

**CIGNA**

**Moderator: Mark Loney  
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1:00 pm CT**

Operator: Good day everyone and welcome to today's Ask the Contractor conference call. Today's conference is being recorded.

And now, it is my pleasure to turn the conference over to Mr. Mark Loney. Please go ahead, sir.

Mark Loney: Good afternoon everybody; welcome to the CIGNA Government Services Ask the Contractor teleconference for DME MAC Jurisdiction C suppliers. My name is Mark Loney as (Chelsea) told everybody there. I'm with Provider Outreach and Education. Thank you for your participation in today's call. It really helps us identify issues that are important and more accurately meet educational needs. Ultimately the overall goal is to reduce claim submission errors.

During today's call, we'll discuss several Medicare updates, cover some of the resources we have available here, and then have plenty of time for questions.

Joining me today are several additional Provider Outreach and Education representatives along with members of our Operations Department, from Medical Review, from Claims, and from Appeals.

Please keep in mind that we are not able to answer questions about individual claim issues. For those specific claim issues, please contact our Provider Contact Center at 866-270-4909. If you need to check claim status, excuse me, you may use our Interactive Voice Response system at 866-238-9650. Our Web site is [www.cignagovernmentservices.com](http://www.cignagovernmentservices.com). On the homepage, please make sure you select the link for Jurisdiction C DME MAC.

We do have several Medicare changes and updates covered today, starting off in an article published June 10 of this year, CGS announced that it would stop corrections for incorrectly billed capped rental modifiers, KH, KI and KJ. We have identified an increase in those billing errors related to the inappropriate use of the capped rental K modifiers during CGS's review of the modifier usage. It was determined that many providers use the same modifier on each monthly billing and rely on CGS to correct those errors.

Effective with claims received on or after August 10, 2009, CGS will no longer provide those corrections and will deny claims that are not billed with the appropriate K modifier with ANSI Reason Code 182, Remark Code N56. When billing a capped rental item or PEN pump, the KH modifier shall only be used for the first month of billing; the KI modifier shall only be used for the second and third months of billing; the KJ shall then be used for the remainder of the capped rental period. CGS does offer an online modifier finder tool which can assist you in determining the correct usage of these modifiers.

If a denial is received due to either the incorrect billing of the K modifier or a missing narrative, correct the information and resubmit the claim. Claims billed with the correct K modifier and denied in error should be referred to Reopenings.

At this point I'm going to go ahead and turn the call over to Adam Hasty, also with Provider Outreach and Education, who's going to provide several updates relating to documentation.

Adam Hasty: Thank you, Mark. I'd like to begin by talking about proof of delivery documentation, specifically to Medicare beneficiaries who are residing in a skilled nursing facility.

In a recent probe conducted on enteral nutrition claims, the priority denial on 111 of 114 claims was non-compliance with proof of delivery regulations. It is important to remember that suppliers are doing business with the Medicare beneficiaries and not the skilled nursing facilities. The results of the probe indicate that suppliers are delivering quantities sufficient to restock the facility supply cabinet and are not documenting medical need and use by specific beneficiaries. Keep in mind that in an audit situation, the supplier must be able to prove that supplies or equipment delivered was actually used by the beneficiary that they were billed for.

Moving on, let's take a moment to clarify documentation guidelines for power mobility devices, specifically the seven-element written order. There has been a lot of discussion about whether or not the order had to be handwritten. We've received clarification from CMS that the order does not have to be handwritten but all elements must be completed by the physician. Suppliers are not allowed to complete any of the elements themselves even if the physician signs the order after the elements are added. Please note that this requirement is specific to power mobility devices.

Additionally, many suppliers have created forms which have not been approved by CMS which they send to physicians to ask them to complete. Even if the physician completes this type of form and puts it in his or her (flow) chart, this supplier generated form is not a substitute for the comprehensive medical record. The medical records including the documentation of the face-to-face evaluation for power mobility equipment should be in the physician's normal charting or note-taking method. Suppliers are encouraged to help educate physicians on the type of information that is needed to document the patient's mobility needs.

Our final documentation item relates to the positive airway pressure device benefit and the use of the Advanced Beneficiary Notice or ABNs. CGS published an article on June 4 of this year updating the PAP supplier frequently asked questions, specifically question number 16. You can find the article in its entirety on our Web site under the Latest News section.

Here's the new question and answer in its entirety. Question 16, would it be considered use of a blanket Advanced Beneficiary Notice to have all new PAP patients sign an ABN at the beginning of therapy, stating that if they do not get face-to-face evaluation or refuse to get the follow-up reexamination by their treating physician between the 31st and 91st day, that Medicare will deny the claim?

The answer to that question is; yes, it would be considered a blanket ABN if the notice was presented at the beginning of therapy. The supplier may, however, after the 60 days following the dispensing of the PAP device, present an ABN to the beneficiary if the supplier has knowledge that the beneficiary has not met the policy criteria for continued coverage. This ABN should advise the beneficiary that if by the 90th day of therapy they do not meet the policy criteria for continued coverage, adherent to therapy and obtain a follow-up evaluation for example, Medicare may deny their subsequent claim or claims and the beneficiary will be liable for payment.

This new guidance regarding a blanket ABN is effective for claims with initial dates of service on or after July 1 of 2009. Advanced Beneficiary Notices executed under the prior instructions contained in the December 2008 frequently asked questions will still be considered valid until the July 1, 2009 effective date of this new instruction.

At this time, I will turn the call back over to Mark Loney.

Mark Loney: Thank you, Adam. First, I want to highlight several resources available to suppliers through CIGNA Government Services.

One of the fairly new services that is being offered is the ability to fax redetermination requests to us. Previously these were only accepted through the mail. The fax number that is dedicated to this workflow is area code 615-782-4630. When you send that to us, please be sure to include the redetermination request form.

On that note, CGS provides the redetermination request form and several forms that make it easier to submit your information. In addition to the redetermination request, there's also a reopenings request and a voluntary over-payment refund form as well, that we encourage you to use. It helps us streamline that – our work here.

There are also several documentation checklists as well as a sample intake form on our Web site. These are all great tools for streamlining your intake and billing processes.

In the unfortunate case of a claim denial, we have a resource for that as well. There are often several choices to make about how to handle that denied claim and the ANSI Denial Guide is the best tool to help make those choices. It will explain the denial reason codes listed on your remit and provide you with a clear avenue for your claim, be it resubmission, reopenings, or the appeals process.

All of these resources available on our Web site, [www.cignagovernmentservices.com](http://www.cignagovernmentservices.com).

Finally, just a simple reminder to double-check claims before their submission. The top request to our Reopenings Department is to add a missing KX modifier. Reducing this workload will allow us to focus resources on other areas and improve efficiency for everybody.

I would like to remind everybody that the CIGNA Government Services Provider Contact Center is closed every Thursday morning from 8:30 to 10:30 am Central Time for customer service representative training. This helps us ensure the most accurate and consistent service to the Jurisdiction C suppliers.

Our Interactive – I'm sorry – our Interactive Voice Response or IVR system now has some extended hours. It's now open from 6:00 am to 8:00 pm Monday through Friday and from 6:00 pm to 4:00 pm on Saturdays. Those times are all Central Time.

The Provider Outreach and Education team here at CGS has been very busy. We've got a full slate of webinars. We're averaging about 25 a month, as well as our face-to-face workshop series that we conduct in cities throughout Jurisdiction C. Next week actually, on June 24, we'll be in Baton Rouge, Louisiana and in July we'll be in both Denver, Colorado and Oklahoma City, Oklahoma.

If you're close to those, we encourage you to come out to them. They're a great opportunity to hear the most up-to-date information about the Medicare program. And probably most importantly, we always leave plenty of time for questions and answers. You can always visit our Web site for the complete schedule and registration information, and the actual registration is on our Web site as well.

All right, this actually completes the update portion. We're going to go ahead and open the lines for questions.

Please keep in mind that we are not able to answer questions about individual claims issues. For those specific claims issues, you can contact our Provider Contact Center at 866-270-4909.

And (Chelsea) will go ahead and take our first question.

Operator: Certainly. And again, ladies and gentlemen, to ask a question, please press star then 1 on your touchtone telephone. Again that is star 1 for questions. You'll hear a tone indicating you've been placed in the queue, then a voice prompt to let you know your line is open.

Caller, please go ahead.

(Louis): Yes, this is (Louis) from Fort Lauderdale. I have a couple of questions regarding the ABN issue and the K modifiers. If we send the ABN after the 60th day because we know the patient has not gone and he basically refuses to sign it and refuses to give the equipment back and tells us to go take a long walk off a short pier, what are our options?

Mark Loney: That's actually a good question, it's something that was brought up to me last week, that there are some states who are I guess controlling those devices under their pharmacy license where you can't just pick the item up, which would have been my first response which is you know there's no requirement as far as Medicare is concerned to keep it in service. But I realize there are those of you that are dealing with pharmacy license requirements to keep it in service, you can't (pick) it up without a doctor's order. You know it's going to be normal business practice for you know collection I guess at that time if they won't sign the ABN.

(Louis): Well, if they don't sign the ABN, they can't bill. So, how is the normal collection practices come into play?

Mark Loney: I mean you'd still bill Medicare ...

(Louis): And get a CO denial which says they can't bill the patient.

(Carol): Mark, this is (Carol).

Mark Loney: Go ahead.

(Carol): Chapter 30 of – hold on just a minute. OK, the Medicare Claims Processing Manual which is Publication 100-4, Chapter 30 is the financial liability chapter in there. And it gives instructions on what to do if the beneficiary refuses. And if you'll hold on just a minute, I knew somebody was going to ask this and I should have pre had it up.

Why don't you take another question and let me look that – you take another question while ...

(Louis): Yes, my second question is on the K modifiers.

Mark Loney: OK.

(Louis): If there has been a break of service or same or similar, even though this is our first month of providing the patient with the equipment, what modifier is Medicare going to be looking for?

Mark Loney: So just to make sure I understand correctly, maybe somebody else has provided it previously for a couple of months.

(Louis): Right.

Mark Loney: We still want to use the modifier that's going to apply to the month's rental that it's going to be. So if somebody else has provided it for 4 months, you'll want to start with KJ even though it's your first month. It's going to be whatever rental month that we are paying.

Does that make sense?

(Louis): Yes, it does.

Mark Loney: OK. I want to introduce (Carol) as well. (Carol) was – jumped in here a moment ago.  
She's a nurse with our Medical Review Department.

(Carol), do you want me to move on or do you have the answer there?

(Carol): I'm still going through it. If you want to move on and by the time you get through the next question, I ought to be able to find it for you.

Mark Loney: OK.

(Carol): Give you the exact citation.

(Louis): Thank you.

Mark Loney: Thank you.

Operator: We'll take our next question.

Sylvia Toscano: Hi, hello. Can you hear me?

Mark Loney: Yes, go ahead.

Sylvia Toscano: Hi. I have a question in reference to ongoing issues that we're having with sending claims to redetermination and then being handled internally by CIGNA as a reopening. We are not getting responses to our redeterminations and they are reappearing on (a grievance) notice as a reopened claim and are being redened. We are having serious problems with having to do

second redetermination requests after we've already done one and having to do a second on the same claim for the same (date of) service.

Mark Loney: We are changing some of those from a redetermination to a reopening internal if the – if it's just a change in information, if it's a clerical error. I don't know if you've got a specific type of appeal that you're sending that's being changed, but yes, we do change them to reopenings if it's been to clerical error.

Sylvia Toscano: The problem is, is those reopenings are denying internally. I believe they're being sent with the intention of them being adjusted and then they're subsequently being denied again and they are – (our) redeterminations are not being processed as a redetermination request. And it's for a multiple – multiple types of claims that this is happening too. And we're trying to do you know we're trying to follow the appeals protocol but we're kind of getting stumped in the process there by not having our redetermination processed as a redetermination.

(John Bergey): Hi, this is (John). I'm with our technical team. And one thing, it may have something to do with how you are – or what you're putting on the request exactly. For instance, if you send us a redetermination request and you put in there, in your reason for request, is for instance, and this may not be your issue, but just for instance, "Please add the KX modifier," well, we're going to treat that as a reopening because that – basically what you're asking is a clerical error or minor omission.

Sylvia Toscano: We are not – sorry. We are not asking for KX modifier because we know those can be handled through telephone review, but we're just sending in normal appeals that need to go to a redetermination for let's say possibly you know there's all different types of reasons, but we are certain in our request for a redetermination.

(Samantha Coleman): And to help you with this – this is (Samantha Coleman), I'm actually the Appeals manager. I definitely would like to get your contact information and get some examples from you.

Sylvia Toscano: I have sent lots of samples already through. I've been waiting over a year for a response on those. So if I could – if you could get my contact information, that would be wonderful.

(Samantha Coleman): That would be fine. But just to help clear it overall, this is not at CGS, this request. The Internet-only manual from CMS, this is a requirement for us, that if there is a redetermination that's been requested and it is considered a clerical error or minor omission, we must handle those as reopenings.

We've really been trying to work through our provider education to help suppliers understand that in those instances it is actually quicker for you to go through the reopening process than to actually go through redetermination. And that does not always mean that whatever the correction is that the provider is requesting, is going to cause payment for that claim. Obviously suppliers would get new appeal rights based on that new (remit) that went out.

But if I could get your contact information, then I can speak with you afterwards and we can see if we can't pull some examples to ensure (indicating) yours are not clerical errors or minor omission.

Sylvia Toscano: Wonderful. Thank you so much.

(Samantha Coleman): Your name?

Sylvia Toscano: Hello?

Mark Loney: Ma'am?

Operator: I'm sorry, caller, go ahead and please press star 3 and I'll open your line once again.

Caller, your line is open.

Sylvia Toscano: Hello.

Mark Loney: Yes?

(Samantha Coleman): Can I get your name and contact number?

Sylvia Toscano: Sure. The contact number is (removed). And my name is Sylvia, S-Y-L-V-I-A, last name T-O-S-C-A-N-O.

(Samantha Coleman): Thank you.

Sylvia Toscano: Thank you.

Operator: We'll move on to our next question. Caller, your line is still open.

(Pam): Hello, my name is (Pam) and I have a question in regards to an appeal decision.

Mark Loney: OK. Is it a – it's a specific appeal decision?

(Pam): We'll keep it more broad.

Mark Loney: OK.

(Pam): We recently received an appeal denial indicating that the physician, it says, "must have an order from the physician for the equipment provided." The records show this physician does not order DME equipment. We've been trying to get more specific information on how to handle you know where this information came from and we're not able to gather information. Is there anyone who could help me on this?

Mark Loney: Yes, there's – actually, unfortunately, several things that could be going on. One of the things we see is, and this, again, it could completely not apply to this specific case, remember, DME items cannot be ordered by a chiropractor, we see that a fair amount. Also, there are physicians who in the course of their practice, especially those physicians that may be in high fraud areas, will tell CMS that they will never prescribe DME because they don't want their NPI being used in any kind of fraudulent manner. So it could be that as well, if somebody has done that.

I'm trying to think about what another case could be. If any of the auditing or review agencies have flagged the physician's NPI, it could be getting that denial as well. So you might want to work with that referring physician to see if they've got an explanation or if they need to double-check to see if that's the issue. But normally that's what we find out, is that if the physician who either based on credentials cannot prescribe DME or has told CMS that they won't.

(Pam): OK, I appreciate it. Thank you.

Mark Loney: OK. Thank you.

(Carol): Mark, this is (Carol). I have the citation.

Mark Loney: OK, go ahead.

(Carol): The citation for dealing with beneficiary who refused to sign an ABN, like I said, it's in CMS Publication 100-4 which you can go to cms.gov and find. And you want to go to Chapter 30 and look in Section 40.3.4.6. And it gives some very detailed information about what to do.

Basically it says that a beneficiary can't properly refuse to sign an ABN and still demand the service. And of course it says that you can refuse to give it, and in this situation you already have it, but it talks about if the beneficiary refuses to sign, what you can do in terms of getting witnesses so that you can document that they refused to sign, and still go ahead and bill for it. So that's what I recommend that people do, is to read that section very carefully.

Mark Loney: OK.

Operator: And caller, your line is open.

Male: Hello?

Mark Loney: Yes, go ahead.

Male: I have a question regarding proof of delivery for the SNF environment.

Mark Loney: OK.

Male: Region C used to have a separate policy for proof of delivery to nursing homes. And again, those nursing home specific. When shipping supplies for long-term care, we send additional supplies in case of late night weekend admissions. The date on our claims is the date the nursing home delivers the supplies from our inventory onsite in the central supply closet to the beneficiary. The delivery date to the nursing home is not the date the resident receives the supplies. Can you help

us understand what is required for the POD in the SNF environment, maybe clarify a little bit more on that?

Mark Loney: What the – the separate policy, and you're saying that – is that something that you're reading now?

Male: Yes, this is just kind of general confusion on our part.

Mark Loney: OK.

Male: Like it says, for a shipping service, if we use a shipping service, you must use the shipping date as the date of service on the claim.

Mark Loney: Right.

Male: Even though, like we – it may actually get to the nursing facility like a week or 2 before the resident even needs to be using that product.

Mark Loney: And I guess I would answer that with the same could be true if you were shipping it to somebody's house.

Male: We have 1700 facilities and if we were to do it all within – I believe we have a 5-day window – then we would have to make 1700 orders for 20,000-plus residents and nursing homes within 5 days of every month. And our shipping service wouldn't be able to handle it.

Mark Loney: So right now you're shipping all of your items at the same time?

Male: It's staggered. No, it's staggered throughout the month.

Mark Loney: Well, it should continue to be staggered if you're doing it you know it would still be the date of delivery. There's – I guess I'm somewhat confused because there's not a separate policy for delivery to nursing home. The requirements are pretty much the same. In Medicare's mind or in CMS's mind, you're doing business with the beneficiary, not with the nursing home. And I realize, in your day-to-day practice, it probably doesn't fall out that way because you talk to somebody at the nursing home and then you may not talk directly to the beneficiary, but you're still doing – doing business with the beneficiary and the proof of delivery requirements are saying that you had to prove that the items that were shipped for that beneficiary were used by that beneficiary and not put in the central supply closet and given out to whomever.

Male: All of the nursing homes we provide for across the nation receive supplies, put it in a central supply closet, and then on a daily basis they get their supplies and administer to the residents.

Mark Loney: Right. And in an audit situation, you would need to be able to work with those skilled nursing facilities for the records that show that the quantity that you were shipping for that patient was being used by that patient. I realize, in the real world, they're going into a closet and being taken out when they're needed, but the inventory control at the nursing home needs to be sufficient enough to prove that the beneficiary is using the quantities shipped.

Male: OK. And then I guess the other piece, you'd clarified that, I guess the other piece is, it says you must use the shipping date as the date of service on the claim.

Mark Loney: Right.

Male: So if we ship product on the 15th of the month for a resident that would begin using that product on the 1st of the next month, obviously you know those two don't match up, but we have to have the product there ahead of time.

Mark Loney: I believe policy dictates that you can contact the beneficiary 7 days prior to their existing supply running out and then you can ship it 5 days prior to when their existing supply is supposed to run out.

Male: OK, yes. And so that ((inaudible)) we got to get everything delivered across the nation within you know 5 to 7-day period at the end of each month for a ...

Mark Loney: I thought ...

Male: ... for a claims basis, for claims date of service to be you know June 1 through June 30.

Mark Loney: Right, but your deliveries are ...

Male: And deliver it on the 15th of the month, it has to be all squeezed in at the end.

Mark Loney: No, not at all because ...

Male: The next month of service.

Mark Loney: ... somebody beginning, there's the need for supply on everyday of the month.

Male: OK, so then the claims service – so the claims date would then have to be staggered also? So if their claims – if the claim date was the 15th, we could have it there on the 10th. And if our claim date went from the 15th of the month to the 15th of the next month, then we can get into that staggered rotation and that would be legitimate?

Mark Loney: Sure, we have beneficiaries who you ship on the 3rd and then you ship on the 4th and then you ship on the 5th.

Male: Got you.

Mark Loney: You know it's all – there's not a dictation at all that you have to ship on the 1st and the 15th of every month.

Male: Yes, or claims don't have to be from the 1st to the 30th.

Mark Loney: No, not at all.

Male: From the 16th to 16th, 17th to the 17th.

Mark Loney: Not at all.

Male: So I got a good idea then of how we need to change our business process to match the claim dates with delivery dates.

Mark Loney: OK.

Male: Thanks a lot.

Mark Loney: Thank you.

(Kyle): Yes, my name is (Kyle); I'm calling from South Carolina. I have a general question regarding mail-order diabetes. And I know that's not really the topic of discussion, but it is a documentation requirement question.

Mark Loney: Sure.

(Kyle): We have several customers that receive diabetes testing supplies from our company that are non-insulin dependent as well as insulin dependent. And of course we're aware of the guidelines that you know a non-insulin requiring person with diabetes can test one time a day without requiring additional documentation as well as someone who's insulin treated is allowed to test up to three times a day without additional documentation.

The problem we're running into is, what is exactly required to be in the supplier's file to be able to ship over the amount when a physician is ordering it? We do have a physician's order and are doing our best to get the blood – 30-day blood sugar logs, but we're just kind of a little bit concerned about what requirements the supplier must keep in their files in order to provide I guess the necessary supplies for them to test according to what the doctor wants them to test.

Mark Loney: OK. That's actually a very good question.

On a very base technical level, you're not required to keep anything in your files. Policy dictates that you have to be able to produce it if we or one of the other auditing agencies request it. So if you have a good enough working relationship with a physician's office that you know you can get the documentation from them very quickly and completely, that's fine, you don't actually keep it in your files.

However, let me move past that and say that that's probably not going to happen most of the time. You're going to want to get – what we're looking for is kind of a complete medical record, not simply a form that's filled out, not simply the order that says "Test more than this." We're looking for the reason for the testing. And then also we're looking for proof, usually from the beneficiary side that that testing is actually being performed.

(Carol), if you want to add anything specific that I've forgotten, go ahead and jump in.

I also want to remind everybody that that documentation needs to be within 6 months of your claim date. It can't be a couple of years old.

(Carol): We have quite a few resources on our Web site regarding glucose supplies that if you haven't checked out, you might want to do that. If you go to the CIGNA Government Services Web site and go to the DME tab and then on the far right-hand column there is a link to Medical Review Documents, and when you get there, there is a little box, Glucose Resources or one of them.

One of the things that you might want to look at is we have a documentation checklist that you can use for each patient that goes into the pieces of documentation that you need to have in the file as well as the – what medical records – you know we recommend that you get the medical records up front, that it's your choice of whether to keep the medical records in your file or not, but you know it's a whole lot easier to get them up front than it is to try to get them when (CERT) pulls a claim for an audit or we pull a claim or someone, that it goes into all that.

We also have letters that Dr. Hoover has written for you to give to the supply – to give to the physicians that you work with that explain the kind of information we need to have in their record. And so I would encourage anyone that hasn't checked those resources out and you billed diabetic claims to do that.

(Kyle): OK. One other quick question: If we had the copy of the 30-day blood sugar log straight from the beneficiary where we mail it with their order and they fill out and send it back to us, is – and we have the physician's order on file with a brief narrative statement from the physician of why, would you say that would be enough or ...

(Carol): No.

(Kyle): No.

(Carol): No, we have to – no, we have to have actual medical (records) to approve supplies above the normal allowances. They have to have been seen by the physician ...

(Kyle): OK.

(Carol): ... within 6 months prior to the initial order.

(Kyle): OK.

(Carol): And we have to have medical records that explain that you know why you know not just confirm that the doctor has ordered it, but the rationale for it you know needs to be on the medical record, either you know in the narrative, in lab reports, things like that, and then what you need in order – once the initial confirmation is given, then you know what you have to have on a 6-month basis is either a log or something from the physicians stating that the patient is continuing to test that that – you know you have to have verification that they're still testing (that frequency).

(Kyle): OK. So if we get the records up front one time, then we just have to have every 6 months the physician to I guess give us a reason why the patient needs to test that many times per day?

(Carol): Or the log. I mean ...

(Kyle): Or the log.

(Carol): And let me clarify ...

(Kyle): OK.

(Carol): ... that that's what the policy says. Things are getting much stricter. (CERT) has started judging things much stricter. And because our job is to decrease the (CERT) error rate, we are having to judge things more strictly. So really watch in the next few months for notifications that some policies may have changed in terms of documentation and the frequency.

For example, there's several – I mean like oxygen for example you know someone may have been on oxygen for years. But if (CERT) pulls a claim, sometimes you're denying them because you're getting medical records you know for maybe like just a few months back, and the doctor may not specifically say anything about the oxygen used in there because it's been something that's gone on for so long, and they're denying claims for that. And so we're trying to get clarification from CMS on how strict do you want us to be and everything, and you know things are looking like that they're really wanting some strict interpretation. So you know right now we're sticking to what's in the policy, but those things may change, so watch out for it.

(Kyle): OK. And is it – some of our physicians are, just like the gentleman said earlier you know hard enough to get a physician's order signed, but they're wanting the – their patient to come in to schedule an appointment so that they can give this information before us requesting it over a fax or requesting it to be mailed. We're trying to work with a physician but a lot of times the physician is asking that customer or their patient to come in for an office visit even if it's been within 6 months that they've seen the patient. Is that, I mean?

Mark Loney: And that's fine. That's up to the physician, before they send you the documentation, if they want to do that.

(Kyle): OK.

Mark Loney: You know they've got their own treatment and billing guidelines as well.

(Kyle): OK.

Mark Loney: I know that may increase the time it takes to get a hold of the documentation you need, but that – if they're going to sign something and provide you with something, that's something they certainly can do.

(Kyle): OK. All right. Well, thanks for taking the call.

Mark Loney: Thank you.

Female: Hi, I just had one question.

Mark Loney: Sure.

Female: Regarding the PAP question on the ABNs, what if we're having a problem getting a certain documentation from the physician in the beginning, like in the policy or in the book it says that we have to have certain criteria like the neck circumference, the BMI, and the upper airway, but the doctor is not giving us like certain pieces of that information and we put in ABN saying insufficient documentation from the physician. Now, is that OK or is – it's still considered blanketing? Because the doctor says he has it there but he doesn't need to sign it over to us.

Mark Loney: So the physician is saying that all that documentation exists but they're not actually going to provide it to you?

Female: Correct. He says that they have it on record and then if we need it for audit – because I always tell them, "Well, what if I get audited, I need it in my records." And they're like, "Well, if you need it, then, and you get audited, then come to us." That's what they would tell me, I mean doctors.

Mark Loney: It's probably not going to be considered a blanket ABN because it is really situational specific, but I'm not sure it's a good reason, a valid reason to execute an ABN. We've got some resources about the physician documentation letter that's out there on what their responsibilities are, but that's – that doesn't seem to me, if the documentation supposedly exists and they do qualify and the need for the sleep study was there on that initial face-to-face, just because a physician's office doesn't want to hand that over, prove it to you, it's not going to be a valid reason to execute an ABN. While it wouldn't be a blanket ABN because you're not doing it for every patient ...

Female: Correct.

Mark Loney: ... it's not going to be a valid reason to execute an ABN.

Female: OK.

Mark Loney: I understand you certainly want to protect yourself. If the item has not been dispensed ...

Female: Yes.

Mark Loney: ... you know that's where you make that business decision. And it varies from state to state, like I mentioned earlier, whether you can pick it up or whether it has to be left in service until a doctor's order to pick it up. But it's where the business decision comes into play, if it hasn't been dispensed, then you (just find a) physician that you can't work with that way.

Female: OK. Item – I'm sorry, just one more question.

Mark Loney: Sure.

Female: Under the LCD for the PAPs, it doesn't specifically say under the LCD what we need in the thing. It came up in an article somewhere that what exactly we need may want it from the actual Medicare guidelines. Where could I find that in the guidelines, stating that we do need that criteria?

Mark Loney: OK, bear with me here just a moment. We're kind of shaking our heads around the table. I thought the LCD kind of stated some of those ...

Female: It says that it needs to ...

Mark Loney: ... scale and things like that.

Female: Yes.

Mark Loney: ... the reason for ordering a sleep test.

Female: Yes.

Mark Loney: What should be done at the initial face-to-face?

Female: Well, that's what I – I try to explain it through some of these ((inaudible)) ...

Mark Loney: Yes.

Female: ... over here, we really do. They say, "Don't come to me about it, I'm tired of hearing it," and it's just horrible. But what – because what I read was you know like in the LCD, I saw the criteria for the ((inaudible)).

Mark Loney: Correct.

Female: But I can't find, unless I'm missing it somewhere, in the LCD, I can't find where you need the face – not the face-to-face, the BMI, the neck circumference and the upper airway, I can't find it, unless I'm missing it in there and I'm overlooking it, I cannot find it.

Mark Loney: OK, I you know I apologize, I don't have – I'm not sitting in front of a computer to look it up either. But I believe all that's stated in either the LCD or the policy article, more likely the LCD I would think. We can take a look at it and maybe give an update here a little later in the call, but, yes, I know it's listed in several of the FAQ questions, but we'll take a look and see if that's listed in the LCD as well, where it gives that bullet list of points of you know not that every last one of it is required on each patient, but things that should be done prior to (setting) for a sleep study.

Female: OK.

Mark Loney: OK? Thank you.

Female: All right. Thank you.

Female: Hi. We have a question about some denials that we're receiving for oxygen equipment. After checking the IVR, we assume that our patient has not reached the 36-month of rental and we submit a claim. And we're getting CO-96 denials for non-covered. Is that your designation that the equipment has been capped?

Mark Loney: Bear with me here just a moment, the technical folks are discussing. You said CO-96, correct?

Female: Correct.

Mark Loney: And when you check the IVR, you're checking the IVR for CMN status?

Female: Right.

Mark Loney: You know again we're looking back and forth here a little bit. Do you have the message for CO-96, do you have an example in front of you? Because I don't think that's a capped more than a, like maybe a CMN or medical necessity issue.

Female: OK. We have a CMN that we've gotten paid for the initial of 1 month but then the second month that we're billing is just denied.

Mark Loney: With the CO-96?

Female: Correct.

Mark Loney: That could be – what is the – do you have an example there, a (remit) or something in front of you?

Female: I do not.

Mark Loney: OK. We've got somebody that's going to look at that as well. It could be a variety of reasons. If it is a medical necessity, if on the CMN, it could be length of (need) or something to

do with (date). It doesn't – that doesn't seem like a capped issue. CO-96, I don't believe, is going to be relating to something capping out.

Female: OK. And what would be the reason – what would your denial code be? Is there a specific code for it not – for it capping out?

(John Berger): Hi, this is (John Bergey) on our technical team again. I don't remember off the top of my head which code that is. We can find out and put it in the minutes.

Female: CO-96 is non-covered.

(John Bergey): And do you know what the actual ANSI message? You said you don't have that in front of you, what the actual message is, (the CMN) can mean more than one thing depending on the type of message you're getting on there potentially.

Female: There's more than one definition for that code?

(John Bergey): Well, it could have a separate message along with the – it could – I'm sorry, separate remark.

Female: ... remark.

(John Bergey): The CO – we just had somebody come back in – the CO-96 is non-covered based on the LCD. It's a medical necessity issue and not a capped out or you know a billing issue like that.

If you've got several examples, probably, honestly, the best thing to do is call the customer service line and let them look at those specific examples. They can look at the CMN as they were submitted and really have – excuse me – an answer in great detail to those claims.

Female: Well, it just doesn't make sense because we had gotten paid 1 month ...

(John Bergey): Right.

Female: ... and then we submit it the next month and it denied for that reason.

(John Bergey): Right. And I hate to even guess at an answer with the sheer number of things that could make that happen on an oxygen CMN or an oxygen claim. But it's not – it does not have to deal with the cap, it's a medical necessity issue.

Female: OK.

(John Bergey): OK?

Female: Thank you.

(John Bergey): Thank you.

Female: Hello?

Mark Loney: Yes, go ahead.

Female: I was just wanting to find out, on – earlier when they were talking about the ABN, she said that we could find it under the CMS Publications 100-4, I didn't get everything and I was wondering if I could get the rest of that.

Mark Loney: Sure. It's on CMS's Web site, not ours. So it's cms.hhs.gov, and you're looking for the CMS Manual System, our Internet – IOM, Internet-only manuals, and there's a whole list of them, 100-1, 100-2, and I believe she was in 100-4. (Carol), if you're still there, what – past that I don't remember.

(Carol): It's Chapter 30 which is the liability chapter. And then I think it's in Section 40.3.6.1, something like that.

Mark Loney: OK.

(Carol): If you look in the table of contents for Chapter 30, what you're looking for is Dealing with Beneficiaries Refusing to Sign ABNs.

Female: OK.

Mark Loney: So it's Manual 100-4, Chapter 30.

(Carol): Right. And then I think it's Section 40.3.6.1.

Mark Loney: I'm going to apologize up front; each one of those manuals is hundreds of pages long.

Female: OK. Also, I also had one of those CO-96 denials ...

Mark Loney: Yes.

Female: ... that that girl was talking about, and it was for elevating ((inaudible)) that they had paid on all of the claims prior and then all of a sudden it's getting denied with that CO-96. I don't know if it's something that is an error for ((inaudible)).

Mark Loney: Yes. Without taking a look at it, I really have no way to even speculate. The best resource is to look at that claim specifically with our customer service people. There can just be a variety of things that can cause that. I won't rule out an error but there can be a wide, wide variety of things that cause that to happen.

Female: OK.

Mark Loney: OK?

Female: OK.

Mark Loney: Thank you.

Female: Thank you.

Operator: And as a reminder to our audience, it is star 1 if you would like to ask a question.

(Deborah): Hello?

Mark Loney: Yes, go ahead.

(Deborah): This is (Deborah) in Nashville. I have a couple of questions; this is regarding the proof of delivery for the skilled nursing facility.

Mark Loney: OK.

(Deborah): We shipped in generally speaking a bulk shipment for products for numerous residents there, and as the gentleman stated earlier, they would you know go to a central supply closet, but what we would do is I think we took it a step further than that, is we don't bill until the month after the resident actually uses it, so we weren't you know only billing on proof of delivery, we were billing on actual usage. Because of that, we wanted to make sure we got a full picture of hospital days, any kind of, if they went hospice, if they expired or whatnot, because we wanted to bill appropriately.

I have been told since then that when we deliver it, we should bill for the whole thing and regardless you know it's up to the family of the resident what to do with that leftover formula or whatever, and I can understand that. But if I do that and the beneficiary happens to have any hospital days or they expire, my whole claim gets denied. So if I know that information on the front end, I can bill appropriately and omit the days that they've been in the hospital or whatnot.

Does that make sense?

Mark Loney: It makes sense, it sounds logical, but unfortunately it's not supported by policy.

(Deborah): OK.

Mark Loney: You know the date of shipment, the date of delivery, if you're actually delivering it by company vehicle or something like that, is going to be the date of the claim. When you actually send that claim to us is up to you, but the date on the claim is to be that delivery date. So you shouldn't you know you can't really back-date claims like that for supplies that were delivered, but it needs to be – the date of service needs to be when it was shipped or when it was delivered.

(Deborah): Right.

Mark Loney: I realize that it's tough and with the increasing documentation requirements, it's tough when somebody is in a SNF and you're trying to prove you know we know that it's headed to a supply cost, to sit somewhere before you know somebody takes it down to the patient's room to dispense to them, we just have to be able to see proof that what was shipped for that patient, the quantity shipped for that patient was used for that patient.

Yes, hospital days and hospice and all that kind of stuff can get in the way as well, it's just part of, I guess, part of the dealing with the – dealing with the Medicare program. But the date that it was delivered, the date it was shipped needs to be the date of service on the claim.

(Deborah): OK. And what if for instance a bill for let's say something we shipped the 15th and I billed 15th as 14th or the 15th as 15th because it's ((inaudible)). And what if during that period of time they did expire?

Mark Loney: If the patient passes away in the middle of ...

(Deborah): Of that 30-day period.

Mark Loney: It could be that the – depending on when the date of death was and when the claim was filed and all that, it could be that the claim will deny. Now, through the appeals process, I believe, and somebody can stop me if I'm wrong in the room here, that the portion or the number that would apply to the days after your delivery date or your billing date that the patient was alive is still payable. And I didn't get stopped, so that's correct.

(Deborah): Well, and that was my huge – my other issue, was that I was noticing that, that the whole claim was getting denied just because the date of death is somewhere within that 30 days which – so now you're telling me that if that does happen, that automatically do need to send it to redetermination and re-bill for the days prior to ...

Mark Loney: Yes. The tech folks are actually saying it shouldn't deny the whole claim if the date of death is after your billing date.

(Deborah): I have several ...

Mark Loney: OK. Well, definitely send those through the appeals process. It does happen there, with the system being fairly automated, it could be that some – that's happening to some. But that is – if you've got examples like that, actually I'm getting those here in real-time, you can call one of our customer service reps ...

(Deborah): OK.

Mark Loney: ... and they can process an adjustment there without having to go through the appeals process, it'll be a lot shorter.

(Deborah): OK. Also, the same thing is happening to me in regards to SNF days. If – sometimes we don't always know about SNF days at the time of billing. And then the claim may get paid and then months down the road you know Medicare will send us the recoupment letter saying that they were you know SNF. But what happens is the whole claim gets recouped and not just specific days. So my question on that is, do we refund the whole thing and then send it to redetermination for the days that they were not SNF?

Mark Loney: Yes, that's correct.

(Deborah): OK. And how is it that nursing home facilities and Medicare are not on the same page as far as SNF days or Part B days?

Mark Loney: Yes. That is – I realize that's a huge issue as well. The SNFs are billing a different carrier.

I know it happens with home health as well, and in that case the home health is billing in arrears, if you will, they're billing for something that's already happened, so it's really got – it depends on how quickly the SNF gets that in, how soon it gets in. We have thousands of claims each month where the SNF data comes to us after the claim has been paid and we have to go through that recoupment process and then through the appeals process.

(Deborah): Right, OK. My last question is, we're having a huge issue with the physician's orders that we are getting for these enteral services. The physician will sign them but nine times out of ten, they don't, even though there's a date on the order that you know that it takes effect, there's also a nurse's signature with the – and the nurse will date it, the physician will sign it but the physician don't date it. We're – are we having to go back and get you know I mean, what do we do in that case?

Mark Loney: Yes, it's something you'll probably have to send back and ask them to date it.

(Deborah): The physician?

Mark Loney: The order has to be signed and dated.

(Deborah): OK. So the physician has to go back and date that?

Mark Loney: Yes, yes.

(Deborah): OK.

Mark Loney: OK?

(Deborah): All right, thank you very much.

Mark Loney: Thank you.

Female: Hello?

Mark Loney: Yes, go ahead.

Female: This question may have already been asked, but regarding the diabetic supplies that we file appeals on, medical policy states that suppliers can provide either testing logs or physician notes in order to provide the necessary documentation to support the claim. And whenever we supply testing logs, we're told that that's not sufficient. Is that supposed to be the case? Because medical policy states that it should be fine.

Mark Loney: OK. And let me ask – and, (Carol), you can jump in too if you want to. If you're getting just the logs from the beneficiary, there's nothing that the physician is taking a look at, yes, my guess is you're probably going to get denials. If the logs are going back through the physician and being signed off on by the physician, I think it will suffice as a medical record then. But just the logs from the beneficiary without any physician involvement is probably not going to support the claim.

Female: OK, so a testing log with a written order that's updated every 6 months is not going to be sufficient as long as the patient is testing within the guidelines that the physician actually ordered?

(Carol): This is (Carol). I think that there's probably a couple of different situations, but let's say that medical review has done a supplier specific review of your claim and found that you've got a high error rate and we put you on a prepayment review, what we're going to look for is you know we're

looking at you historically, so the first month that we look at, at a specific beneficiary's claim, we may look at the medical information and look at the orders and everything and say, "Yes you know they qualify for diabetic supplies," or we may say, "Yes, that qualifies for extra." Well you know you've got one nurse looking at something and you send in for the next month, and in that situation, we've already determined medical necessity, so you know we may be just looking for delivery information and things like that for updates.

But if you've got a situation where either us or CERT or one of the other contractors is just looking at one claim in time, there's no history, so even if you're looking at something a year after the doctor first put them on either testing or testing for excess amount, then you've got to show first of all that day initially did qualify, so in that situation you're going to have to have the medical record for you know the initial start so that somebody can see – or else, current records. I mean you know the first time somebody looks at a claim for that beneficiary for those supplies, you've got to have actual medical records that show that they qualify. And then from that point on, if someone keeps on looking at it you know maybe you only have to have the testing logs and things like that, but medical records have got to be there if it's just one claim or if it's the initial claim.

Female: OK, but the reason I'm questioning it is that medical policy clearly states that you only have to provide either the testing logs or the medical records. You don't have to provide both, but yet ...

(Carol): No, for continued coverage, what you have to have every 6 months is either verification that the doctor – from the doctor that the beneficiary is testing and testing at that frequency or you've got to have a log. For initial coverage, you've got to have actual medical records, I mean that's – that's for anything, to initially show that they qualify, you've got to have actual medical records.

Female: OK. What exactly are you looking for in the medical records? Are you just wanting like several days where they had appointments and then follow it up with the physician addressing the ...

(Carol): Well, it depends. If you're just – like if you're just asking for normal allowances, if you've got someone that's not taking insulin and they're just testing once a day, we've got someone that's on insulin and they're testing three times a day, basically all that we need is verification in the progress note that the patient is a diabetic, that that doctor is treating them. And so I mean you know you look to see, is the diagnosis there you know do we see information to show you know medications and things like that? Just some indication that the patient is actually a diabetic.

Now if you're asking for supplies above the normal allowances, then you've got to have information that shows the reason for that. And you know and sometimes that's going to be maybe visits over several months to see that the doctor has tried various things and to see what's going on with the plan of care. And sometimes it may be a dramatic event. So to say you know there's got to be a number of dates versus one, it just you know that is an individual consideration in terms of whether it's going to be covered or not, so it's an individual situation in terms of what you would need. But I mean basically what we're looking for is, first of all, verification that the doctor has determined that the patient needs to test that often.

And secondly, the reason why. For example, maybe you know they put them on steroids or maybe they're getting – I know in my personal case, my mother was on sliding scale for a while, insulin, so she had to – she was taking injections up to four times a day, so the rationale was that she had a test before each injection so that based on what the result was she knew how much insulin to take. So you know based on the situation, does everything fall into place? You know what – you know basically, what is the doctor doing with that information? And I'm not just making somebody (click) their finger and write it down on a piece of paper, but what are they doing in terms of adjusting the medicines or the diet or the exercise or the whole treatment program?

Female: OK. Just to make sure I did understand you correctly, so on an initial fill then, physician notes might (possibly) need to be provided but on subsequent fills, refills, that type of thing, then testing logs would be sufficient for that type of case?

(Carol): Well, if someone is looking at a number of your claims, but like I say, if you – if like you get a letter from CERT and they have pulled a claim, even if it's 2 years down the line, you've got to show something – you know they're going to expect actual medical records, not just the testing log from the period that the claim covers, but they're going to want medical records to show what's being done with that. So what I'm saying is that if people are looking at your claims continuously, you don't have to keep on showing medical records once the medical necessity has been done. But if you're just looking at one isolated claim, then you're always going to have to show medical records.

Female: OK. And I also have another question; it's in regards to the article that was released regarding beneficiary-owned equipment.

Mark Loney: OK.

Female: There's been some discussion, at least we've contacted customer service reps, (that's your) standard CSR lines, and tried to get some clarification. For diabetic supplies, they are technically used with a monitor. Is the monitor going to be considered equipment where you're requiring the narrative on every diabetic supply that's billed that states what the monitor information is?

Mark Loney: Yes, I want to clarify one thing. This is only going to be in situations where Medicare did not pay for the monitor. If it was purchased by Medicare, we've got it on file, there's not any need for that. But yes, you're correct, technically that is the base equipment that those suppliers are used with. So if a Medicare beneficiary or somebody coming to Medicare for the first time, they already own the monitor, they're going to keep using that old one, and you're going to provide supplies for

it, you would need to bill it the way described there in the article because it's beneficiary-owned equipment that a fee-for-service Medicare doesn't know anything about yet.

Female: OK. Would that narrative be required on every claim or is it only required on the first claim?

Mark Loney: Just on the first one, and that's true for all items coming with beneficiary-owned equipment.

We just want it on the first one with the narrative and the modifier.

Female: OK, that's all I need.

Mark Loney: OK.

Female: Thank you.

Mark Loney: Thank you.

Male: Yes, thank you for taking my call again. I have a question regarding proof of delivery to a patient's home using, for instance, UPS service. What exactly is required? Presently we're using delivery documents and notating the UPS tracking number and then getting a proof that it was delivered to the home. Is that sufficient?

Mark Loney: That's – yes, that sounds exactly what were asking for. If you're using a common carrier like that, UPS I believe, it's got like an account within – they've got that (Quantum view thing) so you know when it was delivered and probably who signed for it if there's a signature requirement. So, a printout of that, or even if you have the ability to access it down the road and print it out, if you've got those online records, that's perfect.

Male: OK. Second question, when a piece of equipment goes beyond the 13th month and title transfers to the patient and then sometime down the road occasionally we get calls that the, from a family member, that the patient is deceased and they want that equipment out of the home, and even after we inform them, that they own the equipment and they can do whatever they want with it, they tell us, "We just want it out of the home," are we allowed to pick it up?

Mark Loney: Yes, I don't – I realize, if the title has transferred and Medicare decides the beneficiary owns it. But if the patient's deceased, the family doesn't want it and doesn't want to put it on Craigslist or something, yes, Medicare is not going to have any reason to stand in the way of that.

Male: Yes, it's almost a service to them.

Mark Loney: Right.

Male: OK. And my last question, regarding signatures on medical documentation, I see that we're allowed to accept an electronic-dated signature if it is faxed to us with a date and time stamp and the name of the doctor's office. Is this considered an electronic date?

Mark Loney: I'm not – let me make sure I understand the question. For the requirement where you have to prove when it came to your office?

Male: No, it's doctor signing the CMN.

Mark Loney: Right.

Male: And electronic dates are acceptable.

Mark Loney: Yes, if there's an electronic CMN, we take those. If the doctor signing it, there's also a date field that needs to be filled out. So if the physician signs it and leaves the date field blank, no, you wouldn't be able to use the date and time that prints on the top of your fax output. If it's a pen and ink paper document CMN that's being filled out, the date field needs to be filled out.

The electronically-maintained is where the actual CMN is completed electronically by the physician and transmitted to you, so there's never a paper version of it.

Male: OK. Thank you.

Mark Loney: OK.

Female: Hello?

Mark Loney: Yes, go ahead.

Female: Yes. I heard earlier at the beginning of the call a question or actually a statement about the KX modifier in the context of telephone reopenings. And I just didn't get that full instruction and I was wondering if you could tell me whether or not there are any changes to how providers are allowed to add the KX modifier if it's inadvertently left off of a claim.

Mark Loney: I think – you're talking about the beginning where we were just talking for a little while?

Female: Yes, my main question is, can they still go through the telephone reopenings process to add the KX modifier?

Mark Loney: It is. Actually the reminder was to try and do your best to remember that on initial claim submission because that's our reopening department's biggest workload, so there was not a

change in the instructions. The best way to take care of it is still to do a telephone reopening.

But it was just a reminder to try to do that because it is their, by far, their largest workload.

Female: And also with the capped rental modifiers, the KH, KI, and KJ, can those go through telephone reopenings as well? Or does that need to be in writing?

Mark Loney: Right now it can be done through reopenings and that will also be true in the future, it will – it would be considered a clerical error. However, the way they're going to deny come August 10 I believe when it goes live will actually just have resubmission rights. So you can change it and re-bill it and it will be fine. That will actually be the quickest. Resubmission is always the quickest. So right now if there's one that you need changed, that's fine; but once it goes with a new requirement on August 10, the easiest thing to do is just to re-bill it.

Female: Just to do resubmit instead of going through the reopening process?

Mark Loney: Yes. If you put the KH on there and you get that denial, once you find out the proper modifier, would just need to resubmit it.

Female: All right, thank you so much.

Female: Hi. I had a little bit of a follow-up question about the ABN on the PAP patients. The commentary that you had made was that you felt like it probably would not be appropriate to give the patient an ABN at the beginning of care if the initial face-to-face and documents from the physician's file were not available to you. First off, it's near impossible to get those records, it doesn't matter if you get them up front or you try to get them 2 years later, and the likelihood that they will be there at the – in the event of a (CERT) is slim to none honestly, speaking from experience.

My – the reason that I asked the question again about the ABN and utilizing the reason of appropriate documentation not on file is because if you look at the CIGNA published document, the documentation checklist and it's titled Required Documentation in the Supplier's File, it does specify that the treating physician's records of the face-to-face evaluation performed prior to the sleep test, that that does have to be in the supplier's file. So, do you still think that it wouldn't be appropriate to ask for the ABN based on that reason?

Mark Loney: Well, and I want to – let's talk about the ABN for just a moment. The ABN is for medical necessity reasons, the reasons about why you think it's not going to be allowed by policy. I guess I realize, because we get this a ton and I can't empathize with you because I'm not in the business of selling medical equipment, but I can understand that the – what we were – what we want, what we require and what the physicians routinely do and give to you, there might be a gap there and that's the struggle for a lot of suppliers, but the documentation simply not being available is not really a reason for you know an ABN. It's not a valid reason for an ABN. So if ...

Female: Even though we actually don't have any way to know that that documentation happened, that the patient did indeed even see the physician, they could have called them on the phone, or that it was done prior to the time of the sleep test. If we can actually know that, can we legitimately put the KX modifier on?

Mark Loney: No, I would guess not. It's – I know we talked about the policy does not actually require you to have a lot of documentation, you just need to be able to access it, but we also I think kind of put that in there with the disclaimer of it you know to operate properly, you're probably going to want to have that documentation and be – and look at it and you're the one that's the policy expert, not the physicians a lot of times.

So I'm going to go back and say that this is a business decision. I hate to do this because we're all you know we're probably all hopefully in the business to serve the beneficiaries the best, but

this is a business decision where if you just simply have a physician that won't or doesn't have a documentation or won't provide it at that point, I don't know that it's you know good to move forward because in an audit situation, without all of that, they're going to take it back. And if you have one claim that they find without all of that, there's a real good chance they're going to look for a bunch more.

Female: And Dr. Hoover's letter, while it was very, very helpful, do you think we could talk Dr. Hoover into writing a letter to the physicians that says very simply, "Look, guys, play ball. Give the guys what they need." Because it really is difficult and experience does tell us that on (CERT) audit, on post-payment audit, on any number of times that you have to produce this information, that it is not in the physician's file or they can't find it ...

Mark Loney: Right.

Female: ... or no, it actually didn't say what they thought it did.

Mark Loney: Right.

Female: And one thing that actually is helpful is this documentation checklist because it does state at the top, "Required Documentation in the Supplier's File," and all of these things are listed there.

Carol: Can I – this is (Carol) – can I interrupt just a minute because if you noticed, there's an asterisk beside that, which really should go down to the note. I just noticed that. I probably need to change that.

But the asterisk is supposed to reference a note at the bottom of the documentation checklist that actually says it is expected that the patient's medical record will reflect the need for the care provided. These records are not routinely submitted to the DME MAC but must be available upon

request. Therefore, while it is not a requirement, it is a recommendation that suppliers obtain and review the appropriate medical records and maintain a copy in the beneficiary's file. So there is a little disclaimer there about that.

Female: Yes. And all of that honestly is very, very helpful for us. But back to the original question for you, sir, was, do you – the ABN ...

Mark Loney: Right.

Female: ... if we really can't know that the documentation exists, is it appropriate?

Mark Loney: No, it's not appropriate for that. There is the EY modifier if you don't have any documentation. If you don't get anything, the beneficiary just wants to buy one, there's an EY modifier basically saying it was not prescribed by the physician, although it could be that the doctor simply wrote a prescription and the beneficiary walked in your door with it. But unfortunately, it's not.

It's why that FAQ was changed. Originally it was thought that because of the way the policy reads and the need for that initial visit before the sleep test and all of that. But it would be appropriate to use an ABN in that situation. Unfortunately, CMS came back and said that wasn't the case.

So I do want to, in response to the one thing you said, I probably can't talk Dr. Hoover into anything, but I do want you to know that our Part B counterparts that do the education for the physicians, for the office managers, for that end of it, this is something that they're talking about in their presentations. You know I don't know that that's a whole lot of comfort but it is something that they are pushing in their presentations as well to— and basically in essence what you were saying is we have to play this game together.

Female: Yes.

Mark Loney: OK?

Female: Yes. All right.

Mark Loney: Thank you. Before we take our next call, I want to make a quick notice here, looking outside, we are having a really, really big Tennessee thunderstorm, so if the line goes dead, that means we lost power and that point the call will be over evidently. So if anything just goes "Click" and I'm not here anymore, that's what happened. But let's go ahead and take our next question, (Chelsea).

Operator: Certainly, Mr. Loney. Please go ahead, caller.

Female: Hello.

Mark Loney: Yes, go ahead.

Female: Hi, I'm just calling for two things. First of all, we received a denial for a rental claim and we appealed and the appeal was approved so we got paid. So then we submitted the rest of the month and they all got denied. And that makes no sense because I'm going to be sending the same documentation that I sent with the initial rental claim. And I'm just wondering if there's a problem in your processing or why would something like that happen.

Mark Loney: There's again a fairly wide reason – variety of reasons that that can happen. In a medical necessity case specifically, a claim that goes to appeals and gets overturned is not going to automatically set the rest of that same equipment or supplies up to pay. I guess it would seem

that that might – should be the case, but it's not, unfortunately, the way it works. So it's not going to automatically do that.

There can be a lot of factors in play. Again you might want to give customer service a call to look at that specific denial reason. Depending on where your beneficiary is located, we have fairly large geographical areas where there are directives in place to always look at documentation. So just because the – one paid doesn't mean that the rest of them are going to pay down the road.

OK?

Female: OK. (It doesn't make much sense) but I – and before I hang up, I just want to take the liberty to say that I speak for every, every single supplier because we all have the same problems, and that is the documentation. I know that it's CMS, but if we are working together, again we need your assistance or cooperation, to go back to CMS and say, "This is unfair, this is unfeasible," because you're putting a burden on us to get notes. And if we don't get the notes, we don't get paid, but we did everything we were supposed to do. Not only do you want certain notes, you want notes and it has to say in your specific language what you want and what it has to say. The doctors don't want to do it. They don't do it. So it's not fair to us to have to have this burden. Pharmacies don't have to have notes. If I do diabetic supplies and I ask for a note and the doctor only wrote you know BMI or diabetes, that's not enough, but I can't tell the doctor, "You have to write this, this and that or else I'm not going to get paid." Somebody has to work this problem because it's not my problem, it's every supplier's problem.

Is there anything that's being done about something like this?

Mark Loney: I realize that; it's something that we hear quite frequently. I'll say this. We work at CMS's direction. I guess our ability to input solutions is minimal. We certainly do that, we certainly try to

streamline our operations, certainly try to do things that make sense. But we are ultimately working at CMS's direction.

And this is going to sound somewhat cliché, but CMS has to make their rules around the law, around the statute. So this thing being driven about more documentation and this and that is ultimately being driven from the highest where the laws are being made. The bottom line is Congress wants to stop Medicare fraud and while a lot of suppliers are – may think that this is unreasonable, it's one of the ways they're going about it.

So yes, I, again, I can empathize with you, I realize it's everybody's problem, we hear the – we hear the issues working with the physicians trying to get what you need, all of that kind of stuff, but while we will certainly try and we do certainly try to do the things that you'd mentioned, our ability to do so is pretty limited because it's coming from fairly high up the ladder.

I can empathize with you but unfortunately it is – it looks like, at this point anyway, that that's the way we're headed, where we're going to require a lot of documentation. That is going to require really building those relationships with the physicians that you do work with quite a bit to help them understand what you need to get paid and ultimately you know one of the ways that we see it most successfully done is that their getting the items, the supplies that their patient needs to provide the best level of care, and we're working in that together. So it's really about building those relationships with the physicians to help them understand all of that.

Female: Yes, I understand. OK.

Mark Loney: OK? Thank you.

(Hussein): Yes, this is (Hussein) in Houston.

Mark Loney: Yes, sir, go ahead.

(Hussein): Hello? Yes, the question that I had, you mentioned earlier that we can contact the patient 7 days prior to sending them their supplies. I thought we were – I was under the impression that we could not contact the patient at all.

Mark Loney: Well, there are some general supplier guidelines about cold calling patients and things like that, but for the suppliers that bill recurrently diabetic testing supplies, things like that, the policy is in there to allow you to make contact with the beneficiary to see what kind of quantity, what kind of – if they need refills and how much, that kind of thing, 7 days prior to – like, let's take – let me back up.

Diabetic testing supplies for instance where you span the date. So you span through the 13th of the month. You back that up 7 days, you can make contact with the beneficiary to see if their supply is probably going to run out on the 13th like you assumed it would, and then 5 days prior to that, you can actually ship the new month's supply. So that language is in the policy to allow you to do that for patients you are already servicing.

(Hussein): If I had a patient that had diabetic shoes and we'll be able to contact those patients 7 days prior to the year when they had the shoes or no?

Mark Loney: No, they – in that situation, that's not a supply where that happens. That's you know once a year, so that's not going to really be able to meet those requirements.

I'm going to cut you short. Excuse me, I'm sorry we'll have to discontinue the call for just a moment. We've been placed under tornado warning. We have to seek shelter. Thank you.

(Hussein): All right. We'll see you guys. Be safe.

Operator: Again, ladies and gentlemen, that concludes our conference for today. We thank you all for your participation.

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