MEDICARE (CAHABA GBA) MINUTES
November 4, 2013 RIC/RAC Meeting

CAHABA GBA REPRESENTATIVES PRESENT:
Dr. Greg McKinney
Ms. Suzanne Evans
Ms. Hiala Eldridge

FACILITATORS PRESENT:
Mr. Ingram Haley
Ms. Karen Northcutt

MR. HALEY: We've got Dr. Greg McKinney, Suzanne Evans and Hiala Eldridge with Cahaba who are here to go through our Medicare-related questions.

1. **Follow up to question #1 from the July 15, 2013 RIC/RAC meeting. At the July meeting you were waiting to get a response from CMS for clarification as to whether therapists can use the burn codes. Have you received any response from CMS?**

   Response: Discuss at meeting.

   Discussion at Meeting

   DR. MCKINNEY: At this time, there are only physician codes. If anything changes, I'll let you know. So that's a long story of saying no.

2. **Follow up to question #3 from the July 15, 2013 RIC/RAC meeting. Please provide update/status on Insight - the new web portal for checking appeal status.**

   Response: Cahaba GBA is preparing the launch of the new portal. The portal will feature Claim Status and Eligibility to assist providers with another self-service tool to enhance their office. We are still in our testing phases of the portal. Our first phase of the testing is with internal associates of Cahaba followed by external beta testing. Our external beta testing will be performed by both a Part A and Part B provider. The portal will also offer future enhancements including Financial and Appeals. Those enhancements to the portal will be released tentatively in mid-2014. Continue to watch our listserv notifications announcing our portal launch and enhancements.

   Discussion at Meeting

   MS. EVANS: Our goal is so that you can file the appeal online. It's going to be an evolving mechanism. Just watch the website. It will be delivered in phases. The first phase is not going to be the appeals tracking. That will still need to be done through our provider contact center. But our goal is to have that probably sometime early next year. And you'll see things on our website called Insight. That's the name of the portal. So when you see that word, that's going to be our online portal for you to have your claim status check online. After I submitted these questions, I saw some dates that are flying around. Now, don't hold me to the dates because you know how that goes. But mid-December they're hoping to be fully live. But

they're just now going into production, and some of the beta testers are working it. But it is moving along. So hopefully we'll see something sooner than later.

3. **Follow up to question #11 from the July 15, 2013 RIC/RAC meeting:**

   Baptist Health received a large number of automated denials based on the 3-day window rationale. The outpatient accounts were denied because services occurred within three days of inpatient admission. The inpatient admission occurred at a different hospital of Baptist Health; therefore, these accounts were appealed due to the fact that the admitting facility did not wholly own and wholly operate the hospital where outpatient services were administered. Federal regulation was submitted with the appeal. All of the appeals were found to be unfavorable by Cahaba due to the fact that the medical record for the denied account was not sent with the appeal. We did not send the medical record due to the fact that the denial was for three day window and not medical necessity. The Decision states "based on information documentation submitted the services rendered do not meet the criteria for coverage under Medicare. It lacks documentation to review for medical necessity." How can RAC deny an account for 3 day payment provision, and then Cahaba deny for medical necessity? Medical Necessity of services was not the focus of the RAC denial, nor was it addressed.

   At the July meeting you requested documentation in order to look into this question. The documentation was submitted to you as requested. Please provide a response.

   Response: Discuss at meeting.

   Discussion at Meeting

   MS. EVANS: I don't have the answer to that yet. I sent it to her, and I have not gotten a response. I'll send it to Peggy and let her disburse it.

   DR. MCKINNEY: Just remember when the RAC has different denials than the contractor, anytime you submit medical records, that, by virtue of submitting medical records, is going to come to medical review. Okay. So any medical records automatically come to medical review, and then we use medical review denials. So that's a different process in the MAC. So anytime medical records come, 99 percent of the time they're going to be not funneled to claims or audit reimbursement. They're going to come to a clinician because they do contain clinical or medical records. So we have to use - by instructions from CMS - medical review denials, and that denial is medical necessity. But we will try to untangle that knot for you and get you an answer as to that.

   Just remember, if you are the billing facility, you are responsible for all documentation to support the billing of that service. Okay. So that means going back to the other facility. If you're billing for something, you are responsible for that. So that's Medicare's rule at this point.

4. **Follow up to question #16 from the July 15, 2013 RIC/RAC meeting. Why are packaged charges, that Medicare typically does not pay, denied for MUE?**

   Response: Discuss at meeting.

   Discussion at Meeting

   MS. EVANS: She and I have gone over this and over this. And I'll be honest with you, I don't really understand the answer that they gave us. I'm going to give it to you, but I'm still going to continue researching it because I'm not real clear on it.

   But they said that the codes are set up correctly as contractual, and they adjust as a contractual adjustment rather than a denial. I'm not sure if that answers your question or not. But I'm going to dig a little deeper because it didn't explain it very well to me. And you know I'm not a biller. But you may know if that makes sense. But I will get back with that one.

5. **We have several accounts that have DEBIT balances resulting from Medicare reporting a payment reversal transaction on the 835 but not recouping the funds via a PLB adjustment to offset the reversal. This all took place after we refunded the excess funds to Medicare.**

   The issue: Why is Medicare reporting the payment reversal transaction on the 835 after we have refunded the money to them?

   We do not want Medicare to report the payment reversal transaction in the 835 after we have refunded the money because it results in 2 DEBITS being posted to the patient account. Medicare might say we can post the PLB adjustment to the account but that is not an appropriate response. PLB adjustments should NEVER be posted to patient accounts.

   Response: Once an overpayment is received it must be posted to the correct beneficiary in an effort to show the application receipt from the provider and to correct patient history. This is done to prevent duplication of audits and request for paybacks when it has already been performed.

   Discussion at Meeting

   THE SPEAKER: But you recognize that that is an additional transaction. We've given you the money back, and then you're taking it back on remit. We have to post the transaction on the remit. So essentially when we refund it, we reduced our account balance. And then you take it back on remit, which further reduces it and puts the money back on the account. So the question is, why are you creating a transaction that takes the money back when you've already given the money back?

   MS. ELDRIDGE: Okay. With the take backs, you have to keep in mind that our system is automated. So there's no control that we have over that. So that's why it's automatically taking it back. So we can't really control that. But if you make us aware of that by contacting the

customer service department, they'll contact the reimbursement department and we'll issue you a refund. I know it's an inconvenience, but the system is automated. So we have no control over it.

THE SPEAKER: We don't really need a refund. What we need is a transaction reversal. So should we contact you to reverse the transaction?

MS. ELDRIDGE: The reversal of the transaction part would have to be handled through the claims department, because we only do the refunds when we're refunding them money. So if you contact the customer service department and tell them what you're experiencing, it's still probably going to come to us. But we can't just do a reversal of the transaction. We will actually have to refund the money to you. Claims might be able to reverse it.

THE SPEAKER: You'll just have to refund the money back. Let me ask you this question. We're trying to get our people not to refund it, is there a time frame that Medicare can go back and recoup their money? Let's say it's five years and we discover, okay, we now owe you money. Could we just contact you and say take the money back or put it on the credit balance report.

MS. ELDRIDGE: Okay. I'm sorry. Can you repeat the question? I know you said something about a credit balance and then you said something about recouping it in a time frame.

THE SPEAKER: We need to refund you some money. For instance, an account that's five years old and we need to refund you your money, would it be better to just put it on the credit balance report and let you take the money back or just contact Medicare and have you take the money back, rather than send you a refund check which results in a refund transaction on a remittance? Which essentially, for our system, creates two debits. So what's the best thing to do?

MS. ELDRIDGE: As far as the credit balance aspect, I'm not really familiar with that. That's a different area. However, if you want to set up an immediate recoupment, you can go to our website or fill out the different forms and ask for immediate recoupments to be recouped for a specific AR or for ARs in the future for all your facilities.

THE SPEAKER: Is there a time frame that we are allowed to go back?

MS. ELDRIDGE: As far as a time frame, I'm not familiar with one. I'm not aware of one.

THE SPEAKER: I mean, Medicare would require five years, ten years if we find we've got money that we shouldn't have, just send it back to you?

MS. ELDRIDGE: I'm not sure of a time frame, but I can check on that for you.

THE SPEAKER: Or if we need a corrected payment.

MS. ELDRIDGE: If you need a corrected payment, is there a time frame for corrected payment? I will have to check on that.

THE SPEAKER: Okay. Well, that would be good to know. Because, I mean, essentially we really shouldn't have accounts that old, but sometimes that happens.

MS. ELDRIDGE: Right.

THE SPEAKER: And if we knew how far back we can go and handle the transaction without actually having to cut you a check, that would be better, I think.

MS. ELDRIDGE: If you send that immediate recoupment for that specific claim number or AR that you're talking about, I don't think it would be a time frame on that. But I will check on it. But if you go out there and fill out the form or fax request, there are several ways you can do it and submit that. We should be able to take that money back through the immediate recoupment process.

THE SPEAKER: Okay. But the final answer is, then, if we send her a refund, you are going to create a transaction on our remit that recoups the money as well? Which means that we now have to send you a refund and now you've recouped it.

MS. ELDRIDGE: Right.

THE SPEAKER: Which puts money back on our account.

MS. ELDRIDGE: Right. So the easiest process would be the immediate recoupment, so it can automatically stop this for you or take the money back as you need it.

THE SPEAKER: For the ones that we already have, is there any recourse for getting you to back out that recoupment?

MS. ELDRIDGE: Not as far as I know, as far as backing that out. I can check on that. But I haven't heard of anything about us reversing that process.

THE SPEAKER: Because this didn't used to happen. So it's something that's new that's happening. Do you know if you've modified your system?

MS. ELDRIDGE: Well, the system is automated by CMS. So they may have made some modifications. We have no control over the HIGLAS system and how it's programmed.

THE SPEAKER: Okay. Thank you.

MS. ELDRIDGE: You're welcome.

MR. HALEY: Any other questions on that?

(No response)

6. **A) We began having first RAC overpayment recoveries for relatively small dollar amounts in October 2012. Patient account information was not provided on the overpayment recoveries from October 2012 through July 2013. Overpayment recoveries occurred in Oct, Nov, Dec, and July. In August, the recovery was approximately 34% of the PIP check amount and the account information was included in the body of the remit. We have determined that the there are many open RAC accounts with take backs that have not been recovered- many from the initial September 2012 take back. Will these accounts that are still open be recovered? Will there be high interest charges? Can a list of all take backs be provided to us so that we can keep our data accurate? If a recovery is on a current year account, we do not actually receive the payment on the remit (since we are PIP) but the recovery is cash. Will current year accounts be included or excluded on the PS&R? How will the unpaid amount be recovered if the account is excluded from the PS&R.?**

   Response: The accounts that are still open will be recouped. PIP claims that were in the DB9996 location are in the process of being finalized to a location status to complete the reconciliation process to get them into HIGLAS. Once these claims are adjusted there will be a demand letter sent with all of that information and it will resemble your other demand letters, the time frames will be present. We do not have an exact list of all the claims involved, this information comes from the RAC. Current year accounts will be included on the PS&R beginning in September.

   Discussion at Meeting

THE SPEAKER: Just to clarify. What you're saying is we need to pull the PS&Rs and balance that back to the remit to be able to post these take backs and payments?

MS. ELDRIDGE: Let me see if I have an answer for you. I might have to take that question back.

MS. EVANS: Could you repeat that one more time?

THE SPEAKER: Okay. From what I'm reading, it says current year accounts will be included on the PS&R beginning in September. So what I'm wondering is if we can take the PS&R and help that to balance the remits. Because on the PIP posting, there will be money that is either given to us and when we call, we're told that it's attached to a certain patient. But the patient's name is not on the remit. So what I'm asking is, can we take that PS&R and find those patients.

MS. ELDRIDGE: Oh, okay. I can answer that. Okay. On the PS&R, no, patient information will not be on there. When the refunds or any money is refunded for the patients,

you're going to have to contact customer service and they'll submit the information to my department, and then we'll get back to you with the information for the patient.

CMS is working on a fix for this to include this information on the remit sometime in the future. We have no time frame. But until then, you will have to contact customer service with that information and give them your provider number, your PTAN number, and the information needed so we can locate who that money is for, for you.

THE SPEAKER: Okay. Thank you.

MS. ELDRIDGE: You're welcome.

THE SPEAKER: Can we e-mail to the reimbursement department instead of having to call customer service?

MS. ELDRIDGE: We don't have an e-mail address set up for that particular thing. I will take that suggestion back, though, and maybe we can get one set up.

But what they do is they do route the e-mails to an e-mail address in our department and assign it to a specific person to research that information. And believe me, your frustration, we feel it, too, because we have to go back and relocate all the information and try to get it in a timely fashion. It's a real hassle. But we'll get the information back to you if you get the information to customer service.

MR. HALEY: Okay. Any others on that?

(No response)

B) A second problem that we have had is with a large batch of take backs that were reversed. The initial take back was never included in a remit (the take back did not post to the account); therefore the reversal take backs resulted in the recording of a duplicate payment and adjustment. The Connelly website shows that the take back and the reversal were posted and the accounts are closed; however, the Medicare website and our patient A/R do not show the initial take back. How will these type errors be corrected?

Response: Prior to the June 2013 submission of PIP RAC claims:

- Connolly submitted PIP RAC claims before time and they did not go to HIGLAS.
- Problem caused: the PIP RAC claims showed in FISS as a DB9996 with a FISS AR which did not offset.
- FISS Maintainer Fix: Created utility to move RAC claims to finalized status without withholding money which did not appear on your remit.
- Connolly Fix:

- Sent a list of claims to the MAC through the mass adjustment process to set it back to the original claim payment which was/still processed through to HIGLAS.
- The RAC submitted a second adjustment through the mass adjustment process to reset to the original denial which would generate a demand letter.

If this happens to you, please be sure to be proactive and submit your payment along with any supporting documentation to the MAC.

Discussion at Meeting

MR. HALEY: Any other comments or concerns with that?

(No response)

MR. HALEY: I think until maybe the process is put into place, certainly with Part A we can certainly use our current communication lines through Suzanne to get some of those taken care of. So if you need something specific please let me or Peggy know and we'll get it forwarded along as quickly as we can.

MS. EVANS: I'm hoping things have gotten better since Ingram took the flag and moved up the flagpole. Have things gotten any better with the PIP?

(No response)

MS. EVANS: I don't know if dead silence is good or not. Okay. Move on.

DR. MCKINNEY: And that's not performance improvement plans.

C) Third, how can PIP hospitals avoid the interest expense charges?

Response: PIP RAC Part A claims are now collected from a PIP provider's remittance on a claim by claim basis therefore now you can use the immediate recoupment process. Providers can elect this process to avoid making payment by check and/or avoid the assessment of interest if the immediate offset recoupment pays the debt in full before day 31.

Discussion at Meeting

MR. HALEY: Anything else on that one?

(No response)

7. **With the new implementation of the Supplemental Medical Review Contractors (SMRC) StrategicHealthsoulutions, can you please discuss the following questions? If you cannot answer these, can you tell us who we should contact?**

A) Are there any limits to the number of records that they can request?

B) What are the timeframes they can look back?

C) What is the appeal process for any denial of these claims?

D) Will there be different rules for PIP hospitals and how money is taken back?

E) Will demand letters be issued?

F) Will we receive a letter informing us of the outcome of the reviews for each claim?

Response: Per the CMS website:

Supplemental Medical Review Contractor (SMRC)
The Centers for Medicare & Medicaid Services (CMS) has contracted with StrategicHealthSolutions, LLC, a Supplemental Medical Review/Specialty Contractor (SMRC) to perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare and Medicaid programs.

One of the primary tasks will be conducting nationwide medical review as directed by CMS. The medical review will be performed on Part A, Part B, and DME providers and suppliers. Services/Provider Specialties to be reviewed will be selected by CMS, Provider Compliance Group/Division of Medical Review and Education (DMRE). The SMRC will evaluate medical records and related documents to determine whether Medicare claims were billed in compliance with coverage, coding, payment, and billing practices.

The SMRC will be performing medical review in accordance with CMS regulations, CMS Publication 100-08 (known as the Program Integrity Manual) and other current and future CMS Provider Compliance Group/Division of Medical Review and Education initiatives.

The focus of the reviews may include, but is not limited to vulnerabilities identified by CMS internal data analysis, the Comprehensive Error Rate Testing (CERT) program, professional organizations and Federal oversight agencies.

In accordance with 1833 of the Social Security Act, providers/suppliers must provide documentation upon request to support claims for Medicare services. This request complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which allows release of information for treatment, payment and healthcare operations.

StrategicHealthSolutions, LLC has a responsibility to notify CMS of any identified improper payments and noncompliance with documentation requests. The Medicare Administrative Contractor (MAC) may initiate claim adjustments and/or overpayment recoupment actions through the standard overpayment recovery process. For questions regarding the overpayment recovery process or your appeal rights, please contact your MAC.

For more details and contact information you can access the StrategicHealth website at http://www.strategichs.com/.

Discussion at Meeting

DR. MCKINNEY: The response that you have is kind of what we've gotten off the CMS website that's kind of public domain. Keeping in mind this is totally a separate contractor from Cahaba. We have no control over what they do and how they do it. We do interface with them just like we do with the RAs.

So our response is basically what you can probably get off the website. I will go back and check to see if they're going to have any kind of education or cause or anything of that nature to educate for our community. But, again, they are totally separate. They deal directly with CMS. They have very little, if any, interface with us, only on the back end for transaction purposes, just like the RA does for transactions. So we are just the receiver of information from them.

But I will go back and see if we can get some more detailed information. But I don't know if we properly accurately answered all your questions because it's just not our purview at this point.

8. **With the new rules related to the IPPS changes for 2014, specific to the Two Midnight Rule and the certification documentation required by the physician we would like to have a few questions answered.**

   A) **If the patient is admitted for an "inpatient only" procedure, is all of the certification documentation still required?**

   Response: Yes

   B) **Can a physician document their discharge plans in the discharge summary or final progress note and meet the certification requirements for an inpatient? Does this have to be signed before the patient is discharged if done in a discharge summary?**

   Response: Certification must be completed, signed, dated and documented in the medical record prior to discharge.

   Discussion at Meeting

   DR. MCKINNEY: There should be some documentation in the chart, whether it's handwritten, then signed, and then later dictated. But there must be some notation in the chart

at the time of discharge to certify that. Now, whether he or she goes on to dictate that in a formal fashion, that's going to be your process. But it has to be before discharge.

THE SPEAKER: I have a question. Regarding the inpatient-only procedures, the two midnight, the presumption that the patient is going to stay two midnights I thought could be excluded, because some of those patients are staying one night. So is it just a blanket yes?

DR. MCKINNEY: Well, when you say certification documentation of —— you still have to certify that the patient needed that procedure. All the elements of certification have to be there. The length of stay, the guarantee, or is it automatically inpatient is a list CMS gives us.

But the documentation always has to support that the admission was medically necessary and that the patient needed that procedure. There's some procedures that may be not covered by Medicare, even though they're on the inpatient list. Remember the inpatient list is given regardless of whether it was covered or not. So your documentation has to support the certification process that it's needed.

But I will take that back just to clarify. But that's our understanding of that.

MS. NORTHCUTT: I think one of the assumptions is because the order is going to be the initiation of that inpatient process; that if you're ordering an inpatient procedure and you're going to order an inpatient status for that particular carotid stent or, you know, whatever that inpatient-only procedure is would be basically ordered and that's signed, then that would be justification for the inpatient stay.

DR. MCKINNEY: I can rephrase what she said. She said that the fact that it's inpatient only and the doctor said admit inpatient and signed the order, that that was justification to admission? Did I quote you correctly?

Again, to us and it may be word smithing, but that would be kind of a certification. You certify that the patient needs inpatient by virtue of the attending physician signature. So I guess we could play on words about what really is a certification.

And I will say the preamble to all this is that you have gotten more education on the Two Midnight Rule through all the calls than we as the contractor have. So we have been a party to those calls. We have had some calls of CMS. But how it directly impacts medical review which I think is probably of interest to everyone. How that impacts how we review your claims, how we select your claims that is to be continued.

I think we're probably 60 to 70 percent there as far as the education of CMS's expectation of us as a contractor. But we're still yet to have calls that will finalize how we're to review these.

There are some changes that are going in place - and I can talk about those at the end - about turning off some current edits and giving you guys some time to adjust to the Two Midnight Rule for the rest of the year.

But our level of granularity to answer all these questions probably have been answered on the phone calls. If you've not listened to the open forums, they've had two or three calls on the Two Midnight Rule.

So our answers to these basically are from CMS resources. And, again, there's more to come for medical review in house training from CMS. So I can talk about the current state of the Two Midnight Rule at the end.

And keep in mind, CMS took two weeks off, or however long they were off. So that means they kind of like start over.

MR. HALEY: Anything else on that one?

(No response)

9. We would like guidance on how the new IPPS Two Midnight Rule will affect medical review. Specifically:

A) How will InterQual be used for screenings? Should the patient be screened and if meets InterQual, then be evaluated for two midnight benchmark?

Response: There has been no change in the instructions for determining the necessity of an inpatient hospital stay. Screening criteria may be used as a tool to assist in decision making. Surgical procedures, diagnostic tests, and other treatments are generally **appropriate** for inpatient hospital payment under Medicare Part A when the physician expects the patient to require a stay that crosses at least 2 midnights, and admits the patient to the hospital based on that expectation.

B) If the patient doesn't meet InterQual, should the second level review be only a consideration of the two midnight benchmark and medical necessity for the admission in consideration of the two midnight benchmark?

Response: For an inpatient stay that is less than 2 midnights, the expectation of the physician should be based on complex medical factors, including the patient history and co-morbidities, severity of signs and symptoms, current medical needs, and risk of adverse event. Unforeseen circumstances may also result in a shorter beneficiary stay than the physician's expectations (that the beneficiary would require a stay greater than 2-midnights). Examples include beneficiary death, transfer or departure against medical advice (AMA). The physician's expectation and any unforeseen interruptions in care must be documented in the medical record. Otherwise, surgical procedures, diagnostic tests, and other treatments are generally **appropriate** for inpatient hospital payment under Medicare Part A when the physicians expects the patient to require a stay that crosses at least 2 midnights, and admits the patient to the hospital based on that expectation. However, the patient must be receiving medically necessary care during the hospital stay. Factors of convenience to the hospital or the patient will not support admission decisions or length of stay.

C) Is it correct to understand that outpatient with observation services for the first midnight may be applied to reach the two midnight benchmark and then one

more additional night as inpatient would then create a two midnight inpatient stay which would not be an indicator for targeted medical review?

Response: The 2-midnight benchmark 'clock' begins when the beneficiary begins receiving hospital services (Observation care, Emergence Department, Operating Room, other treatment area services). The time before the formal inpatient order is written is Outpatient time, but may be considered when determining if the expectation of a stay lasting at least 2-midnights in the hospital is reasonable.

Discussion at Meeting

DR. MCKINNEY: Let me just give a high—level summary. And then if there are questions, then you can ask. I think some of these are cut and pasted from some information that CMS put out. And I guess this is probably the best time to discuss the Two Midnight Rule.

Currently CMS has asked our call contractors to turn off all their reviews and edits that grab claims with two midnights. So we are no longer requesting those type claims, and those reviews have ended. CMS has then said that this will go through the end of the year, and we will start reviewing select claims that they are telling us about that you as a provider will be notified about. Then at the first of the year - those instructions we don't know yet - CMS will educate the providers and medical review of how to proceed with the Two Midnight Rule.

Personally, I would probably not change any of your processes at this point. This presumption is there. The MACs and, I believe, the RACs/RAs cannot review anything that's two—day stay or less or two midnights or less, but CERT can. So that's an important thing. CERT can still grab those claims. They will review by the InterQual criteria.

So if you've ever had a CERT claim grabbed, then CERT will use InterQual just like a MAC will. Not as the basis of the decision, but as a tool in making the decision. But CERT will grab those, and they will continue to review those as they always have.

So I would not do any changes to your process until the first of the year till we get more clarity about how the Two Midnight Rule affects you as far as documentation, how we're going to review, what can be looked at, how long it can be looked at. All those things are still kind of up in the air at this point from a MAC perspective. CMS may know and I may have missed that. But for right now, I wouldn't change your processes because the CERT can still grab those. RACs and MACs cannot.

So at a high level, I think that kind of addresses A, B, and C, for the sake of brevity. If there's anything about A, B, and C that I haven't answered, I'll be happy to. But you should stop receiving any requests for all those two day stays that we had; cardiac procedures, back pain, any records that we have selected that the determining factor is the length of stay or location of the admission, whether it should be in or out. Those reviews have stopped.

The ones that have not stopped are those that determine the medical necessity of the procedure and admission. For example, knee surgeries, knee replacements. Those still could go on and not be under the midnight rule. Because we're not necessarily saying that they could have been in a different setting. Was the service medically necessary?

But if we're looking at the location and acuity of care, then those reviews have stopped. And that's across all MACs. So that was to have been turned off September 30th. And so that's when it stopped. And so those should be fizzling out.

We do ask that if you've gotten the remit - a question or an ADR to send records in, go ahead and send those in. We will release the claim if it's not supposed to be reviewed. But we don't want you to get a denial if one slips through the crack. We don't want you to get a denial because you said, oh, we don't have to submit those anymore because CMS has turned that off.

Again, as we said before, we operate with a system that's on a clock, and it does things without our control and out of our control. Not in or out of our control. And so we don't want you to get a denial. So if you've gotten a request for those and you think, well, gosh, we're not supposed to be reviewing these, go ahead and send your records. We have a process in place to release those.

Again, those should be few and far between and you shouldn't see many of those. But please go ahead and do that. If I get different guidance - Deloris Doreen, as you know, is our Part A manager - I'll go back and confirm that.

But our understanding is, as they trickle out, we're stopping the reviews. So you should see no more requests for those records.

Any questions about A, B, and C for Question 9? Kind of a Two Midnight Rule in ten minutes or less.

THE SPEAKER: I don't want to belabor this issue. But based on what Karen said, are you saying that if an inpatient order is written, that is the expectation of two midnights, and we don't need to be hounding the physicians to write that the patient will spend two midnights in the medical record?

DR. MCKINNEY: Okay. Again, there was two different questions. You asked about the inpatient-only list.

THE SPEAKER: Right.

DR. MCKINNEY: Okay. That's totally different than certification for two midnights. Okay. That's totally different.

THE SPEAKER: Okay. So if it's a medical review and it's not inpatient only, then we do need them to document?

DR. MCKINNEY: Correct. Inpatient only is assumed to need inpatient. But everything has to have an order. Okay? Everything has to have an order. That's just the golden rule. Outside the inpatient only - let's leave that universe into non-inpatient only - we're going to need those certification requirements and all that kind of stuff, however you want to rephrase it, the two midnight issue. Again, whether or not we request those records or not. Because CMS wants you to get in the practice of educating your physicians, knowing if something is going to be beyond Two Midnight Rule. Don't take this as the gospel. I'm taking my Medicare hat off. But they're trying to get you in the groove of knowing that and understanding that and giving you a window of opportunity to understand that.

Then at the first of the year, we're going to see how well you studied and give you a final on that. So when testing comes around the first of the year, we want to make sure that you

studied these three months really, really good, and that you're going to pass the first of the year. So just make sure you get that process down.

This is your chance to kind of massage it, get it in place, work it out, work out the kinks of how you work with your medical staff. It's all a collaboration. Get that all worked out, I think, probably to the first of the year. And that's kind of what we've been told. But it may stretch further out. But just make sure you understand the rule, what's required, get your doctors acquainted with that. And then this is your time to understand that. If that's a foreshadowing of fun things to come next year. Okay.

MR. HALEY: Anyone else have anything?

THE SPEAKER: As far as the elements of the inpatient certification, I think that's something hospitals are struggling with. Because we want to make sure that the documentation is as good as it can be from our physicians. So we've been working with a lot of our physicians to make sure all the elements are there.

Can you go over what you think would be the best way to have those elements there? Some facilities are creating forms. And what you're going to be looking for in medical review. Will you be looking and, say, deny a case just simply based on one missing element or that sort of thing?

DR. MCKINNEY: Realistically, and because it's one of my favorite phrases, is that there's so many grains of sand on the beach, that we probably won't - don't hold me to this - don't quote me - we probably won't look at inpatient-only procedures because, by virtue of being an inpatient-only procedure, it merits inpatient admission. But all the little bells and whistles have to say the doctor signed it.

I can probably tell you, too, though, a lot of doctors don't know what procedures are on that list, which is a total different conversation.

I think where you're going to run into problems with inpatient-only lists are things that we've talked about all along. It started out as an outpatient, it turned into an inpatient, or the doctor didn't know it was inpatient and he admitted him to outpatient. All those mechanical things that are irrespective of the Two Midnight Rule.

So what I would tell you about inpatient admissions - and I'll go back to make sure there aren't any kind of concrete requirements that CMS expects - but I would expect for an inpatient-only procedure, an order to admit and then a good H&P. And really that's about you know, we're not going to look for the doctor to say I realize this is an inpatient—only procedure; therefore, I'm admitting them into the hospital.

It's almost inherent - and I think that's where my only opinion I think that's where CMS is going is that the inpatient-only list is a gimmee. There was really no reason to review that unless something quirky happens; examples I've just mentioned. But we still need an order from the doctor. We need all the documentation there that the procedure was done, the outcomes, how long they stayed, et cetera, for your payment. But the real thrust is going to be then focused on those non inpatient procedures. And so I think it's really just as simple as that.

But I'll just double-check, to make sure CMS hasn't, I am not aware of any; I'll put it that way of any specific one, two, three, four that says this is how the doctor justifies this inpatient admission from a certification standpoint. Because inherently, inpatient-only procedures should

be done inpatient. I'm sure Karen has read something in the Federal Register she can tell me, kind of what's been required.

THE SPEAKER: Well, they do have a requirement, and it is like a checklist. And so my question really pertained not to inpatient-only procedures, but to regular medical review of medical diagnoses. When you're reviewing these cases that are there for one day, are you going to be looking for the elements of the certification? They include an estimated length of stay, they include discharge planning, things like that.

DR. MCKINNEY: That's applicable to an inpatient-only procedure …

MS. NORTHCUTT: No, no. I think she's away from that.

DR. MCKINNEY: Oh, okay.

THE SPEAKER: So any inpatient. It applies to any inpatient that a certification be on — — in the medical record, signed prior to discharge, and then it has these elements in it.

DR. MCKINNEY: And that's true for inpatient-only procedures?

MS. NORTHCUTT: No, no. She's away from that.

DR. MCKINNEY: Okay. That was the frame of her question, though, where she started off the question by saying for inpatient-only procedures.

MS. NORTHCUTT: Inpatient admission.

DR. MCKINNEY: Oh, okay.

MS. NORTHCUTT: The order and then the authentication and basically how and what is the expected length of stay.

DR. MCKINNEY: Right. Okay. So let's leave the world of inpatient-only procedures. We'll go to non-inpatient only procedures - inpatient procedures that are not inpatient-only. However you want to word it.

If you want a form, that's fine. Medical review will look for those components. We dictate content. We do not dictate form.

I think, though, for physicians, we like things very concise; one location, one form. We want everything kind of right there in one location. And I think if you have those components as a sheet, as part of your orders or part of your discharge planning or whatever you educate those on as part of your medical record, we're going to look for those components. We're not going to tell you about a form.

If you choose to do a form, that helps us. It provides more clarity to us. But we will not dictate a form. But those components, I think, probably for you, since you're learning this process, educating your physicians, they would appreciate probably a form. So that way, you

know, as part of your orders. I know you have to go through like 20 steps to add a form to the medical record. But I think that a form would be probably the most logical choice, but we can't dictate that. But we will look for those components once we're educated on that. Again, a lot of this information CMS has not given us on how we review.

Will we deny if those components aren't there? CMS hasn't told us that yet. Again, we won't start reviewing these probably for another couple of months. So we're having some calls about how valuable those components are, the components of the certification, is it a deny or pay. So all those things are yet kind of uncertain. Since we won't have another RIC meeting until March, we can provide that feedback through our channels if we get more clarity.

But I will just say those components have to be there. We'll look for them. If it's easier for you for a form, then I would do that.

THE SPEAKER: And you're probably not going to know the answer to this based on what you just said. We've had some conflicting couple of things people have said one way or the other about the time of the CERT prior to the doctor writing the discharge order.

So if the plan of care is he comes in and writes his discharge orders and sends discharge home and continues all that and all that is dated and timed the exact same, that the CERT will not be met because the discharge home was not written in the record prior to the discharge.

Then we had someone come back and say that CMS has not defined discharge yet. So he may write it after he writes a discharge order.

DR. MCKINNEY: I think I follow that. But what I'd ask you to do is if you can just submit that so that I can just read through it and digest. Because, again, we've not been given a lot of instructions about timing and what's acceptable, what's a good window, what's not a window, what can we wiggle on, where's our gray area.

Because a lot of times CMS gives us our latitude of judgment if we can infer in the medical records that you've met these prescriptive things. Although sometimes in the records, it's not that clear. But we can infer that. They give us the latitude in checking that off and not holding you to a denial or a non valid CERT.

So if you want to submit that, then I can kind of digest that and then I can provide an answer back. But, again, right now I don't want to plead ignorance, but I'm pleading ignorance. But we have not been given the final how this impacts everybody at this point from a medical review standpoint.

MR. HALEY: All right. Anyone?

THE SPEAKER: One more question about the CERT. I think we've got this answer, but I want to make sure we didn't misinterpret it. So are our patients at any risk with the SNF payments, even though we know they clearly have three midnight inpatient qualifying, no doubt about that, but yet the physician didn't document the fourth element of the CERT. So we are technically not supposed to bill it as an inpatient because we didn't give the entire CERT. But, yet, the patient clearly met three midnight inpatient qualifications. So are we at any fear with that SNF placement?

DR. MCKINNEY: From a system standpoint, it sounds like you wouldn't bill that claim. Is that what you're saying? You wouldn't bill it as inpatient? The system will not allow that SNF admission. Because what happens when a patient is admitted to a Part A stay, it looks back for that three-day qualifying stay. And if it looks back and doesn't find that, it will not allow an inpatient stay. So that's how the system works.

THE SPEAKER: It went past the three days, they may just not have documentation as part of the CERT.

DR. MCKINNEY: No, no. What I'm saying is, I think you said that you would not bill that as an inpatient. Is that what you said? You wouldn't bill it as an inpatient?

THE SPEAKER: Well, I guess I may have completely misunderstood. But I assumed after the first of the year that we needed to have every element of the CERT to be able to completely bill an inpatient claim compliant.

DR. MCKINNEY: Right. But I guess what I'm saying is, I'm just telling you the system part.

THE SPEAKER: Yeah.

DR. MCKINNEY: If the system doesn't see an inpatient stay that you're not going to bill, it won't allow a SNF stay. And that's just a system aspect. It looks back.

But I will take that back to see if you fail one of the components and how that affects a SNF admission. I don't know in the new world from a review standpoint, how we review that, how we would audit that if it's appealed from us.

But I can tell you the system is designed to look back in history for a three-day qualifying stay. And if it's unbilled or not billed as such, then it will not allow a SNF payment. That's just the way the system cranks it out.

THE SPEAKER: It's going to remain inpatient. It's going to be a rebill at this point if we identify through a self-audit. So it's still going to be out there as an inpatient.

DR. MCKINNEY: So you're saying up front you bill it, and then later on you'd go back and change it to outpatient.

THE SPEAKER: We identify it. Because it's three midnights they really met. But then you look and say, well, an element was missing. So we can't change the inpatient according to what CMS is saying.

DR. MCKINNEY: Right.

THE SPEAKER: And it's going to be an A to B rebill. So that patient, I'm thinking - or I'm hoping, wouldn't be affected by that, because they did have three consecutive nights of an

inpatient, even though the facility may have messed up somewhere down the line. It's not a medical necessity issue.

DR. MCKINNEY: Right. Again, I'm giving you two different answers. One in how the system will look at it, which we have millions of claims go through that we never see. So I'm just telling you how I think the system will look at that. The system is going to look for a three-day stay. If it sees it, SNF is allowed.

Now, is the system smart enough three months from now, if you rebill it as B, to say, oops, then go back and say, oops, that three-day qualifying stay, where is that now? It's not there. If that SNF patient claim has already been paid, I doubt that it would go back and then deny that.

But I'll have to get the answer to your specific question because I don't know the definite answer. But I do know how the system will work.

MR. HALEY: Got another one here.

THE SPEAKER: I believe this was addressed in the Part A to B rebilling rules. To bill Part A and B rebilling, you first have to submit a no-pay inpatient Part A claim. So that claim would be on record to support the SNF stay.

They also went on and clarified that even if that claim is a no-pay claim or if it is denied as not medically necessary, that if it was the three-day inpatient stay, it still qualifies the patient for a SNF as long as the care itself was medically necessary. So the inpatient admission does not have to be medically necessary for the care to be medically necessary in support of the three-day qualifying SNF stay.

DR. MCKINNEY: And I think two responses to that is, I don't know that they originally would have billed that as a no-bill because they didn't know it at the time. So what happens with that?

THE SPEAKER: If they have submitted a regular claim asking for payment, you have to retract that claim. You have to cancel that claim, submit a no-pay claim, then submit a one 12X type of bill once you get your denial on the no-pay claim.

DR. MCKINNEY: So I think that was the piece missing on the scenario. If they were going to bill it as an inpatient, then oops at whatever point, QA or whatever immediately or a month later or whatever found that it was so they're going to have several steps in their process. And, again, I don't know how the system will look at that.

But you are correct. On the front end, if we deny an inpatient stay, we don't look to see, oh, did they go to a SNF; therefore, we deny the SNF. Okay. But the system will look. Again, that's not conflicting what I said. The system will look for a three-day qualifying stay in the system for a SNF stay. But if we deny an inpatient, we don't then look for anything subsequent to that to deny.

THE SPEAKER: I've had one of our surgeons ask at the time they write the admission orders - because they go to our pre-reg area - can they go ahead and complete that form at that

time, or do they have to wait until the patient is physically in the hospital to throw out we're doing a form at Cullman.

DR. MCKINNEY: So you already know your discharge planning before the patient gets there?

THE SPEAKER: Yes. These are orthopedic surgeons.

DR. MCKINNEY: I guess, though, if the patient had a complication or if discharge did not go as planned.

THE SPEAKER: What they would like to do is be able to go in. And we have a way that they can correct that as a medical error.

DR. MCKINNEY: But it still has to be timely. The correction can't be a month later.

THE SPEAKER: No, no, no.

DR. MCKINNEY: All right.

THE SPEAKER: Usually these are a couple of days before, you know, they've assessed the patient. They're not going to see the patient again until probably they're ready for surgery.

DR. MCKINNEY: I think my answer to that is yes, with the caveat that we expect them to go to home health or we expect them to go home with home health, you know, whatever - outpatient PT, but then have a method timely to correct.

THE SPEAKER: Thank you.

DR. MCKINNEY: If that changes, then I will pass that along.

MR. HALEY: Is that it?

(No response)

10. **We need to know the dates of ESRD episodes, in order to know who to bill--before we bill Medicare (sometimes the claims are for specimen-only labs – a patient is not present to ask; sometimes the patient does not answer the MSP questionnaire correctly). Is there a plan to provide ESRD episode dates on the eligibility record accessible by providers? And why is it that when providers call Cahaba to ask if a specific service date of an unbilled claim falls in an ESRD episode, some reps will tell you the answer, and some reps say they cannot tell you? Their response, instead, is to tell us to bill it and if rejected, they would be able to look at the rejected claim for you. At that point we will know there was an episode because the rejection tells us that.**

We are trying to avoid the rejection/payment delays – as well as needless billing of claims to Medicare.

Response: Currently we are unaware of any plans to provide ESRD episode dates on the eligibility record. We can release ESRD eligibility/entitlement information in order to assist with claim submission. CSRs will be educated/reminded.

Discussion at Meeting

MS. EVANS: And the PCC has taken this and educated the CSRs on this. So hopefully that won't happen again. But if it does, just let us know, and we'll make sure they go back and reeducate them. But they are to be able to do that for you.

11. **A) Is leave of absence (LOA) billing appropriate with the Occurrence Code 74 if the second admission is unexpected and within 30 days?**

Response: Institutional providers must not use the leave of absence billing procedure when the second admission is unexpected. (Medicare Claims Processing Manual 100-04 Chapter 3 40.2.5)

B) With the new discharge status code for planned readmission would the Occurrence Code 74 be required for LOA days?

Response: No. The patient has been discharged, that claim has been submitted.

12. **Please let us know an approximate date when the LCDs will have the ICD-9-CM diagnoses codes converted to ICD-10-CM diagnoses codes or if alternate plans are being made, when can hospitals expect to be notified of these plans? Also, do you plan to make any coverage changes in any of the LCDs and if so, will we be notified of the specific changes?**

Response: CR 8348 instructs that all ICD-10 LCDs and associated ICD-10 articles will be published on the Medicare Coverage Database (MCD) no later than April 10, 2014. All other LCDs and articles (i.e. those LCDs and articles that do not contain ICD-10 information, or articles not attached to an LCD) will be published on the MCD no later than September 4, 2014. Watch our website for further updates.

To date, we have not been instructed yet by CMS on how to handle any requests for LCD Reconsiderations, we will follow CMS instructions as presented.

Discussion at Meeting

DR. MCKINNEY: Okay. We've given you the reference there. CR 8348 outlines the timeline for all contractors. So we will have those, as the response says, no later than April 10, 2014. We will probably have parallel policies out there, because we're going to have to retire

the ICD-9 ones and start an ICD-10 one. So most likely, there will be a window where you can see both. That's the plan now.

Remember, we are beholding to a database that we don't own. It's the CMS database that contains all this information. So we have to work within CMS's database. Just to let you know how arduous the task is, we've gone through the edits, we've gone through our policies. We've converted the majority of our policies already to ICD-10. We had to have those in, I think, by October 1st.

Then the period from October to April will be testing to make sure that those 10s go through behind the scenes in FISS and MCS, both systems. So there will be testing of those ICD-10 codes to make sure that they're accepted.

So it's a big task for us. We try to be fair in converting those ICD-9 codes over to ICD-10s. As you are aware, one code can then extrapolate out into a bazillion other ICD-10 codes. Our policy nurse came to me and said that the CMS the database people have limited the ICD 10 codes. If you exceed 10,000 ICD-10s in your policy, you have to start a Part B policy. But that database will only hold 10,000 codes. I'm like 10,000, really? We only have 50 on the policy.

So we've tried to make it fair and manageable. But as you know, ICD-10 is not our creature. It's not your creature and the database is not. But we're trying to make it fair. By April 10th, I think we're going to have two parallel systems out there because we will have to convert those over to ICD-10. So that is going on now. There is no preview. That's going to be April when that happens. And, again, all contractors are on the same timeline. And as far as the second part of that, we don't anticipate changing a lot of those ICD-9 codes there at the last minute. So probably as you see them by the end of the year ICD-9 wise is how they will be for conversion purposes. A lot of our policies we've removed, the ICD-9 diagnoses, to facilitate it for you and for us. So that will be probably a happy thing that they won't have those edits in place with ICD-10. So we've removed a few ICD—9 code sets from our policies.

But probably by the first of the year, what's in place now will not change. Unless we get a reconsideration which, through Medicare rules, we have to change. But not on our own will we change anything by that first of the year is our goal.

THE SPEAKER: I have a question. You removed the burn codes. And I hate to go back and keep hashing over this, but maybe I'm not understanding, but the burn codes are out on the debridement LCD. And so if we cannot use the burn codes, then what's your recommendation on what we report for burn care in the outpatient wound center setting? Because the LCD recommends that we use the burn codes to report and so does the CPT code book. I mean, I don't know if I'm not understanding.

DR. MCKINNEY: I didn't handle that part, one of our other medical directors did, even though I'm supposed to know. The reason for removing those was because it was causing some confusion about which codes to use. So we removed that diagnosis set so that it would be pure; that if it's a burn, you use the burn codes.

THE SPEAKER: So you're saying we can report the burn codes in the wound center in the outpatient setting?

DR. MCKINNEY: Correct. If they're not inpatient codes.

THE SPEAKER: These are CPT codes.

DR. MCKINNEY: But I'm not sure if the procedure would be an inpatient. Because some burn services you may have to sedate the patient. I don't know all the codes. But if they're outpatient codes and you can do them in the outpatient setting, then that's what you should report, if they're nonsurgical. Does that make sense? Are they surgical codes or are they just simple debridement?

THE SPEAKER: They are in the surgical section of the CPT book. It is stated as debridement and/or dressing change. And there's like three or four different ones depending on the size of the burn.

DR. MCKINNEY: Yeah. I don't have those memorized. But I would think there are some burn services that, if they're extensive enough, would have to be through a surgery sedation. Anesthesia would get involved with those and not just go to the burn clinic. So it depends on the body surface area, I think, too.

THE SPEAKER: Yeah.

DR. MCKINNEY: So that would be clinician discretion. But we wouldn't really expect a person with total body burns to be treated in the outpatient.

THE SPEAKER: Right. But that sort of gives us nothing to use. If we're excluding from those surgical codes in the outpatient wound center.

MS. NORTHCUTT: So I think that goes back to the first question of who's doing it

THE SPEAKER: Is it only who's doing it?

MS. NORTHCUTT: The first question on here is, I think, who's doing it. And those were physician driven for the burn codes, CPT codes, right?

DR. MCKINNEY: Correct.

MS. NORTHCUTT: And a physical therapist or OT —— or a therapist, that's not in their purview to perform those codes to start with.

DR. MCKINNEY: The rationale is, is that physical therapists can do debridement and they can debride a burn. But does that mean they can use that code depends on how the payment mechanism is set up.

MS. NORTHCUTT: Right.

DR. MCKINNEY: You know, are those physician-only codes? And our feeling is, is that the strict burn codes would be for physicians, and then non-physician practitioners would use an alternative debridement code.

MS. NORTHCUTT: So just say a nurse ——

DR. MCKINNEY: Just a plain old nurse.

MS. NORTHCUTT: But you're saying that if I'm a nurse operating in a wound care center, I could use the 97,000 rehab codes, the selective versus the non-selective debridement codes?

DR. MCKINNEY: If you adhere to the incident to requirements, at some point, physician supervision, meaning they sign off on the plan of care, they have a plan of care and all that.

MS. NORTHCUTT: But if I'm a nurse and the physician is not there, then I should not use the burn debridement codes out of the surgical section of the CPT?

DR. MCKINNEY: That would be a correct statement.

MS. NORTHCUTT: Did that help?

THE SPEAKER: No. I mean, I understand and am following what you're saying, your LCD instructs us to go to the surgical section and use those codes, and the CPT book says that burn care is excluded from the 97XXX codes. So, see, that's where the confusion is.

THE SPEAKER: I think the problem is diagnosis codes. The new debridement policy does not have any burn diagnosis codes, an ICD-9 for diagnosis codes. So if a therapist or a nurse performs debridement and has to use a 97XXX debridement CPT code, there are no diagnoses to support the medical necessity of that per your LCD.

DR. MCKINNEY: Which is why I think we took burns out, so that they could use it. Doesn't the policy have 97XXX codes in it?

THE SPEAKER: It has 97XXX codes, but it has no burn diagnosis codes that cover the medical necessity of those CPT codes. So if you bill a claim with the 97XXX CPT codes and you use burn diagnosis codes, they do not meet the LCD edits. So the LCD needs the burn diagnosis codes added back, not the CPT codes, the diagnosis codes.

MS. NORTHCUTT: And I still don't think that addressed this.

THE SPEAKER: No, it wasn't. Well, that's part of it. But the other part is does anybody have a CPT code book that says for burns you can't use the 97XXX. It's only for other wounds like ulcers and other wounds.

DR. MCKINNEY: So the preamble of CPT says that or in the CPT assistant

THE SPEAKER: It's in the CPT code book.

DR. MCKINNEY: Not the assistant?

THE SPEAKER: Not the assistant.

DR. MCKINNEY: Supplement.

THE SPEAKER: No, it's not the supplement.

DR. MCKINNEY: Well, let me do this. I will champion this, and I will get you an answer before the end of November. How about that?

THE SPEAKER: I sent it before and received no answer.

DR. MCKINNEY: I know. It's a recurring thing. It's one of those hanging-around questions. And I chose to answer it simply, but it evidently doesn't have a simple answer.

So I will champion this and have you an answer by the end of November, so we don't see it again. So I'll make sure that we get it corrected. But I think it boils down to I don't know that there's a payment mechanism for physical therapists or nonpayment mechanism for non-physicians to bill the burn surgical codes because those are priced for physicians. Then that would say then what does a non-physician use for burn code if you're not supposed to use the 97XXX codes. Did I get it right? Is that what you're kind of saying, kind of, sort of?

THE SPEAKER: I mean, I just want to know - I want to be clear on what the hospital reports know. Because we report surgical-type procedures out of the emergency department for the facility.

DR. MCKINNEY: And keeping in mind, surgery contains a lot of things that can be done, like wart removals in surgery.

THE SPEAKER: Right.

DR. MCKINNEY: Well, obviously you're not going to the operating room for that.

THE SPEAKER: Right. And when it says debridement and/or dressing change, it gives no other explanation. You know, we do have to give sedation when burn people come in and get dressing changes or whatever. But it's the CPT book partially that's the holdup here. Because if it's telling us not to the 97XXX codes, that the 97XXX codes are excluded for burn treatment and it refers us back to the surgical codes, but then CMS says, no, you can't use surgical codes, then what are we going to use?

DR. MCKINNEY: For non-physicians.

THE SPEAKER: Right. For non-physicians.

DR. MCKINNEY: All right. I promise this will not appear in March. I will get you an answer by the end of the month, now that I kind of get some clarity. Maybe they'll come out with some burn codes for non-physicians in 2014, but that would be too simple. But I'll get you an answer. I think I've got it. If not, I'll contact Karen. And I apologize for the confusion.

THE SPEAKER: Me, too.

DR. MCKINNEY: No, no. We want you to do the right thing.

13. **Providers have received unfavorable Redetermination decisions with the only rationale for denial being that documentation/medical records were not submitted. Prior to completing the Redetermination Cahaba did not notify the provider of the need for additional necessary documentation.**

Excerpt from Cahaba Unfavorable Redetermination Notice:

> The appeal information submitted by the provider did not include a medical record to determine if the services performed was as te provider submitted. The initial determination date, (paid date), was June

Medicare Claims Processing Manual, Chapter 29-Appeals of Claims Decision, 310.4-The Redetermination, D. Requests for Documentation, 2. Requesting Documentation for Provider or Supplier-Initiated Appeals states:

> ***For provider and supplier initiated appeals, when necessary documentation has not been submitted, the reviewer advises the provider or supplier to submit the required documentation. The reviewer notifies the provider or supplier of the timeframe the provider or supplier has to submit the documentation. The reviewer documents his/her request in the redetermination case file. The requested documents may be submitted via facsimile and/or via a secure Internet portal/application……If the additional documentation that was not requested is not received within 14 calendar days from the date of the request, the reviewer conducts the redetermination based on the information in the file. The reviewer must consider evidence that is received after the 14-day deadline but before having made and issued the redetermination.***

Will providers receive a notification from Cahaba (as described above) and be given an opportunity to provide additional documentation prior to completion of the Redetermination? If so, what avenue is available if the Redetermination is completed without the necessary documentation and the provider was never notified or given the opportunity to submit the additional documentation?

Response: Per Part A Appeals Manager

We do request additional documentation when needed. The appeal specialists will order these on their own in some cases (usually outpatient), or if it's an inpatient stay, the nurse will advise us if additional documentation is needed and we will request those records.

Once requested, we do allow the 14 days to receive the requested records. If not received within those 14 days, we will close the appeal and will indicate that the decision is denied based on the documentation received does not support…etc.

We've recently had an update to our workflow system and letters. This update will allow the reviewer to click on which records were received and further, to check which records were lacking which may help to consider their appeal. This advises the provider on what records are needed to assist them at the next level of appeal.

If the appeal is completed without the additional documentation, then the provider can appeal to the QIC.

The best way to avoid all of this is for the appellant to submit all records relevant to the appeal in question.

Discussion at Meeting

MR. HALEY: Does anyone have anything to add to that?

(No response)

14. **When a hospital obtains and transfuses a pooled blood product for which there is no specific "pooled" HCPCS code, for example pooled platelets or pooled cryoprecipitate, should the number of units billed to Medicare reflect the number of units pooled or should one unit be billed for the total pooled product?**

Response: Discuss at meeting.

Discussion at Meeting

MS. EVANS: You list the CPT code for pooling once, which is 86965, and then you put the number of units pooled in the service units column. So the number of units that you pooled goes in the column and you just use one code.

MR. HALEY: Okay. Anything else on that one?

(No response)

15. **If a department is using a drug that is not FDA-approved as part of a test, will that test be covered? Nuclear Medicine was using Kinevac with their Stimulated Hepatobillary Scan. The Kinevac is not available at this time due to manufacturing issues. The substitutes include a compounded form of the drug - not FDA-approved - or they can use a fatty meal. They don't want to use a fatty meal because the normals are not very reliable. (They would have to test up to 50 people to get a set of normals for a particular fatty meal.)**

    Response: Medicare only pays for FDA approved indications for drugs and biologicals – radiopharmaceuticals would fall into this category. Those drugs and biologicals that are addressed in a Cahaba article or LCD contain off label approved use based on approved submitted documentation/literature to support the of label use.

    Discussion at Meeting

DR. MCKINNEY: Again, we have no way to audit this or to say that you used the Kinevac for the wrong reason. We only pay for FDA-approved uses of drugs, unless there is a national coverage determination or a local coverage determination to identify off-level use.

MS. NORTHCUTT: So would the procedure related to the drug use be covered? I think that more of the question is the nuclear medicine procedure itself. Would it be covered because you're using a non-covered, off-label use of the Kinevac? ? But would that be a covered service? The nuclear medicine.

DR. MCKINNEY: Is Kinevac bundled? Would it be bundled

MS. NORTHCUTT: Yeah. That would be a package. So you're going to have the procedure out there. But you're doing the procedure without the correct drug, if you will.

DR. MCKINNEY: Right.

MS. NORTHCUTT: It is?

DR. MCKINNEY: Anybody got a quarter? I'll flip it up and see yes or no.

MS. NORTHCUTT: If you want to think about it, that's okay.

DR. MCKINNEY: Yeah. Because I do know that on certain PET scans and certain other scans where nucleotides are used, we only pay for certain nucleotides. Otherwise, like FDG, those kind of things - there was a time when we only paid for FDG radionucleotide. We didn't pay for Rubidium. I'm just making stuff up. And then they added Rubidium as a covered service. But anything where you used Rubidium would not be covered.

I think we paid for those tracers. And I think that's the issue; that we actually paid separately for those markers. But I need to find out if it's a bundled marker or contrast or whatever, do we really care, you know, how you use it.

And so I can answer it both ways, and I want to be favorable to you. So let me make sure that I don't step out on a limb and then make a decision. But let me ask that question. I guess it was asked that way. I just didn't hear it that way. I thought you were looking for reimbursement of the actual contrast medium. But the basic question is when a medium is bundled.

MS. NORTHCUTT: Right.

DR. MCKINNEY: Off-label.

MS. NORTHCUTT: Is the procedure still covered as a payable service.

DR. MCKINNEY: Okay. All right. I will clarify it.

16. **"CMS has determined that three FDG PET scans are covered under § 1862(a)(1)(A) when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anticancer therapy. 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-tumor therapy will be determined by local Medicare Administrative Contractors." Has Cahaba made a determination of how many FDG PET scans beyond three they will cover?**

    Response: Discuss at meeting.

    Discussion at Meeting

    DR. MCKINNEY: We have not looked at that to determine a cap on those. So my guidance to you now is I would use your medical judgment of your clinicians if they feel it's medically necessary. Then just know they may have to require some extra documentation to support beyond three. But at this time, we have no edits or audits to look at those. If we do decide that four is the number or six is the number, we would publish that in an article for your guidance. But at this point, our guidance would be beyond three, just to make sure that your documentation is in order, knowing that three is kind of the cutoff point and that your clinicians document well the necessity to go beyond three. And I think that's really all we can require and ask of you at this point, until we get you something in writing from a policy standpoint.

    MR. HALEY: Any other comments on that one?

    (No response)

17. **CMS has determined that (unless there is a specific NCD to the contrary) local MACs may determine coverage or non-coverage for PET (within their respective**

jurisdictions) using new, proprietary radiopharmaceuticals for their Food and Drug Administration (FDA)-approved labeled indications *for oncologic imaging only*. This is effective for dates of service on or after March 7, 2013, and includes those radiopharmaceuticals that may be approved by the FDA in the future. This decision does not change coverage for any uses of PET using the following four radiopharmaceuticals: FDG (2-deoxy-2-[F-18] fluoro-D-Glucose (fluorodeoxyglucose)); NaF-18 (fluorine-18 labeled sodium fluoride); ammonia N-13; or rubidium-82 (Rb-82)). Has Cahaba expanded PET coverage for oncologic imaging to any other radiopharmaceuticals?

Response: No plans at this time.

Discussion at Meeting

DR. MCKINNEY: I think the rule of thumb here again is, is if it's FDA-approved, and these things come out futuristically, then use them for our on-label purposes. I would caution you in any realm, not just in these tests. If something is kind of off-label, that you have a litmus test to make sure that you're using things appropriately.

But if the FDA in months to come, before we give you guidance in writing, comes out with new tracers or FDA pharmaceuticals for oncologic imaging, then I would use those as the FDA said, and that should be fine. So as long as they're on-label, used as directed by the FDA, then you should be fine, until we give you guidance to the contrary.

18. **Are the new discharge codes applicable to all claims?**

Response: Yes, TOB 11X and 12X

Discussion at Meeting

MS. NORTHCUTT: The discharge status codes, the new ones, when they actually came out with those, specifically addressing the three DRGs for MI basically that are still alive in the neonates, the assumption was that it was going to be for those specific DRGs that have to be reckoned with, if you will, to try to get this discharge status code down as far as the planned readmission goes. It's extremely difficult to actually do that for all DRGs. And so specifically since they targeted these four DRGs, the assumption was that that's the ones that we would have to apply those to, instead of all claims.

And I think the question came about for all claims, all DRGs, are you going to have to look for that needle in the haystack of a planned readmission back to the hospital.

MS. EVANS: I see what you're saying.

MS. NORTHCUTT: Yeah. They weren't clear either way.

MS. EVANS: Right. And they're not that clear. Because I've researched it, and I've talked to support about it. And the issue was, a lot of times, you don't know exactly what that DRG is going to be when you discharge that patient anyway, to the point. But that if you

anticipate that the patient is going to be readmitted, if you have the plan that it's going to be readmitted, then you would choose those codes. But I haven't found anything that specifically says for all claims.

MS. NORTHCUTT: For all claims? Yeah. Okay.

MS. EVANS: But we talked about it. And even as late as Friday afternoon, she called me and said we still need to stay with yes for type of bills 11X and 12X and see.

MS. NORTHCUTT: So that maybe we could get some clarification from CMS?

MS. EVANS: Yeah.

MS. NORTHCUTT: That would be great. Because right now it is much easier to control just these four.

MS. EVANS: Sure.

MS. NORTHCUTT: You can have at least a target.

MS. EVANS: Sure.

MS. NORTHCUTT: When you start trying to do a discharge status code for any planned readmission.

MS. EVANS: I don't think it's mandatory that you do that, but I think it's just maybe easier, you know. But I'll keep looking.

MS. NORTHCUTT: Okay.

Additional Discussion at Meeting

THE SPEAKER: I may need to submit this as a formal question. But would a planned readmission - wouldn't that be a leave of absence? Or how long do you have to have a patient out of the hospital and expect them to come back for it to be a leave of absence?

So you discharge them today. They're coming back next week. Is that a leave of absence? Or they're discharged today. They come back in two months. You know, they're going to have their hip replaced. Is that a leave of absence?

MS. EVANS: I'm stepping out into a zone I'm not comfortable with. But to me, leave of absence implies that they're not formally discharged. So if you formally discharge them, that's, by definition, not a leave of absence. Leave of absence is I'm in, got to go to WalMart, and I'm coming back. So that's a leave of absence. But if you let them go, then that's a discharge.

THE SPEAKER: That's helpful. Because we've had a Medicare Advantage plan tell us that should be a leave of absence.

THE SPEAKER: We've had a Medicare Advantage plan tell us when they were doing a readmission review that that should have been a leave of absence. And it didn't make sense to me because that clarifies what it means. So it's in my brain that if they're discharged, you're not just letting them leave and come back.

DR. MCKINNEY: Correct. To me, leave of absence says I'm really not done with you yet, but we understand you've got to go do whatever and come back and we'll finish up what we need to do. That's leave of absence. But if you're done with them, goodbye, that's discharge. That's not a leave of absence. So that's how we would interpret that. And I don't know that there's a time frame for leave of absence. I think that was the second part of your question. I think you have to use judgment. If they're gone for a month and you don't see them back, then I think they're pretty much not coming back. But I don't know that there's a date thing.

THE SPEAKER: Could you possibly dispel the rumor that Cahaba has lost their contract with CMS that's going around Birmingham right now?

DR. MCKINNEY: I can dispel that rumor. Just to update you on where we're at, that the award for J10 that now becomes JJ and this has happened for several contracts, even JN and a couple more. CMS was to have awarded that, I think, in April of this year. They postponed it to September of this year. They postponed it to March of next year.

So we are still the MAC and we anticipate to be the MAC. We've had no news contrary to that at all. And CMS keeps things, you know, close to the chest. And so they don't tell a lot. But we have no indications that that's true.

Now, I'm sure our competitors would like that to be true. But those who want you would have that to be true. But as of now, that is not true factually.

THE SPEAKER: What about the RAs?

DR. MCKINNEY: The RAs - I'll tell you what I know. The RAs are to re- compete this year. That was postponed. So they're not going to be re-awarded. The RAs who wanted their jurisdiction have already done their presentation, their pitch to, you know, please like us and keep us. And so that was to be awarded at the end of this year. CMS has postponed that somewhat indefinitely.

MR. HALEY: When was that announced? Was that a recent development?

DR. MCKINNEY: I would say probably in the past three to six months. Well, probably the past three months, I would say, we heard that, that they're not going to award those yet. And then they're going to postpone that until next year is the plan.

So for example, for us, CMS keeps pushing the needle back. So we never know, you know. It's a little bit humorous that they say we're going to award and we'll just use JJ. We're going to award JJ on April 7th. I'm like, okay. So April 7th comes and goes. You don't hear anything. You don't know anything. Then April 18th comes. They say, we're going to award it

September 6th. We're like, okay. How did that just not get pushed? And so September 6th comes. You don't hear anything. You think, hum. . Let me just say, as a contractor, you would know if you were not going to get the award. It's kind of the phone call you don't want to answer.

So September 6th came and has gone and then I think maybe, I'm making up dates. September 14th came and they said, well, we just don't know right now, but we'll get back with you. So now it's March of next year.

So I have a job for at least I think through June of next year is kind of it. So anyway...

MR. HALEY: Anything else?

DR. MCKINNEY: Good questions.

THE SPEAKER: Just have a quick question about the denial of returns where we're due money back. I'm sure everyone knows it's a very complicated process with notification coming in on the PLB lines. And then we know that we've been successful.

And then at some point between one and 30 days, some mix of those days, that's actually repaid to us. But it comes back on the EOB line with a B2 code, with no identifying information. And it could be for one patient with interest or no interest or for ten patients all up together.

And it's very complicated, useless information, other than we have money. It's nice to have money back but not know where to put it or which successful appeal it actually goes to. It's very, very frustrating to come to a large time-consuming part of our RAC team and of our cash posters to try to identify where it's going, to hear some talk about possibly adding some additional information for those repayments.

Do you have any updates on that, and do you have in the meantime, any kind of guidance on how to more effectively and efficiently identify those besides just going to customer service, waiting your ten days, and calling customer service back and waiting your ten days and send it to Suzanne? Thanks.

DR. MCKINNEY: Specific to RA denials? Or is that applicable of any denial?

THE SPEAKER: Anything where we've had money recouped and then we're due money back. It comes to that same method. It's just very difficult to identify where it actually should go.

MS. ELDRIDGE: Okay. As far as CMS and a date as to when this might be changed where it's easy to read it on the remit, we haven't heard anything about that. The only way to retrieve that information from us is to go through customer service, unfortunately.

But when you go through customer service, if you make sure you submit your e-mail address, of course, the remit dates, the dollar amount - the whole dollar amount. I am involved in this process when these refund requests come through. I usually like to see the whole dollar amount that's on the remit because it makes it a little bit easier for us to reconcile versus just saying just want the dollar claim and I can't find that. It just takes a little bit more time.

So you do the PTAN number and your NPI number. If you'd give all that information to customer service, they'll submit it to my department and we'll research it as quickly as possible and get it back to you. We'll send you an e-mail with that information.

THE SPEAKER: Is there a standard turnaround time we should expect for that?

MS. ELDRIDGE: Our process is 72 hours from when we receive it. But you'll never know when we receive it because we get it from customer service. So that's the process that we're given. But we turn it around as quickly as we can.

THE SPEAKER: So it would be safe to say within ten days, like with you and customer service, we should have already gotten a response?

MS. ELDRIDGE: Hopefully. If you do not receive a response, call customer service back. When you called customer service did they give you a GINQ number in regard to this request, too?

THE SPEAKER: Yes.

MS. ELDRIDGE: So once you get that information, if you feel like you didn't receive your information in a timely manner, feel free to contact them and let them know and they'll contact us and let us know.

DR. MCKINNEY: I would submit that if you have to call them a second time and you don't get satisfaction after the second call, that you submit that through the process to find out.

THE SPEAKER: I do. And Suzanne has always been very helpful with anything we've had to send through her. So I appreciate that.

The other kind of quick response to that is, any consideration to setting up an e-mail address where you could just send those in to save that call to customer service? Because it does become very time-consuming if we have eight NPIs that we bill under for that have a lot of activity. So it gets to be very time-consuming to call customer service, sit on the phone, explain to the person in customer service who should have a very good understanding what we're asking about is to explain that to them and then get that seems like we're wasting a lot of time in the middle. If we could just have a way to send that directly to reimbursement, some generic e-mail address where those are pulled from, so we can kind of have a quicker turnaround time on those.

And I know for us that we got the understanding a little bit later on how to get those to reimbursements. So we have a backlog that we're trying to clear up. Any way we can just go ahead and give those to you and say here is what we have outstanding to get those cleared up? I mean, I have the EFT numbers. I have the PTAN numbers. I have the dates that those were sent in. But calling in, giving one at a time to customer service again, it's just a very time-consuming process.

THE SPEAKER: Three. They only take three.

MS. ELDRIDGE: They only take three?

THE SPEAKER: They only take three requests at a time when you call them.

THE SPEAKER: Means you have to call back, give them three more, and call back, give them three more.

MS. ELDRIDGE: Okay. I wasn't aware of that process.

THE SPEAKER: And, again, we've already gone through the process of having to file it and we've already had our money taken back. We've done our process to get this overturned. And then we're having to sit here having to make these phone calls to beg to know who are you paying us on and where do you put this money. It seems like it would be a more streamlined process to make it easier for Cahaba and for us.

Because, again, the customer service center doesn't know what we're calling about. It's just confusion on their end. We can have a more direct length. I think it would be very helpful for both Cahaba and for providers.

MS. ELDRIDGE: Well, I understand your frustration, and I'll take that point back. I didn't realize it was three. But even if you were to send it directly to our department, I mean, you still would have a wait, because we do other things besides that. And it's a manual process. And say, for instance, if it was a refund to your facility for multiple claims, there might be a possibility that I might have done a refund, but five other people in our department could have done a refund, too. And we still have to get all that information together to get to that total that you're looking for.

So I will take that information back and let them know, and maybe we can come up with some kind of way to make it better.

I know they've talked about educating customer service on how to obtain this information and give them access to the software that we use to get this information. So we're constantly trying to come up with a way to make it better. Because I understand your frustration. Because when we get the information, it's a lot of information to go and obtain. So I do understand your frustration. But I'll take that back.

DR. MCKINNEY: I will say that customer service versus an e-mail box is that because those calls are recorded and documented in a file, so that if anything ever is disputed or questioned, we can go back and pull those files. Because every call is recorded to make sure that the customer service is accurate and precise. E-mail boxes can be a dangerous thing unless they're manned all the time and found and logged and all that kind of stuff. But it's a valid concern. I think maybe Insight, our portal, may help with that. That's what our hope is, is to streamline a lot of submissions like that. So that's kind of where we're headed, to make everything self-use.

THE SPEAKER: I just wanted to pass this along. I have been e-mailing the reimbursement department. And I can't remember the exact e-mail address. It's

reimbursementfinancial@cahaba something or another. And it is kind of interesting. Because I may have one refund for $8,000, and I might get an answer for 6,000 of those dollars, with a little note that it was passed onto another person for the other 2,000 or 3,000, whatever. But I get pretty good response with that. Sometimes it does take a while.

But I did e-mail CMS with the question as to when we will be able to get some kind of identifying information on our B2 refunds in the PLB adjustments, and they e-mailed me back and told me to contact our contractor. I can pass that e-mail on to you, if you'd like. I just thought you'd like to know that.

THE SPEAKER: We do have an e-mail we use to Reimbursement Financial.

THE SPEAKER: Yeah. That's the one I use.

THE SPEAKER: Sometimes we get a response, sometimes we don't. I think it goes back to Dr. McKinney's response earlier that he's missed or overlooked. So something that's more efficient would be to call customer service.

THE SPEAKER: I think it depends on whose control it's in. Because I have some people that I get immediate response from and then other people never.

MS. ELDRIDGE: And to clarify that, when you send it to that e-mail box, our department is split. So it goes to someone else in a department, and then they send it to our side and it is assigned to different people.

So, I mean, some of the responses, depending on who you get, like, for instance, me. I do respond to these B2s. And when I respond to them, I like to give you the total dollar amount. I don't like to send you bits and pieces. Because it gets confusing to me. So if I have a dollar claim and somebody else has ten other claims for a dollar or two, I try to get all that information on the spreadsheet and send it back to you.

So, like you said, it really does depend on who gets the e-mail or who actually worked the refund. But we do work them, I promise you, as quickly as we can in addition to doing other processes. Because everything is manual that we're doing.

THE SPEAKER: Well, we're hoping that Insight or something is coming along to give us some identifying information. Because it's very time-consuming.

MS. ELDRIDGE: I don't think it's going to provide it in Insight for you, though.

THE SPEAKER: Well, something. We need an ICN number or claim number or something. Or even if we had individual refunds that we could match up to a recoupment instead of having them all lumped together, that would be helpful.

But my experience of going through customer service, even with GINQ numbers, I have never, zero, never had a response. But I have had response going directly to ALAHA especially if Suzanne helps us, because she's been a great help.

MS. ELDRIDGE: Well, she sends them to me.

MS. EVANS: Yeah. I send them.

THE SPEAKER: Oh, well, good. Now we know.

MR. HALEY: Anyone else?

THE SPEAKER: Is there any date on the closure of the ELGA for the providers?

MS. EVANS: No. I have not heard a date.

DR. MCKINNEY: We'll research that. And it would probably be a good idea to put an article out or something on the website so that you guys can know that. Thank you for that feedback.

MR. HALEY: Anyone else?

(No response)

MR. HALEY: All right. Thank you very much.