

CIGNA

**Moderator: Ronja Roland
September 17, 2008
1:00 p.m. CT**

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

Now it is my pleasure to turn the conference over to Ms. Ronja Roland.

Ronja: Good afternoon, everyone, and welcome to the CIGNA Government Services General Ask the Contractor teleconference for DME MAC Jurisdiction C. I am Ronja Roland with provider outreach and education.

Joining us today on the call also will be Taveo Perry and Max Garner, with our provider outreach and education department as well.

I would like to begin by thanking each of you for your participation in today's call. Your participation helps us to identify issues that are important to you so that we may better meet your needs. The minutes from this meeting will be posted to the CIGNA Government Services Web site.

We are also pleased to have additional representatives from our provider outreach and education team, as well as subject matter experts from our claims, customer service, medical review, overpayments, redeterminations and re-openings departments joining us today.

During today's call, we will highlight changes and updates relevant to the Jurisdiction C supplier community. Please keep in mind that we will not be able to answer questions about individual claims issues. If you have claim specific issues, remember to call our provider contact centers at 866-270-4909. If you wish to check claim status, you may call our (IVR) system at 866-238-9650.

Let's begin with an update regarding the recent hurricanes Gustav and Ike. If your office was impacted by Gustav or Ike, you may submit your claims either electronically or on paper using the disaster code modifiers and claim submission instructions established by CMS.

To submit claims on paper, you will need to send a waiver request to CIGNA Government Services. Once your request is approved, you will be able to submit paper claims for 30 days only. If your office was impacted by either hurricane, and you wish to request a 30-day waiver to submit paper claims, please send your request to CIGNA Government Services, and that's P.O. Box 20010, Nashville, Tennessee 37202.

For disaster claims, suppliers should use the modifier **CR** to identify services and items provided to the victims of Hurricane Gustav and Ike. Make sure that you do include a narrative on your claim that states Hurricane Gustav or Hurricane Ike, this is very important that that narrative is included on the claim along with the **CR** modifier.

Complete details are available on our Web site at www.CIGNAgovernmentservices.com. CMS has also published additional instructions and frequently asked questions and answers on their Web site. Their Web site address is www.cms.hhs.gov.

Since it is hurricane season, there may be additional hurricanes which may present additional challenges for suppliers in Jurisdiction C. CIGNA Government Services would like to recommend you prepare for future weather situations by contacting your information technology unit, billing services or clearinghouses to make sure your electronic data is backed up and available to you from a remote location.

In the event you need to leave your facility due to a public health emergency, or disaster, and need to work from another location, we recommend you take copies of standard CMS 1500 claim form. While this may be a manual process, it may still allow you to submit claims until such a time as you can return to your physical office location.

We will continue to communicate with our Jurisdiction C suppliers by our ListServ, Web site, your supplier state associations, and updated audio recordings on the IVR.

We would also like to thank all of the state supplier associations for their assistance in getting important information to you about the hurricane. We value the relationships we have formed with these state associations. Their support of our efforts to insure you receive important information is greatly appreciated.

Joining us with information on MIPPA is Taveo Perry with Provider Outreach and Education.

Thank you, Ronja. Medicare Improvements for Patients and Providers After 2008, also known as MIPPA, was enacted on July the 15th, 2008. Under this act, the competitive bidding process will be postponed for 18 to 24 months. Another change with MIPPA is the ownership of oxygen equipment. Prior to July 15th, 2008, once oxygen reaches 36-month top payment, the equipment will belong to the patient. Now once the capped period is reached, the equipment will still belong to the supplier.

Another important change implemented as a result of MIPPA is the accreditation and exemption of certain providers. CMS issued guidance regarding DMEPOS furnished by certain healthcare professionals and persons. MIPPA required all DMEPOS suppliers to meet quality standards for Medicare accreditation by September 30th, 2009. MIPPA section 154B, sub paragraph (S) states that eligible professionals and other persons are exempt from meeting the September 30th, 2009 accreditation deadline, unless CMS determines their quality standards are specifically designed to apply to such professional and person.

CMS will work in collaboration with the medical and professional groups to develop specific quality standards. Those providers that were accredited prior to the enacting of MIPPA would not have to undergo a re-accreditation process. The eligible professionals include the following practitioners, physicians, physical therapists, occupational therapists, qualified speech, language pathologists, physician's assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetist, certified nurse midwife, clinical social workers, clinical psychologists, registered dietitians and nutritional professionals.

Additionally, the section also allows the secretary to specify other persons that are exempt from meeting accreditation deadlines unless CMS develops that the quality standards are specifically designed to apply to such other persons. At this time, such other persons are only defined as the following practitioners: orthotists, prothetists, opticians and audiologists.

Existing DMEPOS suppliers, with the exception of those previously mentioned, that are enrolled in the Medicare program are required to obtain and submit proof of accreditation to the National Supplier Clearinghouse by September 30th, 2009.

The NSC will revoke a DMEPOS supplier's billing privileges on October 1, 2009. Please remember the accreditation process may take up to nine months to complete for an enrolled DMEPOS supplier, therefore all of the enrolled DMEPOS suppliers, except those exemptions

mentioned will need to submit a complete accreditation application to the accreditation organization by January 31, 2009.

Since March 1, 2008, new DMEPOS suppliers submitting an enrollment application to the NSC must be accredited prior to submitting the application. The NSC will not approve any enrollment application if the enrollment package does not contain an approved accreditation upon receipt or in response to a developmental request. The NSC shall reject an enrollment application unless the supplier provides supporting documentation that the supplier has an improved accreditation. For more information on accreditation exemptions, CMS has created a fact sheet that is available on the CMS Web site.

Since the transition back to CIGNA Government Services, our medical review department has worked closely with the provider outreach and education department to assist in educating the provider community. Later this week, the medical director will release three new local current determinations for open comment from the supplier community. Please check our Web site for more information.

I'll turn today's call over to Max Garner with provider outreach and education, who will now share with you updates on overpayments and some new Medicare resources that are available to you.

Effective September 29, 2008, change request 6183 indicates that non-provider initiated overpayments will now – will now have overpayment rights as well as the bill rights.

For overpayments subject to this limitation on recoupment, Medicare will not begin overpayment collection of debts or cease collections that have started when it receives notice that the provider has requested either a redetermination or a reconsideration.

The normally scheduled time for an offset to occur is no sooner than 41 days after the initial demand letter is issued, 60 days after the first level decision, and no earlier than 30 days after the second level decision.

In order to stop the recoupments of an overpayment, the redetermination request must be filed within 30 days of the demand letter. If the request is not sent within 30 days, Medicare can begin to recoup on the forty-first day from the demand letter, but will cease recoupment once the redetermination request is received and validated.

The recoupments may also be stopped at a second point if a valid reconsideration is filed within 60 days of the notice or letter. If the overpayment decision is upheld in the appeals process, the overpayment will occur with interest. If at the ALJ level, the overpayment determination is reversed, Medicare will refund with interest any overpayments collected on that debt. Once the provider is notified with the overpayment demand letter, the provider may submit a rebuttal within 15 days to dispute the debt.

Only a provider's timely and valid redetermination or reconsideration request will halt the recoupment. Information regarding this change request can be found in the Medlearn Matters article MM6183, and is available on the CMS Web site.

On August 18, 2008, Noridian Administrative Services assumed the duties of the pricing data analysis and coding contract. This contract was transitioned from the SADMERC contract previously held by Palmetto GBA. There are important details about the transition of these functions from the SADMERC to the PDAC, which we will discuss now.

Effective August 18, 2008, all product review forms and corresponding documentation, along with product samples, if applicable, should be mailed or faxed to the PDAC. The PDAC HCPCS product review forms are also located in the HCPCS review section of the PDAC Web site. And

that Web site is www.dmepdac.com. When sending HCPCS product review forms, only one application with supporting documentation is required. Multiple copies of these documents are no longer required.

Also please discontinue using any SADMERC forms as of August 18th. PDAC will send an acknowledgment letter for all product reviews transferred from the SADMERC to the PDAC. The PDAC contact center hours are from 8:30 a.m. to 4:00 p.m. Central Standard Time. The DME coding system, DMECS, is also available from the PDAC Web site. The PDAC contact center phone number is 1-877-735-1326, and their fax number is 1-866-209-1236.

And one of the newest resources CIGNA Government Services has made available to you is the ANSI denial guide. This tool is available on the CIGNA Government Services Web site and the DME MAC home page section under claims.

This tool was developed to provide the supplier community with guidance on how to address claim denials in the most efficient manner. The denial guide does not capture all scenarios, but rather the most common. Suppliers are strongly encouraged to review all aspects of a claim denial and respond accordingly. The ANSI denial guide details the ANSI reason code found on your remittance advice, the remark code, and an explanation of the denial, things to look for, and the next step a provider should take in regards to the denial.

Also in response to feedback from the supplier community, CIGNA Government Services has enhanced the CMN status option on the DME MAC Jurisdiction C IVR. The CMN status option provides information for all inexpensive or routinely purchased items and all rented items, including capped rental items and oxygen equipment regardless of whether the equipment requires a physician signed CMN or not.

The IVR now provides not only CMN information on the procedure code entered, but also CMN information on all similar equipment on file. In addition to the initial, re-certification or revision date, and the length of need, the IIVR will now provide the previous supplier's phone number, the last date billed, and the total months paid for rented items.

If there is more than one same or similar CMN on file for a procedure code entered, the IVR will prompt you to listen to all related CMNs. This IVR option will save you time by eliminating the need to contact the customer service center for same or similar inquiries on a pre-planning basis.

To access the CMN status option on the IVR, press two, which is beneficiary information from the main menu, and then press three for CMN status. As a reminder for our Jurisdiction C suppliers regarding claim rejections, if you receive a rejection due to your NPI not matching the crosswalk, you must verify the information at NPPES, and then make sure that it matches your information with the NSC.

Also, if an update should be made to NPPES, you may access the Web site and make the necessary corrections. Also, if an update should be made regarding your PTAN or legacy number, contact the NSC to determine if a new 855S form must be completed.

CIGNA Government Services cannot update NPI or PTAN information, so you must contact the appropriate contractor, either the NSC or NPPES to update that information.

The CIGNA Government Services Provider Outreach and Education representatives are currently conducting outreach throughout Jurisdiction C. Some of our upcoming events include West Virginia MESA, MedTrade East in Atlanta, Georgia, and Maximizing your Reimbursement Workshops in Denver, Colorado, Houston and Dallas, Texas.

We are also adding additional Webinars to our calendar. By adding additional encore Webinars, we can allow more providers to attend our online education events. We will also host additional ACT calls for oxygen suppliers and pharmacies. We would like to thank our Jurisdiction C suppliers for increasing registration in our ListServ. If you or your staff is not registered for our ListServ, we encourage you to do so. By joining our electronic mailing list, you can get immediate updates on all Medicare information, including Medicare publications, important updates, workshops and medical review information.

So with all that said, I'll turn it back over to Ronja Roland.

We will now open our lines for general question and answers. Please remember that we will not address specific questions about individual claims. For individual claims issues, contact customer service at 866-270-4909, or you can check claim status at 866-238-9650. Please limit your questions to one per supplier so that we may address as many callers as possible.

Operator, we will now take our first question.

(Wendy): Yes, I have a question about the NU modifier. I was told on the L2770 that I was supposed to use KXNURTLT, or whatever the side it will be. Is that true?

Female: OK. And the – that is – is that a prosthetic item?

This is (Ellen) from the claims area. And normally the (NU) modifier is not required on (L) codes.

(Ellen): You can Check the LCD to be sure, but normally they are not.

(Wendy): OK, because when we're billing the (L2770) with the base code (L1990), that is what a lady from Medicare told me, because– I've had like four denials on that code.

(Ellen): This is something that's happened recently, but the knee orthosis policy went into effect in July, and there was some incorrect denials for additions to that code in that policy that cross over to the AFO KFO policy, and they were incorrect denials. But they have been identified and adjusted, so you may want to go back and see if your claim that denied has been corrected.

(Wendy): OK. So can I just resubmit it, or do I need to call?

(Ellen Edinfield): You can resubmit it.

(Wendy): OK, thank you.

Female: Thank you, (Wendy).

(Jim Larson): This is Jim calling from Florida. I have a question about oxygen claims and denials.

(Jim Larson): When – let's say you have a patient that has had (E1390) rented for a while, and as the patient progresses, they desire – or they need – we get an order for portable oxygen, (EO431). According to all the guidelines, we have to get a revised CMN and attach that revised CMN to the first claim. And since that, we also need to add claim notes as well letting them know that we're updating this CMN, and to make these changes.

About 50 percent of the time it pays, 50 percent of the time it denies for lack of CMN. So I'm just looking for guidance on how to escape this. When you do call to get an explanation, you always have to get to a tier two, because the first person that answers the phone has no clue, you have to teach them.

So I guess I'm looking for guidance, what is the correct way to file these claims? And are we filing them correctly?

Ronja Roland: OK, (Jim), let me ask – just to make sure I'm clear on your questions – with the oxygen tank, are these various patients, or is this the same patient where you're getting some paid and some denied?

(Jim): Oh yes, it's hit and miss.

(Jim): It seems to me if I had to guess, some people are reading the claim notes, and some aren't.

(Jim): That seems to be the only explanation I can get, because when I finally do –get to a tier two, and they can look at everything, they say OK, I can see – oh yes, claim note's there, oh yes, the CMN is there, but CMN kicked out because there's a CMN already on file. Oh yes, it should have been posted as a revised, but it wasn't, sorry.

Female: OK, we're going to let Ellen answer this question for us.

(Ellen): Jim, I think you're submitting your claims correctly, it sounds like we are not processing them correctly on our end. And I would like to give you a call and get some claim examples from you.

(Ellen): So you should be sending us a revised CMN, and it should be coming in and suspending for a claim processor to look at. The note would be very helpful that you've added a portable. But we do have instructions that when an – when a system is added on later, how they are to process those, and it sounds like your – some of your claims are not being processed...

(Jim): Well I got to be honest with you, and tell you first of all, from the transition from Palmetto to you guys, it's night and day in the positive for CIGNA. But also in talking with the tier twos, it used to

be probably 90 or 100 percent in the beginning, now it's just dwindled to probably – I'd have to speak again with my exact billers, but probably 40 to 50 percent are coming back...

(Ellen): ...denials on portable oxygen.

(Jim): Denials for portable after the fact when you have to revise it. If it's with the initial, from the beginning the patient – if it's ordered portable and concentrator, (E1390) and (EO431), no problems whatsoever.

(Jim): It's always later. And then that leads me to a second part too whenever you're ready.

(Jim): The second – the second issue with the oxygen is – and I think it's probably the same situation, a patient had oxygen in 2005, they went off of oxygen, and it's been a year, year and a half, two months, three months, however the time period later, either way, the guidelines tell us if there's a 60-day break in service, we need to get a new initial. Again, we get a new initial, add the claim note that this is a new initial, please post this as a new initial. I've given them, all of my personnel the exact verbiage every single time in the claim notes. And again, it's about 50 percent of the time it gets denied for – and it makes sense, Medicare's looking for a re-cert, because there's already an initial on file.

But according to the guidelines, if there's a 60-day break in service, we need to file a new initial with a new test date,

(Ellen): This is Ellen again. And the – part of the problem with that is your new initial can't get into the system because there's a CMN already there, and it overlaps. So you're probably getting a CMN reject. But what we've asked you to do is to put that narrative on your claim line so that we can have – and it should suspend your claim, and it should go to a special status for someone to go and to pull that CMN in manually, and to load it. But it sounds like some of your claims are not

being handled correctly there either. So I'll again need to get your telephone number and give you a call and get some examples.

(Jim): Yes, again, it started off 100 percent, and over the last I don't know, six or eight months of me going to tier twos, I mean they were wonderful when I got to a tier two, faxing examples, it seemed to get better, but it hasn't – it hasn't come where I think it should be.

(Ellen Edinfield): It's slow progress.

(Stephanie): Yes, Jim, this is Stephanie and I'm a Claims Supervisor and we are aware of this, and we are definitely educating our claim approvers on reading their narratives and processing claims correctly. So I just want to let you know we are aware, and educating.

(Jim Larson): Wonderful. Yes, if you – if you need examples, you can definitely take my name

Ronja: Yes, let me go ahead and get your number.

Ronja: OK. Now do I need to ask for you, or is there someone else in the office we could ask for?

(Jim): I'm going to have (Terry) collect those examples for you. All right, wonderful, I appreciate your help.

Follow up: The provider has been contacted and examples were provided. The claim examples have been forwarded to the appropriate operational areas for education and resolution.

Ronja: Thank you so much for your question.

Ronja: OK, we'll go ahead and take our next question.

(Maria): I'm in Houston, Texas. And I have a general question in reference to a (K) code for a billing for replacement and repairs on equipment that is purchased or the patient owns. And I'm needing a clarification of what modifiers are needed, I have a narrative description of the type of wheelchair, the repair cost, the manufacturer, all that is in the narrative claim notes. But for some reason we're getting a rejection because of combination of modifiers. And I was wondering if you can guide me and as to what modifiers are needed if I'm billing for repairs. The actual wheelchair that the patient owns that we sent to the manufacturer to get it repair. This is for K0004 in specific.

Ronja: So you are actually replacing the entire chair, or replacing a part on the chair?

(Maria): Replacement parts. As far as the seat you know armrests and stuff like that.

Ronja: With that, it should be – if it's the actual replacement, then you would include the RP modifier.

(Maria): Which I have.

Ronja: Depending on the actual code, verify with the payment category for it to see if the appropriate payment modifier is on there, if it's a rental, if it's a NU for one-time purchase, and then making sure if that replacement part also if it required the KX modifier. So you want to verify with the (LCD) to make sure those appropriate modifiers are there as well as the RP modifier.

(Maria): OK, but as a general rule, if we're billing for a specific sale item, repairs, it's not rental, so (NU) would be the modifier.

Ronja: Correct, if it is a sale item, yes.

(Maria): OK. (RP) would be the other – for...

Ronja: If you are truly replacing that part, yes.

(Maria): Got it, OK, thank you.

Ronja: Yes, we'll need them both.

(Maria): Right. OK, thank you.

Roland: OK, thank you.

(Janeen): Yes, my name is (Janeen), and I'm with Clay Hill Medical in Petersburg, Virginia. My question was again about narratives that we attach to claims, particularly again on the oxygen. (CEDI) was telling us that the narratives are going through, but when I would call Jurisdiction C provider assistance, they would tell me that they did not see a narrative attached to the claim.

Ronja: You're saying that you're submitting the narrative CEDI saying it has gone through, however, it's not showing up with Jurisdiction C?

(Janeen): That's what customer service tells me when I call to question about the claim being denied. And it's usually always a (CO176) denial, and it's almost always again where we're asking them to load the new initial. One answer I have received was that there was no narrative attached, and to resubmit the claim. So I did, and it got denied for the same reason, when I called back on that second denial for the same reason, I was told that you can not ask for a new initial to be loaded electronically, you have to get it denied and then send it to redetermination and ask them to do it.

Ronja: OK. I think we kind of have two parts to your issue. The first thing, the narratives are received. One thing we may want to get, especially with the narratives, because every software is different, making sure it is in the appropriate loop.

(Janeen): Yes, I've verified that.

Ronja: OK. And then what we can do, we can try to reach out to our CEDI representatives as well to see if they've been having problems from any other providers.

(Janeen): I have talked to a couple of the providers here in our area, and they're telling me that they're having the same problem with narratives on any kind of claim, that they're either being told that it's not there, or occasionally you'll be told, yes I do see the narrative, I don't know why this denied, it must have denied improperly. So is it safe to say that it would be what you were advising the gentleman from Florida that the narratives just aren't being read?

Ronja: That could be some cases, but again, there are cases where it is truly not being transmitted. So that's kind of two different instances. There's the instance where it was there, and it just not process correctly, then we can research those. But if it was not that transmitted to begin with, there's not much that we can really research on that part.

(Janeen): Right, because what our concern was is we track our denial rate, and since switching over to CIGNA, our denial rates have gone through the roof, and almost all of them are the (C0176) denials, where we're asking them to load the new initial, or if it happens to be where we're asking them to extend the CMN so we can build the remaining capability rental months, either way, it's always because they're telling us that there's no narrative, and it's in the same place that it's always been.

Ronja: OK, what we'll do, just for the sake of time, we'll go ahead and get your number and give you a call back, we'll get some examples. What is your number?

Thank you, Janeen, you will receive a call back from a representative from CIGNA, and we'll get those examples.

Follow up: The provider has been contacted and examples were provided. The claim examples have been forwarded to the appropriate operational areas for education and resolution.

(Janeen): All right, thank you.

Ronja: Thank you. We'll go ahead with our next question.

(Susan): Hi, my name is Susan from Houston, Texas. And my question is regarding the CR modifier for catastrophic related claims. Since I've had a couple of my clients calling in to see if their motorized wheelchairs will be replaced, or repaired for damages, and all of that. I just wanted some clarification on what modifiers to use if I have to replace a wheelchair that was purchased, what would be the combination of modifiers to use? Because I've had only one instance where I have had to send a claim with that CR modifier in the claim, and it didn't go through.

Ronja: For the catastrophic or the disaster claims, you want to make sure the CR modifier is attached. Now, you also need to make sure that all of the required modifiers would be there as well. So if you're dealing with a capped rental item, you want to make sure you have all the appropriate rental modifiers, as well as if it requires a KX modifier. So you want to make sure you have all the required modifiers, and – in addition to those modifiers, you would have the CR modifier. And again, you need to put your narratives, that lets us know that it was for either of the hurricanes that just occurred.

(Susan): OK, well further to that, the only claim that I had previously sent ever with a CR modifier on there, there was five sets of modifiers, and when the (EOB) came back, I noticed that the CR modifier was not even showing, so I was kind of afraid that maybe it didn't even transmit. So if I have, how many sets of modifiers can I actually put in there, for example, if I have to replace a motorized wheelchair that was purchased, would I have to have the CR first, or would I you know just put in all the NU, the you know KX, BP or KH, and then still attach the CR to the end?

Ronja: It will actually allow up to four sets of modifiers. There is a 99 modifier that lets us know that you have more than four for the overflow modifiers. So in that case, if you have more than the four sets, then you would need to indicate on the claim with the 99 modifier.

(Susan): Would the 99 be the fourth modifier, or is there another field that I'm missing on my – on my billing sheet that – where I would have to put the 99 on there?

Ronja: The 99 would be your fourth modifier.

(Susan): So thank you so much, that's been very helpful. And also I want to add to what one of the other callers said, you guys are such a great help compared to you know what we had to go through with Palmetto, and I just want to urge you guys to keep it up, and you know it makes the work easier.

Ronja: Thank you so much for that comment; we really appreciate your feedback.

(Susan): All right, thank you.

Ronja: Thank you. We'll go with our next question.

Female: Hi, my question is in regards to patients that enter home health. We at times find that we bill for supplies such as like on September 1st, and then the patient enters into home health maybe a couple weeks after, but when they enter into home health, it's during the time that we've sent them supplies. So if we sent them a 30-day supply, and they entered home health a week later, we're finding that we're getting denied, or sometimes getting our money retracted for those claims, because during part of the time that we sent them supplies, they were under home health. But really our date of service was before that of the home health agency.

So I wanted to see if you had any guidance on how we could prevent this from happening in the future.

Ronja: We're going to let Ellen answer this question for you.

(Ellen): I'm not really sure; I may need to see your examples as well. But the home health agencies are set up in a 60-day episode timeframe, and if your dates of service fall within that timeframe, it will reject from the common working file with a denial, it's an automatic denial, it's not something we go and look for and do, it's a system denial. It may be that the home health claim date is one thing, but the episode dates are something else. Where are you getting your home health date?

Female: We're getting that from the (EOBs), it's putting the dates on there, and I'm not sure if it's the start of the plan of care, or if it's their date of service essentially, but we're finding that our date of service was before they actually billed for the supplies. So the patients, when we ask them, are you in a home health episode or being seen by a home health agency, they say no, because at that time, they're really not. But then they enter into a home health episode you know a couple days or a week later, and there was really no way for us to have that information, but we're finding that funds are being retracted for that purpose.

(Ellen): It's possible that the physician has ordered home health, the episode has been set up as a common working file, but a claim hasn't been filed by the home health yet, or that the patient may not even realize that they're under that. But we need to make sure that's your issue, and not that we're denying your claims incorrectly.

Female: The other part of the question that's related that I was wondering about is that we check through a third party software every patient's Medicare eligibility each month, just to make sure that their policy is effective. And many times when we check it, we are able to see that they're currently in

a home health episode. But we've found many cases where that information is not updated, and so my question is, how often do the CMS systems get updated with the home health information? Is it monthly so we can check to see if they're in that type of an episode?

(Ellen): Unfortunately we wouldn't be able to address if you're using a third party vendor as far as checking eligibility, we could only you know attest as to our IVR systems.

Female: Right, they're getting it directly from your (IVR) systems, so it's direct pass through. But what we're finding is that your systems aren't updated at all times when we see that the patient is in home health, so I didn't know if there was some type of delay with the updates of your system, like perhaps they're only updated on the fourth or fifth of every month, or if it's real time, as soon as you guys are me aware that somebody is in a home health episode that it gets updated that day.

Ronja: One thing we just want to reiterate too, a lot of that updated information also depends on that home health agency, or that other entity that we rely on to update their record. So if they do not update it timely, then of course our system can't request that if it's not updated in the system.

Female: OK, so if they did update it with you all, how often do you guys update your (IVR)? Is that done monthly?

Ellen: The (IVR) I think goes directly to the common working file for that information, and we don't update that information at all, it all comes from the common working file, we have no control over when it's updated.

Female: OK. All right, and then the very last part of my question, is it – is it true that on the plan of care for home health agencies that they could also take care of patients' diabetic supplies? I know that that's kind of been a question that I believe if it's on their plan of care, then they're to be

providing the diabetic supplies, but if it's not, that that traditional mail order providers could provide diabetic supplies if it wasn't on the plan of care through home health.

Ronja: Diabetic supplies do not fall under home health, it would be ostomy, urological, tracheostomy and surgical dressings, those are the things that would be considered part of that home health, not diabetic supplies, those can still be provided.

Female: OK. We have found at times that diabetic supplies were put on the plan of care, and when – we didn't know that when we provided those supplies to the patient, we did receive a denial for that. So does it depend on if they're on the plan of care? Or do you think that they should never be provided by the home health agency?

Ronja: You shouldn't have – do you remember what the actual ANSI denial code you received? Because it could have been a denial for something other than home health. Like I said, that's not considered one of those that fall into consolidated billing.

Female: No, I don't have those examples with me right now, but we were certain that it was for home health. But I guess what you're saying is that may have been done in error that we – that the home health agency should not be providing diabetic supplies.

Ronja: What we will suggest you do, you can go to the CMS Web site, they have a, home health consolidated billing master code list, and it lists all the actual HCPCS codes that are affected by consolidated billing.

Female: OK. And where did you say we could find that?

Ronja: The CMS Web site.

Female: OK, thank you.

Ronja: Thank you. We'll go ahead with our next question.

(Linda): Hi, (Ellen), how are you doing? Hi, Ronja, this is (Linda) in Ft. Lauderdale, and I have a question.

Ronja: Hi, (Linda).

(Linda): Hi. One of my employers was told at a recent seminar down here, it was not a Medicare seminar, he was told that there is a modifier that can be used by a (DME) company when a patient is in hospice care.

Ellen: There is a modifier for hospice care, but it's used for beneficiaries who are enrolled in a Medicare HMO, and they are also in hospice, and for items that are outside of hospice service, or plan that we would pay – even though they are Medicare HMO, if that modifier is used. But it is only that combination of Medicare Advantage, or HMO and hospice. It is the GW modifier.

(Linda): OK, that answers that question. Thank you, ladies.

Ronja: Thanks, Linda.

Female: Hi, I was calling about the ruling you guys were talking earlier about the MIPPA. On the ownership of the oxygen, is there any decision been made yet? Yes, we still retain ownership, are we getting reimbursed for this added responsibility now? Are we going to get periodic reimbursement for checks? And is there any kind of knowledge about what's going to happen yet? And – because January 1st is coming up pretty soon.

Ronja: .. The ownership change on the oxygen equipment, again, it's part of MIPPA. Currently we do not have any formal instructions on the payment and billing for oxygen come January 1st, we don't have the official instructions as of yet. But providers will be reimbursed for maintenance, and...

Female: Well we haven't gotten anything that says that has changed, the only thing we've gotten that say it's changed is the ownership part. But there will still be reimbursement for the supplies, the maintenance, that type of thing. So as of January 1st, then that's when we'll start being reimbursed for like canulas and tubing and things like that, is that what you mean?

Ronja: Not January 1st, it's whenever the 36 months passed – has passed.

Female: Well that's – but I meant if somebody – that's what I mean, that'll be – if they've satisfied their 36 months, then those items are going to be covered.

Ronja: We have no other instructions from CMS at this time to say anything different than that.

Female: OK, and because...

Ronja: And we will be actually hosting as – once we receive the final instructions, or information from CMS, we will host an additional ACT call as well as a Webinar for those oxygen providers. So just make sure they are signed up for our ListServ. Once we receive that information, it will immediately go out to the supplier community.

Female: OK, super. Thank you so much. The last time that we had an ACT call you all thought you would know by this time, but a lot's changed in three months, so I thank you so very much for your help.

Ronja: Thank you, you have a great day.

(Pam): This is Pam calling from Sparta, Tennessee. I have a question about diabetic shoes. We supplied a patient with diabetic shoes, and got a denial saying that he had already gotten his annual pair this year. I had checked the IVR, and there was no information available, they said that there was no CMN on file. The patient had told us it was his first pair of shoes this year. I called and spoke to someone at your customer service line, and they said that the IVR did not have information about diabetic shoes available. Now the denial we received that we cannot bill the patient. However, I explained to them that we had gotten denials for walkers for at least two patients that had already received walkers, and were not eligible for another one, and we could bill the patient. I said why is it different for diabetic shoes? The response was that if we did not get an ABN signed, that we should not be billing the patient, and I said we did not get ABNs signed for the walkers, they suggested that those walkers had possibly been processed in error, we should not have billed the patient for them. In one case they returned it and the other they did pay for it. I asked well we're not suppose to get an ABN signed for everything we provide and I said what's your suggestion and the response was that we needed to call Medicare with the patient here so they can – the patient could give CIGNA permission to give us the information about whether or not they have received diabetic shoes. That seems like a very strange answer to me. I want to get some clarification on that.

Ronja: With the diabetic shoes the IVR same or similar function is for any expensive routinely purchased items or rental items. Now diabetic shoes fall under a different payment category so you would not be able to check that information through the IVR. Now if you provided the shoes and you did not obtain an ABN and attached the GA modifier if it denies as a contractual obligation then the patient cannot be billed. In providing diabetic shoes it is based on calendar year. Now in that event, you can verify with the patient on a three-way call for the diabetic shoes to verify that they have had them throughout the year before you provide them.

Female: So you're saying that we need to call Medicare – CIGNA every time someone comes in for diabetic shoes?

Ronja: If you're wanting to verify if they have had the shoes in the calendar year and that would be your option at that point.

Female: OK now why is that different from the walkers?

Ronja: I don't know what your walker denial was.

Female: Same or similar.

Ronja: Without looking at the specific denial code it could have been another reason for the denial code for the walker. Without looking at that specific example it's hard to compare diabetic shoe denial to a walker denial.

Female: OK. Thank you.

Ronja: Thank you. We'll go ahead with our next question.

(Paula): Hi. This is Paula from Laurel, Mississippi. I have a question concerning – if a provider puts out a hospital bed and the patient keeps it six months then they give it back and then three months or well six months later they need another hospital bed. They go to another provider to get the hospital bed and they check the IVR and obtain information that you were the first provider – they think you should be providing this bed again for this patient. Are we required to do that?

Ronja: Thanks for your question. Now if you were the provider of the first bed then no you are not. The only time that a provider would be responsible is if it were under the old capped rental guideline and that provider had received the 15th month then you would be responsible for the maintenance of everything. But if you only go six months and the provider no longer need the item then down the road needs it again any provider could provide that item to the patient.

(Paula): But they would only get paid the balance of the 13 months?

Female: They could be a new cap rental if there is documentation to justify the need because we need to know why the patient no longer needed the previous item, and why they are needing the item again.

(Paula): Right. Is that like the 60-day break in need?

Ronja: Thank you. We'll go ahead with our next question.

(Sara): Hi. This is Sara with CFI Prosthetics and Orthotics in Memphis. My question is about a GY modifier when billing for a denial when the patient may have secondary benefits that will cover the service. Specifically, the orthopedic shoes where the patient has a prescription. I called customer service and a reopening line twice yesterday and were given two different answers. Do I use the KXGYRTLTL or do I just use the GY?

Ronja: I'm sorry. What were the modifiers you were told to use? I only got one of those.

(Sara): KXGYRTLTL.

Ronja: So you were told to use the KX in addition with the GY modifier?

(Sara): Yes.

Ronja: The thing to remember is the KX indicates the patient is meeting the coverage criteria and the documentation in your file supports that. The GY modifier is a modifier for non-coverage and there are only certain instances that the GY would apply. It doesn't apply to every item for non-coverage.

(Sara): Well what I was doing was an L3216 for orthopedic shoes not attached to a brace and it was denied and then I called reopened it was told to use – but not use the KX then called back to customer service and was told to use the KX and I've usually just – and then from the beginning when I first started using the GY I thought that if it was non-covered and I was just looking for a patient denial then I could just use a GY but they told me to use the KXGYRTL and then narrate to Medicare that I was looking for a PR patient responsibility denial in my narration line.

Ronja: We do apologize for that misinformation. Again, the KX can only be used when the patient meets the coverage criteria and there's documentation to support it. If in this case they are not meeting it then you would simply use the GY modifier and your RT or LT modifier if you're only providing one, or two.

(Sara): OK. Thank you.

Ronja: Thank you.

(Alisha): Yes. This is Alisha in Corpus Christi, Texas. My question is for the oxygen on the gentleman that asked that second question on a patient that had the break in service. Now I had a lot of problems with a couple of patients that way and I was told that I needed to get a revised CMN since there was an initial on file already regardless on how long the patient had had the O2 previously. I could not submit another initial. I had to submit another revised. I had to submit a

revised and then submit that with it. But then I had a lot of issues getting my revised CMN to even go on the front end. Eventually, I had to do a reconsideration so that I can get my claim paid.

Ronja: Let me make sure I understood your question. You're saying for cases where there's a break in need you're not just adding the portable?

(Alisha): No, not just adding the portable. In my situation I had O2 patients that had – they had O2 back in 2002 and they had it for say seven months and then they returned the oxygen and then years later the doctor ordered it again. Now I – of course initially the patient told me he never had O2 before so I submitted an initial CMN. Well the initial CMN got kicked out telling me that there was already one on file. I couldn't submit my initial so when I went through – you know I understood if there was a break in service or a break in need another initial or another revised was required. I ended up having to get a revised CMN just to try and get my O2 to get paid.

It took me almost eight months to get my oxygen paid after that and initially I couldn't even get my revised CMN to go front end to get the initial one replaced so that I can get my O2 paid. So what is the protocol on that if a patient has had O2 you know say 2002 they had it for seven months. Of course they tell you they've never had it before you submit an initial is it a revised CMN that we should have on file or is it another initial?

(Ellen): No. This is (Ellen). It is a new initial so there's been a break in medical need and it's a whole new thing. The problem is that same CMN is rejecting back because of the one we have on file and what we're asking you to do is to when you submit that initial CMN put a narrative saying that there's been a break in service in oxygen and that you have a new initial CMN on file and we have instructions for those claims to go to a special status for someone to go out and pull that CMN in.

(Alisha): Yes. See and I did that as well. I never could get it to ...

(Ellen): I know. We had – initially we had some issues with it and like Stephanie said earlier we've been working with the claims staff to educate them on narratives and how this should happen so hopefully it's better but if you continue to have issues then you can give us a call. But hopefully those issues are being resolved.

(Alisha): OK. All right. Well thank you so much.

(Susan): Thank you. This is (Susan) with (Merritt) Medical Services in Florida and first of all ladies I would just like for you to pass on to your Tier One and Tier Two representatives their professionalism when they handle our calls. It is so refreshing. But with that question – or with comment in mind I do want to turn back to oxygen and I know everyone's getting frustrated with this. But my scenario was I already had an E1390 initial on file. I added the E0431.

Again, I was told and I was told the words non-qualifying initial CMN because I submitted it as a revised CMN based upon the LCD. I was told this by Tier Two representative. I went through the reopening process. I faxed both the initial and the revised CMN and requested which to be loaded for which date of service. I was denied again and now I'm told that there is no reopening possibility. I now have to go to appeals.

(Ellen): This is Ellen, and when you're adding a portable on it is a revised CMN and it should have come into the system and we have instructions how to process but yours sounds kind of unique where it wasn't even handled through reopenings in asking for a redetermination so how was it denied?

(Susan): It was denied again.

(Ellen): Medical necessity?

(Susan): Not meeting medical necessity. That is the code that's coming out on the ERN.

(Ellen): Susan can I get your number and I'll give you a call and look at that?

(Susan): What is considered non-qualifying because I was told over and over non-qualified? Well the initial for the E1390 which is the stationary was done while the patient was not being exercised but the revised CMN we submitted was a qualifying CMN because it was done while the patient was being exercised obviously showing that it met the criteria for allowing the E0431 portable.

(Ellen): One reason why I wanted to see your example – because what happens on oxygen because it's common that they would go from one modality to a different modality and we auto copy those CMN so if you had the E1390 on file and for some reason that claim came in an auto copied that CMN before your revision got in it would have copied the question sets from the E1390 which would have had the mobility question unanswered and denied your CMN so that's why I kind of wanted to see your example.

(Susan): That will be fine and certainly feel free to call me. I'd be glad to provide those and I don't know (Ellen) if this makes any difference but this particular claim was an MSP claim.

(Ellen): It shouldn't matter. NSP is the last thing that happens on a claim. We would have process this part first.

Follow up: [The provider has been contacted and examples were provided. The claim examples have been forwarded to the appropriate operational areas for education and resolution.](#)

Ronja: Thank you so much (Susan). Go ahead with the next question.

(Georgette): OK. My question is that as far as the oxygen refills once when the patient caps out are you still going to pay on the portable?

Ronja: As I mentioned earlier, we currently do not have any final instructions on actual billing and the processing of those oxygen claims once the 36th month has been reached so again if you'll just stay tuned to our list of messages and our Web site as soon as we get those final instructions we will notify our providers.

(Georgette): And I'm sorry. My name is Georgette. I'm calling from South Carolina.

Ronja: Thank you so much Georgette.

(Stephanie): Hi. Good afternoon. This is Stephanie calling from Florida. I had some issues with my wheelchair cushions. The code the E2601 with a narrative transmitting through the electronic system. Could you give me some guidance on that please?

Ronja: Do you have a particular denial? What's your denial say?

(Stephanie): I'm being denied for C016 which states its lacking information. I've actually had two test cases I had sent in. I actually went to a Tier Two and she had told me what I was doing wrong which you know prior to January '08 I was doing this and it was not wrong but in January '08 on I've noticed that that I continue to do is wrong. She gave me instructions on how to fix it. I sent two test cases in based on her instructions. One came back still denying lacking information and the other one came back saying my code is not valid and I have two examples in front of me if you'd to but I have several cushions that we're having this issue with and as far as the narrative and whatnot and then I have other issues where I'm billing the cushion with the wheelchair and they're denying the cushion as saying they have no information and the wheelchair and the wheelchair is being paid on the same claim.

(Ellen): This is (Ellen) again.

(Stephanie): Hi, (Ellen).

(Ellen): We have seen some claims where wheelchair and cushions coming in on the same claim and because we have some automated edits– we saw where the cushion denied for no information on the wheelchair before we had time to process the wheelchair and setup what we call a dummy statement in our system and it sounds like that’s what’s happened to your claim. We have addressed that issue and hopefully this hasn’t been a real recent. Is this is recent claim?

(Stephanie): 9/15, ma’am. Well the date of service is January 24th, '08 but my denials are 9/15. I spoke to a Tier Two.

(Ellen): Did you put the wheelchair and the cushion on the same claims?

(Stephanie): Not this particular issue, no.

(Ellen): OK because that’s the one we had – we identified and we thought we had corrected that one.

(Stephanie): Right. Part of Tier Two with these two examples – excuse me she had stated that there’s really no information on the wheelchair that you want or initially they don’t want any information on the cushion. They only want information on the wheelchair. Now, it used to be you wanted information on the cushion and the wheelchair. Could you just tell me what it is because I know there’s only I think the 91 characters in the HAO record. What is required to get these cushions paid?

Ellen: If Medicare did not pay for the wheelchair we need the information about the wheelchair.

Stephanie: Right. Make, model number, serial number.

Ellen: Right.

(Stephanie): Now she was told – she told me that when they got the wheelchair. Is that correct too?

Ellen: Right.

(Stephanie): OK. So make, model. When they purchased the wheelchair or whenever they received it?

Ellen: Date of purchase if you have it.

(Stephanie): OK and now what about the information on the cushion?

Ellen: 2601 is just the lowest cushion you can get. There's really no additional information for that one.

Stephanie: OK. Well like I said the Tier Two did give me instructions on these two cases. I sent them in as a test. I called her two days ago and I haven't gotten a call back yet. Can I speak with somebody on your end and give you my examples possibly you can help me?

Female: Sure. You can give us your number.

Follow up: [The provider has been contacted and examples were provided. The claim examples have been forwarded to the appropriate operational areas for education and resolution.](#)

Ronja: Thank you (Stephanie).

Stephanie: Thank you very much.

(Marie): Thank you. This is (Marie) calling from Arkansas. My question is will there ever be any upgrades when we look up for codes and fees and again being familiar with the Palmetto GBA we could put in such as wheelchair we could put in just wheel or whatever on that line and it would bring up every code that was available. Now I find that if I want to look for codes and fees I actually have to have that code in front of me.

Ronja: It sounds like you were referring to what was previously known as the DMECS system.

(Marie): Yes.

Ronja: That system is available with the transition – with the PDAC, Once you go to their Web site the www.dmepdac.com there is a link that says DMECs and it's the same.

(Marie): OK. So that's just www.dmepdac.com?

Female: Yes. And it's the first link on that site. So the system is still available. It's just under a different Web site.

Marie: Great, wonderful. I'll go ahead and access that and I may add a comment and I don't know if it will help anybody but I've been listening to all the comments regarding the narratives not being read and I know for a fact that whenever I have called and Tier Two is the only one that can look at those narratives evidently and you know just whoever answers in the customer service department cannot see that narrative but then they take the call to Tier Two and they come back on the line and indicate that yes the narrative is there and it is or is not correct but one of the comments that was made early on when I got a denial and the narrative was there.

You cannot use punctuation in the narrative is what I was told from Tier Two. I had never heard that before so I'm hoping that maybe you might do some research on that so you can satisfy those others that have called regarding that. You know I put in patient had bed, such and such a date period and then you know like new rental period requested period and they said that you cannot put the punctuation in there. Now I don't know if that's new to anybody there but it certainly was new to me and maybe that's all that is happening with all these other callers.

Ronja: We do apologize on that. We are not aware that you cannot use punctuation. Punctuation is allowed.

(Marie): OK. Well you know like I say that was told to me the one time and like the gentleman early on he said you know it was kind of going 50/50. Fifty percent of the narratives were being read. Fifty percent were not and I know that that fact because one of those that I got a denial on in the same claim batch I had put in the exact verbiage with punctuation and it was paid and the other one was not paid. It was denied and when I called about it they said it was punctuation so there you have it. Anyway, thanks for all your great information today.

(John): Marie, this is John with our Technical support for customer service and – well first off you mentioned that Tier Ones are not capable of seeing that narrative and that's actually not the case. Tier one should be able to read that narrative just like a Tier Two could. If that's happening – I don't know if you happen to have any names or specific instances that you could provide to us of that happening you know that's maybe an educational thing for our Tier Ones that we can address. As far as the punctuation in narratives as Ronja just said we don't know anything about that problem. So you don't necessarily want to put a whole lot of punctuation in there.

James Herren: One thing I could say to Marie and this is James Herren, Provider Outreach. Sometimes punctuation could potentially materially change something that you're trying to say as well so you

know sometimes punctuation is not necessary. It could be misread to read to be something different.

(Marie): Yes. Well and I was just using in this particular incident where it was denied I had just used a period after what I would consider a portion of that and I wanted to separate that with a period because the next thing I said in the narrative was what my request was that you know a comma really shouldn't have been there or just a space but I ended up putting it in just as a space after I was told not to use punctuation and it went through fine but it's just strange.

Like I say, I think that what's happening is some people are reading narratives correctly and some people are just not reading them at all or whatever the case may be but I can certainly see why everyone I think is frustrated when we take the time to do a narrative.

James Herren: Let me ask you. When the Tier Two told you this about the punctuation in there they were saying that this is why the claim denied because that made the narrative invalid or what exactly did they say?

(Marie): Yes. They indicated that no punctuation could be made.

James Herren: But they were still seeing the narrative then and they saw ...

(Marie): Yes. In that case they were seeing the narrative, yes.

James Herren: Well – and I apologize for that if someone told you that. That definitely should not invalidate the narrative in any way.

(Marie): Good. OK. Thank you.

James Herren: Did you get that particular claim resolved?

(Marie): Yes, it did. It did after I just merely resubmitted it without any period after my first statement

James Herren: Well that's something that we will have to bring up with some of our CSRs to make sure that they're educated in that area so thank you for that feedback.

Ronja: Thank you so much for your feedback.

(Marie): Thank you.

Ronja: We'll go to our next question.

Female: Yes. I have a question. I'm from Brownsville. We have a patient that has diabetic shoes that got wet during the Hurricane Dolly and he needs – he wants or he needs new diabetic shoes and I have not found any modifier yet that I could use on the claim that when we serve the patient so I'm wondering if you know the right modifier for diabetic shoes replacement that was damaged by the Hurricane?

Ronja: You said this was during Hurricane Dolly? It was an area declared a federal disaster?

Female: Yes. In Brownsville during Hurricane Dolly.

Ronja: OK. Then at that point we mentioned that the CR modifier earlier you would file the claim for the new shoes and they see our modifier and indicate to us in the narrative that again his shoes became wet after the hurricane.

Female: CR modifier?

Ronja: That is correct.

Female: OK. And thank you very much. I have a next question. Do you have another set of lists other than the CEDI list serv that I'm on?

Female: Yes, we do have the CIGNA government services Web site.

Female: Yes because I seem to have stopped receiving from other than CEDI after they took over so I ...

Female: You can go back out and re-register on our Web site once you've registered for the CIGNA government services list serve message then you will receive a confirmation in like the next hour that says you are registered.

Female: Government.com. OK, my last question if you don't mind. On facility accreditation, I have not received any news yet that this has been discontinued for put on hold for prosthetic and orthotics facility. Is there something out there that I have missed?

Ronja: We actually had mentioned it at the beginning of the call. There is a CMS fact sheet that you can go to the CMS Web site. Under their search function if you'll type in accreditation fact sheet and then you will see it there.

Female: OK. And is there a way that if people can miss this call – this conference can they replay it some other time and is there a password or?

Ronja: Currently, this particular call will not be recorded. However, the minutes will be posted to the Web site in the upcoming weeks so you go out and pull up the minutes to this call.

Female: OK, great. Thank you very much.

Ronja: Yes. Go ahead with the next question.

(Cindy): Hi. My question – my name is Cindy. It relates to patients who are in a skilled nursing facility but they're Part A benefits have exhausted. Are DME items payable to providers in that scenario?

Ronja: You said the patient has exhausted their Part A? Actual DME items are not billable in a skilled nursing facility. There are limited items that can be billed and once that Part A stay has been exhausted.

(Cindy): But if it's not items that are on that normal list like say it's a group 2 support surface and they don't have Part A anymore but they're still on the surface.

Ronja: That would not be billable to the DME MAC no. It's pretty much only prosthetic, orthotic items, and other supplies.

(Cindy): Like enteral

Ronja: Enteral yes. Things like that.

(Cindy): Even if they're in a non-covered say it's still not eligible?

Female: Yes that still will not be billable to the DME MAC or capped rental items.

(Cindy): OK, thank you.

Ronja: Thank you. Go ahead with the next question.

(Andrea): Thank you. This is Andrea from Continu Care. I have a question where DME and home health and trachestomy supplies sometimes they're denied because they're in a home health episode. Where do find a list that's covered by home health and what supplies would be covered?

Ronja: OK that list is available on the CMS Web site.

(Andrea): OK.

Ronja: Under the home health consolidated billing. You should be able to type it in the search function and it will give you all the applicable HCPCs code that apply to the consolidated billing.

(Andrea): OK. Because you know they pay for trachestomy kits and some of the catheter supply but like the cuffs they're saying the home health would supply.

Ronja: All the codes that fall under the consolidated billing are listed on that sheet

(Andrea): OK. So I'm going to go to CMS Web site. Home health consolidated billing?

Ronja: Yes. You can actually type that into your search.

(Andrea): Good. OK. And I have one other question regarding oxygen. We have a patient. She did not get portable until it was time to be re-certed and so it was on the re-cert. Now they're stating I need to go back and get a new initial. Is that true?

Ronja: You're saying the portable was added but it was added at the time of the recertification? And you only submitted the recertification?

(Andrea): We have an initial on file which is for oxygen concentrator but we submitted the re-cert with the concentrator and the portable.

Ellen: We should – the policy actually says it needs a revise but in this situation it all happened at the same time. So you ought to be able to set that portable up with that recertification date.

(Andrea): OK. Can someone call me on that?

(Ellen): Yes. This is (Ellen).

Ronja: And is it just that one example or do you have more examples of that?

(Andrea): I have one that I know of and that I'm real concerned about because they're not processing it.

Follow up: The provider has been contacted and examples were provided. The claim examples have been forwarded to the appropriate operational areas for education and resolution.

Ronja: Thank you.

(Andrea): Thank you very much for your help.

Female: Hi. Can you guys hear me Ellen and Ronja? I wanted some guidance on the new KX modifier that we have to add on the L codes. I noticed especially that we have a new requirement that if you're billing for knee braces and I'm wondering if there's any other kind of bracing that requires

that KX modifier and also if you can answer that for me I also have another question on the K code.

Ronja: With the other code that may require the KX modifier you would just need to verify through that actual LCD for the item you're billing. Refer to the LCD under the HCPCS code section, it would show if the KX is required for the particular code that you're billing.

Female: OK. Maybe I need you guys to tell me how to get on this. Have the LCDs been updated?

Ronja: Yes. When you go to the – you can go either through the CMS Web site or you can go through the CIGNA government services Web site.

Female: OK and it will take you to the CMS Web site?

Female: Yes. When you go to the CIGNA government services you'll click on the DME MAC Jurisdiction C link. Once you select that link looking at your screen it's over to the right hand side, Under coverage and pricing and you'll see local coverage determinations.

Female: OK. When you get on that page is it that page where you actually have to put the code search?

Ronja: You're talking about something different. You're talking about HCPCS code. You're trying to find a code that's the difference.

Female: All right. So I'm going to go through the DME MAC page from the right hand side, click on coverage and pricing?

Ronja: Coverage and pricing is the section. It's the second link underneath it and it's titled local coverage determination.

Female: OK. And it will be – it will take me to – it will give me an option to search the LCD for the item?

Ronja: Yes, that is correct. That's the actual LCD for the item.

Female: OK thank you so much. And my next question is about same or similar when you're trying to get verification through the IVR. And I did hear one of you say that that was only for an inexpensive or routinely purchased or rentals. Is that true or you can search same or similar for any?

Ronja: No. Is it only for inexpensive routinely purchased items or rental items.

Female: OK. So if you have for example – none of the L codes would be there?

Ronja: No they do not. They do not fall under those two categories.

Female: OK. Well that's something I didn't know and then my very last question is on repairs. You can't bill for the temporary replacements anymore so what do you expect us to do if you do have to send in a temporary replacement while you are repairing a wheelchair for your client?

Ronja: I'm not sure where you obtained that information but you can still bill for the temporary replacement, the K0462.

Female: OK, but when I go on the DMEPDAC Web site it doesn't show up on the fee schedule there so I'm not sure.

Ronja: There's not a fee schedule for it. It's because it could be used for numerous codes. There may be a different payment amount so it doesn't have a set fee schedule amount for that because it is a temporary replacement.

Female: OK. So you can still go ahead and service the temporary replacement and bill the K0462 for it?

Ronja: That is correct.

Female: Oh, OK. Then what would be the modifiers that you would have to use?

Ronja: There is no modifier for the K0462.

Female: OK, no modifier. And I'm experiencing some issues with the DMEPDAC Web site when you go on there.

Ronja: Are you talking about the CIGNA government services Web site or another carrier?

Female: No. The Noridian web site.

Ronja: You would have to contact them regarding their specific Web site.

Female: Thank you so much.

Ronja: We can go to our next question.

(Tracy): Yes. My name is Tracy. I'm from Slidell, Louisiana. Can you all hear me? OK, great. My question is concerning A4629 which is the trach kits for established trachs. Ever since the transition to CEDI I have not been able to submit electronically. It will reject out each and every time. I've called CIGNA. CIGNA advises me that it is a CEDI issue. I called CEDI they tell me it's a CIGNA issue. This has been going on for months. Are you all working on that or trying to resolve that issue?

Ronja: And you're saying this is for the A4629? We are not aware that there are any particular – or have had provider feedback issues regarding the rejection on that code but if you want to verify the validity of the code you can check the (PDAC) Web site. You may want to verify it with your actual software vendor.

(Tracy): I've verified everything. I worked on it for almost a month and then it's like one says it's this problem. One says it's the other ones problem but it rejects out every single time I go to bill it so I paper claim it and it gets paid fine.

Ronja: Let me ask are you actually receiving an EOB from CIGNA or are you getting rejection prior to?

(Tracy): I'm getting the rejection from CEDI.

Ronja: Then at that point we haven't even received the claim to know what the denial was so that's considered a front end rejection.

(Tracy): Well how do I go about maybe trying to solve it because like I said no one seems to give me the answer I'm looking for?

James Herren: Tracy, my name is James Herren with provider outreach. Why don't you give me your information and I'll contact somebody with CEDI and we'll see if we can't work this out.

(Tracy Smith): OK. That is North Shore Respiratory and Rehab Specialties and my name is (Tracy

James Herren: OK. North Shore at Lake Pontchartrain?

(Tracy Smith): Yes, sir. All right.

Follow up: The provider has been contacted and examples were provided. The claim examples have been forwarded to the appropriate operational areas for education and resolution.

Ronja: Thank you Tracy so much.

Female: Hello. Is there any mechanism in place to file a grievance against the Medicare Advantage company?

Ronja: You could try going through – CMS might be your best avenue for that because most of the plans are individual plans you could contact.

Female: I've tried that. I've checked their Web site and there's nothing there. The only thing about grievances is for the beneficiary.

Female: OK. Then you may either try possibly sending a letter to your Congressional Office or sending a letter directly to CMS but we as a contractor unfortunately do not have the procedure available.

Female: So what address for CMS, in Baltimore?

Ronja: Yes. That is the one you can use.

Female: OK, thank you.

(Cindy): Hi. This is (Cindy) from Eaton, Georgia. CPAP Rentals. Is the NU and RR modifiers required?

Ronja: With CPAP it is a rental item that would require the rental modifier.

(Cindy): OK. Now the NUs were the new equipment? Is that also required? I know the KX is because we do (Riverside).

Ronja: No. the NU is not required, just the RR modifiers is the main one for the payment.

(Cindy): Right. Thank you so much.

Ronja: Thank you. We'll go ahead with our next question.

(Alisha): Yes. This is (Alisha) with Respiratory Services in Corpus Christi. My question is about the new LCD for the continuous positive pressure device. I know that there had been a delay on that. Has there been any change to that? I know it was suppose to be effective September 1st and I know that it was put on hold.

Ronja: The delay for the PAP is 11/1. I believe we have someone from medical review on it. If that has changed please let us know.

(Alisha): 11/1 of '08 if from the new changes that it should take effect?

Ronja: Tentative for November 1st of 2008.

(Alisha): Tentative is the keyword. All right, thank you.

Ronja: We'll go ahead with our next question.

(Sandy): Yes, my name is (Sandy) in Birmingham, Alabama. I have a question. This is in regard to the oxygen. The revision that is required now for to be added for portable to the initial stationary unit of A1390. If the initial is dated and I'm going to just give you an example of 1/10/2006. That's

going to cap out on 1/10 of 2008 because that's going to be the 36th month. A portable initial date say is August the 12th, 2008 are we still going to be able to get paid 36 months or the portable even though the stationary unit has been capped out?

Ronja: Yes, you will still receive the 36th month payment. Yes, that is correct.

(Sandy): OK. Thank you very much.

Ronja: Thank you. Let's go ahead and take our next question.

Female: I have two questions regarding Enteral tube feeding. When an initial DIF is submitted for the start of pump use when a patient has been previously using (bowl) feedings and also a new supply is being used – a new B code my experience is that only one of the initial hits is being picked up and how do we handle both the start of the pump and the start of a new feeding product?

Ronja: Let me just make sure I have your question correct. You have an initial dip for the pump. And you also have a new DIF for the nutrient? So you have two under the same initial or same beginning date?

Female: Yes, the same beginning date. What I'm finding is that when the claims are paid either the initial for the pump is picked up or the initial for the feeding product is picked up and the pump is denied so I'm wondering how to get both start dates for those two new items to kick in. What I've been doing is submitting on two separate initial DIFs. One for the pump and one for the feeding product but that's pretty time consuming. Is there a way to bypass? My computer supplier informed me that when you're starting two new items on one disc that the procedure is that only one of the items is picked up. Either the pump or the feeding product but not both.

Ronja: Now you said you are submitting these electronically? Does your software allow you to submit one DIF, or is it requiring you to do two as well?

Female: Well I have been – the first time I tried submitting just one DIF with the starting of the pump and the new product. Like I said they paid – that they paid the pump but not the feeding product or they paid the feeding product and not the pump so what I have been doing is submitting on two separate DIFs.

(Ellen): You'll have to submit an initial DIF for each of those codes. One for the pump and one for the nutrient.

Female: OK. That answers that question. Now you had spoken earlier of hospice care being in place. When I'm submitting claims for Enteral tube feeding and my patient is a hospice patient I have not been using any modifiers. Was that a GW modifier that you mentioned

(Ellen): This is Ellen again and you don't need to use any modifiers unless your patient is enrolled in a Medicare Advantage plan and what happens is because of the way they the payment is for Medicare Advantage they can bill fee for service for those items. If the service is unrelated to the hospice say you can bill it to fee for service with that GW modifier but it doesn't mean anything unless your patient is a Medicare Advantage patient.

Female: OK. So if I'm submitting Enteral tube feeding charges to a patient not involved in one of those HMOs, what I've been doing is submitting a narrative that says that hospice is not providing the tube feeding supplies. Is that adequate?

(Ellen): This is what happens with hospice because it's all editing at the common working files. You submit your claims. We send it to the common working file. They reject it back to us saying the

patient is enrolled in hospice and there is a manual check for ICD-9 codes listed on the hospice records versus the claim records and if they are the same your claim will be denied. If the reason for – if the diagnosis is different saying it's unrelated to the hospice stay then we will process it.

Female: So is the narrative then not part of the ...

(Ellen): It's not necessary. It's all editing as a common working file.

Female: OK. Because I've had many claims denied for hospice benefit in place without indicating the narrative but when I submit the narrative they seem to pay.

(Ellen): Well if you are submitting the diagnosis code with your claim to us then it's what's on the hospice record as a common working file your claim will be denied.

Female: OK. All right, well thank you very much for your help.

Ronja: Thank you so much. We'll go ahead and take our next question.

(Georgette): Hello. My name is (Georgette) from South Carolina and I need to know as far as tape and gauze and trach supplies, how can we find an allowable amount?

Ronja: Are you talking as far as the pricing allowable amount or are you talking ...

(Georgette): As far as the amount the patient can have per month.

Ronja: Some parameters for various LCDs or various items are listed in the – in the actual LCD for the item. There are some that we do not release, that would be confidential information. But if the parameters are something that can be released it would be located in the LCD.

(Georgette): OK. Are you talking about as far as wound care supplies that we could provide the patients every month? We don't know exactly how much Medicare will allow for that amount.

Ronja: Yes. There are going to be some items in which we will not release the parameters on how much or many of those items are allowed per month but there are some policies in which we do. I believe urological supplies ostomy, diabetic supplies and I believe some of the surgical dressings. They do have the information located in the actual LCD that tell how many we allow of the item per month or within a certain timeframe.

(Georgette): It's like really not saying they don't really want you to know because you might send in too much?

Ronja: Those are just processing guidelines.

(Georgette): OK. And my other question is as far as like carpel tunnel splints we were told that it was allowable every five years but the warranty on the splint itself is only for six months. Is that correct?

Ronja: You're talking about – you said on carpel tunnel splints?

(Georgette): Yes. Any kind of splint like that.

Ronja: The lifetime is five years. There is certain life time that we do have in place for DME and prosthetic and orthotic items. There is – there is what we call a useful life time. It applies to our DMEPOS items which would include some prosthetic, some orthotics as well as the actual DME items. There is a useful life time on those items and in some cases it may be five years.

(Georgette): OK. But there's nothing stating anything? It just says five years correct?

Ronja: You did say a splint correct?

(Georgette): Yes any kind of splint. We supply – the braces and the carpel tunnel splints, we provide those.

Ronja: Splints do fall under Part B the local carrier coverage. Do you have a specific code in which you're billing because some splints do fall under that Part B coverage. Not necessarily a DME benefit.

(Georgette): I don't have my codes with me right now but, but what about the L3902?

Ronja: There is actually a jurisdiction chart that is available on the CMS Web site that tells you based on a particular ((inaudible)) code what carrier it will be billed to whether it would be the DME (max) or be the fiscal intermediary which would be your Part A or the local carrier which would be your Part B and again some plans and some services are covered under the Part B benefits.

(Georgette): All these codes are under Part B because we are the DME suppliers.

Ronja: There are two parts to Part B. You have the DME benefit and then you have the local carrier. There are some things that will be included with that physician visit or other outpatient services. Again, you can refer to the CMS Web site and there – you can do a search to verify what code would be billable to what particular intermediary or carrier. There is actually a link in Chapter 16 of our supplier manual that will take you directly to that chart so that you know which codes should be billed to which appropriate carrier.

(Georgette): OK. So it's just matters who you bill it to?

Ronja: Yes, because again there are some things that do not meet a DME benefit or durable medical equipment benefit so they should not be billed under the DME MAC benefit.

(Georgette): No. I'm talking about codes that we have been billing and I know they are payable.

Ronja: Like I said there are some things that will have a five year life time. If it has a warranty, warranty should always supersede in the event any replacement, repairs, warranty would always come first. So that is something to consider when the item is provided, the lifetime of it.

Female: Thank you.

(Georgette): Yes, thanks.

Female: We'll go ahead with our next question.

(Sharon): Hello. My name is (Sharon). I'm calling from Florida and I have a question regarding the presentation portion. I am not sure if I heard correctly but I thought I heard that there were three new policy articles being posted later this week.

Ronja: That is correct. You did hear that earlier in our presentation. They will be released later this week and make sure that you're signed up for our list serv. Those policies will be released for (comment) and it will have the information on the (comment) period. We do not have specific LCDs that will be released but again if you're signed up for our list serv you will get that information this week.

(Sharon): OK. And I did have one more question regarding the presentation portion. There was a change request release on recoupment.

Ronja: The actual change request is 6183 and there is a Medlearn matters article and that article number is MM6183.

(Sharon): OK, thank you so much.

Ronja: Thank you. Go ahead with the next question.

Female: OK. We have a patient. We delivered a hospital bed to him on January 1, 2003 and he elected the purchase option. I mean he kept it on rental and what we're needing to find out – he's moved out of our service area now. Can he ever get this from another provider? Can he get another bed from another provider?

Ronja: The patient has moved out of your area?

Female: He's out of our service area, yes and the bed is out of warranty but he did elect you know to keep it on rent so he's on the old cap rental program.

Ronja: Give us just a minute with that because it has been five years. We're needing to make sure that we do give you the appropriate information so hold just a moment for us.

Female: OK, thank you.

James: This is James with Provider Outreach. This is a situation really where the beneficiary and this goes back to the question about the hospital bed and the maintenance and service when the beneficiary has moved out of your area.

If you are still billing for maintenance and service it is still your responsibility to make sure that bed is taken care of if the beneficiary elects to keep that bed. The beneficiary is not required to get a new bed just because five years have elapsed and he qualifies for a new bed. It's a situation where you know five years have gone by so the reasonable lifetime has been used up so to speak and if the beneficiary chooses to get a new bed could then proceed to go forward you know and bill Medicare and so forth.

But if the beneficiary wants to keep that bed it is your responsibility to make sure though that it is being taken care of. You may have to partner with a supplier in his area and pay that supplier or whatever you need to do. So just make sure you are aware of that.

Female: OK. That's what we needed to find out. Thank you.

Male: OK. I know we've fielded a couple of questions about the 36 month cap rental with oxygen and I think it's – my question may be moot. Should we not even ask questions about this at this point?

Ronja: Again, I do apologize but yes I believe we've answered this throughout the call. Right now we just do not have any instructions to provide to the suppliers. So again, as soon as we receive information from CMS that's our number one responsibility is to make sure that education does go out to those suppliers that provide oxygen.

Male: Sometimes because CMS is so interested that they monitor these calls sometimes. Do you know if they're on today?

Ronja: That I do not know. They do have a dial in information. They do have the opportunity to dial in if their schedule permits.

Male: OK.

Ronja: Thank you.

(Janine): Hi. This is (Janine) of Clay Home Medical again in Petersburg, Virginia. I'm going to get a little bit off of this track that we've been on. We had an instance – we had a software billing problem wherein we billed drugs such as Albuterol and the dispensing fee. Our software was not keeping the medication and the dispensing fee together. Therefore the medication paid but the dispensing fee was denied C0107. The related qualifying claim service was not identified on this claim so we're working with our software vendor to get that problem fixed but in the meantime what do we do with these C0107 denials on the dispensing fee? If we just resubmit them it's still going as the medication so how would we put these claims in? Would they have to go to redetermination?

Ronja: No. You would actually send those claims to reopenings.

(Janine): Now I have quite a few of them. How many will reopenings do by phone at a time?

(Sam): They will only do five at a time but if you're having a problem where you have hundreds of claims what I recommend that you do is that you fax that in as an Excel spreadsheet and that way they can get those handled much quicker for you than having someone call in five at a time to get five adjustments done.

(Janine): OK. Now on that spreadsheet do you need to include the ICNs for each claim?

(Sam): Yes. We would need that information.

(Janine): OK. All right and then just of course an explanation attached to that of what happened?

Sam: Yes, correct.

(Janine): OK, all right. That's what I needed. Thank you.

Ronja: Thank you, (Janine). OK, go ahead with our next question.

(Donna): This is (Donna) in Salem, Virginia. I have a question where I'm getting orders for walkers, commercial hospital beds, manual wheelchairs. You start with a script or order and then we're calling to get clinical notes or SOP notes for these pieces of equipment that require the KX modifier. And sometimes we're noticing when we try and decipher or read these notes from the physicians that there's no mention in their clinical note of the piece of equipment they actually order that they wrote a prescription for or an order if they were you know leaving a rehab facility. Do they have to clearly spell out that piece of equipment in their SOP notes and clinical notes or is it just that you're looking like if you did an audit you're looking that we did call the physician and we need the clinical notes for this piece of equipment you've ordered and it would just have his information – you know his or her information in there as to – related to their diagnosis and what they're – do you understand what I'm saying? Sometimes we don't actually see it spelled out in those notes if we can even read them sometimes.

Ronja: OK, we're going to let – we have a representative from medical review that could address that specific question.

(Donna): Well we're just concerned that sometimes you know when we've gotten an order for walkers, ((inaudible)) hospital beds or manual wheelchairs and then we call the doctor's office that wrote the order or prescription for the equipment and we call for clinical notes or (soap) notes, this objective ...

(Carol): Yes, objective, yes.

(Donna): Notes that when we do get them because you have to have that on file to be able to use and send the claim along with the order. You have to have their notes and we're noticing sometimes that there is no mention of the piece of equipment that was ordered in those notes and we're concerned about that. Here they've written an order or prescription for a piece of equipment but yet in their notes there's nothing – there's not a word about that piece of equipment.

(Carol): Well you know in an ideal world we would like to see that. You know if I was reviewing those records as part of an audit I would certainly like to see that. I guess what is more important is for example if the patient is getting a walker is there an assessment in there you know that shows – I mean the patient comes in and they say I'm unsteady on my feet. I've fallen several times. The doctor does you know a physical exam. He writes in there you know some diagnosis and it's clear from the notes that the patient has medical necessity for the item. Do I want to see in the Plan of Care I am going to order a walker? Yes, I do. Would I deny the claim if everything else was in order? No I wouldn't. So you know I mean there's no you know good or bad answer but if the medical records support the equipment it would be lovely for the doctors to have that in there but you know I'm concerned that – I had rather have medical records supporting the equipment than the doctor's saying I'm ordering the equipment and there's nothing in the medical records that tells me why.

(Donna): Right, right. Well that's concerned us also and we're wondering well should we even supply it if they don't fill it out and as it is it's like pulling teeth to get these from some of these physicians. They're fighting that going well other companies aren't asking for all of this. Why are you all?

Carol: Well because you're being a prudent supplier that is protecting your bottom line. You know – I mean I see that you know I can't say yes go ahead and give it or don't give it. I think you have to look at the records and use your best judgment as to whether they support the medical necessity. If you are concerned about that then you know that's where the ABN come in and just you know make sure that that – if you get them to sign an ABN that it's policy specific because I see a lot of

ABNs that are really you know defective notice because it just says something about you know maybe medical – you know Medicare will think that this isn't medically necessary. You know you need to be policy specific with that but ...

(Donna): Policy specific meaning ...

Female: If you go to the policy for the items that you are providing and write in what part of that policy you think the patient does not need.

(Donna): What part of policy that helps. Thank you.

Ronja: OK, thank you and operator this will be our last question.

Female: What do you recommend for doctors who won't sign the CMN for oxygen? When we send it they wouldn't sign it. They want us to send it to the hospitals.

Ronja: One of the options may be to get your beneficiary involved and help them to understand the importance of working with the physicians. Also try to work with the physician's staff. They can complete that Section B of the CMN if they are employed by the physician or someone other than the supplier they can complete that and all the physician has to do is sign it so.

Female: OK, very good. Thank you.

Operator: You're welcome, Ms. Roland. Well ladies and gentlemen that does conclude our conference for today. On behalf of CIGNA I'd to thank you for your participation. Enjoy the rest of your day.

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