PALMETTO
RIC/RAC Fall Meeting
November 6, 2017

Palmetto was unable to attend this meeting with us this time, but did provide answers to our submitted questions. We look forward to having them with us in March 2018.

1. Is there any rule that would prevent a hospital from billing a hospice patient if they do not schedule their care through the hospice (and therefore, the hospice is denying payment)? This occurs frequently in the emergency room. Can we bill the patient?

   Response: **All Medicare providers should verify eligibility, including Hospice election at the time of admission in order to determine how to bill. If the services are NOT related to the hospice care, then they should be billed with the GW modifier. If they are related, the hospice agency would be responsible for the payment of those services. Beneficiaries should be advised that if the services are not pre-arranged with the Hospice, the beneficiary can be held financially liable for them.**

2. If a psych patient seen in the emergency room has an order to admit to psych but is being held in the acute care hospital for more than 1 day while waiting on a psych bed – how should providers bill for the charges from the patient's initial presentation until the psych bed is available?

   Response: **As long as the services provided are medically reasonable and necessary, they may submit a claim to Medicare. A patient may remain in observation for up to 48 hours prior to admission and they would bill the appropriate revenue code cost centers. Note: The documentation will allow us the full picture.**

3. We continue to get denials for NCD 20.33 (ICD-10 PX 02UG3JZ; MitraClip Procedure). These have to be appealed, which delays reimbursement on these procedures. The issue is a coding requirement versus the language of the NCD. The NCD requires that the primary diagnosis be either 134.0 or 134.1. However, many of these patients have more than one diseased valve. Per our Coding Department, ICD-10 requires that a combination code be used when there is more than one valve documented. Specifically, these accounts are coded with 108.0 (rheumatic disorders of both mitral and aortic valves), 108.1 (rheumatic disorders of both mitral and tricuspid valves) or 108.3 (combined rheumatic disorders of mitral, aortic and tricuspid valves). Can Palmetto please review this issue and assist with getting the NCD updated to more accurately reflect ICD-10 coding requirements?

   Response: **Palmetto GBA is not aware of any current billing issues in relation to NCD 20.33. Here is a link to our current JM Part A Claims Processing Issues Log (CPIL) for your reference:**
   https://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/JM%20Part%20A~Articles~Claims%20Processing%20Issues%20Log?open&Expand=1

   Unfortunately we are unable to address any current claims errors, these should be addressed to Cahaba GBA.

4. If a patient receives care at a hospital on the same date of service as the beginning date of a hospice episode and the care is related to the hospice diagnosis, but the services were provided prior to hospice accepting the patient, can both the hospital and hospice receive payment from Medicare? For example, a patient presents in the morning to receive observation services and the decision is made to move the patient to hospice. The patient is discharged at 3:00 pm to home hospice care. The hospice nurse comes that evening and the hospice begins care at 6:00 pm.

   Response: **Medicare allows both claims to be paid on the same day.**

   Additionally, if both the hospital and the hospice can be paid by Medicare – what about patients who are enrolled in a Medicare Advantage plan? Would Medicare or the Medicare Advantage plan be responsible for the hospital care received prior to the start of hospice?

   Response: **Palmetto GBA cannot address Medicare Advantage coverage policy.**

5. Will the "appropriate use" for specialty radiology services as proposed in the MPFS for 2018 affect the radiologists that are billing Part B for interpretations for hospital provided specialty services? [attachment]

   Response: **This document appears to be a proposed rule and not Medicare regulation. When final rules are issued the CMS instructs the MAC through issuing a change request which contains business requirements on how they are to implement the rule. Until such instruction has been received the MAC cannot consider it for billing and coverage regulation.**

6. Providers are getting denials for the 6th month follow-up to the Lung Cancer Screening (G0297) that physicians are ordering based on findings from the first screening. Please provide guidance on how to bill the 6 month follow-up test? Should it be ordered and billed as a diagnostic test with CPT 71250 instead of as a screening?

   Response: **Palmetto GBA is not aware of any current billing issues in relation to billing G0297. Here is a link to our current JM Part A Claims Processing Issues Log (CPIL) for your reference:**
   https://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/JM%20Part%20A~Articles~Claims%20Processing%20Issues%20Log?open&Expand=1

   Unfortunately we are unable to address any current claims errors, these should be addressed to Cahaba GBA.

7. Can we bill for multiple episodes of CPR performed on a patient in the emergency room? For example, if CPR is performed at 1pm and the patient is stabilized, but then requires CPR again at 1:45pm, can we bill for 2 units of 92950? Is there a certain time that should pass in between doing CPR before it is considered a separate episode? Or should we only bill for one unit no matter how many times CPR is performed while the patient is in the ED? Should additional units of 92950 be reported with modifier – 76?

   Response: **The Medically Unlikely Edit (MUE) for this code (92950) is 3, so if it is truly two separate incidents of CPR it can be billed more than once as long as you append the modifier 76 to the second time as opposed to billing a claim with one line with 2 units.**

8. What LCD's will be used for claims that occurred prior to the MAC transition date, but are submitted to Palmetto? Will LCD's from Palmetto be retroactive to govern coverage for claims that occurred when Cahaba was the MAC or will the applicable LCD be controlled by the date of service?

   Response: **LCDs are enforced based on the date of service and not based on the date of claim submission.**

   A listing of the JJ Part A & B LCDs will be available in early December on the JJ Transition website at www.PalmettoGBA.com/JJTransition . These LCDs:
   Will apply to all JJ states
   - **Will become effective on the respective cutover date**
   - **The JJ AB MAC and JM AB MAC will have identical LCDs**

9. How will claims, reopenings or appeals (redeterminations) that are pending with Cahaba at the time of the MAC transition be handled? Will Cahaba continue to work all of these until completion or will some/all of these transition to Palmetto?

   Response: **All first level redetermination requests should be sent to your current Medicare contractor until advised to send to Palmetto GBA. Providers should continue to contact Cahaba GBA about the status of their redeterminations until the cutover, at which point they should contact Palmetto GBA. All workload in process at Cahaba GBA at the time of cutover will be sent to Palmetto GBA and the timeliness will continue to be based on the date of receipt by Cahaba GBA and will not restart for Palmetto GBA.**

10. Will providers be required to complete any enrollment forms for the transition to Palmetto or will all the information on file with Cahaba be transferred over to Palmetto? For example, enrollment for 835 (ERA's)/837 file transfers, EFT's, etc.

Response: **A new Electronic Funds Transfer (EFT) agreement will NOT be required as your existing agreement will be transferred to Palmetto GBA. You will not need to take further action and your current EFT will remain in effect.**

The providers currently submitting claims to Cahaba GBA will not be required to re-enroll or complete a new provider enrollment application with Palmetto GBA. After the cutover date for each Medicare line of business, providers will submit all claims to Palmetto GBA regardless of date of service.

An important part of the JJ A/B MAC transition is the migration of your EDI activity to our EDI gateway, GPNet. In order to ensure that your EDI transition to Palmetto GBA is successful and efficient, it is very important that you transition your claim submissions to us as soon as possible. Therefore, we will begin "Early Boarding" on November 1, 2017 for Part A and December 1, 2017 for Part B. Early Boarding helps to ensure that you will be comfortable using the Palmetto GBA systems for your JJ EDI submissions prior to the final cutover dates noted above. Once you Early Board, all electronic transactions you submit to Palmetto GBA will be forwarded to Cahaba GBA for processing. Palmetto GBA will be working directly with Network Service Vendors (NSVs) to ensure this is a smooth transition. Palmetto GBA EDI will be sending a letter to all electronic submitters identified by Cahaba GBA providing more detailed information on Early Boarding and EDI transition to Palmetto GBA.

11. Will there be any interruption for access to FISS/DDE? Will providers have to re-enroll with Palmetto in order to maintain access after the transition?

Response: **We have not determined whether any dark days for FISS/DDE will occur at this time. Once this is determined, this information will be shared with providers.**

12. Does Palmetto have a Provider Portal; if so, what information can be accessed or submitted using this Portal?

Response: **Yes, Palmetto GBA is pleased to offer secure and fast access to your Medicare information through our eServices provider portal. Providers are encouraged to check their claims status and beneficiary eligibility via the eServices provider portal on our website. Through this system, you can view beneficiary eligibility, claims status, online remittances and financial information. As part of the transition, Palmetto GBA will auto-register those providers that are currently registered in Cahaba GBA's portal.**

13. It is our understanding that there will be a Palmetto office in Birmingham. If this is correct, can you please give some details on the structure of this office and what functions will be handled in Birmingham?

Response: **Yes we will be opening an office in Birmingham but have not determined which functions will be based there at this time.**

14. Can you please provide contact information for Palmetto GBA? Also, can you provide details of the escalation process that Palmetto has in place to assist providers with resolving problematic accounts when a resolution cannot be obtained through the Provider Contact Center?

Response: **Follow us on Twitter @PalmettoGBA_JJA and @PalmettoGBA_JJB and like us on Facebook.com/PalmettoGBA in order to communicate and to stay informed about the latest transition information.**

Providers may also submit questions via email at JJ.Transition@PalmettoGBA.com.

Lastly, Palmetto GBA has a toll-free transition hotline for providers to connect directly with us. Simply dial 1-888-289-0710 to access transition information via our Interactive Voice Response unit or to speak directly to a customer service representative for assistance. We will announce the Jurisdiction J consolidated toll-free Provider Contact Center number in the coming weeks.

We are committed to delivering our service of excellence to Jurisdiction J's Medicare providers and beneficiaries. We look forward to continuing to work with you for years to come.

Our goal is to have first call resolution. In regards to our PCC escalation process, we have a tiered process in which we warm transfer the caller and only as a last resort do we offer to do a callback. We ask all callers to get a tracking number for reference and 100% of our calls are recorded for quality assurance.