MEDICARE (CAHABA GBA) MINUTES
July 15, 2013 RIC/RAC Meeting

CAHABA GBA REPRESENTATIVE PRESENT:
Dr. Greg McKinney
Ms. Suzanne Evans

FACILITATORS PRESENT:
Mr. Ingram Haley
Ms. Karen Northcutt

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

1. **Follow up to question #1 and from the Additional Discussion from the March 11, 2013 RIC/RAC meeting. If the therapists are going to have to use the 97000 codes for burn debridement, are the burn diagnoses codes going to go back into the debridement LCD?**

    - Waiting on response from CMS.

    Discussion at Meeting:

    DR. McKINNEY: Good morning. The decision has not been final, and it will probably be in the next week. But what we're looking at is removing all diagnoses from that policy. So that will probably be the solution for that LCD.

    Part of that has come when we look at our transition from ICD-9 to ICD-10. As most of you probably know, six ICD-9s can translate into 30,000 ICD-10s. So we're looking at that workload impact on us. And the decision probably is going to be in about a week, but the tentative answer is we're going to remove all of the diagnoses edits and audits from that policy so that that won't be a hindrance for you to use those codes.

    We've also bumped this up to CMS as far as those codes. Some contractors feel that the burn codes are physician-only codes, which is why we instructed you to use the 97000 codes. So we're waiting to hear the response. So we'll follow up with AlaHA to give out an answer. But right now the codes will be removed. But we are getting clarification as to whether therapists can use the burn codes.

    Again, as you know, when they're priced through the RVU system, there's malpractice, office expense, and all those things that are figured into the payment, which is why a lot of contractors feel that those are physician-only codes. But the temporary interim fixes of the diagnoses will be removed, but you'll see something on our website on that pretty soon. So that's the response that I have today.

2. **Follow up to question #4 from the March 11, 2013 RIC/RAC meeting.**
    A. **Do you have any additional information on the status of ways to match RAC refunds at the account level?**

        - There is no known way at the moment; however CMS is analyzing various options.

    B. **Please provide a status update on Pub 100-20 Change Request 8092 specifically: When can providers expect a solution be implemented where principal and interest are reported**

separately along with claim identifiers when funds are returned to providers as a result of a favorable appeal?

- Please note that CR 8092, which deals with the reporting of principal and interest when returning previously recouped money, is still being discussed. The analysis is to decide the most viable option to report the principal and interest separately and to also identify the claim. There is no known date as to when the analysis will be completed at this time.

Discussion at Meeting:

DR. McKINNEY: I just want to make a general comment. And I think we probably have said this before. But just keep in mind - and, again, this is part of my soapbox, so it's kind of like when your parents have told you this story five times; but just pretend I haven't told you.

We did check with the reimbursement department for RA questions. Remember, we are not the rock. We are the middle person. So what they do we can't control. So we are struggling, to use a word, just as you are to try to figure out when these retractions come, how to turn that money back around to keep you from appealing to keep that money tied up.

That's why on a lot of these RA questions, we don't have the definitive answer because, again, we are just the processor of the claim as it comes through. So we're trying to partner with the RA to make this more efficient. We're trying to partner with you guys to make it more efficient for you.

So that's just kind of an overarching statement on a whole lot of these questions involving the RA. We just do what we're told. And sometimes things come fast and furious to us. And we're trying to make it less burdensome on you and try to bump that up to CMS to let them know how burdensome it is to you and how burdensome it is to us to kind of bounce those funds around and make sure that we communicate that back to you.

So just wanted to have that up front before we get into a lot of RA questions, which I think they all ought to be RA questions.

3. **Follow up to question #5 from the March 11, 2013 RIC/RAC meeting. Is there any progress on the system being able to provide a specific status code for each step of the appeals status including denials and approvals for all RAC and MAC related appeals process?**

    - Cahaba is working on a project which would allow providers to check appeal status online via a web portal.

Discussion at Meeting:

MS. EVANS: I talked with the appeals manager and she said that Cahaba is working on a project that would allow providers to check the appeal status online via a web portal. It's called Insight. And the first phase is eligibility and claim status. The second phase will include appeals. Now, I have not heard of a date. Have you?

DR. McKINNEY: I would look toward this fall. October/November you will see a lot out on the website. Again, it's called Insight. This will be the mechanism for online checking, status of different aspects of the claim. I think, as Suzanne mentioned, it's going to be eligibility and claim status. And we're going to grow that. So you can check the appeals status online.

We're hoping to evolve that at some point. Our goal is so that you can file the appeal online. So it's going to be an evolving mechanism, so just watch the website. But it will be delivered in phases. But 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. So when you see that word, that's going to be our online portal for you to have your claims status check online.

4. **Follow up to question #12 from the March 11, 2013 RIC/RAC meeting. Medicare requires a REMARKS CODE with denial code 96 (non-covered). Can you tell us why Medicare is no longer putting the REMARKS CODES on the remits when we get denial code 96?**

    - EDI has researched this issue and cannot recreate it. They pulled a Remittance Advice from June 2013 and the remark codes were there. They would like to see specifics; it could be an issue with the provider's software vendor.

    Discussion at Meeting:
    SPEAKER: I'm the one that submitted the question, and examples were with the question.

    MS. EVANS: Okay.

    SPEAKER: So is a remarks code with the 96 or is it on the individual claim transaction? Because there were remarks codes on the remit, but not attached to the 96.

    MS. EVANS: Say that one more time.

    SPEAKER: I'll send the example.

    MS. EVANS: Yeah. Because the example wasn't there. So if you'll send me that, it would be great.

5. **Follow up to question #14 from the March 11, 2013 RIC/RAC meeting. Please provide status on this: We are a Medicare PIP Hospital. We understood that we would receive a DEMAND letter before any funds were recouped; however, we never received any demand letters, and the funds were recouped from our remittances for several claims. We spoke with a Medicare representative, who informed us that there was a system issue preventing the demand letters from being generated. Has this issue been resolved? If not, is there an expected resolve date? How will we know when RAC funds will be withheld from our remittances, other than when we receive the remittance with the payment recouped?**

    - There was at one time a system problem where FISS was not set up to process PIP inpatient claims through to HIGLAS; however this problem has been resolved as of the 06.03.2013 FISS release. RAC PIP adjustments are now being processed through the system through the mass adjustment process, flowing through to HIGLAS and generating Demand Letters. These amounts are owed by the providers

and are processed as any other 935-RAC adjustment. They are being reviewed by the RAC on a claim by claim basis. Payments are due to Medicare and checks should be sent to the address with the letters.

These adjustments had been on hold until such time as the FISS system was capable of handling them to process through to HIGLAS. There were some claims that went through and deducted from the provider's remit before the demand letter was sent and we are handling them on a case by case basis. Cahaba will be working with the RAC to identify these claims and work on a process to get them processed correctly. The RAC is working with CMS to release these adjustments in a manageable manner for the provider.

Discussion at Meeting:
MS. EVANS: Once again, I talked to the reimbursement people for the response.

6. **Follow up to question #15 from the March 11, 2013 RIC/RAC meeting. Were you able to get the number of appeals for Alabama and the number of appeals for Cahaba?**

- The published article was referring to 2010 claims which would explain the difference in the numbers. From the article:

> *Myth: Every RAC denial is overturned on appeal*
> *Fact: The appeals process is a multilevel approach that allows providers to appeal a Recovery Auditor's overpayment determination. This process is exactly the same for all providers who want to appeal a Medicare claim decision.*
> *Fact: To date, only 2.4 percent of all 2010 claims collected have been both challenged and overturned on appeal. Health care providers have appealed 8,449 claims to date, which constitutes 5 percent of all claims collected in FY 2010. Monitoring appeals activity is a key part of the Recovery Audit program. CMS will continue to track the Recovery Auditor appeal rates.*

RAC-related appeals are trending upwards and account for about 50% of Cahaba's appeal workload. CMS is aware of these trends as RAC and non-related RAC appeals are reported to them on a monthly basis.

Discussion at Meeting:
MS. EVANS: I talked to the appeals manager for the response.

DR. McKINNEY: I do want to add something as an interesting fact so you'll realize the magnitude of the RAC appeals on the contractor. At our June meeting this year in Baltimore, since the RAC program came on line in 2009 or 2010, RAC appeals have increased over 12,000 percent. So that is a huge burden on the contractor.

I think I mentioned this the time before last, that we are struggling with those RAC appeals. We encourage you to appeal those RAC claims, but they are coming fast and furious. So we are struggling trying to get people on board to help us with those RAC appeals.

So the data for that is released periodically by the RAC. I think the numbers are low because they combine both complex, which are those claims that require a clinician to review, and those that are automated, those that they go through the system and just put a function in the system, recoup that money without any review of claims. So that is a holistic appeal rate.

I think we have discussed before our experience has been this number is old. I haven't looked at it lately. Be cautious and hear how I word this. Of the RAC claims that are appealed that require a clinician to review them, about 30 to 35 percent are overturned by Cahaba. So we're looking at about a 30 to 35 percent overturn rate of those clinical claims by Cahaba. That doesn't include the automated, the taking back extra units of NEULASTA and all those kind of automated things that they go in and do when units are out or something like that so the providers violate CCI edits or whatever the RAC concept is.

But again, you have to be careful about how you look at the percent of overturns or the appeal overturn rate by the RAC because they do mix all claim types in that appeal. But from a complex claim review, that's the term we use, complex claim review, complex meaning those that require a clinician to review them, we have about a 30 to 35 percent of return rate. And most of those, I would say 85 to 90 percent are DRG related, and the other 15 to 10 percent OPPS, 13X multiple line claims. But the majority are DRG claims.

MR. HALEY: Just a real quick clarification question. On this myth /fact question, is this national or is this for Alabama in fiscal year 2010?

MS. EVANS: I don't know that answer.

MR. HALEY: Okay.

DR. McKINNEY: We can get that clarified. But the 2.9, about three and a half sounds right for national. It may be the same for our jurisdiction, but we can get that clarified. The 8.5, 3 percent sounds similar to the national appeal rate as well.

MR. HALEY: Thanks.

MS. NORTHCUTT: When you say DRG, are you talking both coding and medical necessity?

DR. McKINNEY: The question was DRG is coding and medical necessity. Again, depending on the DRG, we do just a coding review because I know that sometimes that's the RAC concept. And sometimes we do both; sometimes we just do a medical necessity review, but those are all performed by a clinician, or I should say, slash, coder. Any claim that comes to medical review, it's about a 30 to 35 percent overturn rate.

I may be going out on a limb, but I think the coding has gotten a little bit better on the RAC. At first they were not doing too well on their coding, at least by our review, but we think that has somewhat gotten a little bit better.

I think we're seeing a little bit less coding problems from the RAC, but we do have a combination of coding and clinical review of the DRG for IS, SI, whatever term you want to use, criteria for the DRG.

7. **Follow up to question #17 from the March 11, 2013 RIC/RAC meeting. The definition of Technical Component states "includes staff and equipment costs incurred during the performance of a diagnostic test…" Is it appropriate to bill a technical component of a CPT code if the facility doesn't own the equipment nor incur any cost for the equipment on which the test is performed? An example of this would be billing for 93225 (Holter Monitor Recording – includes connection, recording and disconnection).**

    - Please provide the arrangement on how the company providing the equipment is getting paid.

Discussion at Meeting:

DR. McKINNEY: I guess I would answer this with a question. Somehow the vendor has to recoup their cost. So they're not providing that free. So if someone who asked that question could tell me how the vendor gets paid or If they're just donating it to you.

SPEAKER: They're getting paid when they sell the equipment. So their incentive there is to get us to buy it from them or get their equipment. So they're not charging for the monitoring itself. So nobody is billing for that. And the question is, well, can we?

DR. McKINNEY: Well, to whom are they selling it? They have to sell it to the hospital if you're putting on line.

SPEAKER: Yes.

DR. McKINNEY: So you're buying the equipment. So you own the equipment, which is not what the question is.

SPEAKER: Not necessarily. There's a piece of equipment that they want us to use to monitor their device, so we're using the device which is where they're making their money.

DR. McKINNEY: Right. So you've purchased the equipment, or are you just using it for free?

SPEAKER: We're using it for free. So there's no expense on the provider side for that equipment. Now we have the staff, but not the equipment itself.

MS. NORTHCUTT: So they have the staff to hook it up and do all the stuff.

SPEAKER: Right.

MS. NORTHCUTT: So it's free equipment, I guess.

DR. McKINNEY: I don't know that anything is free.

SPEAKER: Well, it might not be.

DR. McKINNEY: I'm just saying, nothing is free.

SPEAKER: It's a loaner.

DR. McKINNEY: It's on loan. Okay.

SPEAKER: Yeah, it's a loaner.

DR. McKINNEY: At today's interest rate, nothing is free. So I would need to know the dynamics of that. Are they not billing Medicare for the DME?

SPEAKER: They're not.

DR. McKINNEY: Okay. If they're not billing us for the equipment, and they're just passing that through to you, and they're just a very nice vendor, and they like you a lot, then, yes, you can bill the technical equipment.

SPEAKER: Even though we own the staff. We don't own the equipment.

DR. McKINNEY: That's fine. The technical component is to accommodate all the equipment. The equipment side of the equation, we don't care where all that comes from as long as we don't get billed five different ways part and parcel of that.

SPEAKER: Right.

DR. McKINNEY: So in that unique case, I would say that that's fine. But, again, I would need some assurance that they're not turning around and billing through a DME number to you guys and the claim pays, getting money for that and then just giving you the device. But as long as it's clean and it is free, then, I would say yes, you could bill the technical component.

SPEAKER: Okay. Thank you.

DR. McKINNEY: That was a lot of ifs, but yeah. Yeah.

8. **Follow up to question #19 from March 11, 2013 RIC/RAC meeting. Was Cahaba able to test the following Health and Behavior Codes : 96150,96152,96153,96101 to ensure that the general rule of " when a professional performs a service in an institution and notates it on their claim, a reduction in professional reimbursement is made to offset the payment make to the institution who incurs the "practice expense" that otherwise would have been paid to the professional" applies to these codes.**

    - Yes, there is a reduction in professional payment.

Discussion at Meeting:

DR. McKINNEY: For that long question, the answer is yes, there is a reduction in professional component making sure all the place of services are correct, which would be the physician's or clinician's responsibility.

9. **Follow up to question #21 from the March 11, 2013 RIC/RAC meeting regarding your claim processing log issue. You said it was to be corrected April 22, but it is still not corrected. Please give us an update as to when it will be fixed.**

    - Per the Claims Issue Log:

      05/29/2013: FS7978 still has a production date of 06/03/13 to correct the system issue with creating RAC adjustments for PIP claims. The FISS Maintainer has provided contractors with a work-around to finalize the initial PIP claims that are stuck in PB9996. Cahaba is in the process of identifying all of the initial claims that are part of this issue to get them to a finalized status.

Discussion at Meeting:

MS. EVANS: It is still an open issue on the claims issue log, but they are in the process of identifying those claims to try to get them to a finalized claim. And I have seen that working, so just try to be patient. If you have a bazillion of them out there, let Ingram know. We can't go in and pick and choose. What they do is the system runs a report to get those claims, and claims works them. So there's no way we can go out there and say I want South Alabama's claims to be up front or I want the ones with the most money to be up front. It just does not work that way.

10. **A. Please provide education on 99495 and 99496 codes.**

    B. We would like guidance on billing the new Transitional Care Management codes (99495 and 99496) for hospitals. The APC rate has been assigned but we would like guidance on what services should be provided to bill for TCM by the facility. Specific questions: 1) Will the physician fee be reduced if the hospital bills? 2) What services is the hospital receiving payment for? 3) Must the physician face to face portion occur in a hospital based department for the facility to bill TCM? 4) What services is the facility required to provide in order to bill TCM?

    - Transitional Care Management (TCM)

      99495 (moderate complexity decision making)
      99496 (high complexity decision making)

        - Goal is to improve care coordination and reduce risk for readmission
        - Transition in care <u>from</u> an IP hospital setting (acute care, rehab, long-term acute care), partial hospital, observation status in hospital or skilled nursing facility/nursing facility <u>to</u> the patient's community setting (home, domiciliary, rest home, or assisted living)

- 99495 (mod) = communication with patient and/or caregiver within 2 business days of discharge; face-to-face visit within 14 calendar days post discharge
  99496 (high) = communication with patient and/or caregiver within 2 business days of discharge; face-to-face visit within 7 calendar days post discharge
- POS = provider should report services with POS appropriate for the face-to-face visit, i.e. POS 11 (office), POS 22 (OP Hospital), POS 12 (home), POS 13 (assisted living facility), POS 50 (FQHC), POS 72 (RHC)
- Payment = one physician for TCM per bene per 30 day period (pays the first eligible claim submitted during the 30 day period that begins with day of discharge). Other providers bill reasonable and necessary services, including E&M services provided to the bene during that time.

  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf

Discussion at Meeting:

DR. McKINNEY: Okay. I probably can sum this up. The information that's given to you here is from the CPT manual. So I would take a minute to read CPT because it outlines the components of that. The role that the facility would play is that these codes can be facility-based, but it is the physician's or clinician's responsibility for performing their part.

So a lot of it depends on the setting. If the clinician is hospital-based, then you can bill your component and the clinician would bill their component, and they would get a reduction in payment with the proper place of service. However, the collective note, the collective service between the two should reflect all the components of this transitional care.

And it's quite extensive. I don't know if you want to go through this or not, but each one has what you're supposed to do and the responsibility and examples. If you read the preamble in the CPT manual for 2013, it's almost a page and a half of what components go into transitional care.

So the facility can have a part in that, to bill the facility component - not the total component, but the facility portion of that, or a PPS, you'll get a payment. But you, collectively with the physician, the note must have all the essential components that are outlined in the CPT. And those are quite extensive, but that's what the CPT has outlined as part of those codes.

Again, those are a one-time, one-time only, set of services. We are having a call the week after next, the medical directors are, to discuss these further. If anything changes or if I need to add anything or supplement what I've said today, I can email Ingram about that. But I think the synopsis that we gave you is pretty much from CPT and from the final rule.

Also, if you want to go to CMS's website, up at the top, search transitional care management, they have a list of FAQs on there, which go through different scenarios about how to bill those, what the components are.

So just keep it in mind that if you're in that physician facility situation, that collectively the note should reflect the components of transitional care, which would be on the onus of the clinician if they were out in a practice or doing it at place of service 11, which is their office. But if they're doing it in the hospital and you're providing it in a clinic environment, like an office or an E&M, then you would need to make sure that you partner with a physician that you fulfill the criteria that are in the transitional care codes.

MS. NORTHCUTT: So a case manager, for instance, would have to work in tandem. It would really have to be more of an office setting to be able to function with this face-to-face visit.

I think under the OPPS, because there was a payment rate and because of the definition, I think that we were hoping that we could have case management who's doing their part bill the technical component of those fees. And it sounds like in tandem with the physician would be kind of a different story or a different scenario than what we think that we would like to do in the case management arena.

DR. McKINNEY: Right. We see that as a collective visit. Not go see the case manager and then a couple of days go see the physician. It is a one-time collective visit that all resources that are going to be part of that visit have to do.

MS. NORTHCUTT: Okay. That would be very clear.

DR. McKINNEY: I'm sure some of you could create a scenario for me. It can be done in the ER, which I don't know, but I see it more so in the physician's clinic when you provide the office, office space, electricity, personnel, those kind of technical parts of it.

But if you want to provide some of that service, it has to be a collective visit, because it is a one-time, one-time only code. The system is set to dupe out if we get different dates of service codes on those codes.

But, again, we're having a call next week. So if anything I've said I need to backtrack on or correct or add to, then I can forward that on to Ingram.

And I will say one last thing. Just because payment is assigned to a code doesn't mean that it's necessarily billable in the sense of covered. A lot of codes in the physician fee schedule have payment, but that doesn't mean that they're covered. CMS assigns and AMA assigns payment rates to almost every code unless they carry a price and they're designated as such. But just because there's money attached to it doesn't mean that it's covered under Medicare.

11. **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.**

    - We should be following the 3-day window rational based on the facility's ownership, using the attached FAQ as a guide. Would like to review the specific appeal.

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/CR7502-FAQ.pdf

Discussion at Meeting:

MS. EVANS: Whoever submitted that question, if they will get me the specific appeal.

SPEAKER: It was provided with the question. An example was provided with the question, so I don't know if you got it.

MS. EVANS: I didn't get it. So do you mind sending that to Ingram? And then we'll look at it.

SPEAKER: Okay. Thanks.

MS. EVANS: Great. Thanks.

DR. McKINNEY: You appealed it, and then a nurse reviewed it?

SPEAKER: This was given to us by the compliance department. And what they basically said was that it was denied for lack of documentation being sent. And they did not send it because it was not for medical necessity.

DR. McKINNEY: Okay. Whenever I hear medical necessity denial, that tends to relate that a nurse reviewed that, a clinician looked at that. So I would be interested in your feedback for us to look at the example, if our nurses aren't looking at it correctly. Because you have to keep in mind that when our nurses get these 12,000 percent increase in RAC claim appeals that they get, everything comes at them.

When Cahaba launches a probe, we review your claims, and we occasionally deny them, and you appeal them. We know what that concept is about because we started it, we reviewed it, we let you know, we looked at it in data, and we know what's going on. But the RAC is just rapid fire, willy-nilly everything. And when a nurse gets a claim that comes to her or him, they pull it up, and they have to kind of tease through really, What was the RAC doing? What were they looking at? Was it a complex? Were they coding? And so sometimes —— not making excuses —— the nurse looks at it and thinks, Was this medical necessity? because the RAC has dozens and dozens of things, and those appeals come in no logical order, so they're all random.

So that would be important feedback for us to know. And I'll look at the claim, but I was just curious if you knew up front what it was. But we'll look at that and see. You know, this is another brick in the wall, to coin an old song, of what we see on a regular basis. So we're trying to get our arms around the variety of the RAC appeals that we see. So thank you.

12. **Will you please review the claim instructions for Part B rebilling due to RAC, MAC, or CERT Denial. Two examples of denials being received are: 1) We have sent 3 test claims to Cahaba for Part B charges for records that have failed the appeal process through Level 2. They have denied with reason code 31809 "Demo Code 65, 66, 0r 67 is present on a 12X TOB submitted by a non-participating provider". 2) Ours are denying for the condition code as not valid.**

- Change Request 8185/MLN Matters 8185 outlines the instructions. As there are so many variables in processing claims, we would need to see the specific claims.

Discussion at Meeting:

MS. EVANS: I talked to claims about this one, and their concern is that there are so many variables that can make a claim denied that without seeing the specific claim, that they really were hesitant to answer this question. And they also suggested that change of request 8185 outlines the instructions for the rebilling. But whoever had that example, if you would send it to Ingram so that we can look at that claim and see what's going on with it. Thanks.

DR. McKINNEY: And the only other comment, if this is the rebilling demonstration, that's only in certain states. But this may not be what this is pertaining to. But the demonstration project for the rebilling was only in like three states, and Alabama was not one of those. But we'll look at the claim, if we can get an example.

MS. NORTHCUTT: Has anybody gotten any through for the Part A, Part B rebilling that's nondemo?

SPEAKER: We've gotten some through, but we're getting more denials. More are getting kicked out.

MS. NORTHCUTT: And I think this is probably some of those examples. So maybe those would be the kind of examples. You know, if we can gather from several hospitals, it might help them figure out what they're doing. If none were getting paid, then I would worry. Because for a while there it was a tough go. So maybe you could get those and then send them on. I think that would be very helpful.

13. **Can we get some clarification on what services can be billed separately for a Critical Access Hospital with a swing bed? I have read that some OP services can be billed separately; we just want to confirm that CAHs are excluded from SNF consolidated billing.**

    - Refer to Medicare Learning Network "Swing Bed Services" January 2013, page 2:

      "CAHs offering swing bed services are exempt from the SNF PPS and are instead paid for their SNF-level services based on 101% of the reasonable cost of the services."

14. **A: 1) Why are we receiving intent to refer letters for claims that are in appeal or already recouped? 2) When we do receive intent to refer letters, why don't we get more information clarifying what claim it refers to? 3) We have to call customer service but then we get no information - we have to wait 10 days to call again but then it starts all over. How can we get an answer?**

    B: 1) How does this affect a PIP vs a non-PIP facility? 2) How does this affect a system that owns a PIP and a non-PIP?

- A. Sometimes we get into a backlog situation and sometimes the system is not updated in a timely manner. To ensure we receive your appeal request in a timely manner, please consider utilizing the Appeal Smart form. If you believe you have received an intent to refer letter in error, please contact our Customer Service area.

  The additional information has somehow been omitted – you should receive the first demand letter with all of the original information along with the intent to refer. If you do not receive the information that advises exactly what the intent to refer letter references, please contact Customer Service and request a copy of the demand letter.

  B. They both are affected the same. As of 06.03.2013 PIP should receive demand letters and the money should be paid back to the Medicare program. The RAC claims for a PIP provider will be treated the same as a non-PIP provider. The adjustment will come from the RAC via mass adjustment straight to the Data Center. The Data Center uploads mass adjustment file into FISS system where the claim processes straight through to HIGLAS where either there is a claim payment, account payable, or some type of denial, account receivable. With an account receivable, a demand letter is generated and sent to the provider. The claim then processes through to remit where, if a payment is owed, it sits there until 40 days has passed before any recoupment while assessing interest every 30 days a balance is due.

Discussion at Meeting:

MS. EVANS: Once again, I talked to the reimbursement people for the response.

SPEAKER: Okay. On the intent to refer, I am fighting this battle on a regular basis. I get the intent to refer. I contact customer service. The first thing is they can't find anything, so they have to call me back within ten days. I never receive a call back. So I mark it on my calendar, call them back again. The same process. I guess the biggest thing is why are we receiving an intent to refer? Because the very, what, first two or three sentences in the intent to refer says you have not appealed it or you have not paid the money back.

Every time I've got an intent to refer, my claim is either in a level one, two, or three appeal, meaning I have already answered the first part of it. It's in some level of appeal, but yet I'm receiving an intent to refer. And then when I receive the intent to refer, I call customer service, exactly what you're saying here, but I get no information. They act as if they have no idea what I'm talking about.

As an example, I chased two intent to refers for about two months, finally requested a supervisor who eventually called me back and said, you're exactly right, there's nothing for you to do, these are in appeal. I knew that already, but yet I'm still receiving an intent to refer that I have to respond to. I have to chase it to make sure if it's okay.

So why are we receiving these intent to refers when we have met the requirements on the front end?

DR. McKINNEY: Was the customer service person able to find your claim?

SPEAKER: No.

DR. McKINNEY: Appeal?

SPEAKER: No. They don't even try to. Basically they said, well, we'll have to refer this over to claims and you'll hear back from us within ten days. And they'll give me a case number or whatever, but basically they'll come back and say, well, I don't have anything on this. We'll have to call you back within ten days. And I never get a call back.

DR. McKINNEY: Well, do this for us, get those examples that you have to us so that we can track it. Because all of our calls are recorded with customer service. We can pull those, and we'll see where we dropped the ball. And we'll look at those.

I will tell you that a lot of times what happens is, and I'm not sure it involves intent to refer, but the RAC denies your claim, and then they send us a mass adjustment. Well, we may not get to that mass adjustment for a couple weeks because we have that 12,000 percent increase, those in line waiting, in the meantime, you've appealed it.

SPEAKER: Right.

DR. McKINNEY: And we have to do a better job. Which it's difficult for those systems to communicate to say, okay, stop the letter because it's in appeal. And we're trying to work through that process. It hits us in medical review where the nurses will get a claim that's been appealed, and they go out and look in the system, and the money has been given back to the provider so they don't need to review that appeal. So we're trying to work better for those systems to communicate.

But to make sure we didn't drop the ball and do a better job, if you would send one or two examples, and then we can follow that through the customer service.

SPEAKER: And I can understand that if it's a level one appeal. But when you're already to a level two or a level three appeal and you're getting an intent to refer, there's a lot of time that's been gone through in that process.

DR. McKINNEY: Yeah. Well, if the systems don't do a good job of communicating, that intent to refer letter is automated, a human doesn't do that.

SPEAKER: Right.

DR. McKINNEY: And the system doesn't know if the systems aren't reading appeal level two, level three and block that intent, then the system auto sends out those letters. Which because this happens a lot. And, again, probably one of our biggest hurdles is RAC retractions, because they go out there and pull all your money, and then they say, oops, we want to give it back to you. Well, that oops doesn't affect the RAC; it affects you, it affects us, because those claims have to get in line for our machine to crank those out. And sometimes we're not efficient in doing that just because of sheer volume, as you can imagine.

But I'd be happy to provide you some feedback. If you want to give those couple of examples to Ingram, we'll be happy to research those for you.

SPEAKER: We'll do it.

DR. McKINNEY: Thank you.

SPEAKER: My question is about PIP versus a non-PIP facility. Our facility is a PIP. We consolidated campuses. The campus that we consolidated to our facility was a non-PIP facility. We're receiving notice to refer letters for the non-PIP facility. We called customer service because we're thinking we need to cut a check. Customer service is telling us not to do anything, so that's why we asked this question.

DR. McKINNEY: Okay.

SPEAKER: Would you like me to give you examples? I could give them to you.

DR. McKINNEY: That would be fine. That would help. And then we could come back. I don't know if that's a unique situation that we need to research to see how the system is looking at that, but we'd be happy to.

SPEAKER: I think it is very unique.

DR. McKINNEY: Okay. We'll be happy to look at that.

SPEAKER: Okay. Thank you.

15. **Claims are denying for overlapping a hospice that has gone out of business or that Medicare has shut down. How do we get payment for these claims if the hospice is no longer existing? Is Medicare responsible for paying these? An 07 condition code means outside the plan of care, but is there something else we can use on the claim to get payment for our service? Usually an 07 is our only way to be paid by Medicare for services provided to a hospice patient. Is that appropriate in this situation? (Attachment)**

    - Submit a new claim with condition code 07 include in remarks that hospice is no longer in business.

Discussion at Meeting:

MS. EVANS: Yes. I had one a couple of months ago, and we were able to get it processed. But if you do that and it doesn't process, if you'll send it to Ingram and he can send it to me and I can see. But, yes, that's how it worked for that claim.

MR. HALEY: And I'll take this as an opportunity to remind you all that we do have a process set up where in these cases where you've got something that's not flowing through right and it kicks out for whatever reason, you've already called customer service and have a ticket on it, you can forward it to me, and I'll send it straight to Suzanne. And typically she can kind of speed up the process. So do remember we have that process in place.

DR. McKINNEY: And don't forget to get your GINQ number when you call.

MR. HALEY: Yes, we need your GINQ codes with that.

16. **Why are the charges that Medicare typically does not pay for the charges denied for MUE? If there is no reimbursement attached to these charges, what is the reason for the denial? How does this affect our cost report? Per the remit, these charges denied for MUE are also "not allowed", therefore it is not a part of the contractual adjustment. Reason code on the remit is CO B5. Does this mean we can adjust this amount to a contractual? (Attachment)**

    - Discuss at meeting.

Discussion at Meeting:

MS. EVANS: We really didn't understand this question. I asked a couple of people, and I got one of those kind of puzzled looks. Can I have further clarification of this? Is whoever submitted this here today?

SPEAKER: I am.

MS. EVANS: And it might be that it was too rainy and we didn't understand, but we just couldn't quite get it together.

SPEAKER: Of course, some of the questions we've come up with is whenever it comes across in the remit, it comes across as not allowed, and in our system where we post the electronic remit, we don't post it as a contractual, and it ends up being a balance we actually have to manually adjust.

And the other part of it was if it's not an allowed charge or it's not something that's payable anyway, why are we even having that as a medically unlikely edit?

MS. EVANS: I'll take this back. And may I get your telephone number?

17. **51MUE – 53MUE – 54MUE. On April 1 we started seeing many claims denied 51MUE. On April 19 issue was on claims issue log advising fix scheduled on 5-20-13. We are now seeing the 51MUE suspended as the issues log states they should be. Our question is do we have to appeal all the claims that denied prior to the claims now being suspended? (Attachment)**

    - Providers will not have to appeal these claims. They will be adjusted by Cahaba.

18. **We would like clarification on the requirement for a public pool to be completely closed to the public during aquatic therapy provided at a community pool. The State Operations Manual, Chapter 2, Section 2300 Revision 03/15/2013 states the "Pool must be closed to public use during the time the organization is providing therapy to protect the privacy and safety of the patients being treated." However, previous revisions allowed a corner or area of the pool to**

be closed. Medicare Benefit Policy Manual, Chapter 15, Section 220.C allows just a portion of the pool to be closed. (Attachment)

- 100-02 Medicare Benefit Policy Manual
  Chapter 15 – Covered Medical and Other Health Services
  Section 220 C

  - Services furnished by providers, by others under arrangement with and under supervision of providers, or furnished by suppliers (i.e. physicians, NPP, enrolled therapists) who meet the requirements in the Medicare manual for therapy services
  - Services provider to Part A IP of hospitals, residents of SNFs in covered days, HHA
  - Services furnished by a clinician in a PT or OT private practice, OP hospital, physician office, OP SNF
  - Practice/office/provider shall rent or lease the pool or specific portion of the pool; use of that portion of the pool during specified times shall be restricted to the patients of that practice or provider.
  - ***Other providers, including providers of OP PT and SLP (OPTs or rehabilitation agencies) and CORFs are subject to the requirements outlined in the respective State Operations Manual regarding rented or leased community pools*.**

100-07 State Operations Manual
Chapter 2
Section 2300 – Outpatient PT and/or SLP (Speech Language Pathology) Services at Other Locations such as a Patient's Private Residence, Assisted Living or Independent Living Facility

- Organization (agency) may wish to use a community pool to provide aquatic therapy.
- State Agency or Accreditation Organization shall verify that the community pool meets all applicable state laws.
- Pool must be closed to the public during the time organization is providing therapy.

Discussion at Meeting:

MS. EVANS: I think when it's all said and done, it's who you are, who is providing the service. If you'll notice, under the Medicare Chapter 15, it's the providers. And the State Operation Manual is an organization or an agency. So I think it is who you are that defines what you do with the swimming pool.

DR. McKINNEY: I can get that clarified at the CMS level, but I don't know.

SPEAKER: But if the pool has to be closed for the privacy and security of the patients, why wouldn't that be consistent, and the situation is that we're an outpatient therapy department. We have a community pool available. It's a zero-entry pool in the community, which is a new facility, so they want to do their aquatic therapy there because it's so much easier for the patients to get in and out. But

it's a community facility. They're not going to close the pool for therapy. They'll be willing to close a corner of it. But if the whole pool has to be closed, that's really prohibitive in that relationship because the facility will not do that, and so then we don't have a place to offer aquatic therapy for those patients.

MS. EVANS: Are you a hospital?

SPEAKER: We are. We are a hospital. And in previous revisions of the Benefit Policy Manual, it allowed just that corner to be closed. And then recently, in the March revision, it now says the whole pool has to be closed. So we've been able to provide this therapy, and now we'll have to stop.

DR. McKINNEY: We'll just see why there seems to be a conflict and then what really is the way you should offer those services. I'll take this back, and I'm sure we'll see it as a follow-up. But I'll try to get it answered before November. How about that?

SPEAKER: All right. Thank you.

MS. EVANS: When you're talking about the March 2013, you're talking about the State Operations Manual; is that correct?

SPEAKER: I'll have to go back and look at my notes.

MS. EVANS: You said Chapter 2, Section 2300, which I believe is the State Operations Manual.

SPEAKER: Yeah, it is.

MS. EVANS: Karen knows.

MS. NORTHCUTT: Well, and I think one of the things that we always have a problem with, because the State Operations Manual says a lot of things that really are contradictive of what CMS says but they all publish that on the CMS website as the facts, and then we get into whether JCAHO is following the State Operations and how we're basically being able to abide by CMS's guidelines and the State Operations Manual.

So I guess a bigger picture would be which one do we follow in the event that CMS has one thing in their benefit policy manual and the State Operations Manual says another. And I think this is a perfect example of that.

DR. McKINNEY: And this is deemed as a community pool?

SPEAKER: It's like a gym. It would be a facility or a community pool like a YMCA.

DR. McKINNEY: Okay. Because I think this talks about if it's a community pool, that it has to be closed. That's what the State Operations Manual says. I think if it were just your pool that you had in your hospital that was not community, open to the public, that you wouldn't have to close it down. But I'll get clarification.

MS. NORTHCUTT: And I know she's not the only one with the YMCA part of the pool.

19. **New 2012 Molecular Pathology codes that CMS directed providers to use in 2013 – 81200 - 81383 and 84000 - 81408. Medicare is not paying. Can we get an update? Has the payment method been decided? APC or fee schedule? Will claims have to be resubmitted once payment rates are determined? Will there be policies?**

    - The codes all have pricing loaded and should be paying. Would need to see an example where the provider is not getting paid.

Discussion at Meeting:

DR. McKINNEY: There should be, on our website, a list of the codes and the payments. But some are not going to be covered. So if we could get examples of codes that weren't paid or if they weren't on the website. But there should be a list in the article forum. I think we were required by CMS to put those out there. So I didn't handle that part, but I can double check if it's not out on the website. But it should be out there, the whole table of codes and the payment rate and all that.

So if you give examples, that would help us, because that's been a whole other fiasco. But we'll look into that.

20. **Should diagnoses be sequenced following inpatient sequencing rules or outpatient sequencing rules for listing diagnoses on the 12x re-bills for all RAC/MAC/CERT medical necessity denied accounts?**

    - Discuss at meeting.

Discussion at Meeting:

MS. EVANS: I asked our support to look at this because I had looked in the manual and I read the CRs, and I couldn't see anything where it said how you do the diagnoses. And they researched the manual and the CRs as well as all the emails that went back and forth about the AB rebilling, and they couldn't find anything specifically addressing the use of diagnoses codes.

So they reached out to the claims person who had been working on these AB rebilling, and her response is, these claims should be rebilled using the medical record and the outpatient services to create a new comprehensive Part B of A claim with the original claim number included in the remarks field for tracking purposes, which really doesn't answer the question.

So my question is have you had claims that have been denied because of the diagnoses listings?

SPEAKER: Yes.

MS. EVANS: You have?

SPEAKER: That is our question. And I don't think we've even rebilled any yet.

MS. EVANS: Okay.

SPEAKER: But we were just trying to get a policy together on how we're going to do this. And I believe, Dr. McKinney, if I am not mistaken, you've stated in the past that the status of that patient remains inpatient.

MS. EVANS: It does.

SPEAKER: So that made us think that we were supposed to bill it using the inpatient sequencing rules but not the outpatient sequencing rules. So that's why we asked that.

DR. McKINNEY: I'll try to make this easy. For us, we read all fields. So to us, how you sequence would be up to how you want to from a coding perspective. The sequencing doesn't matter to us, unless it changes the claim, which it should not, because the claim system reads all fields. If you have a coding rule for that; if you don't, then you have an internal rule for that, then I would just make it easy for you. But for us, it doesn't matter, we have no rules about how you should sequence your diagnoses. So we want to make that easy for you guys.

So if that's a nonanswer, I'm sorry; but we want to give you the liberty of doing it how you want to because our system is going to read them all. So whether it's fourth or fifth, it's going to read the whole system on outpatient and inpatient for the grouper purposes.

And if that's different, then I'll let you know. But to make it easy for you about whatever policy you want to implement would be easier.

21. **We have encountered issues with failure to receive the Unfavorable Redetermination Notice from Cahaba in the mail. Upon follow up call to Customer Service we have been advised Cahaba is not sending the Redetermination Notice to the name and address of the Requestor submitted on the Redetermination Smart Form. Can Cahaba address and mail all correspondence related to a Redetermination directly to the contact name and address of the requestor? (field #9 and 11 on the Cahaba Redetermination Request Form) (Attachment)**

    - Cahaba sends all provider correspondence to the address on file. Recently, the appeals department reviewed their workflow coding for addresses and discovered it was pulling from the 'remit' address. They have changed their coding to pull from the 'correspondence' address on file. In many cases, these addresses are the same, depending on how the provider completes their applications. The recent correction to the workflow system may correct this issue for some providers.

22. **Based on the recent Widespread Targeted Review Results DRG 069, 190, 191, 192, 470, 641 that Cahaba recently published, providers in 3 different states were noted to have denial rates of 50% and greater with most being above 90%. Can you address how Cahaba plans to educate hospital staff as well as other providers to reduce these denial rates?**

    - Overall, the denials resulted from 2 main issues – inappropriate setting and insufficient documentation. Each claim decision and rationale can be accessed in FISS and provides specific details for the claim reviewed. We can ask Provider Outreach and Education (POE) to consider general education regarding medical necessity reviews on inpatient

claims if providers think this would be beneficial. We welcome any suggestions for ways to educate providers and keep them informed.

Discussion at Meeting:

DR. McKINNEY: You see the response there, so I'm not sure what those DRGs are. But I can tell you we're only really looking at one-to -two-day stays. So most likely it's the patient who didn't need to be in inpatient status.

So if you have any suggestions for us. I will say most of you probably have heard about a rule that may go into effect this fall about the Two Midnight Rule that may alleviate a lot of these reviews of admissions. The Two Midnight Rule presumes the patient needed an inpatient status if they met the Two Midnight Rule.

That is still in draft. It is not final, but we feel some version of that will become final for the Two Midnight Rule, so just watch for that. I'm sure your associations are on target to get information about the Two Midnight Rule.

But currently, one-to- two-day stays for a lot of issues are not inpatient status. So we want you to take a really, really hard look at those things that we're looking at. Some of them are pretty obvious: Gastroenteritis, back pain. A lot of things just don't need to be inpatient status. They can have observation services and not be admitted as an inpatient; they can stay as an outpatient.

So that's the majority of what we're reviewing in the medical review. That's what CERT is finding in the errors. That's what the RAC is going to start going after.

So I can't answer any specific questions, but anything that's one or two days is going to be on the radar from now until things change as far as the Two Midnight Rule. The Two Midnight Rule may change the way we review claims. We'll have to wait and see how the final regulations are worded.

We probably can talk about this more in November if it's final by then. But just make sure under the Two Midnight Rule you're very cautious that everybody doesn't need two midnights, because we will be looking at that. The presumption is if they stay two midnights, that they're presumed to meet inpatient. But we don't want 100 percent of your patients two midnights. Okay? So that doesn't mean that, oh, my goodness, okay, they stayed two midnights so we're out of the woods because they're inpatient. We will look at that to make sure that you're not trending to do everybody as two midnights.

But, again, if you have suggestions about that, I will reiterate we do use the admission criteria. But that is not how we deny. We use that as a benchmark for those services. And I think our nurses in general are fairly thorough in their rationales. It's on ongoing education that we have with our nurses to make sure that their language in their denials, how infrequent they may be, are very concise. And we, as the medical directors, review those from time to time.

So if you see some issues with that or you want more education, let us know. But that's pretty much the answer with the DRG things. And I did want to take the opportunity with this question to bring up the potential Two Midnight Rule. Keep that on your radar, because that probably will come up about in the fall.

SPEAKER: Listed on here is DRG 470, which is total joint replacements. And our hospital had several pulled, all being overturned at level two. What's the agenda for those? Typically our patients stay three days for total joint replacements for knees and hips. I'm just wondering where they're going. And the response we got back from Cahaba was related strictly to Milliman criteria and screening for surgical procedures.

DR. McKINNEY: The rationale should not say a specific criteria. They may say that as a tool was not met. But, again, it sounds like those particular sort of joints. We're going to look for, as we did in our review, single joints. We expect documentation to support why they needed it, and if you feel like that they needed it or you find extra documentation from the physician. Again, it's a very collaborative effort.

We don't use Milliman at Cahaba. We use McKesson. McKesson is InterQual. Milliman is the other vendor. I believe I'm getting them straight. But if you look at McKesson's criteria, it is very strict, very strict, it's not or, or, or; it's and. You have failed outpatient therapy for at least four to six weeks and you've used an assisted device and you have an MRI and, and, and. We don't use that criteria. We look at those and we look at the documentation to make sure that what the physician has documented supports that that patient has had some untoward history that now necessitates a joint replacement.

MS. NORTHCUTT: I think there were kind of a dual questions of how these were denied. And I don't think it has to do with the inpatient stay for the joints. I think that was more the reason that you had the joint replaced.

DR. McKINNEY: Correct. Okay.

MS. NORTHCUTT: So I just wanted to clarify that.

DR. McKINNEY: And when she asked that question, that's what it kind of sounded like.

MS. NORTHCUTT: Yeah. So really, they should be inpatients as far as I'm concerned at this time.

DR. McKINNEY: Right. Yeah.

MS. NORTHCUTT: It's just whether they should have had it at all.

DR. McKINNEY: Correct. Well, whether the documentation supports whether they should have it. I will tell you that there are some demonstration projects that have gone on. Those of you who have been at these meetings for a long time, this is something that I've been an advocate for. But there have been demonstration projects wherein specifically single joints are reviewed and I won't tell you where; you probably can find out. But the contractor did a demonstration project where if they denied the inpatient claim, they took the physician's money back.

So CMS is looking at that very, very carefully. I think if you do that once or twice, that might curtail a lot of utilization or would incentivize the surgeon to provide what you need for that claim to be paid. Again, it's all a partnership. But it really is, I think in this case, because you know in Alabama we're looking at single joints. In the interim, I would be happy to speak to your medical society, meet with your orthopedic department, come to their staff meeting, and I'm sure your hospital's represented there and just, hey, give us ten seconds. Here's what Medicare is looking for. This is what we want to have in the record. Thank you. Have a good day. And just list those things: MRI findings, previous drug use, did they use Hyaluronan, did they use Synvisc, did they have therapy, have they had any kind of therapy, do they have a rheumatoid condition that has a destructive lesion. Those are all things that you need to give to your orthopedic department as kind of a cheat sheet to say this is what we need for you to document in the record. We don't have to have the physician's MRI report in the record. But if they reference an MRI report, they should tell us what they found.

What we see a lot of is joint destruction. I have joint destruction, but that doesn't mean I need a knee. So we need a lot more details in there.

So I'd be happy to help you with that. Thank you for clarifying that. For most of these, it's one or two things stated that meet the criteria; but in the single joint, we do consider that an inpatient procedure for now. I hear some swirling that it may not be an inpatient procedure, but that's above my pay grade. So that will be interesting to see how it comes.

But just make sure for the single joints, you partner with your clinicians. And, again, we'll be happy to help you with that. But you know the criteria. You know what we're looking for.

23. **A. If a patient is an outpatient and/or observation but is in the hospital and has some rehab service (i.e. physical therapy), in order for the rehab service to be covered, we need a rehab diagnosis code. Can we pick up the code from the (physical) therapist's documentation? Does a treating physician have to countersign the therapist's documentation in order for us to pick up the code?**

    B. In the outpatient setting (OP rehab), can we use the rehab diagnosis/code documented by the therapist without a physician's signature?

    C. In the outpatient setting (OP rehab), can we code from the cert and/or therapist's evaluation prior to the MD signing the document?

    - For all, coding should be done from evident conditions/signs/symptoms documented by the referring/treating physician whether this be from the initial order or the signed certifications.

Discussion at Meeting:

DR. McKINNEY: For all coding purposes, you have to code from what's documented by the treating clinician. Whether that's in the order that's sent, the cert that's signed, the progress note that's signed, you can only code from what the clinician validates. That can be, again, prescription, the form they send with the patient, the certification that they send. It has to be from what the clinician has validated as true. I start using clinicians because of nurse practitioners, etc. So it has to be what's documented. You can't anticipate a diagnoses.

I will say, too, that on our therapy policies, we are considering removing those diagnoses as well, because, again, the extrapolation of ICD-10. But that still does not change the method that you code from. It should be evident in the medical record that the clinician has supported whatever you coded. And that can be from any piece of information that the clinician has provided based on your protocol, your method of doing business, however you do things, whether it's electronic or record or paper.

So we want to make it easier for you, but it has to be evident that the clinician attested to that.

SPEAKER: What we have a lot of times is that the physician will say, stroke, and then the patient presents and from a coding perspective, the diagnosis might be slurred speech. So I guess the question is how do we get a definitive therapy diagnosis where, I mean, just general stroke isn't going to cover it?

DR. McKINNEY: Now, keep in mind that when your therapist does their evaluation and they do their plan of care, that plan of care has to be attested to by the physician before you bill the claim.

SPEAKER: So we need to hold the claim until we have that signed back from the M.D. And when he's signing off on it, he's agreeing to that therapist's diagnosis?

DR. McKINNEY: Yeah.

SPEAKER: Thank you.

MS. NORTHCUTT: And I think I remember that. It wasn't from you. I remember it long ago; that another one is a late certification, so the late signing of the certs. And I remember a hospital was having problems with that. So you can't drop a bill until you have a diagnosis, and that means that you've got to have a signed cert, you know, all of that. I think that had something to do with this as well.

DR. McKINNEY: Well, see, it's kind of a paradox. You can file a claim without the cert being signed; but if we review it, we will deny it. And you can get a cert a year later, and that's okay; but, again, if we review it, we will deny it. And at what point you get it signed, you can appeal it or however the process goes forward. You can bill anything. Kind of like the IRS taxes. You can file anything.

Our instructions are that you can only bill from what is documented by a treating clinician. And, again, we would only know that if we looked at it. So I think that's just a good rule of thumb, because then you start saying, well, okay, we'll give them ten days. And you just need to get it done. Get her done, as they say.

24. Inpatient and outpatient started rejecting for 39071, 39072 and 39073 reason codes. Those descriptions are attached. This started on or around 1/2013. Claims are not related to open no fault, liability or no fault files and we are including this notation in the comment section of the claim. Prior to 1/2013, this was sufficient and claims were processed. Now, if codes such as 401.9, 305.1 were reported on the no fault, liability or no fault claims that correspond with the open file date, then future claims are rejecting for the health related DX stating they are related. Why are these denying now and explanation in comment section is not enough? (Attachment)

- Per Cahaba Claims Issues Log
  - Cahaba GBA has identified several claims that are cycling with reason codes 39071, 39072, and 39073.
  - Updates/Work Around/Scheduled Fix
  - 06/26/13: The FISS maintainer is currently researching this issue. No provider action is needed at this time

Discussion at Meeting:

MS. EVANS: This is an issue on the opens issue log, and they are swirling around there. But we're working with the maintainer to see what can be done. So right now, there's nothing you need to do for that.

25. For an outpatient encounter can the hospital perform the MSP questionnaire by phone prior to arrival to the hospital?

- No

Discussion at Meeting:

MS. EVANS: No. I checked with the MSP people, and no. Because that is supposed to be something that's done when you see the patient. And things can change between then, and they say no.

26. Does the mental health composite apply to the indicated CPT codes regardless of whether the diagnosis is mental health related or not?

- Discuss at meeting.

Discussion at Meeting:

DR. McKINNEY: I don't have an answer for that. I don't know what the mental health composite rate is, to be frank with you. But I'll do some more research and get an answer.

SPEAKER: The codes are 96118 and 96119. And this is neuropsychological testing. So the 96118 is physician testing per hour code, so it's a time code. So when I submit these claims, no matter what I do, I'm getting the composite rate for mental health. The diagnosis is not a mental health diagnosis. There are two APC assignments to these codes. One has got the Q3 indicator for mental health; the other does not.

So I tried submitting just one code. Sometimes I'll submit 96118 and 96119 together because I have a technician and I have a physician both doing this testing. I attempted the billing with just one code, and I still get the composite rate.

DR. McKINNEY: And you said there's a modifier that you put on there to let them know it's mental health? Is that what you said?

SPEAKER: No. Just diagnosis. The Q3 is the status indicator that says it's the composite.

DR. McKINNEY: Oh, okay. I can research that. But to get a more efficient answer, if you have a claim example please send it to me. Is this a facility claim?

SPEAKER: It's a facility claim. Hospital outpatient facility fee.

DR. McKINNEY: Okay.

SPEAKER: I can send an example. Should I go through Ingram?

DR. McKINNEY: That would be good. I probably could research an answer and give you a generic answer. But I could probably look at your claims, since you tested the system several ways, and see kind of what's butting up against the system and if the system is reading it wrong or what.

And I don't know, I haven't been asked, nor has any clinician been asked, to let a mental health diagnosis, so I don't know how the system would know whether it's mental health or not. So that would help if we had a couple of examples just to drive and make sure I'm researching it down the path you need me to go.

Additional Discussion at Meeting:

SPEAKER: Could I just ask if you would give a brief update on the 1455 rebilling that went into effect on July 1st and how that's going and what the status is?

DR. McKINNEY: No. We'll research that and let you know what the status of that is.

SPEAKER: I have two questions. The first one is we have appealed several RAC appeals, and Maximus is sending letters to some of our patients telling them they agree, not agree, whatever the status is. And you may or may not can speak to this. It may be more for the audience. But I'm just wondering, some of our patients, it's really confusing them. So do you know what their purpose is? Are any other hospitals having that? That's the first question.

DR. McKINNEY: As a general comment, all benes are entitled to a determination letter. So it probably doesn't surprise me that they're getting confused. I don't know anything other than that.

Anybody else have any comments?

SPEAKER: And is any hospital sending letters to your patients up front, when you know that they're going to get a letter saying it was appealed and approved or denied? Any hospitals trying to be proactive?

(No response)

SPEAKER: Okay. The second question is, is there any way that Cahaba could rethink or relook at having a separate address for all of our MAC requests and all of those type things? I know like with Connelly, you can have a separate address, like a P.O. Box or something like that. And the reason I'm asking is because some of the bigger facilities, the mail, as you well know, can go around the world. So can you relook at that, is there any possibility, or are we just stuck with the way it is?

DR. McKINNEY: I will try to be optimistic and say that we will look at that.

I think the different injection is is that the RAs do not use the system, per se, to communicate to you. They create their own database to communicate with you. All ours, because we are the maintainer and we are the processor, we have to go through the system to communicate to you, and the system only sees one address. But I will be happy to surface that back up.

I'm not sure what the online portal will allow. There may be some more flexibilities once we get InSight online portal. But I'll be happy to ask that question again. I think it's a valid question.

The problem with that is that when you get multiple addresses, then we have to know is this a letter that goes to address one or address two and all that kind of stuff. But it's certainly something we should be able to at least have a dialogue about and at least rethink.

SPEAKER: All right. Thank you.

DR. McKINNEY: Yes, ma'am?

SPEAKER: We have several accounts that have a debit balance resulting from Medicare reporting a payment reversal transaction on the 835 but not recouping the funds via PLB adjustment to offset the reversal. This all takes place after we refunded the excessive funds to Medicare.

Our question is how can we keep Medicare from giving us a payment reversal transaction on our 835 when we send them a refund?

DR. McKINNEY: We can ask that question. I think it goes back to when you send that money in, it goes through one system. The RAC system is out here. And if everything was timed in a perfect world, they would all communicate and tell you hold up, you're fixing to get some money back, you don't have to send us the money, if I understand your question correctly.

SPEAKER: Well, these accounts have nothing to do with RAC.

DR. McKINNEY: Well, now, 835 is a RAC code.

SPEAKER: No. That's a remittance advice.

DR. McKINNEY: Okay. Because 835 claims to us mean RAC.

SPEAKER: Okay. Well, 835 is an electronic transaction Pancy 835 standard transaction.

DR. McKINNEY: Okay.

SPEAKER: But they just started doing this. Medicare just started doing this.

And used to, if you sent them the money, that was the end of it. But these are old accounts that someone at our facility decided they couldn't put on the credit balance report because they were too old so they just sent in checks.

DR. McKINNEY: So you had to go dig up some money in the back yard and send it to us. Is that what you're saying?

SPEAKER: Well, it really wasn't much money. But the thing was, then we get a transaction —— Medicare is taking their money back on a transaction. So now we refund it, and now we've got a transaction where they've taken their money back, so now we have a debit balance on our account.

Is there a time frame or is there an age that you can't put the recoupment request on the credit balance report?

DR. McKINNEY: Those are all great questions that I don't have the answer to. Well, submit that question for November, because we'll have to ask Provider Audit Reimbursement, our PAR department. And we'd be happy to do that, we're just not the subject matter experts on that.

SPEAKER: Thank you.

SPEAKER: Dr. McKinney, do we know when the proposed rule is final, will we still have an opportunity to I guess utilize 1455 and rebill for Part B services?

Say we have claims that are still out there now and we're appealing them, but we may not take it to the ALJ; it's right now maybe at the first level of appeal but the final rule comes out. Will we still have the opportunity to rebill those?

DR. McKINNEY: It depends on when the final rule is effective. Every rule has an effective date. So it's going to be depending on when that's effective. And they usually should give instructions about claims yet to be filed or retroclaims. They should give you instructions on that.

And so I have to answer that generically, because I've seen some rules from CMS that would come out and say, today, July 15th, but they want it to be effective the first of this year. So I can't promise that it's going to be when it comes out and say if it comes out in November, just making up a date, that it's going to start November 1. They may say 1/1/2013.

So I don't have an answer for that. We'll just have to kind of face that when it comes. But typically I would think, in their thinking of this big of an issue, they would say effective sometime in the future. They would come out in November and say effective 1/1/14, this is how it's going to be. But, again, there's no prediction about how that's going to be languaged.

However, if this is something - and Karen can speak to this – that's part of proposed rule making or if it ever gets in the Federal Register, they do talk about what their intent is. And so that's not my field or expertise. I know Karen watches that. But they typically talk about when they think they're going to implement it and kind of give everybody a heads-up idea. So that would probably be a window of what you can expect for that. But in general, it's a future effective date, but they have retroed that. So that's a long explanation, so I don't know.

MS. NORTHCUTT: And I think we had an argumentative letter that went out to try to rectify that, and through and several others when we talked about the timely filing rule. And then there's been argument that we should always be able to go as far back as they are, and I haven't heard anything final on that. And that was a different mandate for the Part A, Part B billing versus the proposed inpatient IPPS ruling.

I think really we've got two issues: The Two Midnights were proposed. And that final rule usually, for the inpatients, comes out in the middle of August. So we'll know pretty soon what that's going to look like. And I think that they're supposed to go. But to my knowledge, right now timely filing is a year. The future was going to be that we were going to get to have even a case manager. That was what they were talking about, that even a case manager could make that decision. They were talking about the patient could have already gone home. So then that negates condition code 44.

So there's a lot of stuff up in the air about that. And I can't wait to see what that looks like because that's basically going to flip everybody out. I mean really, in general it will flip them from this condition code 44. So that's why I was saying the people that are going I'll just keep them two midnights and then look at them, and if they don't meet, I can do Part A to Part B billing and get 100 percent of the

Part B. And I can have a case manager do it. The patient doesn't even have to be there anymore, and I don't have to follow a condition code 44.

I mean, that's how that whole spin can take place if this is not thought through that thoroughly on their side is my thing. And so I've already told Dr. McKinney what that would look like if all that goes through. Just an FYI.

MR. HALEY: Is that it?

DR. McKINNEY: Just one quick comment, if I could.

MR. HALEY: Yes.

DR. McKINNEY: We appreciate your input on these questions. I think we've said this before. This helps us do a better job. I do want to throw a figure out there for you. 4.8 million claims are filed every day to Medicare.

So we just appreciate all your help with us. If your claims get hooked up, they get messed up, please let us know. That's our job to research it. Sometimes it is FISS and not Cahaba. The ongoing relationship with the RAs will not change. We're trying to make that as best as possible. So we just appreciate the partnership and letting us know, because we do look at it as a partnership. But just know 4.8 million claims are filed every day in the United States for Medicare claims. So that's a lot to be filed. But we appreciate the partnership. And we want to research this and get it right. We want to do right by you to fix everything that we can and make this seamless and less of a hassle for you. We know that that's probably a tall order, but that's our job. So we appreciate that.

MR. HALEY: Thank you very much. And I know, on behalf of everyone here, we appreciate it as well. I know it's always good answers that we'd like to hear, but I think the dialogue is important and the fact that we can get in the room and have a good discussion on this is very important to everybody. So we sincerely appreciate it.

And thank you also for taking extra questions this go around.

DR. McKINNEY: We can always say no, right. Okay. Thank you.