

CIGNA

Moderator: (Dante Thomas)
March 18, 2008
1:00 p.m. CT

Operator: Good day and welcome to the CIGNA Government Services Jurisdiction C DME MAC ask-the-contractor conference call. Today's call is being recorded.

At this time, I'll turn the conference over to Ms. (Dante Thomas). Please go ahead.

(Dante Thomas): Good afternoon and welcome to the CIGNA Government Services general ask-the-contractor teleconference for DME MAC Jurisdiction C. I'm (Dante Thomas) with the provider outreach and education team.

I would like to thank you for participating on today's call. Your participation helps us identify issues that are important to you so that we may better meet your needs. We are pleased to have invited representatives from CMS.

We have (Joyce Ciancola) with CEDI or Common Electronic Data Interchange and Cindy Dreher from the CBIC or Competitive Bidding Implementation Contractor along with subject matter experts from claims, customer service, medical review, redeterminations, and reopening from our CIGNA Government Services DME MAC operation.

Please keep in mind we will not be able to answer questions about individual claims on today's call. If you have claim-specific question, please call our provider contact center at 1-866-270-4909. And to check claims status, please call our IVR at 866-238-9650.

Presently, there is a technical issue with our IVR which is preventing access to the same or similar and redetermination status information. We anticipate having those functions restored within the next couple of weeks. Please watch your listserv messages for update. We do apologize for the inconvenience. And if you're not signed up for the Jurisdiction C DME MAC listserv, please go to our website at www.cignagovernmentservices.com to sign up.

And we will begin with an update on the national provider identifier or NPI transition. Claim rejections for any claim submitted without an NPI in the primary claim field began on March 1, 2008. The NPI and legacy pairs are currently still accepted. We do however encourage all suppliers who are not submitting NPI only in all of the required fields to begin testing NPI only claim submission in preparation for the end of the NPI contingency period scheduled to occur on May 23, 2008. When the contingency ends, all claims submitted with any legacy number will be rejected.

If your claims are currently rejecting with an NPI included on the claim, there are several items to verify and/or correct. First, verify that the correct NPI was submitted on the claim. If it was, then you review your NPPES record and ensure that all of the information included is correct and make any correction to any incorrect entry. Pay close attention that the Medicare NSC number or your PTAN is listed in the other provider section of NPPES. Also verify that the legal business name, address, telephone number and entity type one for individual or two for organization are correct. If the information in NPPES is correct, it maybe necessary to contact customer service to verify that the information on file with the national supplier clearinghouse or the NSC is correct. If any of the information on file with NSC is incorrect, it is necessary to complete an 855S form to make the necessary correction.

The mandatory NPI only rule that is beginning on May 23, 2008 applies also to the referring physician identifier which would be block 17 and 17B on the claim form. (Of) any post claims requiring ordering physician name and identifier which maybe obtained through the NPI registry at the NPPES website which is <https://nppes.cms.hhs.gov>. If the NPI is not in the registry, suppliers must try to get the NPI from the physician for reporting. Be sure to document the contacts made. If the NPI is not identified for claim submission after following the above, the supplier may utilize his or her own NPI name in 17 and 17C.

Ronja Roland with CIGNA Government Services provider outreach and education will now go over some updates on medical review transition, the CERT process, and maintenance and service claim reminders. Ronja?

Ronja Roland: Thank you, (Dante). On March 1, 2008, Jurisdiction C medical review activities excluding those in support of benefit integrity were transferred to CIGNA Government Services. These activities include advance determination of Medicare coverage, prepay claims processing and probe reviews.

The focus for medical review is to reduce the fee-for-service payment error rate. We are please to announce that Dr. Robert Hoover has rejoined our organization as the medical director for Jurisdiction C. He previously served as the medical director for DMERC region D.

As the medical director, Dr. Hoover is responsible for working with other medical directors to coordinate and maintain the local coverage determinations or LCDs. Dr. Hoover will be presenting at Medtrade Spring in Long Beach, California and will have a question-and-answer session with the DME medical directors.

Now, we will discuss our comprehensive error rate testing program also known as CERT. If you receive a request for documentation from the comprehensive error rate testing documentation contractor, please be sure to submit the requested documentation within 30 days of receipt to avoid becoming a non-responder. Failure to respond to request will result in an overpayment request and increase possibility of future audit. If you receive a CERT request and are unable to comply within the 30-day timeframe, please contact the CERT documentation coordinator also known as the CDC at area code 301-957-2380 to request an extension. Please be sure to utilize the barcode fax cover sheet as your cover page when submitting documentation to the CDC. Please visit the CIGNA Government Services Jurisdiction C DME MAC website at www.cignagovernmentservices.com under the claims section for further details on the CERT program including request letter samples and fax numbers and addresses for documentation submission.

Jurisdiction C suppliers have experience an increase in claims denials from maintenance and service claim. There are two options to get the records updated in order for maintenance claims to be reimburse. Option one, if the claim is denied for maintenance and service and proof of 15 Medicare paid months are on file, request a written reopening for record correction. Any documentation that supports payment will be considered. Please remember that if any of the payments were recouped, they will not be considered as paid.

Option two, if there is no proof of 15 rental payments, for example the rental claims denied, rental claims were not submitted or payment was recouped for rental, a capped rental extension maybe requested. Simply submit rental claims for the missing number of months with the narrative to extend for remainder of rental month and the item will (pop) at the 15th payment. The maintenance and service claim reimbursement may resume after six months have lapse – excuse me – have elapsed from the 15th rental payment.

Now, James Herren, also with provider outreach and education will provide more updates.

James Herren: All right. Thank you, Ronja. We have some claim reminders to help avoid delays and reimbursement. First, we do encourage all suppliers to review the LCDs for documentation requirements. It's very important. Please pay close attention to those policies with KX modifier requirements and to save time and money by appending the KX modifier on the initial claim that this will avoid costly reopenings.

When submitting claims for repairs, please be sure to include the following information in the narrative to avoid additional documentation request. What we're looking for is the HCPCS code and the date of purchase for the item being repaired, we need the manufacturer's name of the item, we need the product name and model number, we need the MSRP of the item provided and the HCPCS code or codes for additional items added as part of the repair. I'm going repeat that again. We're looking for the HCPCS code and date of purchase for the item being repaired. We're looking for the manufacturer's name of the item. We need the product name and model number. We need the MSRP of the item provided and any HCPCS codes for additional items added as part of the repair.

Effectively immediately, if the description, manufacturer name, product name, product number and suggested retail price were not provided with the claim, the claim will be developed for more information. If there is no response to the request for additional information, the claims will be denied for missing information and the supplier will be responsible for resubmitting the claims with the appropriate information.

Also, remember that routine maintenance is not covered by Medicare. So for example if you are adding air to tires, tightening screws, oiling movable parts or just any other routine services, they should not be billed to Medicare unless otherwise explicitly stated in the actual LCD. Claims for labor must include the following information. The HCPCS code and date of purchase for the item being repaired and the details of the labor performed and the cost of labor and repairs, and as a

reminder, it should not exceed the purchase price of the equipment. Again, when you're billing for labor, please include the HCPCS code and date of purchase for the item being repaired, the details of the labor performed and the cost of the labor and repairs, and again, that should not exceed the purchase price of the equipment being repaired.

Next, we would like to provide some guidance on identifying the difference between claims that require resubmission, reopenings or redetermination. If any claim has a message of no appeal rights or an ANSI code of 16 on the Medicare remittance notice, this claim should be corrected and can be resubmitted. You may also resubmit corrected claims for items with ANSI codes 173 and 176 (CO176 or CO173). It is important to include a narrative with these claims when a new item is billed and a CMN (or bid) that's submitted. For 176 denials, please verify that the correct date on the revision or recertification is also submitted.

Claims with minor errors or omissions are corrected through the reopenings process. Examples of these would include changing the submitted charge, changing the number of units, the HCPCS code or adding the KX modifier or if you want to report an overpayment. We do encourage suppliers to utilize the CIGNA Government Services reopening request form when submitting claims for reopenings. I do also want to stress that if your claim is denied for lack of a KX modifier, you do not need to go to redeterminations with that. You can go to reopenings, just append the KX modifier to the claim and make sure you do have the information that the KX modifier indicates that you have if it is requested.

An appeal of an underpayment or overpayment request or a claim denial would begin with a redetermination. Redetermination is the first step of a five levels of appeal of Medicare appeals. Some examples of claims requiring a redetermination would include denials as a result of over utilization, insufficient documentation or items not meeting medical necessity guidelines. We encourage suppliers to utilize the CIGNA Government Services redetermination request form when submitting claims for redetermination. For suppliers who are not utilizing our request form,

please be sure to include all of the following required elements to avoid rejection of the request and that is the beneficiary's name, the beneficiary's health insurance claim number or Medicare number, the specific service and/or the item, the specific date of service, the printed first and last name of the person requesting redetermination and that person's signature.

For more information on reopenings and the other levels of appeal, please feel free to visit our online education course titled "Reopenings and Appeals" found at www.cignagovernmentservices.com and you'll find that under the education page.

I would like to talk about the Medicare contractor provider satisfaction survey for a moment. Those Medicare providers who were selected by CMS to participate in the Medicare contractor provider satisfaction survey are asked to please take the time to complete the survey or to – or respond to the survey contractor, Westat, with their follow-up calls. The survey is designed so that it can be completed in 15 minutes and responses may be submitted via secure website, by mail, fax or over the telephone. Currently, the average response rate is 32 percent. CMS's goal is to reach a 65 percent response rate. Data collection will end in April. So if you have received a request from Westat for the Medicare contractor provider satisfaction survey, we do recommend that you take the time to fill that out and return that.

Also, finally, recently, CIGNA Government Services DME POE recently completed an innovative workshop series on March 11th. We collaborated with our Part B North Carolina contracts to offer a joint Part B DME workshop in Charlotte, North Carolina entitled "Maximizing Your Reimbursement." Approximately 400 attendees equally split between the DME and Part B contracts participated. The highlights of this unique workshop included an interactive helpdesk staff with subject matter experts from both Part B and DME, targeted education via a series of breakout sessions such as DME updates and overpayment recovery.

Customer satisfaction is high and we are looking at expanding this type of education in the future. The next Jurisdiction C DME workshop will be held in Birmingham, Alabama on April 23rd, and some of our other upcoming cities include Orlando, Florida, Miami, Florida, Denver, Colorado, and Atlanta, Georgia for summer workshops. And for fall workshops, we will offer locations in – offer in Baton Rouge, Louisiana, Charleston, West Virginia, Houston, Texas and Dallas, Texas. Please stay tuned to our listserv for registration details and other future educational opportunities. This concludes the CIGNA Government Services update, and now, we would like to turn the call over to Cindy Dreher from the Competitive Bidding Implementation Contractor for updates on CBIC. Cindy?

Cindy Dreher: Good afternoon. For those of you who were in Charlotte last week, I apologize for repeating myself but I don't think you can hear this information enough, a little bit different information sinks in every time.

So the first thing I wanted to discuss was the timeline because that seems to be the number one question on peoples' minds and just to let you know that we are very close to the end of the evaluation period. All those suppliers who submitted a bid, whether they are being selected as a winner and receiving a contract or not, will receive notification before the public announcement. And the public announcement of the winning contract suppliers is expected to be in April.

A listserv went out from CMS last Friday about a new accreditation deadline for those suppliers who intend to submit a bid. And if you are going to participate in the competitive bidding program, you must have a pending accreditation which does means that you must have contacted accrediting organization and have started the process by May 14th. It does not mean that you must be accredited at that date. You have to be accredited by October 31, 2008. But what CMS wants you to do is go ahead and start that process so that there's not a huge backlog towards the end and everybody's trying to get accredited at the last minute.

CMS will also announce dates when the bidding window will open and when the actual registration process will start; so stay tuned for that. If you have not already registered on our website to receive e-mail update, we encourage you to do that and our website address is www.dmecompetitivebid.com. If you go up to the top of the homepage, you'll see something that says e-mail updates and just click on that so you'll be able to get all the information that we sent out through the listserv function.

I'm not going to spend much time today because we don't have a lot of time to talk about the bid evaluation process and some of the other things, but all the information that I'm going to give to you today is posted on our website so you can go out there and look and get that information there as well. I wanted to discuss today though some of the transition policies that all suppliers need to be aware of when competitive bidding is implemented on July 1st in the first 10 CBAs. And what I'm going over quickly today are the grandfathering of the repay and replacement and the traveling beneficiary. There are a few more details out there on the website about prescription requirements for specific item and also the use of the ABN that you can go out and read for yourself. Please review the website for further details on the information that I cover today.

First of all, the only items that may be grandfathered are oxygen equipment and supplies and capped rental items that are included in competitive bidding. It's important to note that enteral nutrition pumps are not classified as capped rental item. Therefore, these cannot be grandfathered. So any supplier who is currently renting an enteral pump to beneficiary and that supplier is located within a CBA or does business within a CBA for beneficiaries who have permanent resident in a CBA. For those of you who don't know our language, CBA is competitive bidding area, then those beneficiaries are going to have to get their enteral pump from a contract supplier beginning July 1st.

Suppliers can choose to grandfather or they can choose not to be a grandfathered supplier. So if you are in a competitive bidding area, you have that choice. You will have to notify the beneficiary of your decision and we will have more instructions about that process posted on our website later and there'll also be some articles on listserv messages that will go out about that. But if you choose to grandfather for instance power wheelchairs for one beneficiary, then you'll going to have to grandfather power wheelchairs for all of your beneficiaries.

With competitive bid the beneficiary also has a choice. They may decide to stay with their current supplier who is a grandfathered supplier or they can also make a decision to switch and go to a new contract supplier. But again, only capped rental items and the oxygen and oxygen equipment can only be grandfathered if there is an existing rental agreement in place prior to July 1, 2008. So I'm going to quickly talk about the capped rental. If you are a non-contract supplier and decide to be a grandfathered supplier, then Medicare is going to pay for the item until the cap rental period is up or until the item is no longer necessary. So once the ownership for the item is transferred to the beneficiary, then it's no longer considered a grandfathered item.

So for instance you're grandfathering a CPAP, the beneficiary gets ownership of the CPAP, and the patient subsequently needs supplies, the beneficiary is going to have to go to a contract supplier to get the mask and the tubing or anything else they need. But as long as there is a contract agreement or rental agreement in place, then they can continue to go to the grandfathered supplier. And the grandfathered supplier is going to be paid the fee schedule amount and the grandfather supplier, beginning July 1, will have to accept assignment on all these claims.

Now, if the beneficiary switches to a new contract supplier from a grandfathered supplier for regular capped rental items, then Medicare will pay for a new 13 month rental period for the cap rental item and this is regardless of where we are in that cap rental agreement. So even if the grandfathered supplier is in month 12 of the rental, the new contract supplier is going to receive

13 new months of the capped rental. And the contract supplier will be paid the single payment amount which is what we refer to as the new bid amount. So you'll hear that terminology a lot, single payment amount, and that's just the new bid price.

Now, for oxygen is just a little bit different, the grandfathered supplier again has to accept assignment for all the claims and the grandfather supplier is going to be paid the new single payment amount or the bid amount and not the fee schedule amount for the rest of the rental period. So that is a big difference between capped rental and oxygen claims with competitive bid.

Now, if the beneficiary switches from a grandfathered supplier to a contract supplier for oxygen claims, the contract supplier will be paid at least 10 monthly payments. Regardless of where the payments are in rental period, the contract supplier will receive no less than 10 rental payments for the oxygen (but if there are more than 10 remaining payments left they may receive all remaining months).

Now, if the beneficiary switches from a contract supplier to another contract supplier for oxygen claims, then the next contract supplier is only going to be paid until the 36 months period up. There is no minimum number of months for oxygen for contract suppliers taking over another contract supplier's claims for oxygen. So if there are only 6 months left in the oxygen cap, that is all the new contract supplier will receive reimbursement for. Please review the website for further details.

I will quickly go over repair and replacement. If any item needs to be repaired, even a bid item, any Medicare rental supplier can repair it. This is just for the repair. There are no parts involved. Labor is not a competitively bid item. And so it is not affected by the competitive bid program and the supplier is going to be paid the fee schedule amount for the labor. But if the labor also includes replacing a part in order to make the item function and that part happens to be a competitively bid item, and again, any Medicare rental supplier can do the repair and provide the necessary parts; But they will be paid the new single payment amount or the bid amount for any

parts that are competitively bid. The next piece of this is if the equipment has to be totally replaced. For instance, you've got a powered chair on the back of your car going down the road, it falls off and a big truck runs over it, you've got to replace the whole item. If the entire piece of equipment needs to be replaced, then the beneficiary is going to have to get that item from a contract supplier.

Now, I'm going to go over to the most (fun) policy of all. And this is the traveling beneficiary. And we say this many times, the best advice we can give to a beneficiary is to stay home because this one is a little bit complicated. There are a couple of scenarios here. First thing to determine is if the beneficiary resides in a CBA. The beneficiary's permanent address on file with Social Security determines this (where the SSA checks are mailed); if this address is within a CBA, then that beneficiary is a permanent resident of the CBA. If this beneficiary travels from one CBA to another CBA and they need a bid item, then they will have to utilize a contract supplier to get any bid items. If the area the beneficiary is visiting is **not** part of the competitive bid program, then the beneficiary may go to any Medicare rental supplier to pick up the item in the visiting city.

Now, another scenario is if the beneficiary resides outside of a CBA and travels into a competitive bid area (CBA) and the beneficiary requires a competitively bid item, then the beneficiary will have to obtain that the competitive bid item from a contract supplier. Even though the beneficiary is a permanent resident outside of the CBA, if they ever go into a CBA for whatever reason, they're going to have to get the item from a contract supplier. Payment is always based on the permanent resident of the beneficiary. This is not changing from how it has been in the past. So if the beneficiary permanently resides in a competitive bidding area, then the supplier is going to be reimbursed the bid amount for that CBA. If they reside outside of the CBA, the supplier is going to be reimbursed the fee schedule amount for the state with the beneficiary's permanent residence. So, again, this is not changing that policy.

I am not going to over some of these other policies because I do want to leave some time to answer some questions.

(Dante Thomas): OK. Thank you so much, Cindy, and we'd like to mention, this is (Dante Thomas) again, in support of CBIC education effort, if you frequent our website at www.cignagovernmentservices.com, we have a link to the CBIC information on our website. It's under helpful links. So if you'd like to visit and read all of the information that Cindy just went over, you may do that through our website as well.

We'll now open the floor for questions specific only to competitive bid will be limited because of time constraints. If your question is related to another topic, we do ask that you please hold it until the general question-and-answer portion of the call so that we may be respectful to the time of our guests. Please limit your question to one per supplier so that we may address as many callers as possible.

(Mariel): Hi. This is (Mariel) and I have a question regarding the May 14th accreditation deadline.

Cindy Dreher: Yes.

(Mariel): I guess I'm confused as how we were supposed to know to apply for accreditation to meet that deadline when we don't have the zip codes yet that go with the round two.

Cindy Dreher: The zip codes will be announced very shortly but the important part to remember is – you know what the MSAs are, the metropolitan statistical areas. And so whether you are physically located within what we call the competitive bidding area or service beneficiaries within a competitive bid MSA, it would probably be wise to go ahead and start the accreditation process. This will ensure that you are prepared to assist the beneficiaries in your area. If you're far removed from any competitive bid MSA, you may make the business decision that you don't need

to participate and submit a bid. But if a good portion of your business comes within that area, then you probably want to submit a bid. So you don't have to have your location or your facility within a zip code in the CBA.

Operator: And we'll go to our next question.

(Lewis): Hi. This is (Lewis) down in Fort Lauderdale, Florida. My question is with respect to traveling patient. We have a patient from up north who lives in a competitive bidding area and he travels down here and he needs supplies. And we are a contractor in Florida, a contracted supplier. We don't have to be a contracted supplier in the up north ...

Cindy Dreher: No. Just for your area. So if the beneficiary travels to Fort Lauderdale and you are a contract supplier, then you'll be able to provide the items for that beneficiary.

(Lewis Oliburn): Do any other competitive bidding area for people who are coming in ...

Cindy Dreher: Yes.

(Lewis Oliburn): Thank you.

Cindy Dreher: They would have to go to you as a contract supplier if they're in that CBA. And instructions will be provided soon. When servicing a traveling beneficiary in a CBA, append the KT modifier on the claim to indicate that the beneficiary was traveling.

Operator: We'll have our next question.

(Pam Ryman): Hi. This is (Pam Ryman). I have a question about negative pressure wound therapy in regards to competitive bidding.

Cindy Dreher: Yes.

(Pam Ryman): Is that considered – you were giving the definitions of cap rental opposed to other products. Is negative pressure wound therapy considered a cap rental item?

Cindy Dreher: No, it's not.

(Pam Ryman): OK.

Cindy Dreher: Your cap rental items are your hospital beds, your wheelchairs, CPAP, (rods).

(Pam Ryman): It shows on the fee schedule that it is one, that it is cap rental. However, it doesn't really give like a 10 or 13 month cap rental period. Usually it only pays for four months. So if it's listed as a cap rental in the fee schedule, I just want to clarify whether it is or whether it isn't.

Cindy Dreher: Yes. It's not subject to the competitive bidding rules for cap rental that can be grandfathered.

Follow-up- While the NPWT is a capped rental item and is subject to Competitive Bid rules if provided to a beneficiary residing in a CBA (i.e., the NPWT items must be provided by a contract supplier at the single payment amount); NPWT is **not**, however, a grandfathered item.

Operator: And we'll go to our next question. Caller, your line is open. Please go ahead with your question.

(Dante Thomas): And we will go ahead and make this our final question on competitive bidding because we do have some other topics that we need to cover. Thank you.

Operator: Caller, your line is open. Please go ahead with your question.

(Dante Thomas): OK. Thank you so much, Cindy. We appreciate your time.

Cindy Dreher: Can I give out our phone number just in case people have questions?

(Dante Thomas): Sure.

Cindy Dreher: We have a toll free number and they can call us at 877-577-5331.

(Dante Thomas): Thank you so much, Cindy. We do appreciate your time and valuable information about competitive bid. We would now like to turn the call over to the Common Electronic Data Interchange contractor for updates on the CEDI transition. We will open the floor to question specific to this topic immediately following their presentation. And I now introduce (Joyce Cianciola) from CEDI. Go ahead, (Joyce).

(Joyce Cianciola): Thank you, (Dante). Good afternoon, everyone, and I want to thank you for giving us this opportunity to present at your call today. National Government Services was awarded the DME Common Electronic Data Interchange or CEDI front end contract by CMS.

With this contract, CEDI will provide a single front end solution for the submission and retrieval of electronic transactions. Suppliers in jurisdiction C must transition to the common EDI front end by May 31, 2008. With this change, the DME MAC electronic submitters will send all electronic claims both 837 and NCPDP and claims status inquiry 276 transaction to CEDI. CEDI will return all electronic front end reports directly to the submitter. CEDI will also receive the ERA, the 835 transaction and the claims status response or 277 transaction from the DME MAC and deliver them to the trading partners CEDI mailbox.

For all CEDI documentation and communication, visit our website at www.ngscedi.com. Our CEDI helpdesk provide support for electronic submitters to resolve issues and answer questions about connectivity, receipt of files in electronic formats. Our CEDI helpdesk number is 866-311-9184 and is available between the hours of 9:00 a.m. to 9:00 p.m. eastern time. E-mail support is also available by sending an e-mail to ngs.cedihelpdesk@wellpoint.com. Electronic suppliers will want to join our CEDI listserv to receive important EDI information during and after the transition. CIGNA will also continue to send EDI-related e-mail list notices during the transition.

Some other key points regarding this transition are that CEDI will use your existing submitter ID established by each DME MAC for current electronic submitters. Electronic submitters who have previously completed electronic registration or enrollment forms with a DME MAC do not need to re-enroll with CEDI. The CEDI system is available for testing. Software vendors must test with CEDI prior to moving their customers to the CEDI. Suppliers, billing services and clearinghouses who use internally developed software and communications or in-house programmers must also test with CEDI. Vendors and in-house programmers should contact the CEDI helpdesk by phone or e-mail to initiate the testing process. Software vendors who have begun testing with CEDI and the list of those are available on the CEDI website. This list changes daily as the vendors move into production. Contact your vendor to find out when you can move into production with CEDI.

CEDI is in the process of finalizing an agreement with STI for support of the PC-ACE PRO32 product. Should there be new submitters in need of the software, we suggest they continue to request the software from the DME MAC until the software is available to download from our CEDI website. CEDI will also continue to offer the Express Plus software which will be modified to include a new communications package. Once the software products are available on the CEDI website, a listserv will be distributed with this announcement and applicable information to access the software. I thank you for giving us this time and I believe you're going to open these questions now, (Dante)?

(Dante Thomas): Yes. We will open the floor for questions specific to CEDI now. If your question is related to another topic, we ask that you please hold it until the general Q&A portion of the call so that we may be respectful to the time of our guest. Please limit your question to one per supplier so that we may address as many callers as possible.

(Dante Thomas): OK. Well, thank you so much, (Joyce). We do appreciate your time and information about CEDI. We will now open the floor for general Q&A. Please keep in mind we will not be able to answer questions about individual claims. If your question is related to numerous claims or suppliers, we may need to contact you following the call to obtain examples of claims for review and resolution. If your question is related to one or two claims, please contact our provider contact center at 866-270-4909 or to check claims status, you may use our IVR at 866-238-9650. Please limit your question to one per supplier so that we may address as many callers as possible. And we will now take our first question.

(Barbara): Yes. My name is (Barbara). I'm calling from Florida. My question is about the website.

(Barbara): On your current LCD listings, I have noticed there has been some items that been deleted from that listing on the LCD.

(Dante Thomas): Yes. And we are aware of that issue and we do apologize for that. All of the local coverage determinations are the same for all four DME MACs. So we are currently routing any questions on LCDs that are not currently listed in our local coverage determination listing to visit the website of one of the other three DME MACs for that information. And we are working diligently with CMS to get the website updated with a full list of LCDs for Jurisdiction C.

Follow-up, the transition of the LCDs for Jurisdiction are almost complete, we expect to have them all available through our website in the near future.

(Barbara): OK. One more question by the website. On – since we have had so many patients, we are in the Florida, I am in Florida, we have a lot of people that are joining the advantage – Medicare

Advantage HMO, and it directs us to a link on the website to get the addresses of these HOM plans. Could you help me find them please? I kind of reached a dead end.

(Dante Thomas): OK. Thank you so much for that question, (Barbara). We are working to locate that and I will come back on the line when we have it. If for some reason we are unable to identify that exact link today, we will definitely include it in the minutes.

Follow-up to access the list, access the CIGNA Government Services Part B website at www.cignagovernmentservices.com/partb; under the Helpful Links section, you will scroll down, you will see where it says CMS Resources, and from there, you will see there is a link to the Medicare HMO directory. We will get that added to the (Jurisdiction C) website as well.

(Barbara): OK, all right.

(Dante Thomas): OK, thank you so much for your question.

(Barbara): Thank you.

Operator: We will have our next question.

(Paula): Yes, ma'am, this is (Paula) from Munro, Louisiana.

(Dante Thomas): Hi, (Paula), go ahead with your question.

(Paula): My question is about cap rental oxygen, the 36 month cap that is coming out. We are running into problems with patients right now, let's say, that want to move to – or need to move to another area so that their children can take care of them, and we are having a hard time finding a supplier that will take them because of the 36 month cap. What do we start to help our patients do in that situation? Hello?

(Dante Thomas): Yes. To answer that question, as far as identifying suppliers, we do not have any instruction on how to find a supplier in another location. The only thing that we can recommend is to check with as many suppliers as possible in the area to which they are moving.

(Paula): That is not my question. My question is that no one is taking them because they are going to be capped.

(Dante Thomas): Right. And unfortunately, I do not have any further guidance other than to continue to try to find a company that is willing to accept the remaining rentals. There may be other companies in the area that will be willing to accept that patient. But, beyond that, there is no other guidance that we will be able to provide because this is going to be determined by the supplier in the other area who will take over that patient. It is like with the current capped rental items; if a beneficiary moves to another area after rental payments are made, it is just a matter of locating a supplier who is willing to accept the remaining payments. And beyond that, there is no other guidance that we will be able to provide.

(Paula): In the capped rental for oxygen they require continued service. A bed, they just take with them. So, I mean it is a problem.

(Dante Thomas): And I do understand your concern, but unfortunately, there is no additional information that we would be able to provide. The ruling was set by Congress through the Deficit Reduction Act (DRA), so we must follow the law as it is written.

(Debby Paris): Yes. My name is (Debby Paris). I am with long-term care in Columbia, South Carolina and I have a question concerning the narrative field. From what I understand, is it still true that we can only use 80 characters, and if so, how can we fit all of the necessary information, HCPCS

code, item description, manufacturer name, product name, number and MSRP in that amount of space?

(Dante Thomas): OK. There are a couple of things that you can do. First of all, we recommend that you abbreviate as much as possible. Secondly, you do have two narrative fields, one field for each claim line, so you do have room for the information on each claim line, and there is also space at the claim level, where you would get an additional 80 characters. So, between those, you should be able to fit the information in there and again just abbreviate as much as possible.

(Debby Paris): Where is the claim level located?

(Dante Thomas): It is going to actually depend on your software vendor. I will refer you back to them for that information because it is going to vary from software to software.

(Sophie): Hi, yes. My name is (Sophie). I am calling from North Carolina Medical Center Respiratory. My question is on reopening and redeterminations. We are having a problem with receiving them back within a quality time. I have been told 45 days to 60 days and I am still working those on – that is back from September and October. Is there any particular time frame that I should be looking for them to be returned?

(Dante Thomas): OK. We shouldn't have anything that far back to September. But, if you fax them in, we only accept faxed reopening requests.

(Sophie): Right. The reopening I just had send and the redetermination that I am talking about is one that I just sent in and sent documents. And I did receive a letter that you guys have received it, but I haven't heard anything from then. And when I call in, all they tell me is it is being processed.

(Dante Thomas): OK. If you received the confirmation letter, we have it and we are working on it, and you will receive either, if it is approved, you will receive a Medicare remittance notice advising that it was paid or if for some reason it was not approved, you will receive another letter advising you of why and include any further appeals instructions. So, if we did send you the letter, then we do have it and we are working on it. We are allowed 60 days to process redeterminations and reopening, and sometimes, those days can go a little bit over. We are working those as quickly as possible to get them out.

(Pauline): Hi, this is (Pauline) from Colorado Springs. I have a question on your labor. If the patient has – we do orthotics and prosthetics and we have a lot of labor orders that come with some of our patients that are going to be lifelong (AFO). But, if they come in and – you mentioned something about tightening the screws, adjusting it, et cetera is not being covered, is that correct?

(Dante Thomas): And we were referring to equipment on those, unless it is specified.

(Pauline): Well, this is equipment, this would be a brace or something that the patient has worn daily for life. Is that still, is that not covered? If they come in and we just have to tighten something or we have to adjust something, et cetera, or replace a strap or something, is that not covered under a labor code?

(Dante Thomas): Now that sounds like you are referring to adjustments to prosthetics, adjustments may be covered. The guidance is outlined in the LCD.

(Pauline): Is there a maximum of how many adjustments that a patient can have?

(Dante Thomas): If there are specific maximums, they will be listed in the local coverage determination.

(Pauline): OK. So, that's where we need to check.

(Dante Thomas): Yes, ma'am.

(Bridget): Yes, my name is (Bridget) and I am calling from Tennessee, and I just have a few questions regarding 36 month cap. Is there any determination – I know there is around \$77 established for oxygen content. Is that going to be like a monthly rate, a quarterly rate, is there any work on – and if there is not yet, is there are any time frame as of when we will be notified about it, when are these guidelines are going to come out?

(Dante Thomas): OK. The contents are payable monthly and we don't have a fee schedule as of yet for next year, which is when the Cap to oxygen goes into effect and you go into the whole DRA process. But, to answer your question about the content, they are payable monthly. Whenever the fee schedule is released by CMS, we will post that information on our website.

(Bridget): OK, thank you.

(John): Hi, this is (John) from Denver. We are a durable medical equipment provider. My question is specific to CPM rentals for total knee replacements. If in fact we do apply this knee cap within 48 hours of the surgery and it is applied for a limit of 21 days, the question is, we cannot bill with the diagnosis that say the surgeon bills with, say for instance, the V4365, which is a total knee replacement. How does that complicate the processing of our claims and should it?

(Dante Thomas): Actually, the diagnosis that you mentioned is a normal diagnosis that you would submit with your claims for the CPM, unless there is a revision and which you would utilize that diagnosis code. And I am not sure that I understand the other portion of your question.

(John): Well, my understanding is this V code, this re-diagnosis is a diagnosis that the physician can submit, but we as a DME provider cannot.

(Dante Thomas): There is a national coverage determination for the continuous passive motion device that you may review and those diagnosis codes are listed within that, and there should also be a policy article as it relates to that, also that may assist you with the submission of those claims.

(John): OK.

(John): And where is this at, I am sorry?

(Dante Thomas): If you go to the CMS website, the national coverage determination is going to be located in the Medicare coverage database or the MCD. If you go to the CMS website, under the top ten links, the second link is the Medicare coverage database that will give you the local coverage determinations; you will also have access to the policy articles and the national coverage determinations from there.

Follow-up- The link to the MCD is www.cms.hhs.gov/mcd

(John): Great, thank you very much for your direction.

(Robert): Hi, this is (Robert); Houston, Texas. My question is regarding CPAP. If you could explain the 12 week rental and what type of documentation would be needed if the patient still needs it after that 12 week?

(Dante Thomas): I am sorry; you said the CPAP and 12 weeks. Could you repeat your question please?

(Robert): Yes, I was pulling up this weekend the document – basically home ((inaudible)) were approved and that CPAP moving forward will require a 12-week rental. My question is what type of documentation would be needed after that twelfth week if the patient still required the equipment for a CPAP?

(Dante Thomas): OK. I am sorry, I misunderstood your question. Actually, what we would be looking for is just documentation from the beneficiary that they are continuing to utilize the CPAP.

(Robert): Could that be done in form of – like the surveys that we have from our accreditation companies that when we call the patient's name, are you benefiting from it, do you still require the fees, would that be considered a piece from the beneficiary?

(Dante Thomas): Yes.

(Robert): OK. And can a DME bill for the home study; can they perform it at all?

(Dante Thomas): No. Suppliers are not allowed to perform the home study.

(Robert): OK.

(Sherry): This is (Sherry), Little Rock Arkansas.

(Sherry): Calling with a few questions about redetermination. And like when you had told the lady before, they are all current. I have some that are out till September and when I call and check on them, they say they are in process. Now, if we have a patient and we bill rentals for, say, six months and in fact I have a case where it happened, and only one month is listed on the redetermination. Why do you not go back and pick up all of the other claims for the same patient for the same item with a positive redetermination decision?

(Dante Thomas): So, you said you did not include the additional month on the request?

(Sherry): No, because by the time we get the decision, the other months have passed and have to be billed. Now, most other insurance companies, when they have an appeal for a patient they will go ahead and review all of the claims for the same item since everything is in the original request.

(Samantha Coleman): Thank you. This is (Samantha Coleman) with the appeals department. (Sherry), I would like to get some information and go back to restart for your September request, because actually we are actually current with our redetermination work load now.

(Sherry): OK.

(Samantha Coleman): And we don't show any outstanding, so that will be a take-away item that I will actually need to address with you. (IOM) requires that we only address specifically the dates of service that you specifically outline in your request. That is the CMS requirement. So, based on that, if you only indicate you are appealing one date of service, that is the only date of service that we are able to address in your redetermination case.

(Sherry): So, am I supposed to – when the redetermination is processed, send them in and then get denied as duplicates?

(Samantha Coleman): No, no. What would happen is, you have some dates of service that you bill and you receive denials on. You have appeal right for each one of those claims. So, you should follow through your appeal process for each one of those separate dates of service. You do not have to wait until you receive resolution on earlier redeterminations that you submitted.

(Sherry): OK. So, then, I will just like do a redetermination for May, a redetermination for June, a redetermination for July?

(Samantha Coleman): That's correct. And depending on how you bill those, you do have a time frame from the remits that you have four months to submit that redetermination request.

(Sherry): As I say, I've got one in September and October and I called customer service last week and they said it was in process.

(Samantha Coleman): OK. (Sherry), can I get your phone number so we can circle back around after the call regarding the September and October dates of service?

[Follow-up: This issue has been researched and resolved.](#)

(Crystal): Hi, my name is (Crystal). I am calling from San Antonio. And my question is on, well, you said that you have representatives from CMS there, correct?

(Dante Thomas): We have invited guests from CMS. I have not confirmed if they are on the line or able to answer questions. If it is something that we are able to address, we will.

(Crystal): OK. Many of the Medicare Advantage replacement plans also have – expect to have Medicaid as secondary payers. And here in Texas, our Texas Medicaid will not pay for those Medicare Advantage plan co-insurances. And so, we are forced to adjust the amount, while currently. Is there any way to resolve that?

(Dante Thomas): For that particular question, I will have to refer you back to the Medicare Advantage plan so that they can work with the Medicaid offices on that, because that is outside of our jurisdiction and we would only be able to assist with fee for service question.

(Crystal): OK.

(Jeff): Hi, my name (Jeff). I am from Orlando, Florida. We were one of the first MSA areas and I have a question about services and beds. Since the beds were in the first go-round, what – if you are a supplier of ((inaudible)) services, what do you do?

(Dante Thomas): I do apologize, (Jeff). Unfortunately, we have the competitive bid contractor, the Q&A section for them was limited to the time that they were on the line, and I would have to refer you to the competitive bid contractor for an answer to that particular question and they have dropped off the line.

(Jeff Cowan): OK, thank you.

(Dante Thomas): That telephone number is located on the CBIC website, which again the link is available through our website. (877.577.5331)

(Jeff Cowan): Thank you.

(Cindy): Hi, good afternoon, this is (Cindy) from Arlington, Texas. I use Pro32 software to bill and I have been coming across the same error for a control solution. When I entered in my system, I obviously put the (NU modifier) and it goes – it gets affected.

The following day one, I put my report, which tells me what has been accepted and what has been rejected. That one was denied because of the modifier is incorrect. So, I go and I take the modifier off, resubmit it again, it is accepted, but yet when I – it comes to the (EOBs), it is rejected because it is missing the modifier.

Now, I am tried of going round and round in circles, through customer service, through EDI and nobody claims to know what is going on or it is not their department, it is nothing that they can

help me with and they send me back and forth, back and forth. Now, I have spoken to so many supervisors on both ends and I am still having the same issue.

(Dante Thomas): (Cindy), I am sorry to interrupt. May I ask what is the HCPCS code that you are billing?

(Cindy): A4256 for the control solution.

(Dante Thomas): Have you tried submitting it without an (NU), because I do not believe that is an item that requires an (NU modifier).

(Cindy): Well, see, that's the thing. When I go back and I re-submit it without the (NU modifier), it is gone through on my end, but when the get (EOBs) from you guys, it is rejected because the (NU modifier) is not attached. So, I don't know if it is an issue with the Pro32 or where the issue is at, because like I said, I'll call customer service and they will say, "Well, you didn't get paid, because you are missing the modifier." Or it doesn't let me attach the modifier because it won't get accepted.

(Dante Thomas): Now, are you including the type of diabetics that you are servicing, the (KS), if they are non-insulin and a (KX) if they are insulin dependent?

(Cindy): Yes, ma'am, because I only usually bill the control solution in the first three months, which is with the glucometer, the strip is ((inaudible)) and excuse me, it's got (NUKX) and all of that.

(Dante Thomas): OK. Are you trying just the A4256 with only a (KS or KX)?

(Cindy): No, I have been told – I have knocked it off, I have added everything I have – every combination you can possibly think of ((inaudible)).

(Dante Thomas): OK. Let me go ahead and get your telephone number and take a look at it, because I am not sure exactly what is going on with it. May I get your telephone number please?

Follow up: Claims for A4256 only require the KS or KX modifier because they are in the Supplies category and are within the Glucose Monitors LCD. If the KH or NU modifiers are added to this code, they will be rejected.

(Dante Thomas): OK. I will give you a call back and this is (Dante Thomas). *Education was provided and the issue was resolved.*

(Abel Davis): Good afternoon. This is Averill Davis calling from St. Thomas in the Virgin Islands. And I am one of two DME suppliers that handle CPAP pretty much for about a four, sometimes five mile island population. And because there are so few of us, I just wanted to know, if competitive bidding going to be mandatory for suppliers living in such an incredibly rural area where we are pretty Sparse as it is? And so, if one of us does not – I mean, so that mean that one of us would expect to get the contract and the other one would not be able to supply because we are on different islands?

(Dante Thomas): If the St. Thomas Virgin Islands is part of the MSAs that were identified for competitive bid, then it is mandatory for items requiring competitive bids. But, we are going to go ahead and give you a number that you can contact for competitive bids, where you can get more information. And that phone number is toll free 877-577-5331. *Suppliers may also review the CBIC website at <http://www.dmecompetitivebid.com> for further information on competitive bidding requirements.*

(Susan): I am calling from Sterling, Colorado, and I have the same problem the other woman did with the control solutions where my claims are suddenly, since June of '07, coming back saying not a valid date or there is no (CMN) attached. I have talked with my software provider, EDI, and the

CIGNA folks but everybody is pointing the finger at everybody else. End result is my claims don't go through because EDI says, "Well, the (CMN) went through the front-end", and my software provider says, "Well, the (CMN) is attached," and then, you guys say, "Well, there is no (CMN)."

(Dante Thomas): I am sorry that this is happening.

(Susan): What do I do?

(Dante Thomas): (Susan), what item are you billing for?

(Susan): O2, E1390s or whatever.

(Dante Thomas): OK, so this is for oxygen, and you are indicating that – and what denial are you receiving?

(Susan): I'll get one – I am sorry; I have to walk away from my desk for a minute. I think it is (CO176) prescription not current or something like that.

(Dante Thomas): So, is this coming in from – are you getting these on an explanation of benefits, are you getting this on a rejection front-end?

(Susan): Well, I am getting them, they passed the front-end. My claims passed the front-end.

(Dante Thomas): But, are you getting a rejection report once they get into the system from EDI, is that what is happening ((inaudible))?

(Susan): No, everything I get from the front-end, so it is OK, then I will get an EOB for the (CO176) and an (M60), and I am telling you, there is a (CMN) attached to this claim. So, what can I do or who can I call when I get claims like this, so we can get to the bottom of this for all these people?

(Dante Thomas): OK. Are these people that possibly had a break in service and you are trying to submit a new one?

(Susan): Well, it is a variety of people. I have some people who have been on O2 for five years.

(Dante Thomas): OK.

(Susan): So, when CIGNA took over, suddenly I am getting the (M60) or the (CO176) denial.

(Dante Thomas): OK.

(Susan): So, some of our new people – so I am just trying to submit the first (CMN) through, but I have problems or it's just the research. Every time I have to submit a new (CMN), something goes haywire with it.

(Dante Thomas): OK, thank you so much (Susan). We will get back with you.

(Susan): Thank you.

Follow up- The examples provided included claims with both contractor errors and claims with patients who already had oxygen on file. The contractor error claims have been submitted for correction and the claims for patients with oxygen on file will be resubmitted by the supplier with the new initial CMN and a narrative on the claim explaining the break in medical need for more than 60 days.

(Laurie): Yes, I am (Laurie) from Albany, Georgia, and I have a question. We sent a prescription into reopening and they received it on September 7, '07 and we just received a letter back on February 21 of '08 and it is telling us that they couldn't process it and they will have to go to redetermination. But, I am past my filing time on this for redetermination because it took so long for reopening to get back with me. So, what am I supposed to do now?

(Samantha Coleman): Hi, this is (Samantha) from redetermination. What you should go ahead and do is submit your redetermination request and outline in the request what was the cause of the late filing and we will look at that and to review it for timeliness.

(Laurie): OK. Well, let me ask you this. On this reopening, it states that the date of service is prior to the date of the initial on the certificate of medical necessity, which is not so, but it is telling me I need to go to redetermination. So, I mean, what do I do about that? We looked at it, it is the same dates and everything. So now, do I have to spend another five months in redetermination waiting on it to come and pay?

(Samantha Coleman): Actually, we are current in redeterminations. We are completing work well within the 60 day time frame, so you would not have to wait five months in order to get a response. But, if you have a specific example where you can see the (CMN) is within the time frame based on your date of service, I could definitely give you a call after the call today to see if we can't review that with you.

(Laurie): Can you please, because I am – I have several things that are in redetermination that we haven't received anything on yet.

(Samantha Coleman): Can I get your number?

(Samantha Coleman): OK, (Laurie). We will give you a call after the call today, OK?

(Laurie): Thank you.

Follow-up: This issue has been researched and resolved.

(Sarah): Yes, this is (Sarah) in Fort Smith, Arkansas. I am calling and just want to mention that I am having the same exact problem with the control solution as far as my ((inaudible)) is not required and so then, I take it off and I get an (EOB) back where it says that it was denied because (NU modifier) wasn't there. I just wanted to let you guys know I was having that same problem.

Follow up: Claims for A4256 only require the KS or KX modifier because they are in the Supplies category and are within the Glucose Monitors LCD. If the KH or NU modifiers are added to this code, they will be rejected.

But, my question is, I am greatly battling with fee for service providers. When I go to the (LCDs) and look up the A4253, it is not list an (NU modifier) and when I try to bill a fee for service, they tell me that an (NU modifier) is required according to Medicare guidelines. But, I can't find anywhere in the (LCDs) where it mentions an (NU). But, when I go back and look at Medicare (EOBs) that we have received, on every single (EOB) we have ever received since CIGNA took over, there is an (NU modifier) added with a CC at the end. So, it is as though you guys don't require it, but you are adding it later. So, I don't know what the total fee for service is, I can't show them a Medicare guideline because the Medicare guideline says nothing about an (NU modifier), but your (EOB) somebody is adding an (NU modifier). But, when I call and ask customer service, she doesn't really – they don't really know what I am referring to. She says that the (LCDs) are – it doesn't list it, which it doesn't it, but I don't know. I mean, I don't know what to tell these fee for service companies. So, can you tell specifically, does that A4253 require an (NU modifier) or not?

(Ellen Edenfield): This is (Ellen Edenfield) in the claims area and you are right that it does not, but the fee schedule amount we get from CMS is under the code with an (NU modifier). So when you submit it to us without that NU, we are automatically flipping to the code with the NU because that's where the pricing is.

(Sarah): OK.

(Ellen Edenfield): So, that is why on your remits you are seeing the A4253 HCPCS code with the NU and CC modifiers appended.

(Sarah): So, should I be billing it with an (NU modifier) then?

(Ellen Edenfield): You can do it either way.

(Sarah): OK. So, what do I tell – in regards to the fee for service, they say that it does require it, so... I mean, I don't really know yes or no then, does it or doesn't it?

(Ellen Edenfield): Well, I don't think according to the policy that it does, but the pricing is coming in under that NU and that's why we are flipping that code for you.

(Sarah): OK.

(Ellen Edenfield): So you could bill it either way.

(Sarah): OK. OK, thank you.

Operator: Thank you. We will take our next caller.

(Elma Avino): Hi, this is (Elma Avino) with the Scooter Store and my question is regarding the spring 2008 supplier manual that was posted on March 30, 2008. I was looking for the page where the highlight all the updates, the chapters that have been updated. Is there a page that identifies what chapters have been updated? There are 18 chapters in total. Or is there only specific chapters have been updated?

(Dante Thomas): OK. To answer your question, (Elma), we are going to have to do a little bit of research on this. If I did not get the answer during the call, I will be sure to post it in the minutes.

Follow-up- The updates were outlined in the Supplier Manual Update CDROM sent to all active suppliers who have billed CIGNA Government Services in the last 12 months. The document has also been added to www.cignagovernmentservices.com under the Supplier Manual link.

(Elma Avino): Thank you. I appreciate that.

(Dante Thomas): Thank you so much. You have a great day.

(Elma Avino): Thank you.

(Carol): Yes, good afternoon. I am (Carol) in (Tipido), Louisiana and I have a question. We have had several claims that we were filing for denials, but we are getting paid on them, and I seriously do not think that these are payable, and I am sure somewhere down the line you are going to recoup or if you would do an audit on it, you will see that they are not payable and I am just – we are just not sure how to handle it.

(Dante Thomas): OK. To handle those, you can do it one or two ways, you may complete a volunteer refund. If you go to our website under the forms sections, there is a voluntary refund form. You can complete that form and submit a check to the address listed on the form. And that way, you

can refund any payment any time that you identify an overpayment or we paid something that we shouldn't have for whatever reason, just include a note explaining why you are refunding on the form. You may also submit a reopening request to report the overpayment. The reopening form is also located on our website under the forms section at www.cignagovernmentservices.com.

(Carol): Will we get a corrected EOB so that we can send to the next payer?

(Dante Thomas): Yes, ma'am. You will.

(Carol): OK. And you see like the files we even – the claims we even filed with the GA modified.

(Dante Thomas): Right. The GA modifier doesn't automatically make a claim deny. We have to process each claim based on each beneficiary and there are times when the GA modifier is submitted and the patient does meet criteria and we are able to pay it; the GA is just to cover you to be able to bill the patient in the event that we do deny it as you expected to deny.

(Carol): OK. Well, I know you don't pay for the color of the chair and you did pay me. So, I feel that whole claim should have been denied on this particular one. But, if we go to the volunteer refund and put a reason as to why, should we include the EOB with it?

(Dante Thomas): Thank you so much, Carol. But to get that corrected you would submit a voluntary refund.

(Carol): OK.

Follow-up- Claims for wheelchairs that are for use outside only, according to the LCD, should be submitted with the GY modifier in order to receive the appropriate denial.

(Pat): My name is Pat. I am from Florida. And my question is the young lady that was speaking about CEDI, she's given out here – the web address so fast, I didn't get it.

(Dante Thomas): OK. So you just need the web address for CEDI? It is www.ngscedi.com.

(Pat): OK. And my other thing was that I am having the same problem with my oxygen patients also. We are getting denials for brand new oxygen patients and EDI is telling us that it is coming across. Then customer service will say that the certificate of medical necessity is not there.

(Dante Thomas): Wait, just a second. I am sorry; can I get your telephone number please, (Pat)?

(Pat): Yes, my phone number is 407-260 – well, I am sorry. 407-268-0179, extension 103.

(Dante Thomas): OK. Thank you so much, Pat.

(Pat): Thank you.

(Dante Thomas): And we will take our next question.

Follow-up- The telephone number provided was not valid so the examples were not collected or reviewed. Pat, you may contact our customer service department for assistance with these claims.

Female: Yes, ma'am. I have a claim that we submitted on some Solu-Medrol. The patient does not qualify of the Solu-Medrol, when sent the claim with the correct modifier on it, we just had to go all the way as to reconsideration and my reconsideration was denied. We have an ABN filed. I sent the ABN with my reconsideration request and they are telling me the advanced beneficiary notice is generic and therefore, is invalid. The ABN that we used is the one straight out of the Medicare manual and my reason on it as to why it is denied is because the patient does not meet Medicare criteria for coverage. I just don't understand. All I am wanting is a denial because we know the patient doesn't fall ((inaudible)). He has a secondary insurance that will pay.

(Dante Thomas): OK. Actually, requirement for ABNs is that it requires a specific reason. So there has to be a specific reason why that patient does not meet Medicare criteria and that's what you want to outline on the ABN. For instance, if you are providing glucose testing supplies to a patient who does not have diabetes, this would be included on the ABN as the specific reason for the ABN. Suppliers must include specific information from the policy as to why the claim is expected to deny.

Female: OK. So you are – So, the state of the patient does not meet Medicare criteria, that's not specific enough, is that correct?

(Dante Thomas): Yes, that is correct.

Female: OK. All right. That's what I needed. Thank you so much.

(Linell): We are calling from Nashville, Tennessee. My name is (Linell). Several other people have addressed a similar issue.

Our issue is pertaining to ambulatory pump billing. We have problems getting both our initial claims and subsequent claims paid. The initial claims appear to – we are actually sending the initial with the paper (CMN). Subsequent claims are not submitted with a (CMN), but we found that we had some luck getting those paid late last year.

But at this point, we still have claims that go back as far as July of '07, initial and subsequent claims that we cannot get paid through Cigna. And we are receiving the same denials, the (M60) denial and at this point, I mean, ours is really bad. I think we've probably got close to – I don't know – 70,000 claims, \$70,000 in charges worth of claims outstanding to DME MAC with no real avenues to get these issues that affect large volume claims resolved. Can you point me to a

person that we could work with that we could, you know, send this information to because it is absolutely too many claims to submit a re-determination on every data service for every patient that we have outstanding.

(Dante Thomas): Oh, I'm sorry. OK, (Linel). So, when you submit the initial claim with the paper CMN you are still having the same issue? Is that what you're saying?

(Linel): We submit the initial claim, but when we submit subsequent claims, we're being told that the initial claim, the initial CMN is not loaded to the system and we, you know, our subsequent claims are going out monthly but we can't get – they all come back denied because the initial CMN was never loaded.

(Dante Thomas): OK.

(Linel): We're being told to send all of our subsequent claims to re-determination.

(Dante Thomas): What are you billing for exactly?

(Linel): Ambulatory pumps and supplies. The EO781 with supply codes A4221 and 4222.

(Dante Thomas): What ANSI code are you receiving with that, if you don't mind? The N60 is your remark code. There should also be a second code on there that would be usually a three digit number.

(Linel): The CO176.

(Dante Thomas): One seventy-six. That's what I need.

OK. For that, you can just re-submit. It sounds like for some reason your – either what's happening is that you're submitting your subsequent claims before that initial claim is processed and those additional ones are denied. What is happening with your initial claim that was submitted with the initial Certificate of Medical Necessity?

(Linel): Well, being that it takes the initial claim 60 days or more to get processed; it is entirely probable that we will have two other months that have been submitted since that claim, but – I mean – in terms of a processing time, how do you gauge that? We can't hold claims for a month or two months waiting for the response on the initials. We work under the assumption that when the initial claim is submitted, the CMN is loaded to your system and processed with the initial claim, but that's not the case.

(Dante Thomas): (Linel), I do apologize to interrupt; OK, with this, because all we're looking for is your initial Certificate of Medical Necessity is to resubmit and it could – are you double checking your – because we've heard this inquiry several times and I will go ahead and take your telephone number also just to get some examples of it. But we have received this inquiry several times before and in looking deeper into those scenarios, what has occurred is that the initial Certificate of Medical Necessity or DIF has actually rejected out on the electronic claims just about, I'd say, of the many that I've looked at, more times than not, it is where that CMN or DIF submission did show up on the rejection report for the electronic claim.

So – but just to be sure, I will go ahead and if I may get your telephone number please and we'll get some examples ((inaudible)) that that is what is occurring with yours.

(Linel): Right. We're not submitting our CMN electronically.

(Dante Thomas): So, all – are you submitting them with a claim or are you submitting – because you indicated the 60 days – are you sending them to re-opening?

(Linel): We submit the initial – the initiation of the pump – the initial pump claim with the paper CMN and our subsequent claims are filed electronically.

(Dante Thomas): OK, but with your initial claim are you submitting those to just regular claims?

(Linel): Yes.

(Dante Thomas): You are submitting those to regular claims. Are those – what is happening with the initial claims? Denying?

Male: The CMN is not loaded.

(Linel): The CMN is not loaded. Even the initial – somehow it's being separated from the claim, but we're not getting – we constantly have to submit – re-submit both. We're re-submitting the CMN and the subsequent claims to re-determination because the initial is not being handled.

(Dante Thomas): Let me clarify that this particular – anytime you see the 176 or 173 as we mentioned during the opening of the at-call – anytime you see a 176 or 173, CO176 or CO173, those are not re-determinations nor are they re-openings. These are items that should be re-submitted with the corrected Certificate of Medical Necessity and for those – whenever you come across those issues where you are submitting those Certificates of Medical Necessity with the claims, you can contact our customer service department to verify that we did receive the Certificate of Medical Necessity and they can go out and we are able to view the original electronic data as it was transmitted to us and our CSR's are able to verify that.

If for some reason the customer service representative verifies that information and the Certificate of Medical Necessity was not attached to the claim, then that would be a situation where we would refer you back to – currently it's JCEDI and will soon be CEDI.

(Dante Thomas): Yes.

(Ronnie): Can I interrupt here? I'm with (Linel).

(Dante Thomas): OK, what's your name?

(Ronnie): (Ronnie).

(Dante Thomas): OK, (Ronnie).

(Ronnie): I don't think you all are understanding the issue. The issue is when the initial claim is submitted with the CMN, the CMN's are consistently lost or not loaded or they're loaded to a portion of the system where the claims processing can't see them and so we were told that we would have to re-submit those through the re-determination.

(Dante Thomas): OK. I do apologize that that was the information that you were provided. Let me go ahead and just get your telephone number and I'll get some examples of it and perhaps we'll be able to get the names of the people that you spoke with. What's your telephone number?

(Dante Thomas): OK. I will give you a call back and get some examples of those so that we can see what's going on.

(Linel): Outstanding. Thank you so much.

Follow-up: The claim examples provided were not submitted on paper with the DIF and electronic submission is not currently provided by the claim submitter's software vendor so the claims in question were denied correctly; with the exception of one claim approver's error for which education has been provided. As mentioned earlier in this presentation, Please resubmit corrected claims for items with ANSI codes 173 and 176 (CO176 or CO173). It is important to include a narrative with these claims when a new item is billed and a CMN (or bid) that's submitted. For 176 denials, please verify that the correct date on the revision or recertification is also submitted. These issues should not be submitted through Redeterminations or Reopenings, simply resubmit the claim with the appropriate CMN or DIF. The Administrative Simplification Compliance Act (ASCA) requires most suppliers to submit claims electronically, so please ensure that you are in compliance.

(Dante Thomas): OK, and thank you. And I would like to also add to that for everyone else who is on the call. Often times an issue could be that the wrong version of the Certificate of Medical Necessity or the (DIF) is being submitted and those we are unable to load into our system. We do recommend that you go out to the CMS website at www.cms.hhs.gov under forms and to choose the appropriate or the newest version of the CMN and (DIF) to make sure that we are able to accept those if you are submitting your claims on paper or electronically. And with that, we'll go ahead with our next caller.

(Shirley): This is (Shirley) from Texas. I would just like to know why you process the claims that have a deductible taken back before you do the other claims, and even though they may have gone in at the same time for other months.

(Dante Thomas): I'm not sure that I follow your question.

(Shirley): Well, I sent in two claims for one particular person, one for December and one for January of '08 ...

(Dante Thomas): Yes.

(Shirley): ... same day, same time and the one that was the deductible was processed right away and it took the usual, about two weeks, for the second one to be processed. I just want to know what the problem was there.

(Dante Thomas): Chances are what you experienced was the payment floor for the one that was paid. If it was a two week delay in reimbursement – that sounds like if you submitted your claims electronically, we do have a payment floor of 14 days for electronic claims before we're allowed to release the payment and that is a CMS directive.

(Shirley): Well, they can sure take the deductible faster – a whole lot quicker than that so I just wanted to know what the problem was.

(Dante Thomas): If there was no payment on it, it's not ...

(Dante Thomas): So, if there was no payment, it's not subject to the payment floor so that's why it was not held for the payment floor 14 days and you received your remittance sooner.

(Ronda): Hi. My name is Ronda in Louisiana. I was calling because I'm trying to obtain the fee schedule allowables for the wheelchair and wheelchair related items for purchase and used equipment, which would be the NU and the UE modifier, and if I'm able to that on your website? The only allowable that is reflected on the website is for the rental.

(Dante Thomas): OK. And you said for manual wheelchairs. Is that correct?

(Ronda): Wheelchairs in general. An example K0837 – just as an example. But it's all of the wheelchair and wheelchair related items.

(Dante Thomas): Bear with me just a moment. Let us research this a little further.

(Ronda): OK. CMS had put this – put these allowables out in November of 2006 and actually it was November 15, 2006 for an October 1st, 2006 effective date back then. But for 2008, I'm unable to get those fees.

(Dante Thomas): OK, thank you so much for your patience on that.

(Ronda): Yes.

(Dante Thomas): Let me do some further research on that. I do not believe that we post that – those allowed amounts at this time, but I will verify that information with our pricing department just to be sure. I will include the answer to this question in our minutes.

Follow-up: We post the fee schedule as received from CMS for our states. The CMS file does not provide the purchase fees, only the rental fees for the power wheelchairs. Per information in the IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 23, section 60.3, the rental is 10% of the purchase new fee and the used fee is 75% of the purchase new fee. Therefore take the rental and multiply by 10 to get the purchase new fee. Once you have the purchase new fee, multiply it by .75 to get the used fee.

Example: The K0837RR fee schedule amount for the state of AL for January 2008 is \$484.27.

The K0837NU fee would be \$4842.70 ($\484.27×10).

The K0837UE fee would be \$3632.03 ($\$4842.70 \times .75$)

(Marie): Hi. This is (Marie) with Health Field in Georgia. I have – can you hear me?

(Dante Thomas): Yes.

(Marie): OK, great. I have two questions. One is in regards to same and similar denials and us requiring the previous provider pick-up ticket. Prior to Cigna, what occurred was we just continued to receive – let's say the previous provider received two months and we started providing if it was the same procedure/HCPCS code, we or Medicare use to just continue the month's rental instead of requiring a pick-up ticket.

I'm finding that it's difficult sometimes to get pick-up tickets from previous providers and then we're having to submit a re-determination to you all that would cut down on the re-determinations if that procedure as far as requiring the pick-up ticket if there was no – if that was no longer necessary and also it would also decrease the calls to your customer service line because we're having to call and find out the previous provider's name and phone number and – you know – and then call the previous provider for a pick-up ticket and then submitting it to re-determination.

Again, prior to CIGNA, the process was we would receive payment – the new provider would receive payment up to the purchase, the 13 month or back then, the 15 month rental. Is that something that you would all revisit where we wouldn't need the pick-up ticket anymore?

(Dante Thomas): (Marie), OK, to answer your question, as long as you're just continuing to provide the rental item for the remaining months, ...

(Marie): Yes.

(Dante Thomas): ... then it is not necessary. Where we would require that pick-up slip is if you are requesting that we start a new capped rental. If there's been a break in medical need for greater than 60 days ...

(Marie): OK.

(Dante Thomas): ... in that situation, we would require the pick-up slip and, again, this information is not something that has to go through the re-determinations process. This is something that you would simply include on your claim narrative explaining what happened if there is a situation where you are requesting us to start a new capped rental.

(Marie): OK.

(Dante Thomas): But as far as carrying on a rental from the previous supplier, if you – let's say the first supplier provided the first two months and you want to pick up at month three ...

(Marie): Yes.

(Dante Thomas): ... you are allowed to do that and that does not require that you submit that pick-up slip.

(Marie): OK and I understand now. I see why maybe that may be happening because our initial date would have a KH modifier and I guess you all see that and think that it's a – OK, so we would have to change the modifiers?

(Dante Thomas): Exactly.

(Marie): So it's just a – OK, great. And also include that in the narrative that we'd just like to continue the rental?

(Dante Thomas): Yes.

(Marie): OK. And my other quick question is in regards to the re-determination request. I guess I would direct this question to (Samantha) and (Sherry) had that question previous.

Anyway, what I'm asking or what I understand is that let's say I have an oxygen concentrator that denied not medically necessary. I stopped the rental in our system so it's not billing anymore and we're submitting only the denied date to re-determination. It's been approved. Everything's fine. It's paid. We release our held concentrator from our system and now it's dropping. What I'm finding is once it's released, it's transmitting to Medicare and what's happening it's also getting denied for same or for not medically necessary when you all have that initial date and prove that it was medically necessary. Do you understand?

(Dante Thomas): Yes.

(Marie): Basically, what I'm saying is the first initial date was denied. We received and approved redetermination. We released the other dates and the other dates also denying. Shouldn't the information that was sent on that initial redetermination show and prove that it was medically necessary, shouldn't that be in the system when the other dates are transmitted?

(Samantha Coleman): This is (Samantha). That would be correct that if you have an approved redetermination case and you've submitted to redeterminations and we've reviewed it, we would update our files to reload that CMN in and so, any subsequent dates of service that you submitted at that point for initial claims processing should be going through and payment should be allowed at that point. So, do you have some examples of where you have favorable redetermination decisions? And then the subsequent months are payable claims.

(Marie): I'll have to find them. What – I had a customer service person – I had one, not particularly one in my hands right now, we were just speaking on general questions. So I didn't have a particular one. But what the customer service rep was telling me – have told me in the past that I would

have to get a denial for each date and resubmit each date to redetermination. That it's not something that's already in your system, but I'll look out and see what's happening in that case. But I think that's what (Sherry) was – I'm not sure (Sherry) from the other provider, she was asking. It seems like it was similar to my question.

(Samantha Coleman): I think hers was a little different because her claims were actually being submitted while the original ...

(Marie): OK. OK. So she's not holding – because we are actually holding our (rental) until we get a determination back.

(Samantha Coleman): No, you shouldn't experience that at all.

(Marie): OK. Good.

(Samantha Coleman): If you have one or more examples of that, we would recommend you contact customer service with those because they would be able to assist you with that. But that should not happen with your situation. With her scenario, it would happen.

(Yolanda): Yes, my name is (Yolanda). I have a question. Can you tell me how to bill the four liter or more patients that are on oxygen?

(Samantha Coleman): OK. And you're just billing for the concentrator? Does the patient have portable also?

(Yolanda): Yes.

(Dante Thomas): OK. A patient with portable – now, of course, we are not able to reimburse for the portables if they are approved for greater than four liters per minute. We're not going to pay for both. We're going to pay which ever one is higher and generally, that is going to be the concentrator and the modifier that you would append is going to be QF or QG, depending on whether or not they have the portable oxygen. So you would just append that modifier to the claim and that would let us know that you are providing the higher liter flow and make sure, of course, that the physician did complete the certificate of medical necessity to indicate that.

(Yolanda): OK. Now, is there – what amount are you reimbursing on that as far as ...

(Ellen): This is (Ellen) in claims and if the criteria is met, based on the CMN question sets, they have to meet criteria on that greater than five liters. But if criteria is met, the (stationary) is paid at 1.5 times the allowable.

(Yolanda): So it's four or more? Or five or more?

(Ellen): It's greater than four.

(Yolanda): OK. OK. Thank you.

(Samantha Coleman): Thank you. We do have time for one more call. Caller?

(Jerry): Yes, good afternoon. This is (Jerry) from Florida. CMS now allows the use of a physician signature stamp on a CMN. Can the signature and date stamps be used in lieu of the physician entering his or her initials and date when the physician changes information on a CMN?

(Dante Thomas): So you're indicating that the physician has made a change on, say for instance a question on the certificate of medical necessity and they are doing a line through it and then, answering with a different answer. Is that the scenario that you're referring to?

(Jerry): Correct. And of course, the typical manner in which the physician makes that change is the physician would also initial and date beside the entry. And our question is can the physician, instead of initialing and dating it, can the physician use a signature date – a signature and a date stamp?

(Dante Thomas): Actually, the instructions specifically indicate that the physician would initial and date it, so they would have to initial and date. That would not include the stamp.

(Jerry): Thank you.

(Dante Thomas): You're welcome.

(Dante Thomas): Actually, we still have time for another question. We'll go with our next one. Hello?

(Christie): Hello?

(Dante Thomas): Go ahead with your question.

(Christie): Yes, I had a question on the redetermination, reopenings.

(Dante Thomas): I'm sorry. What was your name?

(Christie): (Christie).

(Dante Thomas): OK. (Christie), what's your question?

(Christie): It's kind of like more of a reference to the lady with her redeterminations and reopenings where the initial is denied and she is holding her billing while the redetermination is corrected. Or the reopenings. And my case, we do – I hold the billings so that I won't have to go to redetermination or reopenings with further dates and have to wait all of that time for it.

(Dante Thomas): Exactly and that's the best way to handle those.

(Christie): OK. Well, the – what I send in gets paid – usually gets paid and I drop the billing and then it gets denied. When I contact the customer reps, I am told that the wrong information is put on file and that's why it's getting denied. Like if I send in, let's say, a new initial on the reopenings when we have a break in service and we need send in a new initial, the new initial date could be like 10/14 and then they will put in 10/17 and I'm told that I am having to resend everything to redetermination again with my CMN's again which I kind of find kind of redundant. When I already sent in the information, shouldn't the correct information be put on file?

(Dante Thomas): If you could collect some examples of that ...

(Christie): OK.

(Dante Thomas): OK. We'll go ahead and take that information back and we'll – if you can collect those examples, we'll take a look at them to see exactly what's going on. But no, as long as you're holding your claims, once the redetermination decision is made and it is a positive decision, once you've received your explanation of benefits indicating that it is payable, then you are able to go ahead and submit those remaining claims and they should go through without problems. So we will get in contact with you, (Christie), and thank you so much.

Follow-up- The subsequent claims in question were submitted with incorrect information which was causing the additional denials. As explained in the answer above, redeterminations that are approved and corrected to pay, the subsequent claims should pay as long as they are not submitted while the redetermination is still being considered.

And with that, we are now at the end of our time and we do thank you all for joining us today for our general Cigna government services 'Ask the Contractor' teleconference. Our next ACT call will be a specialty call for new suppliers and it is scheduled for April 10th and we encourage small and new suppliers to join us then. Thank you, again, for your participation and have a great week.

Operator: That concludes today's conference. You may disconnect at this time.

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