

CIGNA

**Moderator: Ronja Roland
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1:00 pm CT**

Operator: Welcome to CIGNA's Ask the Contractor Teleconference. Just a quick note that the call is being recorded.

And with that, I'll turn thins over to Ronja Roland.

Ronja Roland: Thank you, Kevin. Good afternoon, and welcome to the CIGNA Government Services Ask the Contractor Teleconference for Jurisdiction C DME MAC. I am Ronja Roland with provider outreach and education, and I will be hosting the call today.

I would like to begin by saying thanks to those suppliers who are participating on our call today. Your participation in these calls is a great way for us to better meet the needs of the supplier community, and we appreciate this opportunity to partner with you to accomplish this goal.

Now, today's call is a Specialty ACT call, and it will focus on the top inquiries that are received by our provider contact center. We will discuss the top inquiry categories and other self-service options available to obtain important information that will assist in claims submission.

Please keep in mind that although we are discussing top inquiries, we will not be able to answer questions about individual claims. If you have a question regarding a specific claim, you can use the (IVR) at 866-238-9650, or you may contact our provider contact center, at 866-270-4909.

Before we begin discussing the top inquiries, let's take a minute to detail information that is available through our interactive voice response unit and our provider contact centers. The IVR is available by calling 866-238-9650. The IVR is capable of responding to a variety of supplier inquiries and requests, and some of those requests include claims status. You may receive claim status information either on a line-by-line explanation or by the claim control number. It will also provide appeal rights information on denied claims.

So you can obtain a wealth of information regarding claims status through the IVR. You may also find out pending claim information that includes payment floor information, pending claims at the common working file and other pending claims. You may obtain information on redetermination status, whether it's pending, whether it has been reversed, partially reversed, upheld or if the redetermination request was dismissed.

You also have the option to order a duplicate remittance advice. You can obtain beneficiary eligibility information, including their Part A and Part B entitlement dates, Medicare Advantage Plan enrollment information, home health information, hospice information, skilled nursing facility information and Medicare secondary payer information. You may also obtain beneficiary Part B deductibles from current and previous calendar years.

Another feature that is available is the (CMN) status, and that provides the HCPCS codes of same or similar equipment on file, initial revised and/or recertification dates. It also provides length of need and the previous supplier's phone number for rented items. The CMN status feature will also provide you with the total month paid for that rented item. You may also obtain pricing information, check information for outstanding checks, check dates and amount of the last

five checks issued. You can also obtain offset information, EFT application status if you have recently filed an EFT application with us, and as well as general information, including contact information, phone number and fax numbers.

Remember the IVR is available 24 hours a day, 7 days a week with the exception of periodic system upgrades or routine maintenance. The IVR menu options, which require system access, are available Monday through Friday, from 6:00 am to 8:00 pm Central Time, and Saturday from 6:00 am to 4:00 pm Central Time.

You may also obtain an IVR flow chart, which is available on our CIGNA Government Services Web site under our Site Help link, and by using that flow chart; you can determine the best avenue to obtain information through the IVR system. When the IVR system cannot answer your questions or provide the assistance you need, you may disconnect from the IVR and call our provider contact center at 866-270-4909 and speak with one of our customer service representatives.

Please note that our CSRs are not able to provide you with the information that is readily available on the IVR. You must contact the IVR for the types of inquiries listed below. Our CSRs are trained to answer supplier questions and resolve problems. They should be your first contact with our office when you need assistance. Helpful information to have when calling our provider contact center include your (NPI) number, your provider transaction access number or PTAN, the last 5 digits of your tax ID number and if appropriate the beneficiary's name, health insurance claim number and the date of service. You are limited to three separate beneficiary inquiries per phone call.

CSRs are available to assist suppliers Monday through Friday from 7:00 am to 5:00 pm Central Time, and please remember that the Provider Contact Center is closed every Thursday morning

from 8:30 to 10:30 for staff training. A listserv message will be sent out informing you of any additional closings or changes in the Contact Center availability.

Customer service representatives are able to clarify the denial reason associated with the claims, provide general information regarding Medicare coverage, explain terminology and information published in the Jurisdiction C publications such as supplier manual and the Jurisdiction C insider. And they may also assist with other complex issues. However, CSRs are not able to provide claims status, beneficiary eligibility or other information which is available through the IVR. They cannot give preauthorization of beneficiary entitlement for specific items. They cannot adjust the claim unless the claim was processed incorrectly by the DME MAC. They cannot answer questions about supplier enrollment. Those would need to be referred to the National Supplier Clearinghouse, and they are unable to answer questions about electronic billing software or claims that have not been received in our claims processing system. You would need to contact the Common electric data interchange for information regarding those claims.

Now that we have discussed what information is available through the IVR, and our provider contact centers, let's focus on the top inquiry categories. I will discuss the top categories and then detail the sub-categories. The first category of our top inquiry is the administrative billing issues. The majority of the information or the inquiries in this category, the answers can be found in our Jurisdiction C Supplier Manual. Remember that our publications are available on the Jurisdiction C Supplier Manual DME MAC homepage of the CIGNA Government Services Web site.

Some of the billing issues that we've received inquiries on include completion of the 1,500 claim forms or claim filing instructions. As of recently, we have received questions regarding the PECOS system based off change request 6421. Remember there are two phases of editing for PECOS, and the first phase began in October and goes through January 4, 2009, and with the first phase of editing a warning is sent to the billing provider that the physician is not enrolled in

the PECOS system. Now, the PECOS system is the provider enrollment system used for Part B physicians and non-physician practitioners.

The second phase of change request 6421, and that begins January 5, 2010, and that – and based on that day, any claims received on January 5 forward will receive a rejection that indicates the physician is not enrolled in PECOS. Remember for additional information, you can refer to change request 6421 as well as Medlearn Matters article 6421.

The next category that we will talk about in regards to top inquiries is claim denial. Now, under claim denial, there are several subcategories. The first is certification requirements. So many of the inquiries deal with questions regarding CMN, or Certificates of Medical Necessity issues. An easy way to possibly resolve this inquiry, verify in the actual LCD for the item billed if a CMN is required. If a CMN is required, make sure that the appropriate CMN has been submitted with your claim. You can also check CMN's status on the IVR systems, as mentioned earlier.

The next subcategory of claim denials is talking about claim overlap, and that may often deal with span date or dates of service that overlap from previous months' billing. It's important to verify your shipping and delivery guidelines as outlined in Chapter 3. Remember there are limited codes or DME items that require span dates when billing, and when billing for supplies or refills, we do allow a 7-day window in the which the beneficiary may be contacted and a 5-day window in which the supplies may be shipped. So again, be sure to reference Chapter 3 or the Jurisdiction C Supplier Manual for those documentation guidelines on proof of delivering.

The next subcategory is coding errors, and that could be either your HCPCS code is invalid or modifiers. For a complete listing of your modifiers, you can find that in Chapter 16 of the Jurisdiction C Supplier Manual. If you have a question related to coding of a particular item or the appropriate HCPCS code, you may contact the PDAC, which is the contractor for coding, and

that's the Pricing Data Analysis Contractor. You can either go to their Web site or call them on their toll free number.

The next subcategory is duplicate claims. Remember that the IVR is available to verify claims status. That could be done prior to calling the customer service center. Same or similar equipment. Many of the inquiries will want to know if the patient has had the equipment previously. Based on provider feedback, we did include same or similar option or CMN status on the IVR to verify if a patient has had previous equipment. So that is another self-service route that providers may use to verify same or similar equipment.

The next subcategory is medical necessity. Claims that have been denied or inquiries based on claims denied for medical necessity. Remember before billing your claim, verify that the patient meets the coverage in the guidelines and that your documentation in your file supports that coverage criteria has been met.

And the last subcategory under claim denials is MSP issues. Remember that for MSP claims or updates to the patient's insurance file would need to be handled by the coordination of benefits contractor.

The next category of inquiries received through our Provider Contact Center include eligibility and entitlement. Now, as I mentioned previously, this information can also be found on the IVR for the beneficiary. Some of the top inquiries under the entitlement and eligibility category include same or similar equipment, beneficiary demographics, HMO and hospice information, and MSP information.

Our next category of inquiries – or top inquiries includes general information. Now, general information, as mentioned, can be obtained through the IVR. General information such as contact information, and that could be phone numbers of other Medicare contractors or other

departments within CIGNA Government Services, fax numbers, forms. That information can also be found on the CIGNA Government Services Web site. If you go to the DME MAC Jurisdiction C homepage, you will see helpful site information or site information links, and that information is available there as well as additional links to other Medicare contractors on our Web site as well.

And then the last category of top inquiries includes policy coverage, and in those inquiries most often includes questions about if an item is covered, what criteria is required in order for the item to be covered by Medicare. Remember that the local coverage determinations outline the coverage criteria required by Medicare for specific DMEPOS. Those LCDs are actually found on the CMS Web site; however, there is a direct link from the DME MAC homepage to those local coverage determinations or policy guidelines. Within those local coverage determinations, you can find out the documentation requirements, whether the item requires a CMN. You may also find (hit pick) codes and the coverage criteria for the item.

That concludes the overview of the top inquiries. I do want to remind all suppliers that the Provider Outreach and Education Department offers a wealth of self-service options and educational outreach opportunities. Currently, we have Webinars available. The upcoming week we have Webinars for Enteral Nutrition. Coming in December we will have Webinars for refractive lenses, documentation, search, CMNs, DIF and DME supplier resources. So be sure the check out the Education link on the DME MAC homepage of the Jurisdiction C Web site for any upcoming outreach activities.

We will now open the lines for your questions. Please keep in mind that we will not be able to answer questions about individual claims. Again, if you want to find out information on specific claims, you may either contact the (IVR) or our Provider Contact Center.

Operator: Ronja, thanks very much. Ladies and gentlemen, if you do have any questions, press star 1 on your telephone keypad, and you'll be placed into the queue, and when it's your turn for your question, you'll hear an automated voice prompt to indicate when you can go ahead. So again, it's star 1 if you have any questions. We have several in the queue.

Ronja Roland: Good afternoon. Go ahead with your question.

Female: Hi. I have a question about the PECOS. I understand from everything I'm reading that this is, of course, the obligation of the physician to upgrade their records in order for our claims to go through, and from what I'm being told from your customer service is that virtually – are these physicians not going to be able to file their claims as well if they don't update their records, or is it only going to affect suppliers?

Ronja Roland: That was a very good question. We thank you for your question. Currently, under the change request 6421, physicians will be able to still file their claims to be considered for payment. So the editing right now only affects DME suppliers.

Female: OK, can I – can I continue on. If that's the case, now I have a physician say that's ordering medical equipment and they have not updated their records because of course there's no ramifications to their billing. They're still collecting money, and if you've ever worked with physicians you know that they're not the easiest to get anything done unless it's going to affect them directly. So I'm going to be fulfilling their orders either – you know I have a verbal order or whatever it is, and then not being able to be paid for my services because they haven't updated their records, and from what I was told from your customer service is that then I could then choose maybe another physician. But the problem I have with that is that I very well could be in the middle of a capped rental where I have a physician that's been – that has been on file as my ordering physician, and when I hit January 5, 2010, if they have not updated their records, my

claims will then be denied, and then I'm told I should go find another physician, which doesn't make a whole lot of sense to me considering that the other physician would not be the ordering nor treating of that medical equipment. Therefore, I would not have the documentation to support it. So this just doesn't seem to really make too much sense to me.

Ronja Roland: Thank you very much for your question and concern. One thing we do want to encourage you, again, the MedLearn Matters article 6421 is available. That information can be provided to the physician as well as some of the A/B MACs are sending out information or they're sending development letters to the physicians to inform them that they currently are not enrolled in PECOS and that they would need to do so in order to prevent claim denials for the DME suppliers. If you – earlier in your question, you also mentioned that the physician was billing for DME supplies,

Female: No, they say that – say I'm on my third month's billing in January. You know I billed my first through second, but then I hit January for my third month billing, and my physician has not updated his records, and we have his (NPI) on file, as we're billing that claim is going to deny because it's not going to match the records because he hasn't updated his system. Is that correct?

Ronja Roland: Well, actually, the claim will be rejected. It is a front end rejection.

Female: A rejection. So now I am – I am stuck between a rock and a hard place. I have a beneficiary that has equipment that was you know of course medically necessary from the first date of service, but I have a physician that if you read the documentation, nowhere in the documentation does it say, hey, doctor, this is a – it says it's requirement, not clearly enough that in my experience that physicians are going to jump to, to do an update here because it doesn't effect them directly, which is a huge problem because we're going to – the suppliers are going to be the ones holding the bag with patients with our equipment that we can't bill because we're depending on a physician to update their records that have really virtually nothing to do with us.

Ronja Roland: We do, again, thank you for your comments on your concerns, and CMS has also hosted several open-door forums regarding the PECOS updates and editing, so we encourage you to participate in those and join the CMS list serve for upcoming information on that as well. We are – as DME MACs and Medicare contractors receiving information and letting them know what issues we're receiving on our provider end. But there are some issues that currently we just do not have a response to or will not be able to answer until CMS gives us further guidance.

Female: Right. So if a physician does not update their records and we continue not to be paid, do we have the availability then to just pick up our equipment, is that correct, or have the patient get involved, which is a horrible solution, but I don't know what else you would potentially do if you can't – if a physician's not cooperating.

Ronja Roland: Now, you can choose to get your patients involved. Now remember, if you have a physician, and let's say currently they're not in PECOS at the moment but they at a later date do become enrolled in the PECOS system, because it is a front end rejection, those claims can be resubmitted once that information is updated. In the event your claim has denied ...

Female: Right.

Ronja Roland: ... you can – if the claim's actually gotten through the system and denied, it would probably be for something else. Like I said, the PECOS editing is a front end rejection, so it would not even get through the door to process.

Female: I would just hope that – and that you all are considering the comments of the – of the suppliers because that's – the two people that are going to be effected by this are the beneficiaries and the suppliers, not the physicians.

Ronja Roland: Again, we thank you for your comments and DMS if aware of the concerns of the suppliers as well as the DME MACs and the other Medicare contractors.

Female: Thank you very much.

Ronja Roland: So we do thank you for your comments. OK, Kevin, thank you. We're going to go ahead and take the next question.

Female: Hello?

Ronja Roland: Go ahead with your question.

Female: Yes, can I ask a question about documentation requirements? Would that be appropriate for this call?

Ronja Roland: It can. Go ahead.

Female: I have a question about CPAPs detailed written orders. I just want to make sure – CPAPs right now do not require a CMN from the physician. Can – if we generate a CMN, can that be used as a detailed written order?

Ronja Roland: Yes. As you mentioned, the CMNs, or the previously required CMS required CMN forms are no longer required for PAP devices. As always, we encourage you to verify in the documentation section of the LCD what requirements or what documentation is required. A detailed written order is required for a PAP device to be dispensed and billed to Medicare. However, remember that there is also additional documentation that must be on file for the supplier to continue billing to make sure the beneficiary is compliant and is using that PAP device,

and we also – so again, I do encourage you to refer back to the LCD to verify what documentation requirements are needed as well as Chapter 3 of the Supplier Manual.

The LCD will give you specific documentation needed for billing the (PAP) device, Chapter 3 will give you documentation on – information on general documentation requirements, and also, if you have the opportunity, this is our respiratory week for Webinars. So if you would like, we do have PAP Webinars available this week. If you can, go out and sign up for that, and you will also obtain detailed information on PAP coverage criteria and documentation.

Female: OK.

Ronja Roland: All right. Thank you. OK, Kevin, we'll – go ahead with our next question.

Operator: All right. That line is open. Go ahead, please.

Female: Hello. Can you hear me?

Ronja Roland: Just barely. Go ahead with your question.

Female: The question I had is I was wondering how long is a sleep study good for the CPAP machine?
Is there a time limit on those?

Ronja Roland: There is no timeframe on how long the sleep study is good. Do remember they have to meet the coverage criteria in effect for the date that you're billing.

Female: OK. Can I ask one more question?

Ronja Roland: If you don't mind, we'd like to take one question for now. If we have time available, you can get back in the queue.

Female: OK. Thank you.

Ronja Roland: Thank you.

Operator: Our next questioner is open. Go ahead, please.

Female: I had a question regarding the phase II of PECOS. Is the data service going to be effected like after January 10, will it be just all claims that come in after that or will it be date of service?

Ronja Roland: That's a very good question. Phase II is based on date of receipt.

Female: Date of receipt.

Ronja Roland: Yes.

Female: OK, so it doesn't matter what the date of service is, it's date of receipt.

Ronja Roland: That is correct. Thank you for your question.

Female: All right. Thank you.

Operator: All right, we'll move on to our next question. Your line's open for your question. Go ahead, please.

Female: I have a question about documentation.

Ronja Roland: OK. Go ahead with your question.

Female: It's been my experience that when changing from – with replacement equipment, say the patient had a BiPAP. Five years later, the doctor – the physician feels it's necessary to get a CPAP. We try to get additional documentation on the front end, but I haven't been able to find any resources, written resources to show the physician what kind of documentation we need in order to get paid for the lesser equipment. Can you direct me to any such resource?

Ronja Roland: OK, it sounds like we're getting into policy questions. When you're talking about a specific item in the beneficiary meeting, the criteria, whether it's replacement or the initial issue, the best avenue to research what's required is the LCD for the item being replaced. If it's oxygen, the oxygen LCD now does detail how to bill replacement oxygen equipment. If it's for any other device, again, if it's being replaced based on the reasonable useful lifetime has been met, then you would need to refer to that LCD because at that point the patient does need to meet the current criteria and effect.

Female: I understand that, but the LCD really doesn't cover any kind of change from going to – from a certain equipment to lesser equipment, and Medicare denies for that being a change. And so I was just wondering if there's anywhere that specifies the documentation needed to send that into appeal. Do you know of anything?

Ronja Roland: One thing we will suggest, especially if you're going through the appeals process, there needs to be justification as to why there is a change in the – in the equipment. There needs to be a medical justification. I'm not sure of the item that you're billing. If it's you know you're going to a lesser piece of equipment or even to a higher piece of equipment. Again, we'll need to have the medical documentation that shows why the current piece of equipment is not sufficient and why the new piece of equipment is now needed medically for that patient.

Female: OK, thank you.

Ronja Roland: Thank you. And Kevin, before you open the line for the next question, I do want to ask at this point if we could keep those questions in focus with the top inquiries. It seems as though we're getting quite a few questions regarding specific LCDs and benefit categories. So at this point, because this call is dedicated to top inquiries, we would like to have those questions that deal with that particular topic. Thank you. Go ahead, Kevin.

Operator: All right. We've got one question holding right now, and that line is open.

Ronja Roland: Good afternoon. Go ahead with your question.

Female: Yes, my question is regarding PECOS. I've read that we should be provided with a list at the first of the year of the physicians that are on the PECOS system, and we can check that. Can you tell me when that will be available and exactly where we go to get that list?

Ronja Roland: CMS is in the process of creating an Internet site that will allow DME suppliers to check the status of their physicians to see if that physician is enrolled in PECOS. We do not have the direct Internet site or actual date, but again, we encourage you to sign up for either the CIGNA Government Services listserv or the CMS listserv as well because that will be the first avenue in which you will receive that information.

Female: OK, thanks.

Ronja Roland: Thank you very much.

Operator: Got another question that has come in, Ronja, and we'll go to that question now.

Ronja Roland: Thank you, Kevin. Go ahead with your question.

Female: Yes, I'm wondering if doctors provide DME themselves. Do they bill the DME, or do they bill Trail Blazers, their carrier?

Ronja Roland: It would depend if that physician also has a DME supplier number, they would bill the DME MACs, just as any other supplier ...If they're billing for services that are not DME related or not – DMEPOS items or services that are provided in their office or as part of that visit, then they would – those services would be billed to the local carrier for that physician.

Female: Just to clarify, if they provide any type of orthosis, that would be billed to the DME?

Ronja Roland: There are certain categories or HCPCS codes that fall into various jurisdictions as to where it may be billed. If that let's say orthotics or prosthetic item is a part of that office visit they're billing for, that may not be separately billable as a DME item. If it is something that could be separately billed as a DME item, again, that physician would have to bill that to the DME MAC under their DME supplier number.

Female: OK.

Ronja Roland: All right? Thank you.

Operator: Next question. Go ahead, please. Your line is open.

Ronja Roland: Good afternoon. Go ahead with your question.

Female: Hi. Can you give me a Web site or direct – somewhere where I can direct my physicians where to go to sign up for this because ...

Ronja Roland: For PECOS?

Female: Yes.

Ronja Roland: The easiest Web site link, if you go to the CMS Web site, and then you can actually go under the search engine and type in PECOS, P-E-C-O-S, or you can always – or the change request that I referenced the (CT-421) actually has the direct link into the PECOS system. They can also contact their Part B or their A/B MAC to update information as well or enroll in the system too.

Female: OK, thank you.

Ronja Roland: All right. Thank you.

Operator: We have one more question right now. Go ahead, please.

Ronja Roland: All right. Thank you, Kevin.

Female: Hello.

Ronja Roland: Yes. Go ahead with your question.

Female: Yes, I – we do shoes and inserts, and our patients will come in and tell us they did not get shoes anywhere else, and when we bill we find that they have and we can't bill the patients. So we're

out the cost of the shoes and the inserts. But this patient can still go down the street and hit six other companies and do the same thing. How can I find out if this patient has received shoes?

Ronja Roland: In order to verify if the patient has had shoes within that calendar year, unfortunately, shoes and inserts, that information cannot be found on the IVR. But you can do a three-way call with the beneficiary on the line to our provider customer service center, and that beneficiary can give you authorization to obtain information on whether or not they have had those shoes or inserts within the calendar year.

Female: So that would only be if we suspect that they're not telling us the truth? Is that what you're saying?

Ronja Roland: No, if you want to call to verify that they've had them before you provide them, you can do that as well. But – and it would have to be a three-way call with the beneficiary.

Ronja Roland: All right. Thank you.

Operator: No other questions holding at the moment, Ronja.

Ronja Roland: OK, we'll give just a few more minutes in case someone does have a question regarding – related to the top inquiries.

Operator: And again, that's star 1 if you have any questions, ladies and gentlemen. We do have one more that's just come in, and that line is open.

Ronja Roland: Go ahead with your question.

Male: I was just curious. We had heard that PECOS was also going to effect prescribing for radiology and clinical labs. One, is that correct, and two, if hospitals provide that service, are they affected as well if physicians are trying to prescribe radiology and clinicals?

Ronja Roland: Thank you for your question. There are some Part B services or claims for Part B services other than DME that will be effected by this edit that is in place based on PECOS.
Hello?

Operator: Are we ready ...

Ronja Roland: I'm sorry?

Operator: Are we ready for the next question, Ronja?

Ronja Roland: Oh, yes. Go ahead.

Operator: OK, that line's open now.

(Cindy): Hi. This is (Cindy). I had a question about the PECOS.

Ronja Roland: Go ahead with your question, (Cindy).

(Cindy): I have checked their site, and I find that the doctors are on that site, and then I go back and I check their (NPI) and make sure I have it in there correctly from (NPI) site, and then they're still giving me warnings saying that they're not in the PECOS system. What's the problem there?

Ronja Roland: Thank you, (Cindy), for bringing that up, and one thing I did want to mention, for those of you that are electronic submitters, CEDI recently released an article, I believe it was dated early

part of November, maybe the first of November. But you can go to the CEDI Web site, in which they mention that when submitting your claims, be sure to submit them in uppercase, but the file that is transmitted from PECOS to CEDI for – to verify the information is sent in uppercase letters. So it could be that you're still receiving a rejection just because when you submit your claim, that physician information may not be in uppercase letters.

Female: I think all of ours are because some of them go through with no warnings and then some don't.

Ronja Roland: And another thing you know just be very specific and not putting doctor. It has to be an exact match. So that could be a reason for the warning. It could be the physician is in PECOS, but the way it was submitted does not match the file on receipt by CEDI.

Female: And that's what I have been checking too to make sure that we have the names in there ...

Ronja Roland: That would be a good avenue start, yes.

Female: Yes, and I've checked everything, and I cannot see – I can't figure out why they're kicking out as a warning. I mean it doesn't make sense to me, but I just keep checking them, and they're there, but – and I got them right, but then there's no (NPI) on PECOS so I can't tell whether the (NPI) I'm using is the one that PECOS has.

Ronja Roland: And another thing to mention, CMS will be updating the PECOS files to include the (NPI) and also make sure that your physician, if you have a physician that may have been in the PECOS system prior to (NPIs) being required, making sure they have updated that information – or updated their PECOS file to reflect the current (NPI) that they have.

Female: OK.

Ronja Roland: Thank you very much for your question.

Operator: And again, we have one question in the roster. We'll go to that question now.

Ronja Roland: Go ahead.

Female: Hi. I just wanted to clarify, when you were saying the uppercase, are speaking of the physician's name in uppercase for the PECOS?

Ronja Roland: Yes, I am. I'm sorry. I am referring to the physician's name, that it is in uppercase letters.

Female: And that's how it needs to be on all of them. OK, thank you.

Ronja Roland: Thank you.

Operator: It looks like we've got one more site that's signaled at the moment. Go ahead, please. Your line's open.

Ronja Roland: Good afternoon. Go ahead with your question.

Female: Hi. Good afternoon. Any possibility from CMS that they're going to delay the implementation of the PECOS permanent claim refection in January?

Ronja Roland: We have not received any indication of that.

Female: Have you received any feedback from the provider community about the high rejection rate that's currently received on the warnings? We're looking at a 70% to 80% rejection rate, and

we're having a very hard time getting physicians to comply with enrolling in the PECOS system because it doesn't effect payment of their claims, and they are a little resistant to education from a durable medical equipment provider.

Ronja Roland: Those are very good concerns that you have raised. Those are concerns we have heard in our outreach, and we have posed those questions to CMS as well, and those questions have been posed on the CMS open door forum. So we have not received any further guidance, but they have heard the concerns. And again, we encourage you to submit your concerns and participate in the CMS open-door forums as well on PECOS.

Female: So that would be the forum to discuss something like that, I would take it.

Ronja Roland: That is correct.

Female: OK, thank you.

Ronja Roland: Thank you very much.

Operator: OK, we've got another question in the roster, and that line is open.

Ronja Roland: Go ahead with your question.

Operator: Hi, folks. Are you on line? Can you hear us? Your line's open for your question. I'm just going to assume there's some sort of problem at that particular site, Ronja.

Ronja Roland: OK. Thank you, Kevin.

Operator: No one else in the roster at the moment.

Ronja Roland: OK and we'll wait just a few more minutes.

Operator: It looks like one's just come in, and that line is open.

Ronja Roland: Good afternoon. Go ahead with your question.

Female: Hi. I have another question. If – I understand that same or similar equipment is obtainable through the (IVR), but only for claims in which a CMN can be logged because the item can be either rented or purchased. Is that correct?

Ronja Roland: That is correct. The same or similar feature on the (IVR) is available for items that can be rented or purchased. It doesn't necessarily mean they actually have an OMB approved form required to go with it. But there is – like I said, it's an item that can be rented or purchased.

Female: OK.

Ronja Roland: At that point, we would create what we call a dummy CMN in order to track the payment history.

Female: OK, so in the event – since CMN's status is not available for items that can only be purchased such as orthotics or purchased only type of supplies, if a patient – if a supplier questions a patient regarding same or similar equipment, and the patient doesn't disclose the prior equipment or does not remember receiving that equipment, understanding that we're dealing with a lot of elderly people, the supplier would have no reason to believe that the service would be denied, so would not have taken ABN in that case. How does the supplier protect themselves in the event of a denial in this type of situation?

Ronja Roland: As I mentioned to a previous caller, one of the options you do have available is you can do a three-way call with that beneficiary prior to that claim being filed to verify if they have had previous equipment or previous items out there. That is one way.

Female: Would CMS possibly consider some way of checking same or similar on items that are not – that are sold as well as rented? Is it something that can be explored, or ...

Ronja Roland: That is something we can always take to CMS as feedback. It would probably take an implementation of our claims processing system, so it may not be an immediate change if it something they did decide to do. But that is valuable feedback we can take back.

Female: I think it'd be very helpful. Thank you very much.

Ronja Roland: Thank you very much.

Operator: Ronja, we've got another question in the roster, so ...

Ronja Roland: OK, go ahead.

Female: Hi. Can you hear me?

Ronja Roland: Yes, I can.

Female: Great. We billed custom fabricated orthotics, where we'd go out to the patient's house and we'd take a cast-molded – excuse me, shoe of their foot, and we send it off to our company to create the custom brace. What we're having an issue with is that during this processing, which is probably about a 45-day processing, the patient passes on, and I'm looking to see what our – we're already in the appeals process. We have an appointment with the ALJ judge. Needing to

know any way we can alleviate all of these appeal steps with – because the data service obviously for a DME company has to be the day that you deliver it. Well, we can't deliver it. So what we do is the day that we send our person out to deliver it is the day that we put on there and the day that we bill it, and that's the date that we've been using as the service date through the – all of the levels of appeals, and we're getting nowhere. Any answers?

Ronja Roland: OK. It sounds like you're talking about – you may have heard it referred to as salvaged claim. We will pay for some items that are – that possibly since – in this case you're talking about fabricated or custom items for a patient. If the supplies or the materials cannot be used for any other patient or used to you know fabricate another item, then at that point you could bill for a salvaged claim ...

Female: Correct.

Ronja Roland: ... for those items.

Female: Is there a certain modifier that needs to be used or a certain ...

Ronja Roland: There's not a modifier that I'm aware of, but you may want to include a narrative that indicates to us the patient died prior to the item being delivered.

Female: Right. We have, and we did, and it's still denied and went through the whole appeals process.

Ronja Roland: At this point, since it's already actually gone through the – you know you've began the appeals process, it will have to continue through.

Female: Right.

Ronja Roland: But any future claims, again, just include a narrative that states the beneficiary died.

You're billing for salvageable parts or services prior to the patient's death.

Female: Right. And we have. We've done that different ways to see what would happen, and we're just – it's the same thing is that it keeps going through all the levels of appeals, and here we – the patient died back in February, and here we are running up on a whole other year. So I was just wondering if there was any type of desk modifier or salvage modifier that we need to be using for clarification that the patient passed or you know when you bill it you've got about 7 to 14 days before you get the denial. Then you have to go through the appeals process, which is a whole other 2, 3 months, and then they deny it. You know what I'm saying.

Ronja Roland: Let me ask this too. Your data service, is the data service that you're billing after the patient has actually died?

Female: Right. Yes. Well, because obviously if we don't get the product in before they die, then we can't deliver it. I mean after they die.

Ronja Roland: OK, bear with me just a moment.

Female: Sure.

Ronja Roland: OK, thank you for your patience. One thing that you would need to do or what may be causing the problem is that you're billing after the date of death because systematically our system will not pay anything after the date of death.

Female: Right.

Ronja Roland: So what we would encourage you to do if this occurs you know in the future for any other patients is that bill the day of death, but also itemize or include in your narrative that materials that were used, the labor, what actual items would have been billed to that patient.

Female: OK.

Ronja Roland: Because it sounds like that may be the problem. If you're billing after the date of death, the system probably automatically denied it because it's saying this patient's already died; we should not be paying services after they died.

Female: Well, not only does the system deny it, but when we fax it over to the appeals redetermination, reopening, whichever one we fax it to, they deny it as well saying that the date of death is prior to the date of service. Well, obviously ...

Ronja Roland: And another thing too to mention you know when you're submitting an appeals request, you have to be specific and explain to us what it is you're appealing and what it is you're requesting the payment for or what you're requesting us to reopen the claim or appeal the claim, what basis you're requesting.

Female: OK. OK ...

Ronja Roland: Thank you very much for your question.

Ronja Roland: Go ahead with your question.

Female: Hi. How are you?

Female: Hi. I wanted to know, if a DME item is delivered to an inpatient facility for intended use upon discharge, the discharge does not – and the discharge does not occur within 48 hours. However, the item does go home with the patient on subsequent release. Does the equipment have to be picked up and redelivered, or can a new delivery ticket be signed by the beneficiary?

Ronja Roland: This is you know a situation we have heard before. As a supplier, you have the option to pickup and redeliver, or you can have the beneficiary sign. The key thing to remember is that your data service is going to be when that patient was actually discharged from the hospital.

Female: OK.

Ronja Roland: OK, thank you.

Female: Thank you.

Operator: And again, we have reached a point where there are no questions holding at the moment,
Ronja.

Ronja Roland: OK. Well, I think we are about close to the end of our time. This was scheduled for 1-hour. So if anyone has a question before we wrap it up.

Operator: It looks like we do have one more that's just come in.

(Monica Blues): Hi. One final question. We are submitting redetermination requests, and they are as a result of denials received from claims that are chosen by the ZPIC for review. When we send in a redetermination request as a result of a medical necessity denial, they are being sent back to the ZPIC, and the redetermination is not being logged into CIGNA's system. CIGNA's not showing any record of the redetermination whatsoever, and then they're going back to the ZPIC, and

they're being pended for very long periods of time. How do we deal with claims going into this large abyss for months and months on end and not being processed appropriately?

Ronja Roland: Let me ask you one question. When you're receiving the request for documentation, is it being done – the request from the ZPIC, is that being done prior to us paying the claim or after the claim is already paid? Let me I guess ...

(Monica Blues): It's prior to paying the claim.

Ronja Roland: OK, so you've received the request from the ZPIC prior to us even processing or paying the client?

(Monica Blues): Correct.

Ronja Roland: You submit the documentation back to the ZPIC. At that point, they deny it, correct?

(Monica Blues): It's either – it's either denied by the ZPIC or denied by CIGNA. Now we don't know if that is a result of reviewing the information that was received or a result of the information not being received within the timeframe specified in the letter. But in any event, what's happening is we are receiving a medical necessity denial or some – it doesn't have to be medical necessity. It can be any denial subsequent to the ZPIC letter, and we are doing what we're supposed to do in filing a first-level appeal. Our instructions are to do a redetermination upon receipt of this type of denial.

The problem is, is CIGNA is not putting their redeterminations through into their system. They're forwarding them back to the ZPIC to be reopened, and they – the redeterminations are not even showing as being completed, and we can't get status from the ZPIC. Nobody can tell us where

our claim is. It's just sitting in this huge pool of claims that are being reviewed by the ZPIC. What do you suggest we do in these cases, and we have thousands of claims like this?

Ronja Roland: Let me ask what – I guess what timeframe is there, like recent claim dates of service or is – are the dates of services varying?

(Monica Blues): They're varying.

Ronja Roland: OK. Unfortunately, like I said, I do not have any additional information at this moment. We may just have to take your information off line. So possibly follow-up with that. So if you could just give me a name and a contact number that would be great.

(Monica Blues): OK.

Ronja Roland: All right. Thank you. And Kevin, I believe that's about it for today. So I want to thank everyone for joining today's call, participating and providing good feedback and good questions, and we hope that you – we hope to see you again or hear from you again on any of our upcoming outreach activities.

Thank you and have a great day.

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