorry. So as long as you put in that registry using the Q0 modifier, that's correct.

AUDIENCE: Okay. So I want to understand, too. There's always an issue, there's always a discussion say between the Medicare Advantage and us on what they're responsible for versus Medicare. And I hope I'm not confusing this with another NCD because this all runs together. But I thought the Medicare Advantage did pay for this particular procedure. Is that correct?

MS. FRIERSON: Yes. Okay. You have to split bill. If you reference back to the previous question, you have to split bill. So the Medicare Advantage is responsible.

AUDIENCE: For anything not related to clinical trial?

MS. FRIERSON: Yeah. Yes. So your routine costs would go to your traditional Medicare, and then the other costs have to go to Medicare Advantage as related to the clinical trial.

AUDIENCE: Okay. That makes sense. I think the confusion earlier was that often times even our auditors ask what the clinical trial number is. But sometimes it's easier just to let Medicare know that you've actually taken the step of enrolling that person in the registry even though there may not be a clinical trial that needs to be reported. So that's an issue that we've had in the past but don't have any longer, thankfully.

MS. FRIERSON: Okay.

MS. NORTHCUTT: And that's what the new decision memo now is saying, you know, the September deadline, if I can understand it correctly, a hundred and eighty days from March 31, that that registry entry will go away and so will the Q0 and a lot of other things. We talked before you got here. So keep that in mind, again, as we go forward through that decision memo that they're changing.

MS. FRIERSON: Okay.

4. Please provide guidance on the most appropriate CPT code for subcutaneous infusion of deferoxamine mesylate (Desferal) via CADD pump. For example: A patient presented to our outpatient facility for initiation of a subcutaneous infusion of J0895- deferoxamine mesylate (Desferal) via CADD pump. The infusion was started at the facility and ordered to continue at home over 96 hours. The needle became dislodged at home so the patient discontinued the infusion after 76 hours. What CPT code(s) would be used for the initiation of the subsequent infusion via CADD? Would any subsequent visits for the same drug by CADD be reported using CPT 96521?

Response and Discussion at meeting

MS. GAUSE: The correct coding for initial and subsequent visits would be 96369, subcutaneous infusion for the therapy or prophylaxis, specified substance or the drug. Initial up to one hour including pump setup and establishment of subcutaneous infusion site. You would use 96371. For subcutaneous infusion for therapy or prophylaxis, specified substance or drug, additional pump setup with establishment of new subcutaneous infusion site. List separately in addition to code for primary procedure.

MS. MILLER: Any questions on that answer?

AUDIENCE: We may need some clarification. But we don't have our CPT code books to look at because I didn't think there was a CPT code for a subcutaneous infusion prolonged where the patient goes home on those. The patient comes in and they're hooked to this CADD pump and they're sent home in fifteen minutes. So an infusion first hour is not going to work. And it's a prolonged infusion when they go home. And there's not a CPT code for that prolonged infusion for a subcutaneous infusion. There is for an IV but not for subcutaneous. And it's not a subcutaneous injection. So what we have been doing was doing the maintenance of a pump. And that's 96521.

MS. GAUSE: This is the answer that we obtained from our medical affairs department, the medical directors. They looked over this question. And these are the codes that they gave and the reasons for using them. But we can take your question back.

AUDIENCE: Yeah. I just don't think that's correct.

MS. NORTHCUTT: And I think the other part of that is I think, now that the understanding is it's fifteen minutes, it's going to play a big key role, too, because there would be no infusion.

AUDIENCE: Yeah. They're going to go in and they're going to get connected to the pump. And then they're going to get sent home. And in order for us to be able to charge or even bill for that subcutaneous infusion, we have to have a start time and a stop time. We're not going to see that.

MS. GAUSE: Okay. We'll get with you after the Q and A session and get your direct question and take it back to our medical affairs department and get back with you.

AUDIENCE: Thank you. I appreciate it.

MS. GAUSE: You're welcome.

5. Is it appropriate to perform a non-face-to-face completion of a MSP questionnaire during a pre-registration telephone or online process?

Response and Discussion at meeting

MS. GAUSE: The weight of the responsibility falls to the provider to obtain the correct information via any means in order to bill correctly. The questionnaire is a means to determine that due diligence was performed by the provider in obtaining the correct insurance information prior to billing. Section 20.1 of the IOM states providers are required to determine whether Medicare is a primary or secondary payer for each in-patient admission of a Medicare beneficiary and outpatient encounter with a Medicare. Prior to submitting a bill to Medicare, it must accomplish this by asking the beneficiary about other insurance coverages. Section 20.2.1 lists the type of questions it must ask of the Medicare beneficiary for every admission, outpatient encounter or start-up care. You can also go to IOM 100-05,

Medicare Secondary Payer Manual, Chapter 3, MSP provider, physician and other billing requirements, Section 20. Obtain information from patient or representative at admission or start of care.

MS. MILLER: So it doesn't matter how you get it as long as you can get it, bottom line. And that it's documented. All right.

6. Please provide education on Palmetto's medical review process.

Response and Discussion at meeting

MS. GAUSE: Well, we have our TPE article on JM Part A side. And, also, you can check up under the JJ Part A website. You should have some stuff up there for your TPE process, too. Change request 10249 implemented the Targeted Probe and Educate process effective October 1, 2017. This is not a new process. Hospitals are familiar with it from the Two Midnight Rule. Providers are selected based on the following. Analysis of billing data indicating variances that may suggest questionable billing practices or on targeted review and is transitioned to the TPE process based on your error rate results or on specific service review error rate results. It's not a hundred percent inclusive of all providers. Palmetto GBA will mail a letter to those who have been selected for TPE review. The letter will outline the reason for selection and will provide an overview of the TPE process and contact information. Your first letters for JJ were sent out the week of February 5, 2018, and they will be sent out in stages. The process consists of three rounds of reviews with a sample of twenty to forty claims selected. Pre or post payment for each round. Progression to the next round depends on denial rates for that round. Subsequent rounds will begin 45 to 56 days after individual provider education is completed. This continuation of review may occur if appropriate improvement and compliance is achieved during the review process. An additional documentation request, ADR, will be generated for each claim selected. For pre-paid review, Palmetto GBA has 30 days from the date the documentation is received to review the documentation and make a payment decision. For post-pay reviews, Palmetto GBA has 60 days from the date the documentation is received to review the documentation and make a payment decision. It is imperative that a point of contact, usually the compliance officer, is on the cover sheet of each request. One medical reviewer is assigned to review all the claims for that provider in a sample.

The reviewer will be reaching out to providers to provide education. So the contact information is pertinent. That is correct. One thing we will educate on prior to the end of the round is easily corrected errors, missing documentation, dates, things you can provide before the end of the review. Providers will have three days after the call to submit the missing documentation. Prior to the conclusion of each round, the medical reviewer will call all providers with a moderate to high error rate to discuss the summary of the errors identified. If requested, we can make an appointment so that you can have time to gather your team, anybody that you want to receive the education and call you back. The best way to respond to an ADR request is through our eServices portal. It's the most efficient and quickest way to ensure timeliness is met through our secure online web portal to submit documentation in response to medical review ADR's and when additional documentation is requested throughout the review process. You may refer to the eServices user manual external link or instructions. If you're not already registered, please refer to registration on page eighteen. A non-response denial count as an error when calculating the error rate.

At the conclusion of each round, a letter with the review results will be mailed. The letter will include the number of claims reviewed, the number of claims allowed in full and the number of claims

denied in full or in part. When a high denial rate continues after three rounds of TPE, Palmetto GBA will send a referral to CMS for additional action.

MS. MILLER: So that's pretty much what was in the presentation. Any questions?

AUDIENCE: Have you ever thought about having that one contact person on file so that it's not sent with every ADR and only if that needs to change would it be changed from the organization to you? Because under the new TPE, every single ADR requires, like you said, that cover sheet with the person's name. Is it possible or maybe be thought about in the future to have that one contact person on file so that it's not missed or something to that effect? Because even like when we had -- with KEPRO, you fill out a provider contact form and every time nothing's missed because it all comes to that one particular person, specifically regarding the education piece that has to be coordinated.

MS. FRIERSON: We can make that suggestion. I would just say that from a provider record perspective, for example, when you submit your 855 forms, normally the contact person is no longer that contact person. Once the application has been processed, they normally don't consider that. Like a contact person at this present, I'm not sure they would have any place in particular to store that. But we certainly can take it back and make that suggestion. And I like your example when you say KEPRO. You fill that out. We can do that. One of the issues with the idea is that from a provider enrollment or record standpoint, it would probably make you responsible for whenever it changes. Or if it changed, then we'd have to go in and make that update. And as far as keeping the records updated, then you'd have to submit it and keep that current. But we will certainly take that back as a suggestion. But right now they're saying that you place that point of contact on there so they'll know exactly who to contact. Because what we find, just as an example, the person that educates on CERT, sometimes they have to go through two, three, four people before they get to the right person. So that's why. But I do like that suggestion. I think just maintaining the information would probably be the largest hurdle. But we can take that back.

AUDIENCE: Thank you.

7. We need clarification from Palmetto on Lifetime Reserve (LTR) days.

   A) There is a lot of confusion in the provider community on how to handle LTR days appropriately. Please provide some written guidance.

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

Response and Discussion at meeting

MS. FRIERSON: Okay. The written guidance as stated in the question will be your MLN Matters SE0663 and also if you refer to the IOM 100-02, the Medicare Benefit Policy Manual, Chapter 5 where it discusses Lifetime Reserve Days. MLN outlines the notice requirements. And to answer the question, providers should refer to and adhere to the guidelines in the MLN and also in the IOM regarding Lifetime Reserve Days. Provider cannot bill Lifetime Reserve Days without the patient's agreement. We suggest

that hospitals determine eligibility at the time of admission prior to the beneficiary being discharged so that the requirement to notify patients who have already used or will use ninety days of benefits in a benefit period can elect not to use their Lifetime Reserve Days for all or part of a stay, as that is the patient's choice.

AUDIENCE: The problem is that the common working file isn't always updated. So the sooner you come in, they have plenty of days to cover our stay and then the patient leaves and we submit our claim. Then two years later we get an update where all the regular coverage for the stay has been wiped out and we're left with a handful of Lifetime Reserve Days. And so obviously we've got to bill for our stay, and it's not always possible to reach the patient. Sometimes the patients are deceased. Sometimes the patients, especially for our psych patients, are very difficult to get in touch with because they've been in five different institutions and no one knows where they're at now. So this is kind of where that question came from. Sometimes we exhaust every means possible, letters and calls to recent patients and they're just not reachable. So what do we need to do in those situations?

MS. FRIERSON: Okay. So you're saying at the time that they're in the hospital that the common working file is not showing you?

AUDIENCE: Right, this has happened with us before. We have a very large in-patient claim for someone who was from out of state, and it was suspended for I think about sixteen months before it was finally paid. So any provider that saw that patient would think, well, we're in a new benefit period or you don't even see those days have been taken out. And they can bill their claim and get it paid. Our suspense claim finally goes through, and then the claim gets recouped and denied because of what phase we're on.

AUDIENCE: And ours have been recouped. And we'll have five claims that are paid and then recouped.

MS. DUNAGAN: It is a difficult situation with the hospital because as you know, the common working file is only updated as those claims come in and process. And when you have claims that are stuck out there in suspense, of course, those claims are not going to actually hit the common working file because they haven't been finalized. So sometimes that information is just constantly updated, updated, updated, and claims are backed out of the system. So really you don't have a way of knowing but by checking at the time that patient is in the hospital or when they're discharged. The problem is you still cannot use the patient's Lifetime Reserve Days unless you have discussed that with a patient. And in my opinion, it's best to try to get something in writing if the patient elects not to use the Lifetime Reserve Days because a lot of times they don't understand what it means to use the Lifetime Reserve Days. All they think about is this is a one-time lifetime benefit. The days are not going to renew. So they really don't have a clear understanding of what it means to utilize those days. But unfortunately, you as a provider, you cannot use Lifetime Reserve Days unless you discuss it with the patient and the patient agrees to utilize those days.

AUDIENCE: Okay. So we understand that process. You know, we discuss it with the patients when we know.

MS. DUNAGAN: Right.

AUDIENCE: We do realize that really the attestation that they fill out is to indicate if they refused to use their Lifetime Reserve Days because they're going to be responsible. But that is a very precarious situation that you place providers in where you're saying Medicare doesn't have to be held accountable for the common working file being up the date but we have to be held accountable for speaking to the patient when we're not aware that we need to. And talking to someone with sixty regular days and thirty co-insurance days and Lifetime Reserve Days seems like a colossal waste of time, frankly, for everybody that comes through the door. So, again, in the situation that I gave you, we've wiped out all that patient's days. And any provider that saw that patient after the fact would never have any idea that they had used those many days. And we didn't know how many days we were going to have because it was suspended for so long that we didn't know what was really out there. So what do we do? Are you asking providers just to basically eat those claims when we can't speak to the patient?

AUDIENCE: We're going to have to.

MS. DUNAGAN: Unfortunately sometimes that is the case because, again, as a provider you can only go by what's in the common working file. And that's what you're doing before you submit the claim in. You're verifying eligibility, of course. And that's what you're doing. But, again, when you have a lot of institutional claims that are out there hung up in suspension, those days in the common working file are not going to update until those suspended claims have come to a finalized state. So really there's nothing that you can do besides verifying eligibility. So in some cases depending on how the claims come into the system and process and edit, you may just have to eat those charges.

AUDIENCE: We could bill Part B.

MS. DUNAGAN: Right. Sometimes in some cases you can bill to Part B. But a lot of times that is the situation. And it is a tough situation to be in.

AUDIENCE: I will say that was not the response that I got from Cahaba GBA. Cahaba said that if you exhaust your efforts and you clearly document that you could not reach this patient, that you could bill Lifetime Reserve Days, keeping in mind that the patient reserves the right to withdraw their permission to bill those days. I'm just saying that's what Cahaba said. So it seems like a much fairer position for providers to be in than just to say that you can't bill anyone for those. You're just going to have to take a loss on that.

MS. DUNAGAN: I mean, you can always appeal anything and send in your documentation and it can be reviewed at that time. I'm pretty much basically just saying that a lot of times that's the end result for a lot of facilities. But I'm not saying that you can't utilize the appeals process to state your case.

AUDIENCE: But if you follow your own rules, you won't be able to overturn it. Lifetime Reserve Days acknowledgment is statutory.

MS. DUNAGAN: Yes.

AUDIENCE: So you couldn't. An appeal would be fruitless. Technically, you could not overturn it. It's statutory.

AUDIENCE: Hey. Just wanting to confirm with regards to the statement. Was it Chapter 500-2 that has this language? We know that you cannot bill the patient without notifying them. But where is it?

MS. FRIERSON: It's in the IOM 100-02, Chapter 5 that discusses Lifetime Reserve Days.

AUDIENCE: Thank you.

AUDIENCE: Would Palmetto accept a blanket acknowledgement upon admission?

MS. FRIERSON: I think we'd have to ask.

AUDIENCE: That's what I took at your suggestion was that we need to tell every patient. That's what I took as your suggestion earlier. That's a note I wrote down. That means that let every patient know there's a potential that they'd have to use their Lifetime Reserve Days regardless of what the working file says. So that's not what you were saying earlier.

MS. DUNAGAN: What I was saying was specifically answering a question whether or not you would be in conflict. If you decided to bill Lifetime Reserve Days when you're unable to reach the patient, that is what my response was. I was answering that question. Yes, you would be in conflict if you choose to bill using Lifetime Reserve Days without addressing that issue with the patient. That is what I was addressing.

AUDIENCE: I think part of that question that I had is, when you talk about psychiatric patients, what is your stance on who can approve that? You know, obviously there's got to be not necessarily a sponsor but there is a family member. Or does it specifically have to come from that patient? Because if they're being committed or if they're actually having to be in a psych unit, what do you think about that?

MS. DUNAGAN: If the patient is unable to, the patient should have a legal representative that has been documented with Medicare who is able to make those types of decisions for them. It could be a family member.

AUDIENCE: So if we had something in writing from them

MS. DUNAGAN: Yes. Yes. Yes. Definitely.

Additional Discussion at meeting

AUDIENCE: I've got a couple questions. What is your average time now for processing new provider applications?

MS. FRIERSON: I don't know the average time. I would be telling you an untruth if I tried to quote a number. I'm not sure. But we certainly can find out and send that back.

AUDIENCE: The reason I'm asking, because it seems like it took an inordinate amount of time to process new provider apps as well as 855. So I was just curious. From a provider, that's a real pain point to why it takes so long to get something so simple processed.

MS. FRIERSON: Right. I understand. And, of course, we go for the guidelines that's in the regulations. And I cannot quote them right now, but I know it's so many within forty-five, so many within sixty days.

MS. DUNAGAN: If it's a new application which is an initial enrollment, it should take up to sixty days for processing. If it's just a change of information, the guideline says to allow up to forty-five days for completion. However, Cahaba was behind in provider enrollment. And all of those applications that had not been completed are being transferred over to the new incoming contractor Palmetto GBA. So, of course, now Palmetto GBA has inherited that back log of enrollment applications. So the typical time is sixty days for new initial applications, but I'm pretty sure that it's probably taking longer than that because they were already outdated when they were transferred over to Palmetto GBA. But those are the typical guidelines, sixty days for initial applications and forty-five days for change of information applications or reassignments.

AUDIENCE: For those that didn't make it over to Palmetto, if we can provide evidence that it was received, when it was sent and when it was received, will you backdate it?

MS. DUNAGAN: I'm sorry. Say that again.

AUDIENCE: For those that we sent in to Cahaba that were in review for months that never made it over to you and now we're going to have to resubmit them, will you accept the date originally, if we can provide evidence it was received by Cahaba, will you accept that date?

MS. DUNAGAN: So you're saying that Palmetto GBA has no record of even Cahaba ever receiving the enrollment application?

AUDIENCE: Correct. Correct.

MS. DUNAGAN: Now, that is a different situation because there's no record of ever receiving the application. And there are CMS guidelines on how far they can backdate an application. So that I can't really answer to. That's something that you would need to call into the Provider Contact Center to get further information on because that's a different situation. Because you're saying the application is not showing to have never been received. So you're basically starting over with Palmetto GBA. So we're

basically going to start from the date that they received that application. And based on what date you're requiring the effective date to be, I don't know how far back they would be able to backdate the effective date.

AUDIENCE: But we never sent anything to Cahaba that was not sent certified mail.

MS. DUNAGAN: So if you have proof, I'm sure –

AUDIENCE: There were cover letters. On the cover letter it's by certified mail. Here's the number. And we have the certified mail receipt that matches what was on that cover letter.

MS. DUNAGAN: And that's what I'm saying. That's what would be considered an extenuating circumstance. So with your proof -- because otherwise, without proof, I'm not sure how far they would be able to backdate it.

AUDIENCE: We have the proof.

MS. DUNAGAN: With your proof, if you would send that in with your enrollment application, I'm sure that they'll look at that and take that into account.

MS. MOTES: How did you verify that Palmetto didn't receive it? There's a reason I'm asking this.

AUDIENCE: Well, our credentialing person has called to try to check on the application and it's we have no record.

MS. DUNAGAN: Everything hasn't been transferred. Everything hasn't been transferred over yet.

MS. MOTES: The migration of the two systems of trying to get everything from Cahaba into Palmetto's system is requiring some things be done manually. And so I do know that certain things have not been completed because human eyes are having to look at all of them. So it's possible that they do have your applications.

AUDIENCE: Just haven't been keyed into the system yet.

MS. DUNAGAN: Yes.

MS. MOTES: That's possible.

AUDIENCE: Okay. How long should we wait? I mean, I understand the predicament you guys are in.

MS. FRIERSON: It's a valid question. They didn't give us a specific time frame. But I know during the meeting last week when everyone was discussing it -- we had an operations meeting and we were discussing the status of the transition. What they're saying to you, all of that information has not been downloaded or uploaded into our systems yet. I really don't have a specific time frame for you at this point. Yeah. Call the Provider Contact Center, and they may be able to give you a better time frame but just allow us a little bit more time in order to get all of that information uploaded into our system. But I will also add, in addition, for any new applications or changes, that if you would do the electronic PECOS system (Provider Enrollment, Chain, and Ownership System), the electronic 855 Forms. That would be a faster process as far as getting your updates made.

AUDIENCE: Which we do.

AUDIENCE: I have one last question. It's kind of in regards to question number five, MSP's common working file. What I'm being told by my billing staff is that you guys have a lot different ways of processing MSP claims. When we submit a Medicare claim, we submit the claim as primary and it conflicts with the common working file and it kicks out. And I'm trying to recall exactly what they told me - that once the patient calls in and corrects it, the common working file, that then we have to submit a 137 corrected claim to get it paid.

MS. FRIERSON: You have a specific situation that I cannot speak to.

AUDIENCE: Has anyone else run into that yet?

AUDIENCE: I have that issue quite often on MSP claims. I'll call the call center and I get two different responses on how I should bill it.

AUDIENCE: On how to bill it?

AUDIENCE: Yes.

AUDIENCE: So have you been told to do a 137?

AUDIENCE: I have. And I have been told to wait so many days and do a new claim.

AUDIENCE: 45 to 75 days is what I have been told.

AUDIENCE: Either way I do it, I get a rejection.

MS. DUNAGAN: So you're saying the first claim actually denied for MSP and the system is now updated with the correct information?

AUDIENCE: Yes. Patient calls in and updates.

MS. DUNAGAN: As long as the common working file is updated with the new information, I don't see why you would file an adjusted claim. You should be able to submit a new claim. As long as the system is updated it should go through if the first claim is denied. I don't see why you would file an adjustment to it.

AUDIENCE: The vast majority of issues that I'll have is that the patient will contact coordination of benefits Medicare and update files. There are even files out on their information that have been closed, settlements or whatever. It could be workers' comp or whatever. Those cases have been closed for years. Patients will contact coordination of benefits. I will wait in some cases thirty to forty-five business days, go back out to the system and that information is still there. Then I'll call and I'm told it's still updating. You know, submit an adjustment, a different claim and some say submit a new claim. As of today, I think I have about nineteen claims - seven of them are in-patient claims that I'm having this issue with. And some of them are dated all the way back until August of last year. And I have brought in five of those beneficiaries in my office and they have contacted coordination of benefits in front of me to make sure they were correct because sometimes the elderly don't always understand. So I've taken it a step further to help them. And six of them it's still on their file. And three of them even had to submit some proof that the cases are settled and done. But they're still there. So MSP has become a headache for me in general.

MS. DUNAGAN: MSP has always been a headache.

AUDIENCE: And I have several outpatients like that. But it is my 111 claim that I'm pretty much concerned with the biggest because those are the DRG claims. You know, I have a lot of issues with MSP in general.

MS. DUNAGAN: And unfortunately since the Medicare Administrative Contractors are not responsible for updating the information, it's really nothing that the MAC's can do until the common working file is updated. So nothing is going to process appropriately if it's not updated in the system yet. And as far as how long it takes them to get it updated, I couldn't tell you what that time frame would be.

AUDIENCE: But the representative will tell you to wait ten to fourteen business days, and it's still not done.

MS. DUNAGAN: And I've seen it myself not update that fast. It's a tough situation.

AUDIENCE: I have two claims that are from the end part of 2016. Well, now they're considered past the filing. So now I'm probably going to have go through this long drawn out appeal process that I'm probably not going to get paid for.

MS. DUNAGAN: I understand. But, again, from a MAC perspective, there's really nothing we can do on MSP claims until the system is actually updated. And once it is, my suggestion would be to submit a brand new claim.

AUDIENCE: All I can do is just give it so many days and then just submit a new claim.

MS. DUNAGAN: Check it out again and make sure it's been updated. And once it's been updated, submit a brand new bill.

AUDIENCE: So I guess what we're looking for is a definite answer as to how to file the claim and how many days to wait to submit a claim after it has updated and why is it taking so long for it to update in the common working file.

MS. DUNAGAN: And I can't answer that question as far as why it's not updated in the common working file.

AUDIENCE: Okay. But once it is updated -- I know that the MAC's don't have any control over that because you don't handle that - but when the common working file is updated, what you're saying is we should be able to resubmit a new claim and it should hit the 14 day payment?

MS. DUNAGAN: Right.

AUDIENCE: Okay. We'll try.

MS. DUNAGAN: Try that.

AUDIENCE: Thank you so much.

AUDIENCE: I have two questions. The first one is we have a Railroad Medicare beneficiary. The card will say enrolled with Medicare. Is there anything in the eligibility response or something on your website that would allow us to systematically or automatically recognize that this is a railroad beneficiary?

MS. FRIERSON: Whenever you receive the remittance advice, it's going to be the logo on there. But yes. Whenever you receive the remittance advice back, it's going to tell you that it's a railroad beneficiary. And that was part of the presentation. What you need to do is to go ahead and identify -- I don't know how you can program your system, but just so you can identify those patients with RRB because you're not just going to be able to look at the HICN and know that it's going to be a railroad beneficiary. You're probably not going to know that information until after you get their remittance advice back.

AUDIENCE: For Part A it's not a big deal because we're sending it to Palmetto regardless. And now for Part B it's not such a big deal because it's going to Palmetto. But I guess if that's a suggestion you can take back, if there could be something on the front end so we could capture those for the system since these numbers are all going to be the same now. If there was some way CMS could add something. I don't know what your relationship is to request that. But to be able to add something in eligibility response that would flag this so the providers could be sure that we identify those.

MS. FRIERSON: We definitely can make that suggestion with upper management or possibly the CMS team. We'll pass that information along.

AUDIENCE: And another issue I have was last week I identified a file that we had transmitted to Palmetto GBA that we received a 277 acknowledgment on. We've gotten it back and it shows that all of our claims were accepted, even had the DCN number listed from the claims processing system. But I went into FISS to check on those claims. They weren't there. The reason why I found this was because of cash projections and I wasn't showing any cash for tomorrow for Medicare. So I went through like a two-day process with your EDI department and finally found out that several providers according to your representative had similar issues where you were showing that they received an acknowledgement but the claims weren't actually listed. Thankfully they were located. But I never saw anything from Palmetto. I never saw any announcement saying this was an issue. I know that other providers had the same issues. I spoke with someone specifically about that. And the representative did not give a helpful suggestion which was for us to take our claim file, to hike it up to 277, wait forty-eight hours and then go check the FISS and see if the file is loaded. It seems like a Palmetto issue. So I guess my question to you is -- and I hope to get a better response than what he gave me -- what do providers need to do when they send a file, receive a 277 acknowledgment but then our files aren't there? Is there some kind of internal process that Palmetto has in place to verify that these files are actually being loaded?

MS. FRIERSON: I think you've got us stumped on that one. I spoke with the manager of the EDI department before I left, and I know they're having an issue with contact information. I'm not sure about your claims loading, but I know that a lot of the contact information, current information, they are having to ask for contact information, it wasn't uploading as seamlessly as we need it. A lot of the information when we uploaded the information, it wasn't current information. So a lot of the information that was on file is not current. I know they were having problems with that. As far as the issue you were just asking about, I don't know of any problems with claims transmission. We were sitting here discussing it among ourselves, and we are not aware of any claims transmission issues. I don't think there was a CPIL that was put out for that. But we can find out. If one needs to be put out there, then we will certainly get one loaded out there. But that is certainly an issue as far as the claims not transferring over.

AUDIENCE: I guess that was my concern. Like before then, I could have already checked and already let my CFO know, hey, we're going to be short this day. But there was nothing out there. And like, again, the representative even said you're not the first person who has had this issue. So it would be better communication when something like that comes up so providers can be aware and make any allowances for basically, you know, a missing payment, a day's worth of payments.

MS. FRIERSON: You were speaking with the PCC?

AUDIENCE: I do have a ticket number if that would be helpful.

MS. FRIERSON: Yes.

AUDIENCE: I spoke with Greg and the ticket number is 440952.

MS. MOTES: If I'm remembering correctly, I do believe that was an issue they had identified at the end of last week. And they were working on it. Hopefully it will be something that resolves shortly.

AUDIENCE: My file was located. They were able to find it. It was just a concern that we weren't notified. We had no idea that that was actually going on.

MS. MOTES: Yeah.

MS. DUNAGAN: It probably hasn't been enough time for them to determine whether or not it's a widespread issue or what the issue is. As Paula mentioned, she heard something the later part of last week about it. We haven't heard anything about it. So it probably hasn't been enough time for them to determine whether or not it needs to be a CPIL created to determine whether or not it's affected a lot of providers. But we'll definitely take the ticket number back to address it to see if we need to have something placed out on the website for other providers to see.

AUDIENCE: I just wanted to say I did have the same issue as well. And it took three or four times to call because each time I needed to have different information. And I just want to tell you they were very rude. I hate to tell you that. Well, they kept requiring different information. I got our billing vendor involved. And we had a three-way call so that I made sure we had the information. And they said, well, we don't allow a three-way call, and she hung up. She said, one of you will have to call back, and hung up on us. So I just wanted to let you know that. But, we're talking about cash, a whole day's claims. Three million dollars in gross charges and they didn't care. So I just wanted to let you know.

MS. DUNAGAN: Any time you call into the Provider Contact Center and you have an encounter like this where you're saying you were not treated as you should have been, they were rude, make sure you get that person's name and make sure you call back with that reference number because all of the calls are recorded. And that should never happen. You should never be mistreated or you should never have someone be rude to you when you call in for assistance. So don't let it slide. Follow up on it and make sure that we know about it so that we can handle it. And I also would like to ask you all to be very patient with us. This is a huge transition. We have a lot of new staff. Paula and I both are new to Palmetto GBA as well. So there's a lot of people who may not have the experience yet to handle the tough issues that you may be experiencing right now. So be patient with us. But, again, you should be treated with courtesy. So make sure that we're aware of that when you're not.

MS. MILLER: Okay. I think we're going to have to end this for today. We knew it was going to be a lot of questions for you. We do appreciate you coming down and meeting with us, and we hope to see you back in July. Thank you.