MEDICARE (CAHABA GBA) MINUTES
November 3, 2014 RIC/RAC Meeting

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

FACILITATORS PRESENT:
Ms. Margaret Whatley
Ms. Karen Northcutt

MS. WHATLEY: Suzanne Evans and Joy Fowler are here from Cahaba. I know they're familiar faces to everybody. I'll turn it over to them first, and then we'll start the questions.

MS. EVANS: Good morning. The first thing I want to tell you is that Dr. McKinney is no longer with Cahaba. He has gone to work for another contractor. But don't worry. We are in the process of hiring a new clinical physician. I don't know what kind of role he'll play with us in AlaHA, but we will have somebody soon and I'm sure there will be an announcement of some sort. If not, Joy and I will tell you. But we will miss him, and I know he brought a lot of laughs to us when he was here. Joy and I aren't that funny, but we'll muddle along.

MS. WHATLEY: Thanks Suzanne. We will start with the questions now.

1. Follow up to Question #1 from July 21, 2014 RIC/RAC meeting:
a) When will Cahaba be able to provide claim identifiers when provider's interest payments are posted?

Response: CR8485 was to be implemented October 6, 2014, to report the principal and interest amounts separately and provide individual claim information when refunding previously recouped money on the Remittance Advice (RA). However, CR8485 has been rescinded and will not be replaced.

b) What instructions should providers follow in the interim to identify RAC and MAC interest payments and to what claim they apply?

Response: Process to retrieve B2 information is as follows:

- **The provider should contact the Provider Contact Center (PCC) (877) 567-7271 with the**
  - **Email address**
  - **Remit date**
  - **Amount**
  - **PTAN**
  - **NPI**
- **The information will be routed to the appropriate area in PAAR for a response. Please allow 72 business hours from the time PAAR receives your inquiry for a response by email.**

Discussion at meeting

MS. EVANS: The instructions in the interim won't be the interim. It will continue this way.

If you don't get a response from PAAR within 72 hours, then we will continue the way we've been doing. And if you will e-mail it to Peggy at AlaHA with your GINQ number - your reference number - then I will get it to them and we'll take care of it.

I hear many times that I'm not given a reference number when I call. When you call, be sure you get a reference number. You ask for it. Tell them you won't hang up until you get one, because that's our documentation. That's our link. They're typing it in the system and when they do the click on, they get a reference number. So you tell them that you're not going to hang up until you get a reference number. And that reference number you will give to Peggy, and then we won't have to go through any PHI stuff. Okay?

THE SPEAKER: So Medicare would rather us make 20 calls a week and your folks have to answer them and submit all that information that way, wasting our time and your time, than provide one little ID number on a remittance? Makes no sense.

MS. EVANS: I understand.

THE SPEAKER: Well, the customer service people did tell us that they were being given access to that information in your system so that they wouldn't have to be submitting all those questions back to the financial department.

MS. EVANS: Let me tell you a little bit of what's going to happen. There's going to be a little bit of change in the way things are done. And yes, customer service will be able to do some of those things.

It's not like you give me something I need identification on is $7,000, this lump sum. You just don't go into the system and pull it up and say this $7,000 goes to where? There's several things that you have to go through.

So yes, they are going to be able to do it, but it probably won't be when you call that first time. They'll probably say to you, I will get back with you. Because it's going to take some time to get that done.

It's my hope, and I have been campaigning for this, that they have somebody that's dedicated to that so that not all customer service reps have access to that. Because that's not practical because of the amount of training that you have to do to do that. So hopefully, they will have one or two people that are good at that and can go and get that quickly without having to send it someplace else or to Peggy or me.

So, yes, there is some change coming. I don't know when. I don't know how much detail. But as soon as we find out, I'll let you know. Maybe by March we'll have something.

THE SPEAKER: Did they give you any explanation whatsoever as to why a manual process like this is more efficient for Cahaba and the hospitals than doing it the right way and just providing the ID number.

MS. EVANS: No. It's not efficient.

THE SPEAKER: But identifying each one of those transactions, it's got to be in the system somewhere.

MS. EVANS: It's very time-consuming. Yes. Because they'll say to me, come up here and see our spreadsheets. I don't want to see where we have to go to get these things. Because a lot of stuff is in HIGLAS, but then you have to go other places and get it. It's not all compact. So, to answer your question, I don't know.

THE SPEAKER: Thanks. And by the way, some of the folks up there, like LaShondra and Miguel, I'm already getting e-mails from them, sometimes a couple of times within the same day. So that process is already working, depending on who you get.

MS. EVANS: Great. It was worth the trip. I will certainly share that. You don't always get a positive.

2. Follow up to Question #2 from July 21, 2014 RIC/RAC meeting. What are the interim instructions for filing Part B rebills when 121 and 131 dates of service overlap and the claim is rejected? Change Request 1412 (MM8820) released August 1, 2014, but is not effective until 1/1/2015, with an implementation date of 1/5/15.

Response: **Will discuss at meeting.**

Discussion at meeting

MS. EVANS: If you think that you have some that did not overlap with an inpatient but rejected as a duplicate, if you will send the claim number to Peggy at AlaHA, she'll send it to me and we'll have it adjusted. There really isn't any good work around for that other than that.

So if you'll take your claim number and send it to Peggy, that's not protected information, and she can send that to me, and I'll be in touch with you. I talked to the claim senior, and we tried to figure out something good, but that was the best we could come up with. And she will adjust those for us. And then 2015 will be here before we know it.

3. Follow up to Question #3 from July 21, 2014 RIC/RAC meeting. The 2014 CCI manual states that "only one respiratory inhalation treatment can be billed per encounter." CCI representative Linda Dietz clarified the definition of encounter as direct personal contact between the patient and physician (or hospital clinician). (*Medicare Claims Processing Manual, Chapter 2, Section 90.6)* stating "if the professional completes the inhalation service(s) and terminates the patient encounter but returns later that day to initiate additional inhalation treatment(s), …an addition UOS of CPT code 94640 may be reported for this subsequent patient encounter."

This would allow for multiple units of CPT 94640 during an observation stay or ER visit if each involved a separate encounter as defined above. Do you agree with this interpretation?

Response: **94640 x 1 for initial/first treatment per date of service**
94640 -76 for each additional treatment

Discussion at meeting

MS. EVANS: There's the answer. We won't see this again.

MS. NORTHCUTT: That's a good answer. And the other part is, Medicare is not going to pay us for it anyway in January.

MS. EVANS: But it will look nice on the claim.

MS. NORTHCUTT: Yes, it will look really nice. It will fail your claim if you don't modify, even though you're not going to get paid for it.

4. Follow up to Question #9 from July 21, 2014 RIC/RAC meeting. Providers continue to have MAC and RAC denials which they are attempting to rebill as Part B which are rejected as past timely filing despite being appended with the W2. When can we expect Cahaba to be able to process these correctly?

Response: **Need to see examples.**

From Ask Cahaba A Teleconference 03.04.2014

Q: We are putting A/B Rebilling, ICN and actual date of our claims withdrawn or dismissed. We are filing in the timely filing limit of that date and the claims are rejecting stating we are not using date of original denial. We are putting condition code on all these claims.

A: We need the date of the last rejected claim. FISS began recognizing the W2 condition code 07.01.2013. Remove the W2 condition code if DOS on the claim is prior to 07.01.2013

Discussion at meeting

MS. EVANS: Well, as always, we need to see examples. So if you have some of these claims and you've called customer service, and didn't get any kind of response that you liked, if you'll send the GINQ number to Peggy at AlaHA, she'll send them to me and we'll look at them.

But while I was researching, I found where we had done an Ask Cahaba A Teleconference back in March. So if this example affects you, then take it off. If not, then just send them to Peggy and we'll look and see if we can't get some resolution to it.

5. Follow up to Question #12 from July 21, 2014 RIC/RAC meeting. With regards to Medicare not keeping the same DCN# when processing a RAC denial, recoupment and repayment. *Medicare Claims Processing Manual Chapter 29-Appeals of Claim Decisions S. 310.1, B. What constitutes a*

Request for Redetermination, 2. Written Requests for Redetermination Submitted by a State, Provider, Physician, or Other Supplier, b. A written request/letter does not indicate the DCN/ICN is a required element to a valid Redetermination; however providers are having appeals dismissed for failure to provide the correct DCN/ICN. Please clarify which ICN/DCN should be submitted on the Smart Form. We would like to request that Cahaba remove the requirement of a DCN/ICN on the Smart Form and utilize the other elements to identify the denied claim rather than only the ICN/DCN.

Response: **Discuss at meeting.**

Discussion at meeting

MS. EVANS: I have lots of examples of these. I have been working with the appeals department. And I think they finally see that there are multiple ways and multiple places that tell you how to file an appeal that are contradictory or that are not all the same.

You know, our form says original DCN, and then they'll say we want the retracted DCN or we want this. All that to say that we are working on either a teaching aide or something that says when you file this appeal for this, we need this ICN number. I don't have it today, but we are working on it. Our provider outreach education and the appeals seniors are working to see what we can get out there that is specific.

And I know it's confusing. It's confusing to me. So more to come. And I will let you repeat this one in March. Maybe we'll have a resolution by then. But we are working on it.

THE SPEAKER: Well, my question is why do they assign a new ICN number? They're repaying the same claim. They're just paying it differently. And they don't always assign a new ICN number. Sometimes they do and sometimes they don't.

MS. EVANS: No. Because if it's a RAC adjustment, they're going to assign a new DCN.

THE SPEAKER: Not always.

MS. EVANS: Most of the time they do. So that's the one you need to appeal, not the original like it says on the Smart Form.

THE SPEAKER: we need some sort of notice to know that you're unable to identify our appeal so that we're not sitting there for six months saying, okay, we think Cahaba is processing it and they kicked it out as soon as we submitted it. Does that make sense?

MS. EVANS: Oh, yes, it does. So if you have some like that that you don't know, things do get lost, let me know. You know, we're a technological world and we do still depend on the mailman. But we have been successful in some of them.

6. Follow up to Question #15 from July 21, 2014 RIC/RAC meeting. Trauma Response should be reported under the following revenue codes: 0681 Level I, 0682 Level II, 0683 Level III, 0684 Level IV. We are trying to bill a Level III Trauma Response, the edits will not allow this revenue

code to be billed on a 13X or 11X bill type. All other revenue codes are allowed. Please give us a date when the edit for 0683 Level III will be turned on.

Response: **Screen has been updated to accept Revenue Code 0683.**

Discussion at meeting

MS. EVANS: I am so glad to be able to respond to this, and it is fixed, thanks to Fran at DCH and her perseverance.

THE SPEAKER: Thank you.

7. a) Our hospital has accounts that we received Denial Result letters for medical necessity and have not been transacted by Cahaba with the issuance of a Demand Letter as required by CMS rules with a deadline date of June 30, 2014. What are hospitals supposed to do with these that Connolly issued Denial Results and Cahaba has never sent Demands on and this has happened throughout the state of Alabama, both for PIP facilities and non-PIP facilities?

b) Another hospital has received a Demand Letter in excess of 1 year from the RAC and when the hospital submitted the appeal based on the Demand Letter date, it was dismissed as past timely. The SOW specifically states the Demand Letter date begins the time clock for the due date. What process should providers follow if this happens? [Examples submitted to Suzanne Evans via secure email by Claire Owens.]

c) Another hospital has a claim that was determined by Connolly to be an Underpayment, but Cahaba never processed the payment. A new notice from Connolly was received stating "Connolly will not be reviewing…these claims are no longer eligible for review per CMS instruction". What process should providers follow to receive appropriate reimbursement of these types of claims.

Response: **Discuss at meeting.**

Discussion at meeting

MS. EVANS: Let me just say this in summary, there's still not a good answer for this. What I'd like for you to do, when you have these demand letter issues, is to call the provider call center and let them try to handle it and get the reference number. If it still doesn't work, then send the reference number to Peggy at AlaHA and I will work on it. Is this common? Are we seeing a lot of this?

THE SPEAKER: Yes. A decent amount. And the issue is you'll go in and do your appeal, and then you'll get a dismissal notice saying that it's outside timely filing. However, my demand letter was dated, say, November 1st from a claim that was denied two and a half years ago. And through this entire process, we never received a demand letter. You receive a demand letter. You file your appeal. Therefore, you're timely because you just received your demand letter dated November 1st. But then once you go through the appeal process, you get a dismissal saying that you're outside the timely filing.

MS. EVANS: Have we talked about this? Have you sent this to me?

THE SPEAKER: I thought I did. I'll resend it to you.

8. When will Medicare start reimbursing for end-of-life care planning codes?

Response: **As of this date, we have not received any information from CMS.**

Discussion at meeting

MS. EVANS: We've read about it, but we have not seen anything yet. So be watching the website. We'll put something out there when we do.

9. a) Will Cahaba require the new X(ESPU) modifiers in lieu of modifier 59 for any specific services? If so, when and will there be further education regarding these modifiers?

Response: **The new modifiers will be accepted on any claim that accepts a modifier 59 currently beginning 01.01.2015.**

b) For example, if a duplex scan of extracranial arteries (CPT 93880) was performed in cardiology by one physician and a thyroid ultrasound (CPT 76536) was performed in radiology by another physician, which X(ESPU) modifier would be appropriate?

Response: **XP Separate Practitioner, A Service That is Distinct Because It Was Performed by a Different Practitioner.**

Discussion at meeting

MS. EVANS: For a), POE is already starting with some education. I know Part B has included in some of theirs. And so you should be seeing some education on that.

For b), I had asked support services about this because they deal with all that, and they felt like, given that description, the XP separate practitioner would be the one that you would use for that.

But keep watching the CRs and keep watching the website because we will have some stuff out there. And the webinars. Please take advantage of those.

MS. NORTHCUTT: And just to say, your billing department or whoever has to do this is going to hate you when you bring that to their attention. Right now it's voluntary. I think, as we were talking, that probably will become mandatory. Because they're trying to get away from the 59 modifier. So we're going to have to sort it out into four different criteria now of why you're modifying that.

10. Does Cahaba plan to review Part B "related claims" as described under Transmittal 541? And if so, verify your timeframe for requesting permission from CMS and when do you expect these reviews to begin?

Response: **Medical Review performs ongoing data analysis to identify new issues and will utilize this concept if/when indicted. These explicit instructions will be followed if it becomes necessary to deny 'related' claims. Cahaba will seek CMS approval as instructed.**

11. What is the correct discharge status code for a patient residing (living) in a residential mental health institution, such as an inpatient psychiatric facility (Bryce) or a residential community mental health home (**not** an acute care psychiatric hospital or unit)?

Response:

1. **Living in a residential mental health institution, ie IP psych facility such as Bryce = 65 Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital**

2. **Residential community mental health home = 01**

    a. **Per FAQs SE0801:**

    What is the difference between residential care and assisted living care?

    In terms of a patient discharge code, there is no difference. Discharges to residential care and private (non-state designated/supported) assisted living facilities are coded alike (01).

12. Does Medicare cover hypoglossal nerve stimulator system for treatment of obstructive sleep apnea? If so, as there is no specific CPT code should we use 64999 (Unlisted)?

Response: **Cahaba GBA considers hypoglossal nerve stimulator system for treatment of obstructive sleep apnea as investigational – not yet proven effective based on review of available literature using standard strength of evidence guidelines.**

MS. EVANS: This response is per Dr. Humpert.

13. CCI originally did not allow a modifier to by-pass edits between a CT of spine with intrathecal contrast and a myelogram. However, after input from the American College of Radiology that these tests provide different clinical information, CCI now allows a modifier. Therefore, can a hospital bill and modify with modifier 59 when a CT scan and myelogram are performed in the same session if there are separate orders, interpretations and medical necessity for each test?

Response: **Discuss at meeting.**

Discussion at meeting

MS. FOWLER: First of all, I'm not a coder. So our coder in Part A has been working with 3M - and I'm sure you all know them well - about this particular situation. And 3M, I believe, has been bombarded with a lot of questions because there are changes for 2015. You know, modifier 59 is okay for this year, but for 2015, there are different codes and different modifiers.

An answer came through from 3M, but, it's dealing with the 2015 changes. And four new codes were created for 2015 to bundle the injection and imaging guidance. For the myelography and the radiologic supervision and interpretation, there are also three new codes for that.

So, 59 is still in effect for this year, but next year, as you coders out there know, everything is going to be totally different. Things are going to be bundled.

So that's the answer we got from 3M just this morning, right as we were leaving.

THE SPEAKER: So there will be new CPT codes for that? Is that what we're saying?

MS. FOWLER: According to what 3M has told us, yes.

14. For the Hospice 07 widespread audit, what documentation are you looking for to support a claim that the acute care stay is NOT related to the hospice admission? Please provide clinical examples of claims where they stay is NOT related.

Response: **The clinician checks HIMR to confirm Hospice overlap or revocation of services. If an overlap is confirmed, the medical record from the inpatient hospitalization is reviewed and compared to the hospice diagnosis.**

EXAMPLE 1 - PATIENT CURRENTLY ENROLLED IN HOSPICE WITH DX CHF.PRESENTS WITH OPEN, DRAINING SURGICAL WOUND AFTER THORACIC SPINE SURGERY WITH SPINAL FUSION. POST-OP WOUND INFECTION, NOT RELATED TO HOSPICE.

EXAMPLE 2 – HOSPICE DX OF RENAL CANCER. PRESENTED TO HOSPITAL AFTER FALL OFF TOILET IN THE BATHROOM. NOW WITH PARENCHYMAL HEMORRHAGE. WATCHED OVERNIGHT AND SENT HOME. NOT RELATED TO HOSPICE.

EXAMPLE 3 - PATIENT CURRENTLY ENROLLED IN HOSPICE WITH DX COPD. PRESENTS WITH INFECTED SURGICAL INCISION RELATED TO INCISIONAL HERNIA REPAIR DONE ABOUT 1 MONTH PRIOR. I&D DONE AND DRAIN INSERTED. NOT RELATED TO HOSPICE.

EXAMPLE 4 - PATIENT CURRENTLY ENROLLED IN HOSPICE WITH DX CIRRHOSIS. PRESENTS AFTER FALL FROM W/C, STRIKING HEAD AND +LOC. CT HEAD SHOWED HEMATOMA, NO HEMORRHAGE. TRAUMA DX, NOT RELATED TO HOSPICE.

Discussion at meeting

MS. FOWLER: When the clinicians in medical review look at these, the first place they look is HIMR to see if there truly was or was not an overlap. And in a lot of instances, there was not. So of course, we would pay that hospital claim.

But if there is an overlap, then the clinician has to look at the record - has to see the hospice diagnosis and look at the record to make a determination as to whether the hospital session was related to the hospice diagnosis. And I know sometimes this gets down to total clinical judgment on the part of the clinician. And if there's a question, a lot of times the medical director is involved in trying to make that decision.

But in conjunction with that, we've got you four examples there. That's really all I know to tell you about the way the review takes place.

THE SPEAKER: I have kind of a new question that I e-mailed Suzanne about the other day. If the hospice agency is supposed to cover all of the care for the hospice patient and what we're finding when these patients come into the hospital is the hospice agency is telling us it's not related. Okay. So we go with what they say, because they're the ones that know the hospice diagnosis, know their patient.

But when we get the denial or we get the redetermination notice from the appeal, the assignment of who's responsible for the payment is saying that the hospital is responsible. And when we go to the hospice agency and say Medicare paid you for the hospice care, you need to pay us for the care we provided, then they're giving us grief over it. And the denial is not supporting that they should be responsible for paying it.

So is that letter just kind of like a template letter that maybe needs to be adjusted?

MS. FOWLER: It is, and I'm not sure that we can assign liability to the hospice. The facility is responsible for collecting that from hospice. The facility has to make sure that the hospice reimburses them for whatever number of days that they're responsible for.

THE SPEAKER: But then the rationale, it says that hospice should cover the care.

MS. FOWLER: That's right. But since we're not a contractor who reviews hospice claims, we don't have the option of assigning the liability to the hospice. We can say that, but we either have to assign the liability to the patient or to the inpatient facility. So the inpatient facility then has to work with the hospice to get the payment.

15. CMS issued a Decision Memo for Carotid Artery Stenting (CAG-00085R) which requires that the record contains documentation stating that the patient is a poor candidate for carotid endarterectomy (CEA) “in the opinion of the surgeon.” For the purposes of this NCD, would an interventional cardiologist qualify as a surgeon? Would any type of surgeon be able to make the necessary statement? Please explain.

Response: **Discuss at meeting.**

Discussion at meeting

MS. EVANS: We don't know. We've talked about it, and we bounced it back and forth.

MS. NORTHCUTT: I did research this again, after this question from the decision memo that was written. And the decision memo was basically when we started the clinical trials, when they first

approved it. And so I took that memo and went back to the NCD, which is the latest national coverage determination on carotid artery stenting and they took that wording out.

So I think when they made the original decision, they were including the surgeon in their opinion. And then over time, in this last NCD edition, I could not find that verbiage anywhere. And I think, just as a side note, just to let you know out there, carotid stenting is becoming the treatment of choice.

The bigger issue we're having is that the surgeons are losing business to the interventionalists that are putting the stents in. And I think that at the initial determination where the surgeon's opinion mattered, and now it's not in the NCD - I think that's where some of this is stemming from. I think we've got doctors that are actually turning on each other based on this policy

MS. WHATLEY: We'll break question 16 down into several parts because it's several scenarios for cancelled inpatient-only procedures.

MS. FOWLER: You see all kinds of different scenarios. Every time you look at a record, something different goes on. The documentation is different. It's a combination of a medical necessity decision and coding rules. And some of these things get very difficult sometimes. But I try just based on what you told me here and not having a record to tell you what I think I would do. But, let me say this from the onset. I might look at a record and go a totally different direction. But I'll answer on the particular examples submitted.

16. For cancelled inpatient only procedures (IOP), please indicate the following for each scenario listed below: 1) The status of the patient at the time of DC and 2) Whether to bill Part A or Part B for the patient.

a) The patient is scheduled for an IOP. She comes to the hospital and completes PADT (Preadmission Diagnostic Testing) 3 days prior to the procedure as planned. The patient presents on the morning of the surgery and has eaten and the surgery has to be cancelled.

Response: Part B

b) The patient is scheduled for an IOP. She comes to the hospital and completes PADT 3 days prior to the procedure as planned. The patient presents on the morning of the surgery and is taken to the OR. The procedure is cancelled intraoperatively because the patient has a MI (or some other complication). The patient goes to a bed and meets 2 midnight stay.

Response: Part A with coding instructions as below, at the end of the question.

c) The patient is scheduled for an IOP. She comes to the hospital and completes PADT 3 days prior to the procedure as planned. The patient presents on the morning of the surgery and is taken to the OR. The procedure is cancelled intraoperatively because the patient has a MI

(or some other complication). The patient goes to a bed and does not meet a 2 midnight stay.

Response: If 2 MN "expectation" is met, bill Part A with coding instructions as below, at the end of the question.

Discussion at meeting

MS. FOWLER: The issue with a situation like this is the expectation of the two midnight stay. If I have a patient who has an MI, I'm going to expect that patient is going to be there for two days. And if that patient recovers earlier than that or there's an unexpected recovery, you can still go as inpatient.

THE SPEAKER: The inpatient-only procedure is the reason why the patient was admitted in the first place. So even though the surgery is cancelled, it's still inpatient.

MS. FOWLER: That's correct, and that's the way we review them. If it's an inpatient-only procedure and you have an unforeseen circumstance, you know, after anesthesia is administered we would pay that.

But, if you have a patient who goes in and the surgery is canceled because of an MI and the procedure is not done, you're going to expect that patient to stay two days.

So, if you were scheduled for an outpatient procedure and you come into surgery and the patient has an MI and they don't get to complete the surgery, the expectation is the patient is going to be there because of the MI. So yes, we would pay that inpatient. The reason for admission would be the MI.

THE SPEAKER: So let's say they're scheduled for an inpatient-only procedure and, for some reason during surgery, they stop the procedure. The patient goes to a room. The only expectation for the inpatient was because it was an inpatient-only procedure.

MS. FOWLER: We would pay it as inpatient. Absolutely.

THE SPEAKER: So the fact that they have inpatient-only procedure scheduled but not done, we don't have to change that to Condition Code 44?

MS. FOWLER: No, you don't have to. We would look at that. We would see it was on the inpatient-only list, and we would pay that.

THE SPEAKER: Now, it would be coded an inpatient. So how would we need to document that for you to know, would it help you if we put that with the medical record?

MS. FOWLER: Absolutely. Of course.

THE SPEAKER: I have a question. You said you're referring to modifiers. But if it stayed inpatient, there wouldn't be a modifier on the claim. You can't modify an inpatient claim. Is there something else on the inpatient you would expect to see?

MS. FOWLER: The V codes for surgical or other procedure not carried out, do you do a contraindication? Do you do a complication? For other reasons, there are V codes for that.

d.) The patient is scheduled for an IOP. She comes to the hospital and completes PADT 3 days prior to the procedure as planned. The patient presents on the morning of the surgery and is taken to the OR. The procedure is cancelled intraoperatively because of something found and is changed to another procedure that is not on the inpatient only procedure.

Response: Implement condition code 44 and convert to outpatient.

Discussion at meeting

THE SPEAKER: That makes sense.

MS. FOWLER: Yeah. And convert to outpatient. To the best of my ability, those are the answers.

THE SPEAKER: Well, thank you for talking to us about it, because I think anytime we discuss it, it does help us a lot. Because, like, to me, that question about the procedure changing - but, yet, if it was scheduled as an inpatient-only procedure, your expectation at the time of admission was for two midnights. So to me, the same situation where the procedure was cancelled and the patient stayed, but they didn't meet the two midnights. It would be the same thing in the next question.

MS. FOWLER: Right. Now, we're looking after the fact here and, if I were in the hospital and I caught this and I could change it to Condition Code 44 and bill it, I probably would. But if we pulled this record and saw that it was an inpatient-only procedure and the intent was for an inpatient-only procedure and something happened, we would pay that.

Response (continued)

Since Medicare requires an admission order prior to an inpatient procedure, patients generally are admitted as they enter the hospital on the day of their procedure or surgery. If the procedure or surgery is cancelled because it becomes apparent that the patient's condition is not optimal to proceed, the treating physician must decide on the proper action to take based on the acuity of the clinical problem. Should the patient be transferred to an inpatient medical bed for treatment? This would be appropriate if admission is justified based on the usual Medicare admission guidelines, including the patient's clinical condition and the treatment plan at the time the admission decision is made (as well as the physician's clinical judgment and risk assessment). Should the patient be discharged to outpatient management? In this case, the hospital could bill Part B for any ancillary services that have been provided (Benefit Policy Manual, Chapter 6, Section 10: "Medical and Other Health Services Furnished to Inpatients of Participating Hospitals") or implement the Condition Code 44 procedure to convert status from inpatient to outpatient prior to release. In either case, the hospital would not be able to bill for the procedure or surgery.

On the other hand, if anaesthesia has been administered before the case is cancelled or terminated; the hospital would provide routine post-op care and bill for the inpatient procedure even though it hadn't been completed.

It is critical that the nursing staff and the physician clearly document the reason the procedure is not completed as planned and communicate this information through the medical record and by direct messaging to the hospital's billing department. Use of the proper modifiers and V-codes allows a hospital to receive payment for services even when the procedure isn't completed as planned.

Hospitals may be paid for procedures that are cancelled due to a patient's condition or other unforeseen circumstances by billing with the appropriate modifiers. Transmittal 2386 of the CMS Claims Processing Manual, Pub 100-04 (effective Jan. 1, 2012) contains updated provisions that allow hospitals to use modifiers to bill Medicare for cancelled procedures.

"Modifiers provide a way for hospitals to report and be paid for expenses incurred in preparing a patient for a procedure," the transmittal reads, "and scheduling a room for performing the procedure where the service is subsequently discontinued."

Modifier -73 is used when a procedure requiring anaesthesia is terminated "due to extenuating circumstances or circumstances that threaten the well-being of the patient" - after the patient is brought into the treatment room, but prior to the administration of anaesthesia. Anaesthesia includes "local, regional block(s), moderate sedation/analgesia (‘conscious sedation'), deep sedation/ analgesia or general anaesthesia." Any services provided in the recovery room are included.

When a procedure is terminated due to circumstances that threaten the well-being of the patient or other extenuating circumstances (for example, failure of a critical piece of O.R. equipment) occurring after the administration of anaesthesia, or after the procedure is started, Modifier -74 is used. Transmittal 2386 explains that Modifier -74 "may also be used to indicate that a planned surgical or diagnostic procedure was discontinued, partially reduced or cancelled at the physician's discretion after the administration of anaesthesia." The same broad definition of anaesthesia is applied.

There is also a set of ICD-9 V-codes for cancelled procedures. These V-codes are never used alone and cannot designate a principal diagnosis. They are reported along with the procedure code, the appropriate modifier and the ICD-9 code for the reason the procedure was aborted.

V64.1: Surgical or other procedure not carried out because of contraindication.

V64.2: Surgical or other procedure not carried out because of patient's decision.

V64.3: Procedure not carried out for other reasons.

Billing with the above modifiers is allowed only when there are clinical or "extenuating circumstances" that prevent completion of procedures. Transmittal 2386 explains that "the elective cancellation of a procedure (such as a patient not showing up or changing his/her mind) should not be reported.

17. When sending medical records on CD, how can we provide Cahaba with a password so the CD may be encrypted?

Response: **Most providers that send encrypted CDs will send the CD and the password under separate cover on the same day. Process Control does not have email set up to receive passwords for the CDs.**

Discussion at meeting

MS. EVANS: I talked to the manager at process control on this. You send it separately. Is anybody doing that and having issues?

MS. EVANS: You are not having any problems? That's good.

18. In 2011, CMS extended the use of the FB modifier to diagnostic radiopharmaceuticals received free of charge or with full credit (see January 2011 OPPS update Transmittal 2141, CR 7271). In the January 2014 OPPS update (Transmittal 2845, CR8572), CMS states “Effective January 1, 2014, CMS will no longer recognize in the OPPS the FB or FC modifiers to identify a device that is furnished without cost or with a full or partial credit.” Instead value code "FD” is to be used. Do facilities use the FB modifier or the FD value code to report radiopharmaceuticals received at no cost?

Response: **FB/FC are ASC modifiers and are only approved for the services with TOS F, and there are only 72 codes where the reimbursement rates are altered by the use of FB/FC modifiers per the ASC fee schedules provided by CMS. Radiopharm drugs will not accept FB/FC modifiers.**

Discussion at meeting

MS. EVANS: I asked support services about this one.

THE SPEAKER: So we just use the value code, right?

MS. EVANS: Yes.

19. KX modifier on Pet Scan MLM MM8739 dated 5/28/14

a) We need clarification on what is meant by different cancer diagnosis and the fact that you can start over with the subsequent treatment strategy count. Does this mean a totally

different primary site or does it include when a primary diagnosis metastasizes? Basically does the subsequent treatment strategy count start over every time there is a different/new diagnosis or when it changes diagnosis codes but is still related to the primary cancer?

b) We are seeing a lot of lymphoma then B cell lymphoma then non- Hodgkin's; So, are these the same or different and would the subsequent count start over? Also primary breast cancer then metastasizes to the lungs or bones……would the lung and bone be considered different/new diagnosis and the subsequent count start over?

Response: **The basics of CR or MM8739 state:**

A. 'MACs … cover three FDG PET scans when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same cancer diagnosis. Coverage of any additional FDG PET scans (that is, beyond three) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same diagnosis will be determined by your MAC.'

B. If a different cancer diagnosis is reported, whether reported with a -PI modifier or a -PS modifier, that cancer diagnosis will begin a new count for subsequent treatment strategy for that beneficiary.

C. '… to end the prospective data collection requirements across all oncologic indications of FDG PET'

1. **What is meant by different cancer diagnosis?**
   Answer: **Different diagnoses are listed by / related to the 'Tumor Type' as listed in the MM8739 spreadsheet.**

2. **You can start over with the subsequent treatment strategy count?**
   Answer: **Yes - related to 'Tumor Type' as listed in the MM8739 spreadsheet.**

3. **Does this mean 'begin a new count for subsequent treatment strategy' with a totally different primary site (of the same 'Tumor Type') ….does it include when a primary diagnosis metastasizes (of the same 'Tumor Type')?**
   Answer: **No. The MM8739 states 'Coverage of any additional FDG PET scans.. will be determined by your MAC'.**

4. **Does the subsequent treatment strategy count start over every time there is a different/new ICD-9 diagnosis?**
   Answer: **No. The MM8739 states 'Coverage of any additional FDG PET scans.. will be determined by your MAC'.**

5. **Does the subsequent treatment strategy count 'begin a new count for subsequent treatment strategy' when it changes diagnosis codes but is still related to the primary cancer (of the same 'Tumor Type')?**
   Answer: **No. The MM8739 states 'Coverage of any additional FDG PET scans.. will be determined by your MAC'.**

6. **We are seeing a lot of lymphoma then B cell lymphoma then non- Hodgkin's….. would the subsequent 'begin a new count for subsequent treatment strategy' count start over?**
   Answer: **No. These would fall under the same 'Tumor Type' as listed in the MM8739 spreadsheet under 'Lymphoma'**

7. **Also primary breast cancer then metastasizes to the lungs or bones……would the lung and bone be considered different/new diagnosis and the subsequent count start over?**
   Answer: **No. These would fall under the same 'Tumor Type' as listed in the MM8739 spreadsheet under 'Breast'.**

Discussion at meeting

MS. EVANS: I gave this to our CMD, Dr. Humpert.

THE SPEAKER: So are three, four, and five all retrospective? Do you have any information on what the MAC will use to determine whether they're going to pay for that or not?

MS. EVANS: The CMD will look at it and determine it.

THE SPEAKER: What are they going to use? I mean, we need to know that before we do the test.

MS. FOWLER: CMDs basically just use their knowledge to make their decisions. There's nothing that I can give you to tell you what the CMD would do when it looks at it. They don't really have to use anything but their knowledge.

20. Do you have an update on the status of the Medicare 68% settlement?

Response: **Appeals is working on the Medicare 68% settlement. Be sure and complete the spreadsheet completely and contact information correctly.**

FAQs (as of 10.27.2014)

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/External-FAQs8-cleared-updated-for-10-27-v5-1.pdf

MS. EVANS: They are working on it. I think they're seeing some issues where the contact information is not correct or the spreadsheets aren't filled out correctly. There are some facts on the website. And I put the link here.

Additional/follow up discussion at meeting

THE SPEAKER. I just wanted to ask for some follow up back on the hospice question. So we're running into some other issues in addition to the issue with trying to get the hospice to pay us when they say it's not related and you guys say that it's related. We're also seeing the revocation happen on the same day as the patient presented to the ER. So my question is do we bill hospice for that one day, discharge them, and then readmit them on the 2nd?

MS. FOWLER: No. It's okay for that day to overlap. We'll pay that. We should pay that. If we do not pay that, appeal it. The revocation and the date of admission, it's okay for that to be on the same day.

THE SPEAKER: Okay. Thank you.

THE SPEAKER: I have a quick question about the second round for the probe and educate. From information I believe from Suzanne that you had updated instructions from CMS indicating that you should initiate the second round of probe 60 days from the date of the letter - rather than the actual education call - can you provide a little bit more clarity on that?

MS. FOWLER: It's just exactly that. Updating information that CMS gave us, we received instruction to use the date of the letter. So CMS issued another clarification, and we had to go back and go 60 days from the date the letter was sent to your facility.

THE SPEAKER: Will round two of probe and educate mirror the first level? When you complete our second level, we have an opportunity to have another phone call with you before we move on, if we have to do that?

MS. FOWLER: Yes. It's going to work exactly the same way.

We've probably completed about 25 providers. I think we have sent 22 letters, and I think this morning I checked and there might be three more that were about to send. So we've only completed 25 providers so far.

And you will get the same letter, the same explanation, the same opportunity to schedule a call.

THE SPEAKER: But we should go ahead and start the appeal process? If we received a denial on a case that we don't agree, go ahead and appeal?

MS. FOWLER: Yes. Go ahead.

THE SPEAKER: I have a question back to the hospice. I'm in the insurance billing department. So I'm seeing the rejections. The first rejection is just for the overlap, because we did not bill with the

07. Do we have to bill with the 07 and then get the denial to do the appeal? Because that's what we're seeing is that the claims are being denied after we submit with the 07.

MS. FOWLER: Right. Well, that's part of the edit parameter. We pull based on the 07.

THE SPEAKER: And then also, if the patient revokes on the second day, do we need to bill that one day separate?

MS. FOWLER: Yeah. The second day. Yes. There's no choice.

THE SPEAKER: Okay. Thank you.

THE SPEAKER: I have to go back to something with the two midnights because it's coming up, and we want to do the right thing for the patient.

So if someone comes in really late that night, they stay maybe 30 minutes prior to midnight. So they've made that night. And as part of the work-up, it goes throughout the day and it's late into the afternoon before they've completed that. We have physicians that are not going to go up at 8:00 or 9:00 at night and discharge a patient home.

So they're not being discharged, but there's not a medical need for that next midnight, but they're going to stay because it came in so late. And I don't want to do the wrong thing for the patient.

So what was the intent? Do they want someone to be discharged that time of the evening? The consult may not even be back. If the results come back, the consult may not see them back again until the morning.

MS. FOWLER: Well, the issue is if there is treatment of a condition for a period of two midnights and the original expectation is for a two midnight stay, then the presumption is it should be covered. So, all this depends on what's going on with the patient. The patient can't just lie in the bed and not be treated, you know. The patient may have maybe IV fluids or antibiotics or maybe they're getting labs or radiology or whatever during that two midnight period. And we take all that into consideration.

THE SPEAKER: I have one more question about the two midnight. Can you share with us how hospitals are doing, or will there be any statistics on how many hospitals pass Phase II, how many are not passing Phase II?

MS. FOWLER: Well, we're still too early in the process for me to really tell you that. You know, we've only really totally completed 22 of 350 or 400 hospitals. So it would really be too early for me to give you an estimation of what's going on with that at this point.

However, I'll go so far as to say it's going a lot more smoothly this time, and there seems to be less confusion. Based on what I have seen, I think there's a little better understanding

THE SPEAKER: This is going back to question number 13 about the modifier bypass edit between a CT of the spine with intrathecal contrast and a myelogram. There was actually some information in

the CPT Coding Clinic September 2014 publication that said that after July 1, 2014, NCCI is recommending that modifier 59 be added to the CT of the spine with the contrast codes.

MS. NORTHCUTT: And I think the CPT update that 3M was alluding to, they were talking about CT guidance. And this is really a CT scan

THE SPEAKER: Since the physician certification requirement is changed, can we use post-discharge queries now as a part of that documentation to support that inpatient admission? Since all of the documentation or the necessary language was required in the certification. And if that's changing and going away and we just really have to have the inpatient order signed prior to discharge, can we use post-discharge queries to support that admission?

THE SPEAKER: If we review the account and we feel like the physician needed to justify the medical justification, can we ask him after the discharge to come back now and support it when we're trying to make a decision?

MS. FOWLER: And dictate an addendum to the record?

THE SPEAKER: Or a query.

MS. FOWLER: We will look at the entirety, everything that's in the record. We will look at everything from the ER record to the discharge summary. Anything that you send us, we will look at. Okay? Does that answer your question? If it's in the record, we'll look at it.

THE SPEAKER: Has anything been in place to eliminate those claims with the occurrence span code 72 yet?

MS. FOWLER: Oh. When we set up the edits to pull the two midnight claims, we excluded records with a current span code 72. Our edit should be excluding your stays within an occurrence span code of 72.

MS. WHATLEY: Any other questions?

MS. WHATLEY: Thank you, Suzanne and Joy. We appreciate it. Very informative as always.