CIGNA

Moderator: James Herren
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1:00 p.m. CT

Operator: Good day everyone and welcome to the Ask the Contractor Teleconference call. At this time, I would like to turn the conference over to your host, Mr. Herren. Please go ahead, Mr. Herren.

(James Herren): Thank you, Kelsey. Good afternoon and welcome to CIGNA Government Services' first "Ask the Contractor Teleconference" for Jurisdiction C DME MAC. For today's call, we will be referring to CIGNA Government Services as CGS.

My name is James Herren and I'll be acting as the moderator for today's call. I'm with CIGNA Government Services Provider Outreach and Education department.

We would like to begin by giving thanks to those suppliers who are participating today. Your participation in these calls is an important way for us to better meet the needs of the supplier community and we appreciate this opportunity to partner with you to accomplish this goal.

We're joined on the call today by representatives from CMS and from (Palmetto GBA), the EDI contractor for Jurisdiction C.

Also with us are representatives from several departments within CGS who will be available to answer your questions pertaining to their respective areas.

Please keep in mind we will not be able to answer questions about individual claims. If you have a questions regarding a specific claim, please contact our customer service specialist at 866-270-4909. That number again is 866-270-4909.

Also, we are not the correct resource to answer questions regarding competitive bidding. If you do have questions about competitive bidding, please contact the Competitive Bidding Implementation Contractor at 877-577-5331. Again, that's 877-577-5331.

I would like to begin the call by giving general information about CGS, discussing transition activities, and other updates. After the call, we will open the lines to your questions.

Based in Nashville, Tennessee, CGS is a wholly-owned subsidiary of CIGNA Corporation. CGS, and our predecessor companies, has been a Medicare contractor since the inception of the program in 1966. Also, CGS was one of the original four DMERC contractors holding the Region D contract. In addition to the Jurisdiction C DME MAC contract, CSG holds contracts for Part B Operations in Tennessee, North Carolina, and Idaho.

CIGNA Government Services recently received two of the top three national awards among Medicare claims payers for claims payment promptness, accuracy, and efficiency from Athena Health, an independent on-demand business service company.

In 2006, CGS received the International Organization of Standardization ISO 9001:2000 Certification. ISO 9001 certifies that recipients have incorporated sound quality management strategies to ensure that work is performed with quality, efficiency, and continuous improvement.

Right now, I'd like to go ahead and turn the call over to Dante' Wynn, who is also a representative of Provider Outreach and Education for CIGNA Government Services.

(Dante' Wynn): Thank you, James. Good afternoon. CGS successfully completed transition of the Jurisdiction C contract and began full operations on June 5th. Pending work from Palmetto GBA was transferred to CGS at cut-over as planned. If you have already submitted claims or other requests to the previous contractor, please do not resubmit to CGS as they will be processed from the original submission.

CGS is completing transferred work on a first in, first out basis. In some cases, we received more work than expected and are bringing in the necessary resources to address this.

With the transfer of such a large contract, we did encounter some system-related issues. Chief among them was the timing problem with our interactive voice response system. Though we were able to identify this issue quickly, we do regret that this may have kept some of you from receiving immediate information, on submitted claims. This also impacted wait times in our call center. We are happy to report that the IVR issue was resolved on June 14th. Following resolution of the issue, our customer service call center wait times are improving.

Since the transition, CGS has completed a total of 169,651 calls. Of that, 147,301 were taken by the IVR and 22,350 were directed to the customer service call center.

Since the June 1st transition, CGS has processed over two million claims. And we have processed those within a timely filing of 99.41 percent of the clean claims, which exceeds the CMS goal of 95 percent.

If you have a claim that has a minor omission or clerical error, you may request a reopening. You can send a reopening request in writing or by telephone. Please note that the reopening telephone line is temporarily unavailable so that resources can aid with the unexpected high volumes of calls to our call center. During this time, we are accepting fax copies of the reopening

form at 615-782-4505. That number again is 615-782-4505. We do expect the reopening telephone lines to be available again, in early July.

I will now turn this over to (Christy Harwood), who is also a Provider Outreach and Education representative.

(Christy Harwood): Thank you, Dante' Wynn, and good afternoon. CIGNA Government Services edits claims for review to ensure that coverage, reimbursement, and documentation requirements in the National and Local Coverage Determination NCDs and LCDs and the CMS Internet-Only Manuals are met. This includes proper use of the KX modifier to indicate that specific required documentation is on file.

Several LCDs, including manual wheelchair bases, power mobility devices, and hospital beds have been revised within the past year to include of the KX modifier when coverage criteria are met. To avoid unnecessary claim denials, refer to the documentation requirement section of each LCD at www.trustsolutionsllc.com. Again, that's www.trustsolutionsllc.com.

I will now turn the call over to (Melody), who will speak to you about EFT.

(Melody): Good afternoon. We wanted to let you know that we have currently validated EFT authorization forms for over 12,000 suppliers. We have found that many suppliers have either submitted incomplete or inaccurate EXT applications. For those who submitted incomplete forms, the top areas we have identified include:

Multiple suppliers being listed on a single form.

The fee-for-service contractor field in Section 5 does not show CGS as the fee-for-service Service contractor or CIGNA Government Services.

And Medicare identification number is incomplete or missing. In many cases, the NPI or your submitter number is being used instead of the Medicare identification number.

We didn't receive a voided check or the confirmation of the account information, on bank letterhead.

The banking information didn't match the voided check or the deposit slip submitted.

We have found out that some banks are no longer printing the entire routing number on deposit slips. So before sending a deposit slip in with your authorization form, please verify that the number on your deposit slip matches the routing number on your check.

The mandatory authorized signature was also not provided on some forms.

Another issue that we have identified is that the bank account information, the name on the bank account does not match the information, on the EFT authorization form or the information provided to the NSC to identify supplier names.

If your form was incomplete or invalid, CGS will be sending a letter indicating which information caused the form to be rejected. Today, we currently have 500 authorization forms pending updated information and another 900 new authorization forms to be processed.

We will be working with CMS for timing for when we will discontinue making payments via the EFT to those suppliers who have not submitted an accurate and complete authorization form. We will put that information, on our Web site and send out letters notifying you in advance when that date will happen.

And now, I'm going to turn this over to (Erin).

(Erin): Good afternoon. Provider Outreach and Education representatives, formerly known as Ombudsmen are now centrally located in Nashville, Tennessee. Provider Outreach and Education is responsible for providing online education courses, Webinars, and in-person seminars. Ombudsmen are no longer assigned to individual states. Rather, this role is now incorporated into the customer service department.

A process has been designed for all claim inquiries and policy questions are handled through customer service. If you have an educational need, your request will be referred to the Provider Outreach and Education team through customer service. Upon receiving your request, a member of the Provider Outreach and Education team will contact you to discuss your specific educational needs. You can expect to receive a call from a member of that group within 10 business days.

Fundamentally, all DME MACs perform work in much the same way, as such, little change once the Jurisdiction C contract transitions to CIGNA Government Services.

CGS and the previous contractor, Palmetto GBA, have many things in common and the transition has not changed any of the following: The Jurisdiction C Program Safeguard Contractor will remain Trust Solutions LLC. This is a change for the state of Virginia and West Virginia only.

Jurisdiction C EDI is still performed by Palmetto GBA so that the EDI process and products will remain the same. This also is a change for West Virginia and Virginia only.

Though not related to the transition, there are two differences that we would like to bring to your attention.

While supplier numbers are the same with both contractors, with the implementation of the NPI, the legacy numbers or National Supplier Clearinghouse numbers are now referred to as PTANs, which stands for Provider Transaction Access Number. This is the number that is used for verification with the IVR and when contacting the customer service center.

The enrollment process is still handled through the National Supplier Clearinghouse, though now an NPI must be obtained from the national plan and provider enumeration system in addition to the NSC enrollment number.

I will now turn the call back over to (James Herren).

(James Herren): Thank you, (Erin). Before we begin with your questions, we would like to mention our online resources that are available at your convenience. We invite all of you to enroll in the CGS ListServ so that you may stay abreast of updates, news, and Medicare program information. To sign up for our ListServ, please visit our Web site at www.cignagovernmentservices.com. Again, that's www.cignagovernmentservices.com.

While there, please take a few moments to review the other resources available on the site. There's a wealth of information that can assist you. Please note that if you previously enrolled with the ListServ through Palmetto GBA, it is not necessary to re-enroll with CGS. We do recommend, however, that you update your ListServ membership profile.

This concludes our brief update session. As we prepare to take your questions, please keep in mind that we will not be able to answer questions about individual claims. If you have a question regarding a specific claim, please contact our customer service specialist at 866-270-4909. Again, that's 866-270-4909.

Also, we are not the correct resource to answer questions regarding competitive bidding. If you do have questions about competitive bidding, please contact the Competitive Bidding Implementation Contractor at 877-577-5331. Again, that number is 877-577-5331.

We are very interested in answering as many different questions as possible. So if you hear your question answered prior to your turn, please remove yourself from the queue.

A transcript of today's call will be available on the CGS Jurisdiction C DME MAC Web site posted in the education section.

Again, we would like to thank you for your participation today and we will now open the lines for the question and answer portion of the call.

Operator: Thank you so much, Mr. (Herren). Ladies and gentlemen, if you wish to ask a question, please press star then one on your touch-tone telephone. You will hear a tone indicating you have been placed in the queue. Then a voice prompt on your line will indicate when your line has been open.

Now, like Mr. (Herren) said, if you find your question has been answered, you can remove yourself from the queue at any time by pressing the star key followed by the digit two. And do keep in mind that if you are using a speakerphone, to please pick up the handset. And once again, that is star one for questions.

Caller, please go ahead.

(James Herren): Go ahead, caller.

(Michelle): Hi. I'm from KCI. And we're wondering how to get favorable appeal decisions paid that we initially get paid as an incorrect rate?

(James Herren): OK, so your question is, you're curious about how to make sure you're getting appeal decisions paid at a correct rate?

(Michelle): Right.

(James Herren): OK. What issues are you seeing? Are you saying that you're actually getting favorable decisions but then not receiving any money at all or just not the actual, correct amounts?

(Michelle): Well, sometimes we don't receive any money at all. But sometimes, we don't receive like the correct rate like the ((inaudible)) rate, the discounted rate.

(James Herren): Capped rentals?

(Michelle): Right.

(James Herren): We have not identified that as a problem as of yet. I guess that is something we're going to have to look into. Did you notice this…

(Michelle): It's something that we've carried over from Palmetto.

(James Herren): OK.

(Michelle): So we're really, you know, it's been an issue we've had to deal with, with them so we're really hoping to get something in place right away so we're not running into a – because we've really run into a wall with them on the deal. So we just want to kind of avoid that.

(James Herren): Well, it is possible for you to send us examples?

(Michelle): Sure. Yep.

(James Herren): Let me get your phone number and then we'll get some information from you to where we can get some examples, (please).

(Michelle): My phone number is.

(James Herren): And I'm sorry, what is your name again, ma'am.

(Michelle): (Michelle).

(James Herren): (Michelle). And you're with KCI?

(Michelle): Right.

(James Herren): OK. Like I said, we will review this. And if you can get us some examples, we'll look into this for you.

(Michelle): Do you want me to fax them to you?

(James Herren): We will contact you. We'll have a member of the Appeals department contact you and then you can just go from there.

(Michelle): OK. Thank you.

(James Herren): Thank you.

(Ashley): Hello?

(James Herren): Yes. Go ahead, caller.

(Ashley): Who would we contact in case customer service is not being able to help us?

(James Herren): Your question is, you'd like to have another number of you need to know who to contact if customer service is not able to help you?

(Ashley): Yes. I'm having a problem with mass denials on our patients that receive surgical dressings. All my patients are being denied the tape. And it's every patient ever since the June 14th remittance. And I've talked to customer service twice. They can't tell me why it's denying because everything's there. They've told me to contact telephone appeals. I've contacted them. I've faxed them six times. And I've not gotten a response from them either. I have e-mailed CIGNA and I've not gotten a response from that either. And so I'm just kind of at a standstill while my remittances are piling up for patients that aren't being paid.

(James Herren): Have you received a response, by any chance, e-mailed us on this or have you received a response from customer service?

(Ashley): No, I have received a response from customer service. I've e-mailed twice and I've faxed everything over to telephone appeals six times, and never gotten a response yet.

(James Herren): When did you do this, ma'am? How long ago was this?

(Ashley): It started with the 14th, when my first denial went on my patient's, on that remit were being denied tape for surgical dressings, and pretty much every day since then.

(Dante' Wynn): You said you faxed your request into the telephone reopening, you called the telephone reopening line and they phoned the number provided you faxed that into our office at the 615-782-4505?

(Ashley): Yes.

(Dante' Wynn): OK. Give me your phone number. I can give you that confirmation that we've received your request. Your work is probably just in queue for the work that we've received in that area and as we stated earlier, it's a first in, first out process.

(Ashley): OK.

(Dante' Wynn): But I can get that confirmation for you.

(Ashley): OK. My phone number is. And my name is (Ashley) and I'm with All South Services.

(Dante' Wynn): OK, then thank you.

(Ashley): All right. Thank you.

(James Herren): OK. Go ahead, caller.

Female: Hello? Can you hear me?

(James Herren): Yes, ma'am.

(Shawn Blessingame): This is (Shawn Blessingame) calling from Rocerts Home Medical. My question is in regards to the claims that were transferred from the previous DME MAC over to say CIGNA?

(James Herren): Yes, ma'am.

(Shawn Blessingame): I understand that you have, you know, the huge influx of claims. But what's the ETA on getting those transferred claims processed and, I guess, what dates are you working on if it's first in, first out basis?

(James Herren): Your question is, on work that is transferred from Palmetto to CIGNA, you're wondering what date we are at right now as far as work being processed?

(Shawn Blessingame): Yes.

(Roc): Hello, this is (Roc) and I am the claims manager. Right now, we are working on Julian date 169. I'm not sure if anybody knows what calendar date that corresponds to but Julian date is 169. We had received all claims from Palmetto. They did successfully transfer over. And at the current point, we are processing 99.4 percent of the electronic claims are clean claims within the required time frame of 30 days.

(Shawn Blessingame): So you can verify that all the claims transferred successfully?

(Roc): Correct.

(Shawn Blessingame): There were no issues with the transfer?

(Roc): That is correct.

(Shawn Blessingame): OK. The IVR issues do not seem to be corrected on our end. As late as today, we tried to call into the IVR and was not able to get through. It's saying that the PTAN number is incorrect. This is the same PTAN number that we've been using consistently since we were able to access the system. So the IVR issue does not seem to be corrected. Can you guys verify that that is the case? I know in your opening statement, you said that it's been corrected on 6/14?

Female: That's correct. The IVR issue's of which one was on the error message callers were receiving regarding their PTAN was corrected on June 14th. You were the first issue that I've heard of since June 14th of still having that error message.

If you'd like, you can give me your name and your phone number and we can see if we can work it off-line with you.

(Shawn Blessingame): Right, because we have also sent an e-mail and have not received any response on the PTAN issue and we've contacted – I mean, I sat here one day and just went through all the phone numbers that I had for you. And I think someone in EDI actually picked up and we told them we were having the issue.

Female: Then you're saying as recently as today that happened or within the last several days on the …

(Shawn Blessingame): Yep.

Female: Ok.

(Shawn Blessingame): Monday.

Female: If you can give me your name and phone number, we can take this off-line. Again, I appreciate you raising the issue. We'll see if it's isolated.

(Shawn Blessingame): Sure. It's Shawn, S-h-a-w-n. The last name is Blessingame. My phone number is.

Female: OK, thank you, (Shawn).

(Shawn Blessingame): I have one more question.

What other resources do we have to check on claim status if we cannot access the IVR? And is the online Web site, if we're not getting a response?

(Roc): This is (Roc). You do have the option of working through the Jurisdiction C EDI contractor to request access to what is called the system and that will give you online ability to see some additional claim information.

(Shawn Blessingame): I'm sorry, what was that system?

(Roc): It's called, I'm sorry, Claim Status Inquiry.

Female: Thank you, (Roc).

(Roc): ((Inaudible)) is more of an internal term. I do apologize.

(Shawn Blessingame): Claim Status Inquiry?

(Roc): Correct.

(Shawn Blessingame): And where do we access that?

(Roc): That can be accessed through the Jurisdiction C EDI Web site. And (Sue), would you provide the Website address for that?

(Sue): I certainly will. That would be www.palmettogba.com/jcedi. Everything is on there about claim status inquiry. We also call it CSI. But if you want to, you can also contact our technology support center.

(Shawn Blessingame): And how do you contact them?

(Sue): 888, toll free, 613-9271.

(Shawn Blessingame): And that's your technology support center?

(Sue): You bet.

(Shawn Blessingame): Now, with sort of doing away with the Ombudsmen, what is the ETA on questions that we give to customer service? Because I've noticed we've called customer service and put some questions towards them that would normally ask our Ombudsmen and we haven't received a response from them yet. Is that because of just the influx of work? Or what would be their ETA of getting back to us?

(James Herren): There is a large influx of work. So yes, that is part of it but if the question is not directly related toward education or something like that that is going to be a part of Provider Outreach and Education, it will be handled through customer service. So unless you have some specific need at Provider Outreach and Education, that department actually will not receive it. But if you do

have a request of Provider Outreach and Education, we will get back to you within 10 business days.

(Shawn Blessingame): If it's related to Outreach and Education. But if it's not related to Outreach and Education, is it true for all the departments? That they're going to get back to us within 10 days?

(Erin): Yeah, that is not correct. This is (Erin). I did want to extend some clarification, on that. Similar to the influx of calls that we are receiving in the call center, many of our areas are getting more in, inquiries than we were expecting. So we do have a timeliness of 45 days to respond to those inquiries.

(Shawn Blessingame): Forty-five days? Wow. Wow. OK.

(Erin): And that is a CMS requirement.

(Shawn Blessingame): OK.

Operator: Anything else, caller?

(Shawn Blessingame): No, that's it. Thank you.

(Jackie): This is (Jackie) with Arkansas Ostomy.

(James Herren): Yes, ma'am.

(Jackie): We've had problems getting our secondary claims paid ever since they stopped letting us do paper claims way back with Palmetto and having to do them online or EDI. We have not been able to get them paid. We've talked to other people in different regions and we were doing the

same thing they were doing and they were getting paid and we weren't. And so we still are not getting paid on our secondary claims.

(James Herren): Ok, to make sure I have your question correct, you are having problems getting paid on your electronic claims?

(Jackie): On secondary claims. We're getting paid on…

(James Herren): Secondary.

(Jackie): ((Inaudible)) primary. It's the secondary that we still have not had any luck getting paid.

(Klayton): Ok, this is (Klayton). I'm assuming you're speaking at Medicare being a secondary payer in claims submitted that way?

(Jackie): Yes.

(Klayton): Versus claims paid by another contractor.

(Jackie): Yes.

(Klayton): You do have the functionality on the electronic claims to submit the Medicare secondary payer claims through your EDI files.

(Jackie): Yes, and we are.

(Klayton): There are a number of potential reasons why those claims may not be being submitted correctly into the system for processing. Or there could be some data that's missing. Depending

on the error messages you're receiving or the denial messages that you're receiving, you have different courses of resolution.

If you're able to get the claim into the system to the point where you get a claim control number on an electronic receipt listing and you receive a denial message, our customer service center should be able to provide the information, on the denial message that you're receiving to tell you what further information is needed.

If you're unable to get the claim to a point where you get a claim control number, the Jurisdiction CDI support center should be able to assist you in getting the electronic claim submitted correctly.

(Jackie): Well, what was happening, while it was still under Palmetto, every time we would end one in, we would get a denial saying, information lacks needed for adjudication and so we called our software people and they gave us a person's name in a different region who handled the same type of supplies that we did, and they gave us a formula that they were using, that they put on their claims to transmit them. They were getting paid.

But every time we used the same formula, we got the same denial that lacks information needed for adjudication.

(Klayton): OK. The missing information denial is a common denial that we see. The customer service center will be able to look at that claim and be able to identify the missing information.

(Jackie): Well, back when it was still Palmetto, we called customer service and they would keep telling us that they could not see our formula on there, even though we were doing it just like that other region. Now, we have talked to, since CIGNA took over, we've sent in a couple of them with, oh, in a paper form for reopening type deal, and we haven't heard anything back on them. But one of the things we were told is that when before we submitted them, we had to go in and put a

narrative showing we had a doctor signature on file and we've been doing that. Is that a requirement for every time or once you do that on a particular customer, will it stay there?

(Klayton): You do need to submit for a beneficiary that's covered by a payer that's paying primary to Medicare, the information regarding that payer must be included for every claim.

(Jackie): Right, yeah, that formula that shows what the primary allowed or what they paid, et cetera, yeah.

(Klayton): As well as the primary care information.

(Jackie): Right.

(Klayton): So again, I'm going to redirect you to our customer call center to be able to provide some claim-specific support in this instance.

(Jackie): OK. And they should be able to, with that claim number, they should be able to pull it up and see what we've put on there and then be able to tell us what we're doing wrong?

(Klayton): That is correct.

(Jackie): OK. Because Palmetto couldn't so…

(Klayton): If they are unable to assist you, we have a three-tiered customer service support center that would escalate it to higher levels.

(Jackie): OK and that number would be?

Female: That number would be 866-270-4909.

(Jackie): That's the same, just the regular line.

Female: That's correct.

(Jackie): OK.

Female: All calls would go there, resolve those first call as many as possible. If it's a complex issue, it will be referred by those folks to the second and third tier.

(Jackie): OK. So if they can't help this. We've got secondary claims that go back to last August that we haven't been paid on.

Female: So we will ask you to call customer service, see what they can resolve for you on the line. And if there are some items that are more complex that will require more research, that customer service person will make the proper referral to the other tiers within the contact center.

(Jackie): OK, well, thank you very much.

(James Herren): You're welcome, caller.

Female: Thank you. Hello?

(James Herren): Hello. Yes, ma'am.

Female: Yes, my question is regarding some re-determinations that I sent in to Region C before the transition, that I got a favorable response to. And I haven't yet – I think you guys addressed this

shortly, just briefly, I'm sorry, ago. I haven't gotten the payment yet. Now, how should I proceed to get that payment?

(James Herren): Your question is, you received favorable appeals to sit a re-determination decisions…

Female: Correct.

(James Herren): … from Palmetto and you are yet to receive payment.

Female: Correct.

(James Herren): Is that correct? OK.

(Roc): Just to help us diagnose this problem, how are you receiving your payments? Were they electronic or were they in paper format?

Female: Electronic.

(Roc): And these were processed – can you give us what time frame these were processed in by Palmetto?

Female: The date of the decision? Ballpark would be fine.

Female: May. April or May, somewhere in there.

Female: OK. Again, as we had commented, we have received workloads, transferred workloads from the outgoing contractor and we are working cases in a first in, first out basis.

Female: That far back.

Female: Yes, ma'am.

Female: All right. One more question, on the cap rental hospital beds that I was receiving payments from Palmetto for and there were no KX modifiers added to it at that time. And now, I'm receiving the denials for because of the KX modifier was missing on my reoccurring? Was there no way that could have been let go through? I mean, that just seemed like it was thrown in there because we were just automatically sending the reoccurring rentals. And the KX modifiers were not added to the initial ones so therefore, it didn't go across each one. And I'm getting my denials like crazy on all of them.

Mia: This is Mia. Based on the local coverage determinations, it is indicated in there that the KX modifier is required on the claims for those hospital beds. And I do understand that previously, you were being paid for those. But based on the local coverage determination, we are processing claims as they should be.

As with many suppliers, many suppliers are going through this. We do have something out on our ListServ in regards to this.

Female: OK.

Mia: And you can certainly submit those to reopening if it was just a minor omission of the KX modifier…

Female: Oh, OK.

Mia: If you do, in fact, have the documentation, on file.

Female: OK.

(James Herren): Caller, do you need the fax number again for reopenings?

Female: I have it.

(James Herren): OK, thank you.

Female: On the VRU, is there ever going to be a way that we can check the payment …

Female: I'm pleased to announce that we are actually looking at programming that feature. We do understand from our Jurisdiction C suppliers that that was a favorite option at the outgoing contractor's IVR. We are looking at the programming of that and we are looking to have that available to our suppliers by early or mid-July. I encourage you to watch the ListServ on our Web site for updates for when that feature will become available.

Female: OK, OK. I'm done. Thank you.

Female: You're welcome.

(James Herren): Thank you, caller.

Male: Hello?

(James Herren): Yes, sir, go ahead.

Male: You know, there have been a number of referrals to contact the 270-4909 number for support. I have called it all different times of day and I'm just getting busy signals. Is there a period when there's lower call volume that we have a better chance of getting through?

(James Herren): Your question is, when is the best time to call the…

Male: Yes.

(James Herren): customer service line? Usually, the early morning. They open up at 8:00 a.m. Eastern Time, so usually between 8:00 a.m. and 9:00 a.m. or 9:30 a.m. is usually the best time to call in.

Male: OK. Frankly, I was starting to think the number might have changed but I've heard you allude to it several times so I guess it's still relevant.

(James Herren): Yes, sir.

(Lori): This is (Lori) and as (James) had said, right now, the lowest time of call volumes would be between the 8:00 and 9:30 a.m. time frame, and about the 4:30 to five-ish time – I'm sorry – that was Central, between the 5:00 and 6:00 time frame Eastern Time.

We do know that the whole time and the external blockage has been higher than anticipated. That's because the call volume has been significantly higher than expected. There has be improvement over the last couple of weeks so I appreciate the patience and yes, if you can try those lower-peak times, you should have a better opportunity of connecting.

Male: OK. And then, my second question and last question is, I almost hate to refer to it as the good old days, but before Trust Solutions had part of the responsibilities carved off from Palmetto GBA, we

used to get LCDs and updates in a very, easily-researchable format. We'd get the CDs in the mail and we knew when the changes came through.

Now, and this obviously, it's not a CIGNA issue so much as the division of responsibilities, it's really hard for us to know when policies change. The Web site's very hard to research and we don't get information in a compact, consolidated fashion the way we used to. Are there any plans to give us a half a chance in knowing what's going on?

(Roc): And just to give you a little feedback, we have also heard this from other suppliers and so forth. We meet on a frequent basis with Trust Solutions and we are passing this information, onto Trust Solutions, so hopefully, facilitate an improvement to their Web site or ((inaudible)) for the supplier community to go and access data and so forth.

We will continue to push this because this is something we have heard numerous times so we will continue to…

Male: That's the reason we have this KX modifier issue is a lot of folks, I think, just didn't know about it. And although you can find the LCD on the Web site, which we've gone and found, there's no like hot link to what's new…

(Roc): Right.

Male: if you will.

(Roc): And we are going to try working conjunctively with Trust Solutions to get some of this information posted to our Web site, especially such things as KX modifiers, and what you would call like hot items and so forth. So you know, we will work with them and try to be very diligent in making sure

the information gets posted to our Web site. And if we cannot post it to our Web site, then it's very visible on their Web site and a little bit more easily accessible.

Male: Thank you.

Male: Thank you.

(Carol): Can you hear me?

(James Herren): Yes, ma'am. Go ahead.

Female: Yes.

(Carol): This (Carol) with American Home Patient. I've heard your response in reference to the reviews that you have just received from Palmetto. Palmetto used to have, through the phone system, that we could access to see if you had received our re-determinations. And I don't see that you have that access.

Female: That's correct. We do not have that feature available to you now. But it is one that we are researching to see if we can add it just like we're doing the pay me information, the claim payment information. So please, watch our ListServ for updates. And we are looking to make that be an added feature to your IVR.

(Carol): OK. So in reference to that, so how do we know that you received the re-determination from Palmetto?

Female: At this point, you'll need to call customer service and ask for a re-determination status.

(Carol): OK, so they will have that information, on their system?

Female: Yes, ma'am, they can access that.

Female: But let me ask you, were you able to determine that Palmetto had received it?

(Carol): Well, no, because these are all the re-determinations that I'm looking at now, should have been received in (April). And like I have one that right before it went to CIGNA, I checked in, the re-determination was received (April) 3rd through Palmetto. But still, nothing has happened to the re-determination.

Female: And as we said, if you did receive confirmation from Palmetto, that they received it, during our cut over and our transfer of workload, we verify that every piece of work was transferred. And we are working on a first in, first out basis. So if you did receive your verification that Palmetto has it, then we also have it.

(Carol): OK, thank you very much.

(James Herren): Thank you, caller.

Lisha Wiley: Hello?

(James Herren): Yes, ma'am. Go ahead.

Lisha Wiley: Can you hear me?

(James Herren): Yes, we can.

Lisha Wiley: OK. I am calling from a small DME company called Home Comfort Medical Equipment and, of course, being a small company, you know, and Medicare pretty much is one of the biggest payers that we do have. For some reason, we are having some trouble receiving our checks. The amount we have taken in this month from CIGNA is not – maybe is a tenth of what we usually receive. And I have contacted the customer service line numerous times, and at one point, was told to contact the finance department. And the finance department, of course, said they would have to get with their manager or their supervisor and get back with me.

The next day when they called back, I was out to lunch and she said the exact message that she left for me was to call customer service back and make them help me. Well, when I called the ladies at customer service – and I do mean this very respectfully – they do not understand. The information that they are able to tell me is very limited. And I just keep getting confirmation or, I'm sorry, ticket numbers and they say, well, it's been escalated to Tier 2.

And I just feel like I'm kind of getting the runaround and I can sympathize with the IVR issues because I, myself – let me see – I think it was the 25th of June – sat on the line for three-and-a-half hours waiting to speak to someone and, you know, I really need someone's help.

And I've contacted all the numbers. I've sent in e-mails. I mean, and we're a small company and, you know, we're depending on our money that's owed to us, you know, to receive it in a timely manner.

Female: The first question I would ask you is how do you receive your payments? Do you receive them …

Lisha Wiley: Electronic deposit.

Female: OK. And you have been receiving your electronic payments, correct?

Lisha Wiley: Yes.

Female: OK. And have you been able to get into the IVR to check specific claim statuses.

Lisha Wiley: No.

Female: And have you tried to do that?

Lisha Wiley: Yes.

(James Herren): So you were unable to get in or you just could not – the IVR could not locate them?

Lisha Wiley: Could not locate them, I believe, yes.

Male: Do you submit these claims electronically or paper?

Lisha Wiley: Submit them all electronically. And I am getting back the ECS status reports where they are being accepted.

Male: OK.

(James Herren): And how long ago were you sending these claims in?

Lisha Wiley: As early as, well, the beginning of June. Pretty much everything I've sent in all month and the end of May, we haven't received, like I said, about a tenth of what we always usually receive and I mean, we can handle it this month, but, you know…

Male: This is a little bit difficult to determine over the phone. But there's a pretty good chance that when you submitted these, these are actually sitting on the payment floor.

Lisha Wiley: Well, see, that's what I thought also until, of course, like I said – and I do mean this respectfully – the numerous people that I have talked to there, one of the customer service representatives told me our money was lost in the system. Another one told me, her exact words were – let me look here – I'm looking at my notes – I wrote everything down. We were on hold, yes, I'm sorry. She kept referring to the money that was showing outstanding at money that was on hold and it is a fairly large amount. And I told her, if she could please notify somebody of this, and she said that she would, and she said it would be 10 to 25 business days. Every person that I've talked to has been 10 to 25 business days. And, you know, it has certainly not been within 10 days.

Mia: OK, ma'am, this is Mia. If you can, please, provide me with your name and telephone number, and I'll reach out to you tomorrow, if you'll prepare with some individual Medicare numbers and things of that nature, we'll be able to discuss this matter.

Lisha Wiley: OK. I already have everything typed up and I've forwarded it to our congressman and also the insurance commissioner for Tennessee. I think I spoke with somebody there. So I will forward you what I have already prepared for him. And it's in detail.

Mia: OK. I'll certainly reach out to you. If I could get your name, please?

It's Lisha Wiley. My telephone number's. And I'm sorry, what was your name?

Mia: It's Mia. And may last name is Hillman.

Lisha Wiley: And what is it that you do there?

Mia: I am over the written inquiries department.

Lisha Wiley: Written inquiries.

Mia: Yes, written correspondence, PRRS.

Lisha Wiley: OK. OK, well, I look forward to hearing from you and I hope that all these things that everyone's having trouble with get resolved very soon. Thank you.

Mia: Thank you.

(James Herren): Thank you, caller.

Sandra Sullivan: Hello?

(James Herren): Yes, ma'am. Go ahead.

Sandra Sullivan: Hi. I'm not sure this question is for this conference but I'm going to try it anyway. It's a billing question I have on a specific code we bill out of our company?

(James Herren): Go ahead, caller. We'll do our best.

Sandra Sullivan: All right, good because I've just go nowhere else. The specific ((inaudible)) code we're trying to bill for – or actually, not even get payment – but just get a simple denial where we can bill either the patient or the secondary insurance – is E0218. Is anybody there familiar with the billing and that specific code?

(James Herren): What is that code?

Sandra Sullivan: The code is a cold therapy unit, which is a (capped) rental item. And as a company, we don't rent it. We only do it as a new purchase.

(James Herren): Sure.

Sandra Sullivan: So when I do bill out for it, I put an NU modifier, and I put a GA because we have the ABN on file which gives us the right to bill the patient afterwards, once we get a denial, which is my problem. I can't get a denial. I keep getting a not billing it properly.

Male: OK.

(James Herren): One moment.

(James Herren): Unfortunately, on the something that we take as a capped rental item, if you bill it as a one-time payment item or a new item, it's actually going to get an invalid denial. It will not receive a PR denial or CO denial. It's just going go be a straight denial, but invalid.

Sandra Sullivan: So as a company, I guess we can't bill for this specific item as a new unit. I mean, I just can't understand how they can tell us how we can bill it. I understand how it's getting denied. But there's not way we can ever put an NU modifier and bill it out for a patient's responsibility or a secondary submission denial.

Female: That may be something that we have to research that I know…

Sandra Sullivan: Could you?

Female: … in the past on items such as that, that in order to bill a secondary insurance, if you're billing the way you are, you're not going to get the denial that…

Sandra Sullivan: Exactly.

Female: you're needing…

Sandra Sullivan: Exactly.

Female: And I'm not sure what the work around or whether there is one for that or whether you have to follow the cap rental guidelines. So that's something that we would need to check into.

Sandra Sullivan: OK, and then you would get back to me if I gave you my information?

(James Herren): Yes, ma'am.

Sandra Sullivan: All right. My first name is Sandra.

(James Herren): OK.

Sandra Sullivan: Last name's Sullivan. I'm with EBI, Electro Biology Incorporated. And the number is.

(James Herren): OK.

Sandra Sullivan: Thank you.

(James Herren): Thank you, ma'am.

Female: Hello?

(James Herren): Yes, ma'am.

Female: This is maybe a relatively simple question for you instead of what's been going on for your guys. Working on denials or somewhere where we need some assistance from customer service for claims that were prior to May 15th, what is the proper phone number that we would call for assistance on those claims?

(James Herren): For assistance on those claims, you will still want to contact our customer service.

Female: You're saying 866-270-4909?

(James Herren): Yes, ma'am.

Female: OK, so you basically assumed all the denials and rework that rolled over?

(James Herren): Yes, ma'am, that is correct.

Female: OK. How's that for a simple question? Thank you.

(James Herren): Thank you.

(Bernie Lipovitch): Hello, my name is (Bernie Lipovitch) from CareCentric. I have a question considering for billing of wheelchairs where a modifier is now required, the BR, the BP, for electric wheelchairs. But how do we define electric wheelchairs. We're a software vendor. I'm looking for maybe perhaps a range of ((inaudible)) picks that define electric wheelchair?

(James Herren): You might want to contact the SADMERC for Jurisdiction C and let me get you that phone number.

(Bernie Lipovitch): Thank you.

(James Herren): Kim, or (Sue), do you by any chance, have the phone number to SADMERC?

Female: I don't but I'll be happy to look it up. Just a moment please.

(Bernie Lipovitch): Thank you.

(James Herren): Actually, caller, thank you. We do have it. It's 877-735-1326.

(Bernie Lipovitch): 1326?

(James Herren): Yes, ma'am, 1326.

(Bernie Lipovitch): Thank you very much.

(James Herren): Thank you. You're welcome.

David Sommerfeld: Hello?

(James Herren): Yes, sir. Go ahead.

David Sommerfeld: Yeah, hi. I'm calling from ((inaudible)) Medical. We had our number revoked on (April) 23rd for some licensing issues, filed a cap at the end of (April). It was accepted by the NSC, forwarded to CMS. CMS accepted it, sent us a letter dated May 31st, reinstating our

number as of May 1st. And as of today, CIGNA is the only DME MAC that is still denying our claims. And when we call up to find out what's going on, we're told the number is still revoked. When we speak with the NSC, we told us that they have notified CIGNA that, in fact, we're reinstated. How do we go about getting this straightened out?

Female: That would have to do with actually the information is transferred to us from the NSC. Again, we're probably going to need to get your name and phone number so we can research what actually happened with that transition or the transmission from the NSC.

David Sommerfeld: I understand that they post that on a bulletin board and you all pull that information down?

Female: We actually get a daily update from the NSC electronically.

David Sommerfeld: So would it be helpful for us to be able to forward you a copy of the letter we have from…

Female: No, sir, unless we've got that update, that electronic update from the NSC, you're going to continue to have the same issue.

David Sommerfeld: What do you need from me to resolve this?

Female: I need to get your name and phone number so we can get back with you after we talk to the NSC.

David Sommerfeld: Very good. My name is David Sommerfeld. My phone number. And the name of our company is Rite Aid Medical.

Female: All right. And we will look into that and get back to you.

David Sommerfeld: Thank you so much.

(James Herren): Thank you, caller.

(Ann): Hi, this is (Ann) from …

(James Herren): Yes, ma'am.

(Ann): Actually, I have one question. My question is this. If it's an error on Medicare's denial, you know what I'm saying? Like we got a bunch of 107 denials and we also have a denial on all of our DME equipment on our 13th month. Those are all being denied in error. Is that something that I can just call through the phone appeals line to have that get that adjusted? Or do I need to send those to re-determination? Or do I need to send those through, you know, the address for the appeals, reopening appeals?

(Samantha): You're stating that the 13th month of your cap rentals?

(Ann): On all of our DME equipment, not a lot, it's like hit and miss, on a lot of them. On the 13th month, they're denying out from maxed reached and every single one has been error. And so, I wanted to know, is that something I call phone appeals to get an adjustment? Or do I got to send that to reopening appeals?

And then, I also have another denial that like a mass denial, 107s on our aerosol mixes for the J7615 and J7645, on that particular mix, all of our dispensing fees is denial for 107s, which is all in error. So I didn't know if like you all can do a mass adjustment on those errors or do I need to call for an appeals or send them to – I'm not sure which way to go with them.

(Samantha): So you have identified that they were denied incorrectly…

(Ann): Correct.

(Samantha): For all of them?

(Ann): Yes.

(Samantha): It's something you can certainly go through our reopening line for.

(Ann): Oh, OK, so if it's Medicare's error on that denial, I can go through the phone appeals?

(Samantha): What I would suggest, if you have a high volume of claims that are the same reason for denial, it's going to be better if you actually send that in, in writing to the reopening.

(Ann): OK.

(Samantha): What we can do is it's called an express adjustment because if you call our telephone reopening line, we're only going to be able to adjust up to five claims.

(Ann): Exactly.

(Samantha): Obviously, if you have anywhere – because we have heard from some suppliers where they maybe have 100 claims – it's better for you to send those in, in writing because we will do what we call an express adjustment where we can get those done a lot quicker instead of you having to constantly call back in to our telephone reopen…

(Ann): OK.

Female: line doing five at a time.

(Ann): OK. So I would send those to the reopening appeal review, not the re-determination.

(Samantha): No. I just want to clarify for you. We have reopening and then we have re-determination. A re-determination is your first level of appeal. A reopening is a situation that you're speaking of where there's a clerical error or a minor omission. They are two totally separate departments and you can actually fax that in to the reopening team to have that handled.

(Ann): OK or I can mail it, correct, on their (form)?

(Samantha): Mail it, that's correct.

(Ann): OK. Do you have any questions? OK.

(James Herren): Thank you, caller.

(Jan Clarke): Yes, my name is (Jan Clarke) and I had a couple of questions. We bill for labor quite a bit on repairs and I noticed since CIGNA has been paying us, our labor rates went down. Where can I find some information about the E1340 rates?

(James Herren): So your question is about where you would find information about the rates for labor?

(Jan Clarke): Yes. I've experienced the same kinds of issues that a lot of these other callers have. Literally, it is nearly impossible to get through on the 866-270-4909 number. I did finally get to speak to somebody after being on hold for about an hour and 10 minutes. And she said she

didn't know where to find anything about E1340 because it's not in any of the manuals. It's not in any of the books. And that's how we bill the labor on repairs of items.

(James Herren): Yes, ma'am, I understand that. We were looking at the fee schedule and…

(Jan Clarke): And it's not on there.

(James Herren): … it's actually manually priced.

(Jan Clarke): But since CIGNA's been paying it, it went down. It was 13.66 per quarter hour. And now it's $12.43.

Male: All right, caller, what we're going to do on this one, if it's possible. This is the E1340, correct?

(Jan Clarke): It's E1340 and you don't put any modifiers on it or anything.

Male: OK, no modifiers? And you were getting paid 13…

(Jan Clarke): 13.66 per quarter hour.

Male: OK.

(Jan Clarke): And now, we're getting paid 12.43.

Male: OK. What we're going to do on that one, that does require some additional research…

(Jan Clarke): OK.

Male: … just because, unfortunately, individuals in this room do not have the expertise to answer…

(Jan Clarke): Sure, I understand. If I'm having it, other people are, too.

Male: That's probably true. If this works for you, we'll put this in the minutes of this meeting, if that's OK.

(Answer: CIGNA Government Services is using the same fee schedule amounts published by Palmetto GBA on January 1, 2007. Please see the chart below.)

E1340			9	AL	M	12.43	14.59	14.59	14.59	14.59
E1340			9	AR	M	12.43	14.59	14.59	14.59	14.59
E1340			9	CO	M	12.43	14.59	14.59	14.59	14.59
E1340			9	FL	M	12.43	14.59	14.59	14.59	14.59
E1340			9	GA	M	12.43	14.59	14.59	14.59	14.59
E1340			9	LA	M	12.43	14.59	14.59	14.59	14.59
E1340			9	MS	M	12.43	14.59	14.59	14.59	14.59
E1340			9	NC	M	12.43	14.59	14.59	14.59	14.59
E1340			9	NM	M	12.43	14.59	14.59	14.59	14.59
E1340			9	OK	M	12.43	14.59	14.59	14.59	14.59
E1340			9	PR	M	12.43	14.59	14.59	14.59	14.59
E1340			9	SC	M	12.43	14.59	14.59	14.59	14.59
E1340			9	TN	M	12.43	14.59	14.59	14.59	14.59
E1340			9	TX	M	12.43	14.59	14.59	14.59	14.59
E1340			9	VI	M	12.43	14.59	14.59	14.59	14.59

(Jan Clarke): That works great for me. One other question I did have, though, and it kind of goes back to what – for instance, Medicare came out earlier in the year and said that you could reprocess your claims for – we've done a few K0825s for example – and it was a higher rate. And it was retroactive. Now I get denials back that say same or similar because they're not reprocessing them at the right rate. And I think the other callers are having that same issue. So somebody needs to look into that, the fee changes and the retroactive because then, you have to follow re-determination and send a copy of the deal and get that reprocessed, I guess.

I haven't gotten paid on any of them.

Male: And we're really not sure. Again, this is an area where we have to look in more detail but some of this is based on the data service of fees may vary from quarter to quarter just depending on, you know, the fee schedule says. And you're probably aware of that obviously.

(Jan Clarke): Yes.

Male: So without looking at specifics that would be hard to answer. But we will take a look into that.

(Jan Clarke): OK.

Male: What code was that again?

(Jan Clarke): Well, it's the – there were some fee changes that were affective of K0825, K0850, 851, and 859 for 2006, from November 15th to December 31st. Than there were some other ones that were – then additional codes were added for 2007 to that. And that was on the Palmetto. But it says beginning (April) 2nd, suppliers may submit previously processed claims for these items with states or service, you know, on or before either, whether it's the 2006 change or the 2007 change.

(Samantha): Can I clarify something here?

(Jan Clarke): Sure.

(Samantha): What you're saying is that the claims were initially processed and paid and then, based on the update, it said that we could process the claims under the new rate. So you billed new claims?

(Jan Clarke): Right. When I called the help desk, that's what they told us to do. They told me to bill it again.

(Samantha): Unfortunately, you had incorrect information because if you've already billed the claim that's been paid on, and then you bill it a second time, it's going to deny the duplicate claim because we've actually already paid that claim once.

What you actually need to do is to send that into the reopenings because what we'll go in and do at that point is adjust the claim to pay at the correct amount for you. That is not a new claim that you should be billing.

(Jan Clarke): I agree with you. I just called the help desk. This was not on your watch so don't worry. But they told me to re-file the claim. And then I still didn't believe it and I called the people in technical support.

(Samantha): My name is (Samantha). I'm actually the reopening team. That is work you should be sending to reopenings.

(Jan Clarke): Got you. OK. Well, that clarifies that a little bit for me. I really appreciate it and I know there's a learning curve. Just keep up the good work.

(Samantha): Thank you.

(James Herren): Thank you, caller.

Male: Hey, how you doing? I'm calling from a DME, a small DME in Baton Rouge, Louisiana. I had a question about internal nutrition. With the new ((inaudible)), that a big problem at our ((inaudible))

reinstated, it's kind of impossible for us to get payment on patients that need the internal nutrition that aren't tube fed.

I was wondering if any corrections are going to be made to that because we deal with a lot of AIDS patients and they need the internal nutrition but it's kind of impossible for us to do Medicare, internal nutrition at this moment.

(James Herren): Can I ask you a question, caller? Did you say for patients that are not tube fed?

Male: Yes, sir. Yes, sir.

(James Herren): According to Medicare policy, claims are not paid for beneficiaries who – they have to have a feeding tube, excuse me, before Medicare will consider payment.

Male: OK. That's not going to change any? Because we deal with a lot of HIV AIDS patients…

(James Herren): Yes, sir.

Male: … and one of our patients, he was – I tried to get Medicaid to pay his claim but they said he had Medicare Part A and B so he couldn't get payment from Medicaid. And I was just wondering if that was going to change any?

(Ellen): This is (Ellen) and I'm the benefit analyst for claims. And what you could do is file that claim with a BO modifier which says it's taken orally.

Male: Yes, ma'am.

(Ellen): We will deny it that there's not a benefit, which may help you to file your Medicaid claim.

Male: OK. All right. All right. Thank you.

(James Herren): Thank you, caller.

Female: … questions. I have to go now. Hello?

(James Herren): Yes, ma'am. Go ahead.

Female: Yes, I have a couple of questions about eligibility on the IVR line. I've had some problems, it the patient hasn't had a claim processed with CIGNA Government Services, they're saying the patient isn't eligible. Have you heard that complaint since – this is since June 14th corrections?

(James Herren): I have heard that, yes, ma'am.

Female: Can you…

(James Herren): On each of your beneficiaries, are you getting copies of their Medicare numbers?

Female: Yes, we have copies of their cards and we're trying to verify the eligibility before because we're a DME company, before we provide the oxygen and such. And it's telling us that the patient isn't eligible so in tern, what we've had to do it call the 866-270-4909 because we don't have any other way to verify the eligibility. That was another one of my questions. Is there software that you offer that we can verify the eligibility through?

(Sue): This is (Sue) with Jurisdiction C EDI. It's not a software per se but it's connection to an application called Claims Status Inquiry that (Roc) mentioned earlier.

Female: OK.

(Sue): OK. It's real easy. If you'll simply get on to our Web site – do you need the address?

Female: I have it. I wrote it down…

(Sue): Good.

Female: ((inaudible)).

(Sue): Or call the customer service line, although I would tell you to look at the Web site because everything is there…

Female: OK.

(Sue): … for you to sign up. It's called Claims Status Inquiry, or CSI, and you can check eligibility through this application.

Female: OK.

(Sue): OK?

Female: Now, would I get the same answer being that there's not a CIGNA process claim, do you think?

(Sue): Well…

Female: … going through the IVR?

(Sue): … looks at them.

Female: OK.

(Sue): OK?

Female: It just seems that anybody that I've from Palmetto, they're not verifying through the IVR, unless I've had a paid claim from you guys on them.

Female: OK, you're saying you were able to verify eligibility if CIGNA had processed and paid a claim…

Female: Correct. Correct.

Female: … CIGNA …

Female: Exactly right.

Female: We're actually aware of that issue and we are further researching that.

Female: OK.

Female: And once we receive a claim, it will continue to give you the eligibility through our automated system.

Female: OK.

Female: But we are researching that information. And thank you for bringing it to our attention again.

Female: OK, also just a quick question for the EDI. What is the official NPI deadline date, not for a provider having their NPI but for the claims being submitted? I already have been testing with them but what is the actual date of requirement they must be on, on all claims?

(Sue): I wish I knew.

Female: Oh, good, OK. Then I was right when I answered my boss in the meeting this morning.

(Sue): If you said, "I wish I knew," you were correct.

Female: OK. Thank you, guys, so much for everything.

(James Herren): Thank you, caller.

(Marianna): Hi, this is (Marianna) from Diabetic Care Network.

(James Herren): Yes, ma'am.

(Marianna): We sent in some claims for re-determination to Palmetto. They were returned to us. They were dismissed. They were missing the signature. Palmetto did never require the signature on the claim form. We only got four of them. What happened to the other ones?

(James Herren): Let me clarify. Did you say that Palmetto had dismissed them or CIGNA had dismissed them?

(Marianna): CIGNA.

(James Herren): OK.

(Marianna): And they only returned four back to us saying we were missing the signatures on the…

Female: Is that a letter that you just received just recently?

(Marianna): Yes.

Female: The signature and what we call the elements are required to be submitted on all of your re-determination request forms. And the signature is one of the required elements. Apparently, we became aware that palmetto wasn't requiring that and they did not have it on their form for you to send in.

(Marianna): Right.

Female: You would have only gotten one of those dismissal ((inaudible)) for one day before we determined that ((inaudible)) that we did receive from Palmetto, since they were not requiring it, that we would not require it on the work that they sent to us.

Now, going forward, we will be requiring that you use a form that does have a signature.

(Marianna): OK. So on some other claims I have out there, you're going to put them through and they're going to be OK? They won't get rejected because we don't have the signature?

Female: For the ones that you had sent to Palmetto, when there was no signature on the form that they sent in, we will not be requiring that. But going forward, we will be requiring that on work that you do send to us.

(Marianna): OK. All right. You answered my question. Thank you very much.

(James Herren): Thank you, caller.

Female: Hello?

(James Herren): Yes, ma'am. Go ahead.

Female: I had a couple of questions. One of them was, I don't quite understand about the new PTAN number. I have 10-digit provider number I've been using. I've only been here a few months. And now, when I call the 270-4909 number, I can use that 10-digit number but if I call any of the other numbers, they tell me that's not the correct number, the my PTAN is supposed to be a six-digit number. And I don't anything about receiving a PTAN number.

(James Herren): To call into CIGNA Government Services to check, for instance, claims status, those kinds of things, you're PTAN number is your – it's formally called the supplier number, so you are OK there.

Female: Right.

(James Herren): As far as the six-digit number you're referring to, what other areas would you use that?

Female: Well, I had some different numbers that I called back when they got our of their dark days, just whatever numbers I could find pretty much trying to get answers to some of my questions. And like I said, I'm new to this so…

(James Herren): Sure.

Female: … you know – let me see if I can find the number that I called.

(Mia): Ma'am, where are you located?

Female: In Fayette, Alabama …

(James Herren): OK.

(Mia): Well, the only concern that I would have is that perhaps you were calling a number besides the DME number because it sounds like maybe it might be a Part B or a Part A requirement.

Female: OK, OK, that may have been the problem then. I wasn't for sure if there was something I had did wrong or not done.

Female: You might have been calling customer service number other than for DME.

Female: OK. And I had one more question, which was, we received a claim and it had several people on it that said, the payment had been sent to the patient, more or less, to the person who was insured. But it's because it wasn't covered by Medicare so would it still have sent it to secondary or would it have actually sent it the patient where we can bill them?

(James Herren): Actually, that could be a variety of reasons as to why it would have sent it to the beneficiary. One of those could have been maybe information was entered inadvertently that indicated that the beneficiary had actually paid for the item. I'm not real sure – have you contacted our customer service number about this?

Female: No, sir. We just got it in today.

(James Herren): OK. Check with them. They'll be able to look at the actual claim to see how it was billed.

Female: OK.

(James Herren): OK?

Female: OK. Because like I said, I was confused about that because I'm new. It said that they had sent them, you know, the money for the payment. But I didn't know who to re-bill to get the payment, whether they would have sent it on to, say, if their secondary was Blue Cross or if they sent it to the patient.

(Mia): It sounds like to me, we sent the money – if Medicare sent the money to the beneficiary, then you'll need to pursue payment through the beneficiary but you want to talk to customer service to be sure that's what took place.

Female: OK.

(Mia): Medicare actually sent the money to the beneficiary.

Female: OK. All right. Thank you very much.

Female: You're welcome.

(James Herren): Thank you, caller.

(Penny): Hello?

(James Herren): Yes, ma'am. Go ahead.

(Penny): Hi, this is (Penny) with KCI. And we have a couple of problems here. But one of the issues we're having right now is when we bill for an E2402, which is a wound VAC, ((inaudible)) guidelines have to bill that monthly. And we're billing Medicare secondary. The primary want it to be billed ((inaudible)). Well, you guys, because of your guidelines, we can't lump them together because of the claim doesn't match the ((inaudible)) and for your guidelines they must match. And if we just submit them exactly like we submit the primary, you'll pay the least amount, like a $20 claim for one day, and then, deny all the others as dupe. So we don't know how to fix this problem. This has been ongoing for a couple of years now.

Female: The only thing I can think of is one of the exclusions to the ((inaudible)) requirements for paper filing is that if you have multiple EOBs, which you will have if you have to bill daily to the primary and monthly to us, so you could file that claim monthly with a copy of all the EOBs that apply to that claim.

(Penny): OK, so we can get an exception to file it on paper then?

Female: I would think so. If you can't do it electronically …

(Penny): … And then, if we wanted maybe someone to come out and talk to us about this, you know, if we try this, if it works, then great, but if we have other issues, do we just go through your customer service line and say, help?

(James Herren): Yes, ma'am, that is where you would want to begin there, at customer service and they will escalate to the Provider Outreach and Education department.

(Penny): OK. The other issue we're having is Medicare secondary, we're billing our claims out with the KX modifier, which we've always done, and they're going electronically, but KX modifier is being dropped off of our claim. And they're getting denied for CO-50 all of a sudden when this wasn't happening. And this is a new development since Palmetto GBA left.

(James Herren): Have you checked with your software or your EDI vendor on this to see if it's being dropped there?

(Penny): Yeah, our EDI vendor says everything's going through just fine. And everything looks great on our end. It just seems to be coming across to you guys somewhere on your end, it's not picking up the KX. And we are billing it with the new …

(James Herren): Is there any way you can send us some examples on that?

(Penny): Sure. Where would you like me to send them to?

Male: … Ellen Edenfield, and her fax number is…

(Penny): and that’s Ellis?

(James Herren): No, Ellen.

(Penny): Sorry.

(James Herren): That's OK …

(Penny): OK, great. All right. We'll be glad to do that. And where do I find that reopening form that you mentioned for getting a hold of the appeals line?

(James Herren): It should be on the CIGNA Government Services Web site under Jurisdiction C, under the Forms.

(Penny): OK.

(James Herren): Actually, I do believe it's on the very front of the site.

(Penny): All right. Sweet. All right. Thank you so much for your help.

(James Herren): You're welcome, ma'am, thank you.

Female: Hello? Can you hear me?

(James Herren): Yes, ma'am, we can.

Female: This has to do with electronic fund transfer agreements that have been forwarded to you folks. I have ((inaudible)) seven different provider numbers that I still have no status on that was sent in on (April) 17th. I did receive a letter on, one but the letter is a very generic form that states, "You may have mismatched information. Please complete this new form and return it to us."

The letter you spoke about earlier that was going out, is it a more specific to tell us that it's a name issue or an account number issue or is that the letter you were referring to?

(Melody): That was the letter that we were referring to. Basically, again, what you need to check is the name that is on your check or your bank verification information.

Female: I did do that and I've been doing these EFT enrollment forms for years and I don't see where the issue is. So I called customer service. On two of the, customer service created a ticket for me. I have not heard anything back and it's been about 10 days at this particular point in time. so how long should I wait for a response for my ticket? Is that up to 45 days?

(Melody): Yes, ma'am, it is up to 45 days.

Female: OK. And then, the next time I called in, I talked to a different customer service representative who told me I needed to call Palmetto. I knew that that was incorrect. I did call Palmetto anyway and they did refer me back to CIGNA. So when I called back, they're telling me they don't show anything in the system other than it was received. There are not comments out there. So customer service is not able to tell us what the mismatched information is. Is that correct?

(Melody): Well, now, if they're telling you that if they're confirming that it was received, that the list that they have at customer service is the list of supplier numbers that your EFT information was valid.

Female: Well, it's not valid because we're still getting paper checks.

(Melody): We haven't turned off anybody for EFT. Did you send in a new application?

Female: Yes, I sent in all new applications with CIGNA Government Services on the second page. Out of the 25 or 27 I submitted, I only have seven out there that they were electronic and now they're going paper.

(Melody): OK, the only way that that would have happened, ma'am, is with the information that we sent you, or that you sent to us, that when we sent the EFT to the bank, it rejected. Now, my question to you is, what kind of banking information did you submit with your authorization form? Was it a deposit slip? Was it…

Female: It was a combination. Two of them were a deposit slip. And then, the other five of them were a letter from the bank because on their deposit slips, the routing numbers have the 8888s and I realized that that would create a mismatch in your system.

(Melody): OK, and basically, we have not turned off anybody was being paid. And if you sent in all new authorization forms and your EFT payments have not started, then it would have been because of being rejected by the banks.

Female: So there's something wrong with the banking information.

Female: Yes, ma'am.

Female: OK because they're saying it's on so they can see that it was received. Now, five of the provider numbers are from West Virginia.

(Melody): OK.

Female: Does that make any difference because they're a converting area?

(Melody): Yes, because we had to set those up as new.

Female: Right.

(Melody): But they were added to the system and you should be receiving EFT payments from those.

Female: I'm not. And then there's two from Florida that prior to the conversion, they were electronic. After the conversion, they are not and I had sent in the documentation, on (April) 17th.

(Melody): OK. So again, we would have – if there was a change to information and what we found with a lot of these authorization forms, is that with bank mergers, that type of thing that routing numbers and sometimes account numbers were changing from when you first set up your EFT payments with Palmetto or with NGS. And as those were submitted, depending upon what information you provided to us, some of those are being rejected from the banks.

Female: All right. So my best bet at this point is to verify the information with the bank. If there's a change, I'll submit a new form. If there's no change to what was put on the original application, then how do I – do I have to open up a ticket with customer service and wait the 45 days until somebody gets back to me with an explanation?

(Melody): And that's pretty much all we can do at that point, yes, ma'am.

Female: OK, thank you.

(James Herren): Thank you, caller.

Female: Hello?

(James Herren): Yes, ma'am. Go ahead.

Female: Yes, I had a question about the Trust Solutions, about the letters that they send out to you. What's the turnaround on getting a response for now?

(James Herren): Can you give me a more specific example of a letter from Trust Solutions?

Female: They sent out a letter asking you for like delivery tickets or doctor's orders, medical records, like certain DME supplies or equipment.

(Roc): And really, that question need to go to Trust Solutions because we're not really aware of their work or their volumes and so forth. I think they generally have a turnaround time – and please don't take me – don't write this down basically – but I believe the turnaround time is about 45 days.

Female: OK. There's not a number to contact them. There's no real contact.

(James Herren): There's no contact information, on their Web site?

Female: No.

(James Herren): One minute. We're actually going to see if we can't try to locate a contact number or information for you.

Female: OK.

(Roc): This is just a question. Does the letter state what the turnaround time will be?

(James Herren): Ma'am?

Female: Yes.

(James Herren): We do have a fax number for you for Trust Solutions. Just let me know when you're ready.

Female: OK, I'm ready.

(James Herren): It's Area Code 417-863-0054.

Female: And you can just fax it into them?

(James Herren): Yes, and you can fax your request in to them.

Female: OK. OK, that'll be it. Thank you.

(James Herren): OK. Thank you, caller.

(Linda Jones): Hello?

(James Herren): Yes, ma'am.

(Linda Jones): Yes, this is (Linda). I'm calling from Medical Management Services in Beaumont. I have two questions and a statement that was made earlier by (Shawn) in reference to the IVR system.

I did notice that on Monday when I did put in my PTAN, that it did kick it out and then I re-entered it again, and then, it went through so it could be a slight glitch.

Then, in that process, maybe starting Monday, I don't know, but I agree with her. I did find it kind of strange.

(James Herren): OK.

(Linda Jones): My first question would be, in the process of Palmetto still going through doing the claims and sending them over to CIGNA, I find that, even though I may have submitted a first claim with Palmetto prior to the change, when I submit my second claim, currently billing because I'm a durable medical equipment company, I'm noticing that my claims are being rejected. Could it be because the first claim is still in process? And it's maybe every other patient. And I'm using my correct modifiers, showing a second RRKI, but I'm noticing that it will kick it out. And should I wait until my first claim gets processed and then go and appeal it? Because I don't want to do two things and knowing that it should have been paid.

Female: What type of denials are you receiving?

(Linda Jones): Like my last denial was for a CO-57 and it shouldn't have been because this a CPAP and it's my second denial. And all the documentation is there. This is the first bill out, I mean the second bill out, I'm sorry. But my first bill out, I haven't received yet because this was prior to. This is date of service May 27th.

Female: Are you putting KX modifier on there?

(Linda Jones): Yes, ma'am. But I don't want to do an appeal on it until I find out if my first claim is going to be able to be paid. So I don't want to do like get rejected like twice.

Female: Have you checked on the status of your first claim?

(Linda Jones): Yes, ma'am. And it does say "in process." I did that this Monday. And someone did tell me it's in process. So I'm thinking because of maybe – and I'm starting to find it just this week and maybe last week – maybe last week – because I'm finding that when I do check my claim status, it'll say in process. So like I said, I can go to download my ERNs and then, boom, my

second or third claim, then got denied. And my first claim, I still haven't gotten, you know, my payment on it yet, or process completed.

Female: Can I get your name and number so I can follow up on this issue with you after …

(Linda Jones): Sure.

Female: … either this afternoon or tomorrow?

(Linda Jones): Sure. My name is (Linda Jones), … with Medical Management Services.

Female: Thank you.

(Linda Jones): And my second question would be, as of yesterday, with the ERNs, I don't know if you guys can answer this, but apparently, we checked the IVR for claim payments on the floor. Well, when we go to check it and it's ways what's supposed to be there like two or three days later, as of this week, it's not showing as being downloaded. So we called the EDI and let someone know that, hey, our ERNs were not there but we show a payment out there on the floor. So then he stated yesterday, he had to reset it. Is this going to be an issue? Maybe there's a glitch in the system right now because I found that strange. It never happened before.

(Sue): This is (Sue) with Jurisdiction C EDI. Are you saying that when you called our help desk, it was indicated that he had to put your remits out again for download?

(Linda Jones): Exactly. And then was as of yesterday. And the payment floor, she looked at it and it showed an amount out there. She checks it daily on what amount is out there. But when she went to down load it, there was nothing there so that's where she found it to be strange. So she

called the EDI and he said, well, let me go back and reset it. And this morning, it was there. So we downloaded it.

(Sue): Yeah, that would be correct. What we do is we look in JC EDI, we will look out in your mailbox to see if there has been a remit sent to your mailbox for download or not. If there has been, and it's already been downloaded, we can put it back out there for you and that sounds like that's what happened.

(Linda Jones): OK, OK.

(Sue): One thing I do want to tell you just from horror stories of all the years. Sometimes we do have a situation with customers where somebody's downloaded the remits and either they thought they did and they didn't or the ((inaudible)) didn't tell somebody else. So that may be the situation.

(Linda Jones): Well, the strange thing about it, when you do see something that is there, in our system, the way our software's set up, it kind of puts it in – it saves it. Even if somebody downloaded it, I can go and see…

(Sue): You know what, maybe they tried and didn't.

(Linda Jones): OK.

(Sue): But all I can say it what EDI did is correct. If you ever have any questions or you ever need us to put anything out there for you again, and it should be out there, just call in we'll be happy to do it. It's very simple.

(Linda Jones): OK.

(Sue): All right?

(Linda Jones): All right. And I just have one other statement and it does not reflect anything on Medicare but I just wanted to make this statement. I know Medicaid is getting ready to have everything done on the Web site. And I know that this is way off in the future because there are so many software vendors. Will there be a possibility that CIGNA will incorporate something like that to where everything is physically done instead of having different softwares, you can actually see, not just going and get Pro 32 to see a claim payment, but you can actually see it on the site.

I know I'm throwing it out there. It's way out there.

(Klayton): This is (Kleyton). We have actually been working closely with CMS over the past number of years with multiple proposals in trying to move applications and data to be more Web-based and accessed over the Internet. CMS has instituted some pilot situations over the past couple of years and they're looking at the results of pilots to move into a direction in embracing the Web technologies that are available.

(Linda Jones): OK.

(Klayton): At this time, the CMS ((inaudible)) requirement better dictated by CMS that all Medicare contractors have to follow do not allow for information regarding beneficiaries, any Medicare data to be available over the Internet.

(Linda Jones): OK. OK.

(Klayton): … looking at. It's a direction that we here at CIGNA have partnered with CMS on a couple of things. And I know that Palmetto GBA had some pilot projects in the past also. And we do

continue to work with them on ((inaudible)) up with Web technology solutions to simplify accessing and submitting Medicare data.

(Linda): OK, OK. All right. Well, thank you.

(James Herren): Thank you, caller. Go ahead, caller.

(April): Hello?

(James Herren): Yes, ma'am. Go ahead.

(April): Hi. My name is (April) and I'm calling from SuperMed and I'm calling to alert you also that I hear the lady before saying she was having trouble with her PTAN number. I, too, called on, I believe, was the 26th, which was yesterday, I called three different times. And I put in my PTAN number and it did not accept it at all.

I called this morning and it was OK. So I thought maybe it was just a glitch but I wanted you to be aware that it did happen to me also.

(James Herren): OK, thank you, ma'am.

(April): You're more than welcome.

(Tomonsa McKinneyl): Hi, this is Tomonsa. I'm calling from an orthopedic facility in Memphis, Tennessee.

(James Herren): Yes, ma'am.

(Tomonsa McKinneyl): I have two questions. Number one, how do we obtain extensions on requests from the carrier when we have a question about the request itself and have to wait for someone to return our call within that 10 to 45-day window? And generally, Medicare only gives us between 15 and 30 days to give them a response back.

(James Herren): Well, caller, let me make sure I understand the question right. You're wondering how to obtain an extension, on something when you're waiting for us to respond to you within the 10 to 45-day window?

(Tomonsa McKinneyl): No. When we only have 15 to 30 days to get the information back to the carrier. Now, this information is additional information Medicare's requesting, such as the manufacturer's invoice, a copy of the (benies) HICN, or just a refund request. But if we disagree, of course, I know we can do a re-determination. But how do I get an extension, on the time frame if, when I talk to customer service, they're telling me someone has to call me back. My time is just as important and I don't want my information held up and I definitely don't want information or money recouped when it's not necessary.

Where do I get my extension? How do I get my extension? Customer service…

Female: ((inaudible)).

(Tomonsa McKinneyl): I'm sorry, go ahead.

Female: There is a separate line…

(James Herren): Ma'am, are you talking about development letters or overpayment letters?

(Tomonsa McKinneyl): All the above.

(James Herren): All of the above. I think, unfortunately, we're going to have to look into this a little more. Can I have your name and phone number and we'll call you back today or tomorrow with this?

(Tomonsa McKinneyl): Yes. My name is capital Tomonsa McKinney. And my number is.

(James Herren): OK, thank you.

(Tomonsa McKinneyl): And my second question is very short. Could the guys repeat the Julian date they were working on presently?

(Roc): It's June 18th or I believe its Julian date 169.

(Tomonsa McKinneyl): OK. Thank you.

(Roc): And when I say that, that is the vast majority of our claims. There are a small volume of claims would be older than that.

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

(Debbie): Hi, my name is (Debbie). I'm with (ProMed 1). When we have our EOBs, we have the reason codes stating what the error may be. But I understand customer service has a different code so they're not matching and it takes an awful lot of time between us and customer service to figure out what the issue is. Is that going to be resolved so everything matches up?

(James Herren): So your question is, you've got a concern about not matching up with the denial codes between customer service and what you're seeing?

Female: Hi, (Debbie)? (Debbie), are you there?

(Debbie): Yes.

Female: OK. Based on the EMO codes that you are seeing on your remittance notices, excuse me, those are very generic. Your claim can be denied for any number of reasons so when you contact customer service, they are trying to get you more specific information than what you see on your remittance notice. They're taking the information that's in our system and based on what they see on your claim and trying to get you a more specific reason for your denial other than the vague explanation that you're receiving on your remittance notice.

They're able to see your denial reason code as well. But they're just trying to get you more specifics.

(Debbie): And I understand that. But why couldn't we all have the more specifics so that we could address our issues in the very beginning versus staying on the telephone for 15, 20, sometimes 30 minutes after we've gotten through the waiting time of 30 minutes to an hour to have these issues addressed?

Female: I do understand that, (Debbie). However, those codes are mandated and that's not something that we can make changes to. We can only try to streamline our efficiencies internally to better assist you. But those codes that you see on your remittance notices are mandate.

(Debbie): OK, so there will never be anything else?

Female: I can't say never. Hopefully, hopefully. This would make both of our jobs easier but I can't answer never.

(Debbie): Right. I mean it just seams throughout listening through everybody's conversations, the waiting period that everybody has and once we get on the phone, is waiting for customer service to try to figure out what our issues are.

Female: Right.

(Debbie): It would streamline everybody's time and make it more efficient.

(Roc): … before because this obviously is not a new issue. And we'll continue to provide that feedback whenever that is possible.

(Debbie): OK, thank you.

(James Herren): Thank you.

(Roc): And this is (Roc). I do want to clarify one thing. Somebody asked about the Julian date that we're currently working or a couple of people asked that. Those are only for the claims that, for some reason, ((inaudible)) edited in our system, we must manually cut. The vast majority of claims we receive, which is in excess of 80 percent, no one ever has to touch so those will be processed much quicker.

(James Herren): Go ahead, caller.

Female: Hello?

(James Herren): Yes, ma'am. Go ahead.

Female: Hi. I have a question about the CMNs extending and loading CMNs, Again, I get this from you customer reps all the time and I do realize that you guys aren't Palmetto. But whenever, like, for instance, the oxygen CMNs, whenever there's a 60-day break, we are supposed to get a new initial CMN.

The new initial CMN, we send that over electronically with our initial claim. This has always been an issue with Palmetto to whether we added certain ((inaudible)) notes, whatever the case may be. If there was an initial CMN already there, that CMN would just not get put on file.

There would be sometimes when we didn't catch that another CMN was there until, for instance, maybe three months later we start getting a ((inaudible)) denial when we know there shouldn't be a ((inaudible)) denial because the initial is just three months prior or two months or whatever the case may be.

We would be able to call in. They would look at the record and see that there was a 60 (break), would be able to go back to our initial claim that our CMN was attached to and load in our initial CMN and we would be able to resubmit the claim.

They're not doing that for us at CIGNA. And we're getting back way different answers from different reps, whoever we call. Some are telling us to go re reopening. Some are telling us to go to re-determination with the new initial CMN. Some of them are telling us that just add it on the ((inaudible)) note and resend. So we don't know what to do or how to get that fixed.

(Ellen): This is (Ellen) again. And that is an outstanding issue with all four of the DME MACs. And we are working with our programmers to try to resolve it. But it's not going to be a quick fix.

The quickest thing probably would be to send it through reopening and have them manually set that ((inaudible)) because a lot has to be done. It has to be taken off of CW at the previous one and your set out there. It's not like a quick-fix customer service could do for you.

We have not put anything in place where you describe where you would call and they would look on your ((inaudible)) screen, where the CMN was submitted. But we rejected it out. We haven't put anything in place like that. I mean, we can discuss here but if we do that, we would put something in our bulleting so you know how to file your claim.

Female: OK, so we just need to go to reopening with that.

(Ellen): I think that's the quickest fix for those things.

Female: … you have like that should be sent re-openings because that is a clerical error. That would not be something you would want to send to re-determination.

Female: OK. And the next part of the question is on the CMN, when Palmetto was processing claims, there was the maintenance payments were an issue when the full 15 payments hadn't been extended. The first – we started getting denials and we went back and told us that it was because we weren't getting the 15 payments but here were like really old claims that we had gotten four to five maintenance payments. And then we were told that CMS had taken that back and said if they had allowed two maintenance payments that they would go ahead and allow the maintenance payments.

Then they paid for a little bit and they started denying again right before the transition and we were told that it was because they rescinded that and 15 payments weren't allowed, that the maintenance payments weren't going to be made.

So then, we just lost communication and we weren't able to do it.

Now, we're getting our maintenance payments denied. I know we're getting them denied because the whole 15 payments weren't made. On the newer claims that on our first maintenance, you know, we can go back and re-bill that last 15 payments if we only had 14 payments or we can go back a re-bill. But on the older claims that we've already billed for five months, I mean maintenance charges, they're telling us you've only got 13 payments so we have to go back and re-bill the two extra payments.

But if we go back and re-bill those two extra payments, they're past filing deadlines. And we don't know how to correct that. Some of the reps are referring us to Tier 2 and giving us confirmation and we get to Tier 2 and they're telling us that they're going to send it up to the TRS department and that we're supposed to wait 10 to 45 days. They'll either call us or they'll go ahead and make payment. And I know they're going to deny because the 15 payments weren't there. So that's 10 to 45 days that we're waiting for them to just deny when they won't answer my question as to how we fix it.

We know there are 13 payments. You're not going to give us maintenance unless we have 15 payments. So how do we fix it when the regular payments are back in '04 or '05 and we don't and it's passed on deadline with you all? Did I make any sense?

(Ellen): And maintenance and service is an outstanding issue here that we are looking into and trying to work with CMS to come up with some resolutions to your issues.

The best advice I can give you for the past file times is if you bill those rental dates with a day currently within file time and put in your narrative that to extend the CMN for 15 months payment, we will extend that CMN and allow those rentals so you can get your 15 months pay.

Other than that, we're on the waiting – yeah – we're discussing with CMS how we can more readily resolve this issue without so much of an impact to the suppliers or to us.

And we hear about that or get a resolution back, we will let you know.

Female: OK and what about the maintenance payments that they paid? Do we need to refund them? Or do we just keep them?

(Ellen): You'll have to refund them.

Female: We'll have to refund them?

(Ellen): Yeah, until we get resolution from CMS, that's the last direction that was given to Palmetto that we inherited, that they're to be recouped.

Female: OK. And I have just another question.

Whenever there have been time when I'll get ((inaudible)) denial on my general for instance and I'll call in – well, they'll make payment but ((inaudible)) denial because the like down code because the amount of calories are not the same or whatnot. We used to be able to call and verify – I know that they can't give me out initial ((inaudible)) service that you have on file with another provider or even with our own ((inaudible)), I know that. But we used to be able to call and ask them if they could verify the date, the initial date and amount of calories on file. And they're telling me they can't do that any more.

(James Herren): One minute, caller, while we look at this.

Caller, thank you for the question. We're going to have to research this and what we'll do is we'll put the answer in the transcription that should be posted in a few days.

Female: OK. I just want to make sure that I said the right thing.

I give them the date and they can verify yes or no. Did I say that?

(James Herren): You give them the date and then they should be able to verify yes or no, is that correct?

Female: That's what we used to be able to do.

Female: You're talking about the initial date on the CMN that's causing your denial?

Female: That's on file, yes.

Female: We'll check into that and put them in the minutes for you.

(Answer:

CMS Internet Only Manual 100-9 Ch. 3 Section 30 states:

Contractors shall use discretion in determining what information to release. Contractors should release information about CMNs or DIFs that will facilitate providers / suppliers billing Medicare properly. Although not an authentication element, the caller will need to provide the HCPCS Code or item description in order for the CSR to provide the correct information about the CMN or DIF.

- *Initial date*
- *Recertification date*
- *Length of need*

Contractors shall confirm whether or not the answers to the question sets on the CMN or DIF on file match what the supplier has in his/her records.)

Female: OK, great and one more. I'm sorry. Someone was going to fax (Ellen) some claims and there are some claims that I've had where they're changing the codes on me and like really weird, like we'll submit a ((inaudible)) code and then underneath, we'll deny in parenthesis and then, they'll change my code to an A1390 and deny it for no CMNs.

(Ellen): Oh, that's an issue.

Female: Yeah.

(Ellen): You can fax those to me as well.

Female: OK, great.

(Ellen): I'll be glad to look at them.

Female: All right, thanks.

(James Herren): Thank you, caller.

Female: Hello, can you hear me?

(James Herren): Yes, ma'am, go ahead.

Female: I'd like to find out about the NPI registry. I know it's supposed to open tomorrow but can you tell me what the, I guess, what the Web site, the name of the Web site would be?

(James Herren): One moment, caller. I'll see if we can locate that information for you. And again, you want to know what Web site to go to for the NPI registry?

Female: Yes, so we can find the doctors' NPI numbers because the doctors are getting impatient with us calling and asking for the NPI numbers.

(James Herren): Sure, we understand.

Female: I really believe that Web site information you can find on CMS' Web site. There is a link there to the NPI current contractor. Are they doing a crosswalk to…

(Sue), do you know off the top of your head whether the NPI contractor's doing a crosswalk to the NPI numbers?

(Sue): I don't know.

(James Herren): Caller, again, I'm sorry. What we'll do is we'll research this further for you and we will put this in the transcribed minutes.

(Answer: Taken from the CMS Website -

CMS Delays Dissemination of National Plan and Provider Enumeration System (NPPES) Data

The NPPES Data Dissemination Notice (CMS-6060-N) was published on May 30, 2007 - see the Downloads Section below for a copy of the Notice as it appears in the Federal Register. The Notice describes the policy by which CMS will make certain NPPES health care provider data available to covered entities under the Health Insurance Portability and Accountability Act (HIPAA) and to others.

- *The Notice states that NPPES health care provider data that are required to be disclosed under the Freedom of Information Act (FOIA) will be made publicly available 30 days after the publication of the Notice. In announcing the publication of the Notice, CMS had stated on this web page that these data would be disseminated on June 28, 2007.*
- *The FOIA-disclosable data will be made available in an initial file downloadable from the Internet, with monthly update files also downloadable from the Internet, and in a query-only database whereby users can query by NPI or provider name. The query-only database is known as the NPI Registry.*

- *The Notice encourages health care providers who have been assigned NPIs to review their NPPES data at this time and make any necessary updates or corrections prior to the dissemination of data by CMS to ensure that their information is accurate when disclosed.*

The document entitled, "National Plan and Provider Enumeration System (NPPES) Data Elements – Data Dissemination – Information for Providers," dated June 20, 2007, will assist providers in knowing which of the FOIA-disclosable data can be updated, changed, or deleted.

Source: http://www.cms.hhs.gov/NationalProvIdentStand/06a_DataDissemination.asp)

Female: That will be great. That will be great. I'm in Richmond, Virginia. Can you tell me if you have any seminars that are going to be scheduled in this area?

(James Herren): We don't have any plans as of right now. But that is not to say we aren't looking at things down the road.

Female: Thank you so much. I appreciate it.

(James Herren): You're welcome.

Female: Thank you.

(James Herren): Go ahead.

(James Herren): And (Kelsey), we'd like to make this the last call, please.

Operator: Certainly, sir. Caller, please go ahead. Your line is open.

Female: Hello?

(James Herren): Yes, ma'am, go ahead.

Female: Yes, sir, one second, please. I've left my questions on the other desk. I didn't think I was going to be this fortunate to get through.

(James Herren): OK.

(Cynthia): Hi, my name is (Cynthia). And about a week ago, we received an e-mail from Trust Solutions pertaining to documentation request by PSC. And it may spoke of oxygen. It's indicated that when we – it's possible that Trust Solutions may want to audit some files and they want the (post-oxemitry) test itself and it has to be proven that the patient had the test by a Medicare provider. If we have patients who has been on service with us a number of years and the only thing we have is a CMN, how are we to obtain copies of the (post-oximetry) test and how are we to know, not only back then, but now, if that provider was a provider of Medicare?

(James Herren): Ma'am, I do apologize but I think the best thing to do on this will be to contract Trust Solutions on that.

(Cynthia): OK. Is there anyone there with Trust Solutions?

(James Herren): No, ma'am. We're not. We can give you the fax number to Trust Solutions.

(Cynthia): I've gotten it already. I got that. OK. Another question I have. When we go through the automated systems, the IVR, when we were under Palmetto, we could obtain a status of claims that was in re-determination. It doesn't give us that option now. Will that change in the future?

(James Herren): I'm sorry, ma'am…

Mia: (Cynthia), this is Mia. The status on re-determination is something that we're checking into and ((inaudible)) on our IVR. We are actually looking into that. Currently you are unable to check the status of re-determination through the IVR.

(Cynthia): Right. We can't check it. We have to go through customer service. And the only thing customer service can tell us is the initial denial.

Mia: Now, are you looking for the status or looking to the reason why a…

(Cynthia): I'm looking for the status. I know the reason why a claim was denied. And I've submitted a re-determination. And in actuality, several of the re-determinations were submitted like in (April) prior to CIGNA taking over. And, of course, all the re-determinations, as well as all the other claims, came from Palmetto to CIGNA. Now, CIGNA does have certain re-determinations in their system but it's still pending. And it's been over 60 days. And no one can actually tell us, you know, OK, what's going on with it. And at one point, we used to be able to go through, like I said, IVR, and get status of that claim. All we had to do was put in a document control number. But of course, with CIGNA, there is not document control number. But back then, when we submitted the re-determination, there was a document control number.

And it just so happens that the majority of them were oxygen patients because a recertification was required. And then, we bet this e-mail from Trust Solutions. I do understand that there's no one there from Trust Solutions to answer my question. But now, I'm concerned are my claims being held up in re-determination with CIGNA simply because of this e-mail we got from Trust Solutions requesting additional documentation? Not that we've gotten any type of correspondence from Trust Solutions stating I need this.

I need help.

Female: The issue that you're having with Trust Solutions is not related to the things that you've sent in for to appeal and re-determination. I can tell you that we are still working on we-determination cases that were transitioned from Palmetto and we're doing on a first in, first out basis…

(Cynthia): I understand that.

Female: However, the two are not related. The issue you're having with Trust Solutions and the issue that you're having with checking the status of your re-determinations are not related.

(Cynthia): OK.

Female: They do not have the functionality on our IVR to be able to check the status of a re-determination. You would have to go through customer service. And being if it's an older re-determination case that you sent originally to Palmetto for the appeals, they may have to do a little more research and they may have to transfer it on to second level or third level…

(Cynthia): OK, when you say transfer to second or third level, what are you meaning by that?

Female: They would have to transfer – if you call into the customer service line, that individual may not be able to answer your question. But they should transfer on to a second-level CSR that would be able to assist you. If they're unable to assist you, then they would transfer you again to a higher level.

(Cynthia): OK. What time frame do we have? Like I said, it's been way over 60 days. Actually, it's going into the 90th day. How far behind is CIGNA on a lot of the claims in re-determination?

Female: At the beginning of the call, ma'am, we talked about some of the workloads that we assumed from Palmetto being larger than we anticipated.

(Cynthia): I understand that. I remember that.

Female: And re-determinations is one of those. So as we've often said, we're bringing in additional resources so that we can work those and we are working them first in, first out.

(Cynthia): OK. Will you all be sending out any type of correspondence statement that yes, we do have this re-determination and we are still processing it so we know what's going on? That way, we won't tie up your customer service line trying to find out what's going on with the claim.

Female: No, ma'am. As we said earlier, if you were able to confirm that Palmetto had received your re-determination, we did receive everything that Palmetto had pending.

(Cynthia): OK.

Female: Just to clarify something I heard you say earlier, you submitted these for re-determination because they needed a re-cert. CMN?

(Cynthia): Right.

Female: That's something you can submit to the reopening. You do not have to go through an appeal for something like that.

(Cynthia): Well, one time we were resubmitting that through reopening with Palmetto. And they said, no, we have to a re-determination now. And that's exactly what we did.

See, also, with the oxygen patient, once a CMN has gone over, Medicare doesn't want to continue to see the (CMN) and so we have to tell our software system, stop submitting every

month. Don't send the CMN. Once recertification comes up, we forget to go back there and flag the system, OK, this is a re-cert.

This causes us to have a lot of denials from Medicare when re-do the recertification because we didn't flag our system.

Female: OK, and actually, you have the option. You can bill that as a new claim with the re-cert. CMN or you can take the option of sending it to re-openings. But it does not have to go through re-determination for your first level of appeal.

(Cynthia): OK, well, that's not what we were told. But so if that's the case, can I go back on all the claims that we did a re-determination under Palmetto, and submit those as just reopening? Will I be penalized because the questions, someone has failed filing deadline. We only have four months from the date of (DEOMB).

Female: I mean, we'll still complete the re-determination because they're in the pipeline. But if you want to submit those either as new claims, you can go ahead and do that or…

(Cynthia): It won't dupe out?

Female: No, ma'am. The claim was denied and you're now submitting it with the required information, which is the re-cert. CMN.

(Cynthia): OK, hold on, one second.

Female: I just have one quick question for you regarding the capped rentals.

(James Herren): OK.

Female: My question is this. Is there a way to determine exactly what month a patient is in prior to us providing an item, let's say a wheelchair or bed or oxygen?

(Mia): That would actually be something that you would need consent from the patient in order for us to be able to release that information to you.

Female: OK. What would represent the patient's consent? Because, I mean, I'll be – I'll give you a scenario.

(Mia): OK.

Female: Let's say, for example, you're talking about, you know, there's only so many months before you stop paying for equipment and it's considered purchased by the patient. Let's say the patient calls us, they've had the equipment for 11 months prior, how am I going to find that out and so that according to your records, I don't get one month of rental and be told, OK, great, now the patient owns the equipment from you even though we've only paid you one month?

(Mia): Well, in that event, what you do to protect yourself is you would do a conference call with the patient on the line and Medicare. If the patient is willing to give consent to you to get that information from Medicare, if you do a conference call, it's the same or similar call to see if they've had same or similar equipment on file before.

And with the patient's consent, we can tell you how long the patient's had the equipment, what the previous provider's name is, what their telephone number is. A lot of times, the beneficiaries don't remember, so we could give the phone number as long as the patient consents to it, we can give out the phone number of the previous supplier. You can reach out to them for that information.

Female: OK, and what phone number is that you call? Is it that 866-270-4909?

(Mia): Yes, ma'am. The customer service line.

Female: OK, now, does the patient actually need to be on the phone? Can I fax written consent? What exactly do you qualify as consent?

(Mia): You would have to call into that line with the patient on the phone. If the patient's not on the phone with you, the CSR have been instructed not to hold on the line if you don't have the patient on the conference call with you.

Female: OK. So you can specifically tell us exactly what that month that patient is in with the patient on the line?

(Mia): Yes. And whatever information you need to know, you would probably want to come up with some type of format or questions you want to ask the CSR so you don't forget or what have you. It's typically what we've experienced in the past on the Region D contracts. You have some type of form and just questions that you ask the CSR as long as the beneficiary consents to those questions, you can get that answer through the customer service line.

Female: OK. So I mean, is there also any specific time frame that's been set by CIGNA as when that we can quote, unquote, "pick up" equipment? Like after so many months or something like that?

(Mia): Picking up. Well, I guess the picking up of equipment would depend on the situation, the scenario that you are experiencing with the beneficiary.

Female: OK.

(Mia): What would be the reason for the pick up?

Female: OK, for example, let's say the patient is in the seventh month, all right, and for some reason won't consent to us contacting you to obtain that information. And I find out after I get the first month that the patient is in the seventh month and I don't want, obviously, to paid just a few months for a piece of equipment. Can I pick the equipment up?

(Mia): In most situations, yes. It depends on the denial that you've received and whether or not you omitted something from the client. That is really a very specific question to…

Female: No, it's denied for (same) or similar.

(James Herren): Caller, the best way to do that would be, prior to dropping the equipment off with the beneficiary, do the same or similar call before that.

Female: I know. But the problem is occasionally is that the patient may be coming from a hospital and the patient may or may not be able to make that call. And all I have is a caregiver. You're not going to take a caregiver's word or a family member, you need the actual patient.

(James Herren): It would depend on whether or not that person has the right to speak for that beneficiary. For instance, are they are a rep payee or something like that. Also, you can have a family member assist the beneficiary in providing information but it has to be the family member and not someone from the provider or supplier's staff.

Female: OK. And how would they have – would there be any certain way they have to prove that they were a family member? I mean, if they just say I'm so-and-so's daughter, that would work?

I'm not trying to figure out a way to get around this. I'm trying to figure out a way that I can call because we have been burned, I can't tell you how many times, that we find out that the patient has already had the equipment even though we get all of these insurances from everybody that, you know, oh, we've never had it before. Then all of a sudden, we get a denial from Medicare saying, you know, they've already had the equipment before. Oh, yes, I remember. I did have that equipment before. I bought that for grandma, you know, two years ago.

(Mia): Yeah, this is certainly an ongoing issue with, I'm sure, many other suppliers as well. The only thing that we can offer is for you to call in on the same or similar line and do that. As far as picking up the equipment, if you're getting same or similar denials than most situations, you would be able to do that. It just depends on the denial that you're getting from Medicare.

Female: OK. I have one other question and then, I promise, that's it. Will the KX modifier be required on accessories for bed and wheelchairs?

I believe the answer is yes. I just wanted to make sure.

(James Herren): Yes, ma'am, it will be.

Female: OK. Thank you very much for your help. I appreciate it.

Operator: Yes, Mr. (Herren), you wanted that to be the last question, correct?

(James Herren): That is correct.

Operator: OK.

(James Herren): Thank you.

Operator: You're very welcome.

(James Herren): This will go ahead and end the Ask the Contractor teleconference for today. Thank you for your participation.

Operator: Thank you, ladies and gentlemen that does conclude our conference for today. On behalf of CIGNA, I would like to thank you for your participation. Enjoy the rest of your day.

END