

**CIGNA Government Services Ask the Contractor Teleconference ACT  
September 26, 2007  
1:00 p.m., CDT**

(Dante' Wynn) Good afternoon and welcome to the quarterly CIGNA Government Services, "Ask the Contractor Teleconference for Jurisdiction C DME MAC." I would like to begin by extending thanks to those suppliers who are participating today. Your participation in these calls is an important way for us to better meet the needs of the supplier community, and we appreciate this opportunity to partner with you to accomplish this goal. We are joined on the call today by representatives from CMS; we also have Sue Allsop and Kim Campbell representing Palmetto GBA, the EDI contractor for Jurisdiction C. Also with us, are representatives from several departments within CIGNA Government Services who will be available to lend their expertise to answer your questions pertaining to their respective areas.

Please keep in mind; we will not be able to answer questions about individual claims. If you have a question regarding a specific claim, please contact our provider contact center at 1-866-270-4909.

I would like to begin the call by providing an update on our DME MAC operational performance since the transition of the contract to CIGNA Government Services in June. Following the update, we will also discuss other important topics affecting Medicare suppliers. After that we will open the lines to your questions.

CIGNA Government Services is committed to providing excellent service to all of our Jurisdiction C customers. We recognize that our Jurisdiction C customers are experiencing service issues, including busy signals when trying to reach a customer service agent, as well as concerns with claims processing, redeterminations, and

reopenings. CIGNA Government Services is taking the necessary steps to improve operational areas.

The first operational area that we will address is our Customer Service area. Since our June 1, 2007 implementation, call attempts into the Contact Center have exceeded expectations which are impacting our ability to answer all calls received. We anticipated 3,500 calls per day based upon historical information and outgoing contractor volumes; however, volumes have exceeded that assumption.

Actions that we are taking to address the problem include:

- CIGNA Government Services continues to add and train Customer Service staff.
- We are providing refresher training for existing staff to improve call handling efficiencies and knowledge.
- We are making outbound calls to those customers who make frequent, high-volume calls to the Call Center and whose inquiries represent a significant portion of the daily call volume.

We are pleased to report that our efforts are yielding positive results: The additional staff has resulted in the percentage of blocked calls (busy signals) being reduced by 42% over the past several weeks. We expect to see results continue to improve as we add trained resources to the Call Center.

The next area we will discuss is the Re-Openings (Clerical Errors) area, which has a higher than expected volume of Re-opening requests to correct clerical errors. CIGNA Government Services is shifting skilled resources to address this workload. Additional resources are also being added to the Telephone Re-opening line to enhance service provided over the phone.

We have identified the following trends upon analyzing the Reopenings workload:

- The KX modifier is the primary reason for many denials. Omission of the KX modifier is a clerical level omission, so most of these denials can be corrected in the Re-openings team. We expect to see the number of KX modifier re-opening requests to decline as suppliers begin to submit correct claims.
- CIGNA Government Services is receiving multiple requests for the same re-opening request. For example, some customers are faxing in their request(s) then calling the Re-openings unit for corrections. Duplicate request(s) increases processing time for a Re-opening. I will now turn the call over to Christy Harwood also a member of the Provider Outreach and Education team; Christy will provide an update on Claims Processing.

(Christy Harwood) Thank you, Dante, and good afternoon. Our Claims Processing area continues to exceed CMS expectations for claims processing timeliness. In August, 2007, we processed 98.3% of clean claims in 30 days - exceeding the CMS requirement of 95% processed in 30 days. Nearly 3 million claims were processed during the month of August. To date we are at 2 million claims for the month of September.

We have identified the following trends upon analyzing the Claims workload:

- CIGNA Government Services continues to see omission of the KX modifier.  
Analysis of reopening requests indicates that suppliers are frequently omitting the KX modifier when it is required by policy and the supplier is indicating supporting documentation is present. Detailed information on the proper use of the KX modifier on our Web site at [www.cignagovernmentservices.com/jc](http://www.cignagovernmentservices.com/jc) . Click on the “Latest News” section of the DME MAC Jurisdiction C Web page and click on the article titled “Modifier KX Billing Errors.”
- Incorrect billing using the NPI and supplier numbers has resulted in CIGNA Government Services having to delete a larger than normal volume of paper claims. Please refer to the Jurisdiction C Supplier Manual, Chapter 6, Claims Submission, for detailed instructions on submitting NPI and PTAN numbers. Special attention should be paid to the requirements of blocks 33A and 33B. Also verify that your NPI number is on the NPI crosswalk. By accessing the NPPES website and reviewing your records at <https://nppes.cms.hhs.gov/> .
- Suppliers submitting claims for Maintenance and Service are reminded that fifteen months must be paid before the first maintenance and service claim can be paid. CIGNA Government Services has identified a number of claims (submitted prior to June 1, 2007) that were improperly paid for maintenance and service before completion of the fifteen rental months. We will be notifying those suppliers and recovering those overpayments.

**Redeterminations:**

Current Issues experienced by our redeterminations department include:

- Redetermination decisions not processed within expected time frames.

- Customers are unclear whether a redetermination request has been received and whether it is being processed.
- Acknowledgement letters do not include a “date of service” which is causing confusion over which redetermination request is being acknowledged.

Why is this issue happening? CIGNA Government Services received an unexpectedly high volume of redetermination cases at the beginning of our DME contract. This high volume has impacted timely completion of Redetermination cases.

What are we doing to address the issue?

- CIGNA Government Services continues to add and train full-time staff.
- Completing work on a "first in - first out" basis - meaning, those cases received at cutover on June 1, 2007 are being completed first.
- Increasing supplier education on how to determine when to request a redetermination versus a reopening.
- We are working to revise the system-generated acknowledgement letters to include the “date of service” of the claim being appealed.
- Providing refresher training to customer service agents on retrieving and reviewing the status of the Redetermination requests.
- Providing clearer instruction and online education to suppliers on the redeterminations process.

How are our efforts yielding positive results in the Redeterminations workload?

- We have added additional resources to process all requests received. The estimated completion date of requests submitted prior to June 1<sup>st</sup> is mid-October.

How can the Jurisdiction C Supplier Community help to reduce the timeliness for Customer Service, Reopenings, and Redeterminations?

- Please continue to use the Interactive Voice Response (IVR) for claim status inquiries and denial reasons, beneficiary eligibility, and payment information. The Customer Service line should be used for complex inquiries that cannot be answered from the IVR. Please refer to our Web site at [www.cignagovernmentservices.com/jc](http://www.cignagovernmentservices.com/jc) for a complete listing of IVR options.
- Please do not send duplicate Redetermination and Re-opening requests. We are processing all work transferred to us by the outgoing contractor. CIGNA Government Services is sending an acknowledgement letter for all redetermination cases received post-cutover. The letter serves as your confirmation that the redetermination case was received and will be processed.

James Herren will now discuss the differences in Redeterminations and Reopenings.

He will also provide additional information on Maintenance and Servicing Denials.

(James Herren) CIGNA Government Services would like to remind suppliers about the differences between Reopenings and Redeterminations. Both of these tools are a valuable part of the process for paying claims accurately, but they are distinctly different. A reopening is not an appeal rather it is an adjustment of a claim due to a simple clerical error, whereas, a redetermination is the first level of an appeal.

When a claim is denied for a minor clerical error, the supplier may use the reopening process to provide the information needed to correct the claim. Examples of minor errors are mathematical mistakes, transposed diagnoses codes, and inaccurate data entry. Other examples can include computer filing errors; incorrect date of service;

missing modifier; or an incorrect PTAN, which is the provider transaction access number formerly known as the NSC supplier number. Addition of a missing KX modifier is included within the Reopenings department. Remember, if adding the KX modifier to a claim, you must have the documentation on file that the modifier indicates. For instance if you leave the KX modifier off of a claim for a wheelchair, hospital bed, or corresponding accessories you may go through reopenings to get this corrected. Please remember, a reopening can be submitted for a denied, underpaid or overpaid claim.

Reopenings may be submitted by fax, mail, or telephone. Telephone reopenings are limited to five claims per phone call. There is no limit to the number of claims submitted by fax or in writing; but if there is a significant number of pages in question please mail the request. To avoid unnecessary delays or returns of reopening requests, we strongly recommend use of the Reopening Request form found on our website in the forms section at [www.cignagovernmentservices.com/jc](http://www.cignagovernmentservices.com/jc).

Please note some requests may require additional information beyond what may normally appear to be a simple reopening. In these cases the contractor does reserve the right to request a written redetermination request from the supplier.

The second option for claims corrections is through Redeterminations. A redetermination is the first step in the appeals process. Redeterminations are necessary for denials that involve over-utilization, insufficient documentation, items that require a CMN but do not meet medical necessity, and/or denials as the result of a development letter with insufficient documentation submitted. Redeterminations must

be submitted in writing within 120 days of the initial claim determination. To avoid unnecessary delays or rejections, please utilize the Redetermination Request form located on our website in the forms section at [www.cignagovernmentservices.com/jc](http://www.cignagovernmentservices.com/jc).

### **Maintenance and Servicing Denials**

Changes to capped rental rules, based on the Deficit Reduction Act of 2005, are effective with new rentals on or after 01/01/06. Capped rental items provided before this date are still subject to the 15 paid rental months followed by maintenance and servicing. For capped rental items falling under the old policy, CIGNA Government Services will deny MS claims with ANSI reason code 179 and remark code M6 if 15 rental payments have not been paid. Any MS previously paid in error will be sent for recoupment. There are two options to obtain MS payment for these.

#### **Option 1:**

If the claims for maintenance and service are denying and there is proof of 15 Medicare paid months on file, a reopening request with proof of 15 paid months may be submitted for record correction. We will update the records of the beneficiary to continue paying the maintenance and servicing payments as scheduled.

Suppliers who receive an overpayment request but have been paid 15 rental months by Medicare should follow the appeals process for overpayments. Please include documentation of 15 paid rental months by Medicare with the appeal request.

Option 2:

If there is not proof of 15 payments on file and the claims have denied or payment was recouped for maintenance and service, the next steps will depend upon the dates of service in question.

- If the remaining Rentals are past timely filing, Suppliers will need to submit the remainder of rentals using dates of service within the current file time. Refer to Jurisdiction C DME MAC Supplier Manual, Chapter 6, Page 26, titled "Time Limit for Filing Claims." Indicate in block 19 (paper claims) or in the line note on electronic claims, "extend for remainder of rental months".
- If the remaining Rentals are within timely filing requirements but outside the original 15 months, suppliers will need to submit the remaining rentals and indicate in block 19 (paper claims) or in the line note on electronic claims, "extend for remainder of rental months".

For further details on this, please review the "Archived News section of the Jurisdiction C website for an article published July 10, 2007, titled "Maintenance and Servicing Denials."

Ronja Roland, Provider Outreach and Education Representative, will now discuss NPI, the EDC transition, and upcoming provider outreach and education events.

(Ronja Roland) Since October 2, 2006, providers have been encouraged to submit both the NPI and Medicare legacy identifier, also referred to as PTAN or NSC DME PIN, on their claims. During this timeframe providers were allowed to submit invalid NPI/legacy ID combinations.

Effective October 29, 2007 CIGNA Government Services, the Jurisdiction C DME MAC, will begin editing the NPI/legacy ID combinations for validity against the NPI crosswalk file. Where a match cannot be located on the crosswalk, claims will be rejected or returned to the provider. As of this date, all claims must be submitted with a valid NPI. Claims submitted with only a Legacy number will also be rejected. Please take action now to ensure that your records are correct and to help avoid costly interruption of reimbursement.

Currently claims submitted with invalid NPI/Legacy combinations will receive messages to notify suppliers of issues with the NPI/Legacy combinations. Please verify the following to make any necessary corrections before claims are rejected:

1. When the claim is returned, first verify that the correct NPI was submitted.
2. If the correct NPI is submitted or new application for an NPI is needed, access the NPPES website at <https://nppes.cms.hhs.gov> and verify or submit all demographic information in NPPES and compare against NSC records for consistency.
  - DME suppliers should take care to ensure that the NPI types match the NSC types. That is, if the company is enumerated at the NSC as an individual company, the company must also obtain the NPI as an individual company or Entity Type 1.
  - Likewise, if the company is enumerated as an organization with the NSC, the company must obtain the NPI as an organization or Entity Type 2 in NPPES.

- Make sure the NPI you are using is compatible with your Medicare enrollment.
3. If the records in NPPES are correct and there is incorrect information on file with the NSC, please correct the records with the NSC.
  4. When updating your information with the NSC, please include all of the NPI's that will be used in place of legacy numbers.
  5. If you are applying for an NPI, please include all of your Medicare legacy numbers.

As stated in CR 5649 all Medicare providers could receive phone calls or letters from their contractors if their claim suspends due to problems mapping an NPI to a legacy number.

### **EDC Transition**

The Medicare Prescription Drug, Improvement and Modernization Act (MMA), enacted on December 8, 2003, placed new information technology requirements on CMS. To successfully support the data processing and hosting associated with MMA's new Medicare benefits and fee-for-service contracting reform requirements, CMS has established an Enterprise Data Center (EDC) initiative that will be the foundation of the future CMS enterprise infrastructure. This initiative will assist CMS in complying with present and future legislative mandates and ensuring the ability to meet increasing claims processing demands. CMS is in the process of moving all of the Medicare contractors to one of the three EDCs over the next several months. CIGNA Government Services is moving the Jurisdiction C DME MAC processing system to the EDC the weekend of October 12-15, 2007.

Due to the implementation of this initiative **CIGNA Government Services will be closed for operations on Monday, October 15, 2007** as we transition our Medicare

processing system to the Enterprise Data Center (EDC). We are working closely with CMS and the EDC to transfer processing data and test our processes in the new data center. As a result of the transition activities, the CIGNA Government Services systems will be unavailable for processing or inquiries on October 15, 2007 as we migrate to the EDC. Because our systems will not be available, we will not be able to respond to calls through our Provider Contact Center or perform any processing of claims or inquiries on Monday October 15th. This interruption of service also includes the Interactive Voice Response (IVR) and the EDI Claims Status Inquiry function. CIGNA Government Services will tentatively resume normal processing and operations on Tuesday, October 16, 2007.

**What do Suppliers need to do?**

This transition will not require suppliers to take any actions or make any changes. Suppliers need to be aware that CIGNA Government Services will not be available on October 15. Suppliers should continue to submit claims through the Palmetto GBA EDI processes. P.O. boxes and telephone numbers will not be affected by this transition.

**Will Suppliers be impacted?**

CIGNA Government Services does not anticipate any disruption outside of the planned outage on Monday October 15. Suppliers should not experience any delays in payment. CIGNA Government Services will closely monitor the progress of transition activities taking place and will provide updates via our ListServ and our Web site, located at: <http://www.cignagovernmentservices.com/jc> . Please monitor these sources for the most up to date information.

## Upcoming Events

The CIGNA Government Services Provider Outreach and Education team is excited about the educational opportunities we have scheduled through the rest of 2007.

Please make plans to participate in one or more of the following activities.

- CIGNA Government Services invites interested parties to participate in our Jurisdiction C DME MAC Provider Outreach and Education (POE) Advisory Group. The primary function of the Advisory Group is to assist us in the creation, implementation, and review of provider education strategies and efforts. The Advisory Group provides input and feedback on training topics, provider education materials, and dates and locations of provider education workshops and events. The group also identifies relevant provider education issues, and recommends effective means of information distribution to all appropriate providers and their staff. If you are interested in being considered for this group, please access our website at [www.cigna.com](#) and send a completed application as an attachment to our Advisory Group email address.
- For those suppliers planning to participate in the Fall MedTrade Conference in Orlando, Florida next week, Jurisdiction C invites you to join us for a contractor update on October 2<sup>nd</sup> from 4:00 PM – 5:30 PM in the Orange County Convention Center in Room W109B. While at MedTrade we will also be participating in the DME MAC Update with the other MAC Jurisdictions on October 3<sup>rd</sup> at 8:30 AM in the Orange County Convention Center in Room RB-11.

- James Herren will be representing the Jurisdiction C DME MAC at the West Virginia MESA Fall Conference on November 7, 2007 at 8:30 AM at the Charleston Marriott in Charleston, WV.
- We are also happy to announce that CIGNA Government Services will be holding our DME Fall Workshop in Nashville, TN. Please mark your calendars to meet with us in November to receive valuable updates on Jurisdictions C. A ListServ will be sent soon to provide registration details. Please continue to visit the Education Section of our website for more information.
- ListServ

To receive the most current news and Medicare updates, please enroll in the CIGNA Government Services Jurisdiction C ListServ. The process is very easy, just go to our website at [www.cignagovernmentservices.com/jc](http://www.cignagovernmentservices.com/jc); click on the ListServ link; complete the form; and click the submit button. Please make sure that your firewall is programmed to accept emails from CIGNA Government Services, we have identified that some firewalls will block the ListServ messages as spam.

I will now turn the call back over to Dante' Wynn.

(Dante' Wynn) This concludes the update portion of this call. We will now open the phone lines for your questions, please keep in mind that we will not be able to answer questions about individual claims. If you have a question regarding a specific claim, please contact our provider contact center at 1-866-270-4909, that number again is 1-866-270-4909. Again, we would like to take this opportunity to thank you for participating in today's call, and we will take your questions now.

Operator: We'll take our first question from Jeanne Rogers at Parkwood Medical.

Jeanne Rogers: Hi. I got a couple of questions. One is what is the timeline once we receive a favorable response after the claim has already gone to redeterminations? How long should we have to wait before we get a check after it's been favorable response?

Dante Wynn: OK. Let me make sure I understand your question. You're asking, you've already received a favorable response and you'd just like to know how long it is between the time that we make the decision and the time you receive your check.

Jeanne Rogers: Yes.

Dante Wynn: OK.

(Debbie): Hi. This is (Debbie) and I'm with the appeals department and that should take approximately 30 days.

Jeanne Rogers: All right. We got a favorable response on a patient in July and we still have not gotten a check and I was wondering if maybe that's part of the reason people are sending stuff to redetermination two and three times because we still are not getting checks.

(Debbie): I would need to look at that individually so I would have to call you separately from this call.

Jeanne Rogers: OK.

(Debbie): I would need those examples to look at that.

Jeanne Rogers: OK. Do you want me to call you after I pull the chart out?

(Debbie): I can call you.

Jeanne Rogers: All right. I don't have the chart in front of me right now. It's not even at my desk.

Jeanne Rogers: And my other question is you had said that they were limiting them to five patient requests on the phone when we do redetermination by phone but that's not what we've been getting. They've been telling us on the phone only two requests. They aren't – is five a change from two or have they all along suppose to be doing five and they're only doing two.

Female: OK (Jan). Let me understand your question. OK, are you talking about telephone reopenings?

Jeanne Rogers: Yes.

Female: So your question is you're saying that you were told that they will only do two telephone ...

Jeanne Rogers: Yes.

Female: ... reopenings in a single telephone call.

Jeanne Rogers: Yes.

Female: Are you aware whether there were two beneficiaries or only two claims because it could be a situation where you have two beneficiaries that yielded five claims. Is that the situation?

Jeanne Rogers: I'm not sure. The lady that told me that they are only limiting up to two, I assume is patients. So there could be more than one item on the line, I'm not sure. She's not here today so she could have answered that better than me but she said that it's been limited to two requests so she's now just faxing everything.

Female: OK. Actually it is five claims per phone call. So, for instance, if you have one beneficiary and there were three claims on that one beneficiary, even though it's one beneficiary, that would be three of your five.

Jeanne Rogers: OK. I understand that.

Female: So perhaps that is what's occurred.

Jeanne Rogers: Yes, I'd have to have specifics from her.

Female: OK.

Jeanne Rogers: OK. And the only other thing we wanted to know about is the five digit (Medigap) identifiers that are suppose to be enforced by October 1st. I noticed you didn't address that at this meeting but we are having a heck of a time getting secondary insurances to give us a five digit number. Do you have any Web site where we can go and pull it from ...

Jeanne Rogers: OK.

Female: OK. Actually that is a great question that you pose. We're going to go ahead and put that in the minutes to everyone when we put this out because we're going to do some further research on that. So we will put the answer to this in the minutes. We'll be posting the minutes to the call on our Web site under the

Ask the Contractor section of the education Web site at  
[www.cignagovernmentservices.com](http://www.cignagovernmentservices.com) ...

The Coordination of Benefits Agreement list for Medigaps may be found at the  
following website:

[http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-  
based%20COBA%20IDs%20for%20Billing%20Purpose.pdf](http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf) . You may also  
review the COBA website for more details at

[http://www.cms.hhs.gov/COBAgreement/01\\_overview.asp](http://www.cms.hhs.gov/COBAgreement/01_overview.asp) . Finally MLN Matters  
article number MM5601 may be viewed for further details.

Female: Thank you.

(Cassandra Johnson): Yes, this is (Cassandra Johnson). And I'll actually be speaking  
for Carla.

Female: OK. Go ahead.

(Cassandra Johnson): I have a question about the B4 185 on Medicare; they're not  
paying them correctly. Every – we submit let's say 65 units a claim, Medicare  
and the LCD policy allows 100 (cc) units. We only get paid for one unit and I was  
wondering if anybody had called that attention yet?

Female: OK. I'm sorry, (Cassandra), what is the item again?

(Cassandra Johnson): It's B4 185. It's the lipids for total parenteral nutrition.

Female: OK. And you said you're placing 65 units ...

(Cassandra Johnson): That's just an example. The concern I have is I have about seven different patients that Medicare is only allowing one unit every time we bill for this service and I've talked to several reps and some of your reps cannot even tell me how you mathematically get the formula for this for units.

(Ellen): This is (Ellen) and I'm with the claims area. And the pricing of that particular code is going to depend on the medical necessity information that's on their DME Information Form ...

(Cassandra Johnson): Right.

(Ellen): ... Parenteral nutrition and the spanned dates on your claims.

(Cassandra Johnson): Right. My question is, I have a patient that the doctor ordered 200 cc ml's seven days a week. We bill at let's say 20 percent concentration. We bill – that's 155 units ((inaudible)) rate for 31 days. Medicare only allows 100 cc unknown. We only get paid for one unit.

(Ellen): I'll need to see the examples of those (planes) because there's something wrong if you're only getting one unit.

(Cassandra Johnson): Well ...

(Ellen): ... there's something wrong in the ...

(Cassandra Johnson): ... one thing is I talked to a tier two rep one time, I can't recall her name at the time, and she told me that the reason that they're not paying them right is because I'm figuring my math wrong and they totally left the concentration out on the formula.

(Ellen): That wouldn't be acceptable with me either. So I'd like to look at those claims though. Can I give you a call after this conference call?

(Cassandra Johnson): Yes.

(Cassandra Johnson): OK. We do have one more question, OK?

Female: OK. Go ahead.

(Cassandra Johnson): We're wondering on the UPIN numbers, you're saying that there's going to be a crosswalk from the UPIN to the NPI. Is it not true that there's no longer going to be UPIN numbers?

Female: That is correct. The NPI is replacing the identification number of physicians and providers and suppliers. So the NPI will be the new number. There's not a crosswalk between the two but there is a NPI registry that works very much like the UPIN registry.

(Cassandra Johnson): OK. That was my question. I know we've got some doctors who aren't – since they're not given UPIN numbers who don't have one but do have a NPI and we were wondering how you were just going to crosswalk that. But I think you've answered my question.

Female: OK and I would like to mention that the registry, the NPI registry is currently down but we did receive notification yesterday that that they are expecting to have that back up within the next week or so.

[The NPI Registry is currently functioning.](#)

(Cassandra Johnson): We had one more question regarding redeterminations. I have a patient that was sent to redetermination when (Palmetto) was contractor.

Female: Yes.

(Cassandra Johnson): And we sent three different redeterminations for three different dates of service. CIGNA comes back and finds two of them favorable and they deny the other one as it was already determined when (Palmetto) was contractor. But my problem is, is the reason why I sent it back to redetermination is because when it was (Palmetto) we could send it back to reopen review decision and so I got two different answers on three different claims. Does that make sense?

Female: I don't know that – let me make sure I follow you question.

(Cassandra Johnson): OK.

Female: So you had three different claims.

(Cassandra Johnson): Right.

Female: And two of them yielded a favorable decision and one did not ...

(Cassandra Johnson): Yes.

Female: ... because it had already been determined with (Palmetto)?

(Cassandra Johnson): Right. See when – I had sent – they denied for research (CMN) when I first submitted the claims so I sent them to redetermination with the research (CMN). (Palmetto) found them favorable but did not pay one of the procedure codes correctly so I sent them back to reopen review decision because that's how (Palmetto) worked. You could send it back if they did not pay it correctly even though they found it fully favorable. And on those three claims, I get two decisions from CIGNA that are fully favorable. They were all three sent for the same reason and one of them denied saying it was already determined by (Palmetto).

Female: OK. Thank you. Is this (Cassandra)?

(Cassandra Johnson): Yes.

(Debbie): This is (Debbie) again with the appeals department. And you did do it correctly so I would need to look at that specific case in general.

Operator: If you find that your question has been asked and answered, you can remove yourself from the queue by pressing star two. To enter the queue for questions, once again, it is star one. And we'll take our next question from Dale Lang of Advocate Medical Supply.

Dale Lang: Yes. We have a couple of questions. One has to do with -- we're in the state of Arkansas. To get anything that is not covered by Medicare, to be paid by Medicaid, it first has to be submitted to Medicare for denial for medical non-coverage and then billed with that denial to Medicaid. We are using the GY and GZ modifier to indicate those to Medicare but they are not getting through the first level. They're being kicked before they even (adjudicated). We've made a couple of calls to both CIGNA and EDI and it's kind of a (pointed) thing, well it's our table, it's their table, it's our table, it's their table but we're not getting it resolved. So therefore, we're holding a number of claims that we can't bill to Medicaid because we can't get them through the Medicare system.

Female: OK. Let me make sure I understand your question, Dale. So what you're indicating is that your claims are -- are you indicating that they're rejecting with the GY and GZ modifiers?

Dale Lang: GY and GZ.

Female: GZ modifier.

Dale Lang: Before they even get to adjudication.

Female: So it's not getting into the system at all?

Dale Lang: That's correct.

Female: Bear with me just a moment. What rejections are you receiving exactly on those?

Dale Lang: Let me pull one up quick. OK. It says the rejection is procedure code modifier invalid. These would be things like diapers, shower chairs, transfer benches, any of those kinds of things that are not covered by Medicare as a benefit but are a benefit for Medicaid but our state requires for Medicare to reject them first before they'll pay them.

Female: (Sue), are you on the line?

(Sue): Yes, I am. EDI will reject anything that the table doesn't give us to take as an acceptable modifier. And EDI is not the area that determines what modifier should go in the tables. Wish we were but we're not allowed to do that.

Female: OK. So all of the GZ's and GY's are rejecting. We will have to do some further research on that Dale. May we get your telephone number please?

Dale Lang: Yes. It's area code 501-372-4444.

(Roc): Dale, this is Roc from the claims department. Have you ever tried billing those without the modifiers?

Dale Lang: I believe we have but I'll have to research that. But, you know, again, this is suppose to be the proper way to bill them to tell Medicare that we know in advance that this is not a covered service.

Dale Lang: And if that's all we need to do is to bill it without that then that's fine.

(Roy Bob): Let's research that and verify.

Dale Lang: And one other question that we have, it involves the recent audits in Jurisdiction A and Jurisdiction B. We've done some researching ourselves of claims that prior to going out and we might find a technical glitch in one of those and let me give an example. Let's say you've gone through everything in for a power chair and ((inaudible)) all over it and a post-audit prebilling again goes through and says, OK, we've missed the 45 days by one day and this particularly happens when people can't count the 30 days in the 31 day rules and when it actually starts. Does it start the day of the doctors' note when you stamp it or so on and so forth? Is there anything that we can do to clean those claims up to be in compliance ((inaudible)) technical issue without being rejected?

Female: I don't know that I follow your question. Can you repeat that?

Dale Lang: OK. Let me go through this. The process of going through is that before you can bill a claim, you have to go through X, Y and Z and including delivering the chair. OK? If you have delivered a chair and you have all the other documentation but, a case we saw, we were like one day over the 45 day limit because they miscounted the days. Is there anything you can do to correct that item or have you just left the sale? Everything – every other indication of medical (necessity) is done face to face ((inaudible)).

Female: OK. Actually you can – if the claim does not meet the policy requirements and you have documentation to support the medical need and everything else, you are allowed to go through the appeals process in order for us to reconsider that.

Dale Lang: OK. So it's not going to be an absolute denial because you missed it by a day if we can ...

Female: It will deny because it doesn't meet the requirements but it does not mean that it stays denied.

Dale Lang: OK. That's most helpful.

Female: OK. Thank you.

Dale Lang: Thank you.

Operator: We'll take our next question from Ashley Woodruff of Alert Respiratory Services. Ms. Woodruff, your line is open.

(Ann): This is (Ann) with Alert Respiratory and I have a question about the payment for options on the IVR system. When calling, they'll tell you how many claims, total amount and expected payment amount. What is the turnaround time when these payments are actually released?

Female: OK. So your question is when you hear the payment (floor) information on the IVR, what is the timeframe on when those claims are released for payment?

(Ann): Correct.

Female: Do you bill electronically or paper?

(Ann): Electronically.

Female: OK. What we're giving you is everything that's sitting on the payment (floor). So it could be at day one, it could be at day 14 but there's really no time to tell – we can't really tell you when that amount of money's going to be released to you.

(Ann): OK. That's kind of vague. The other thing that we're experiencing is something new from Medicare is remittance of ((inaudible)) that are reflecting year 2003, 2004 from maintenance month stating the rental months have not been paid. I understand that but I'm not getting the traditional overpayment notifications that Medicare has sent in the past.

Female: So, OK, let me follow. So these are situations where we have paid maintenance and service and 15 months have not been paid and now you are receiving the remittance (advices) for those...

(Ann): Yes, what ...

Female: ... overpayments.

(Ann): Right. I'm – well it's not really an overpayment. What's actually very confusing is the remittance itself will state total amount to provider and then actually pay. On the remittance it reflects that those 2003, 2004 dates of service, they're showing, on the remittance (advice), paid, like it was paying that date in September of '07. Unfortunately, it's the same amount that's been omitted on the total remittance line and it paid to provider. So it does impact – and I called and I was told, no, that's just to let you know that's what we tend to recoup for those dates of service. And I go, well, I'm not getting the traditional overpayment of services or payments toward that I normally get from Medicare for these people.

(Rita): This is (Rita) from the overpayment department. If you have multiple overpayments, as we adjust them, they may show up on your remit but our overpayment letter will not go out until all of the adjustments have cleared. So you may see them on your remit and then you will get an overpayment letter for that at a later date.

(Ann): OK. And then that way it'll have a total for us.

(Rita): Right. If you had 10 overpayments, we would send you 10 separate letters for that.

(Ann): Great. OK. I was just kind of concerned because it was kind of confusing. I've never had this – I've never seen it before. One of my last questions is when billing for an upgrade such as an electric bed and we're billing for a full, code EO265, I have been advised that we don't need to bill the secondary code, EO260, which is Medicare's allowable code for the semi-electric. That you would go ahead and downgrade and pay the semi-electric bed allowable.

(Ellen): This is (Ellen) again. Are you billing the full electric bed as a beneficiary requested upgrade?

(Ann): Correct.

(Ellen): Then you would have to bill it on two lines with your EO265 on the top line ...

(Ann): Right.

(Ellen): ... your ABN information and your EO260 on the second line with the GK modifier.

(Ann): OK. We did that and we were told not to do that.

(Ellen): By whom?

(Ann): From the Medicare rep when calling.

(Ellen): If it's an upgrade, that's how you should bill it.

(Ann): OK. Because you know, we have to reflect an upgrade being that's what the patient's equipment that they were issued.

Female: If they requested it that way then, yes, you have to bill it that way.

(Ann): OK. Well I thank you for your time.

Female: Thank you.

(Ann): OK.

Operator: We have a question now from Dina Flores, Steven Douglas Inc.

Dina Flores: Hello there. Thank you for taking my call. We have a couple of things here. When Medicare is denying an error, why does it need to go to redetermination? A lot of the reps are saying that and that way it can take up to at least 60 days and it should be a clean claim.

Female: OK. Let me make sure I understand your question. So you're saying that Medicare made a mistake in processing the claim, to your understanding?

Dina Flores: Correct. We've had quite a few of those.

Female: And you're being told to go through redetermination?

Dina Flores: That's correct.

Female: Anytime there is a clerical error on a claim that is not a redetermination, that would be a reopening.

Dina Flores: OK. That would – our understanding but like I said, when we get the remit and it says – and we call up and question the denial, our biller is here and she is finding this to be quite common.

Female: OK. Let me – we will look into that on this end and just ensure that the customer service representatives are advising the difference between the reopening and the redetermination. If it is a clerical error, it would go to reopening. If it is something other than a clerical error, that would be a redetermination.

Dina Flores: OK. I understand that ...

Female: So we'll ...

Dina Flores: Excuse me.

Female: I'm sorry.

Dina Flores: The error is not on our part. The error is on Medicare's part so when we called and questioned it, they said, that is our error but you have to send it to redetermination.

Female: Actually that may still go to the reopening – that still can go to the reopenings department.

Dina Flores: OK. So you're saying we should handle that when they tell us that, then we should accept their answer and then call the reopening line. Is that what you're telling me?

Female: Yes. You may submit it as a reopening.

Dina Flores: Even though it's Medicare's error? Are you still there? Hello?

Female: I'm sorry. Actually, yes, that is an option that you may take to ensure that they are adjusted because the reopenings department is able to make adjustments to claims.

Dina Flores: OK. And then what, again, is turnaround time? If we call on a claim and then we the response from the Medicare rep and they say, we've denied that in error, then what should our response be? How should we handle that?

Female: Our current internal process is to have the CSRs send the claims to Tier 2 for further research before the claim is sent for adjustment which may take longer than submitting a reopening request directly if you are certain that we made the error. The reopenings department does not research the reason for denials and

the CSRs do not adjust claims. Requesting the reopening is another option that you may choose to expedite your requests.

Dina Flores: OK. Secondly, we all – I've got two more questions if you could oblige me here. When we were providing wheelchair cushions, in the past with (Palmetto), we were not required to provide a serial number or purchase date if we did not provide the chair but some of our clients they get them from family members or they buy them at garage sales. Is this a new requirement?

(Caroline): This is (Caroline) from pricing. In order for us to cover accessories for a piece of equipment, it is policy that we have to see if these pieces of equipment is covered by Medicare so we do have to show that they own the piece of equipment and that's why we're asking for information on the wheelchair.

Dina Flores: OK. So if we can just ask a client to locate the serial number and what other information?

(Caroline): They don't specifically have to have the serial number. If you give us the make or model of the chair, approximately when that chair was purchased, we can ...

Dina Flores: Make or model?

(Caroline): ... yes – so that we can match it up to make sure that we have medical coverage for that.

Dina Flores: And proximate purchase date, even if they didn't purchase it from you all, you all will still provide the batteries and that sort of thing, right?

Female: We have to make sure that it meets Medicare coverage criteria ...

Dina Flores: OK.

Female: ... if they didn't purchase from Medicare, if we have no record of any chair on file, we would have to get – ask for medical documentation in order to ensure the patient meets Medicare criteria.

Dina Flores: OK. Normally we do that with the ICD-9 code. And also does Medicare have ombudsmen or liaison people because we've had quite a few issues and I know everyone else has too and it's just been frustrating for us. Is there someone that we can contact other than just the, you know, calling the regular Medicare line?

(Dante'): CMS has changed the structure of inquiries with the implementation of the MAC contracts to keep accurate data of the different inquiries received. The process for inquiries would be to go through the customer service department

and there's an escalation process. We do have provider outreach and education representatives but we are reserved for educational needs— it's not an ombudsman where you would go for specific claims issues. Actually the issues would go through customer service and then they – if it's not going to be handled at the first level, they will transfer it to the tier two. Generally, the answers will come from tier two. If tier two is unable to do it, then it would go to our PRRS level and generally between those three levels, any issues that you've encountered will be rectified. But if you have education requests, such as you need to see an online education course, additional information posted on the Web site and things of that nature, that is when the provider outreach and education department would be able to assist.

Female: OK. All right. Can you – let me see if (Bill) has anymore. I know we're not suppose to ask case specifics. OK. (Caroline), thank you so much and I appreciate your answers.

(Caroline): Thank you.

Operator: And once again if you have a question, it is star one and if your question has already been answered, it is star two. We'll take our next question from Teena Baber of Reimbursement Services.

Teena Baber: Hi. I have a few questions. The first one is on these maintenance recoupments and considering the fact that we're suppose to provide proof that the prior 15 months were paid and considering the fact that, as I understand it, a supplier only has to retain documentation for seven years. Is there any limit to what you all are going to be recouping as far as maintenance? I think I've seen some that the initial dates of service were 10 years ago.

Female: OK. Let me make sure I understand your question. Your question is are we limiting how far back we will recoup maintenance and service payments, is that correct?

Teena Baber: I'm kind of asking that. I'm asking if the initial billing was over seven years ago, are you all still going to recoup if you don't show 15 rental months paid because the suppliers aren't required to keep the documentation except for seven years so there will be no way to prove if the 15 months were paid if they purged the documents?

(Ellen): This is (Ellen) and we have been instructed by CMS to recoup those maintenance and services if we cannot find those 15 paid months in our system or the common working files.

Teena Baber: OK. Could you follow up with CMS and see if you're suppose to recoup even past seven years?

(Ellen): We can. We shouldn't have that much history in our system but we could follow up with that.

Teena Baber: OK. I'd appreciate that. And then another question is when we are going through customer service, we're being referred to PRRS on some things and we're being told the claims denied in error and from the get go, when you all took over in June, we were told, well, we'll refer this to PRRS. We're given a confirmation number and we're told it'll be 10 to 25 working days for the claims to be reprocessed or you might get a call or a letter.

Now when we hear the words, it'll be 10 to 25 working days for it to be reprocessed, we're thinking the claims going to adjust but what we're seeing is, in August, more than 25 days later, we're getting a letter dated in August saying that PRS has referred it to reopenings and we wait another month and the claim still hasn't paid and we call Medicare and they say, oh, it could be 60 days from your letter date.

I have one example that's 99 days since the day it was referred to PRS. And I don't understand why we're – why PRS isn't able to fix it or, if they are able to fix it, why it's going through all this – these steps?

Female: OK, so your question is, when you submit a request to the customer service representative and it is referred to the other levels of customer service.

Teena Baber: Right. They word it that it'll be "reprocessed or will receive a call or a letter within 10 to 25 days", now that has jumped. First we were told 10 to 25 working days, then 45 working days, then 60 working days. And then once it gets to PRS and they do handle it, they refer it to reopenings rather than fixing the claims themselves.

So we've got one that we've got a 99-day, it has been 99 days and the thing's still not finished and I don't understand why it's being sent to PRS if PRS can't fix it.

Female: OK. Actually, to answer that question, if it is a situation where you are looking for a correction to the claim, that request would best be handled through the reopenings department, so you would bypass customer service altogether and just submit a re-opening request and that would avoid any delays in the time that you expect that to be completed. So you would just go straight to reopenings, there would be no need in contacting the customer service department for a request if it's a request for a (claim) adjustment.

Teena Baber: We've had several and didn't know that's what we were to do. We kind of figured that out in the past few days that we shouldn't even – they'd tell us

“We’ll send it to PRRS” and we say, “Can we just send it to re-opening and bypass it” and they say “yes”.

Female: Yes.

Teena Baber: I didn’t understand, I mean, we’ve got dozens that went through that process that are just sitting there now.

Female: And what we’re doing when a tier one is unsure what to do, they do send it through the other tiers for research. And if it makes it to those tiers and once it’s researched, and it is identified and it is transferred accordingly. So, if you know on the front end what it is, then bypass customer service altogether.

Teena Baber: OK, very good. Now are you all having a problem with capped rental items for the 13th month is denying an error? You know, it’s denying so it’s capped out and it’s actually the 13th month. Have you noticed that problem, and if so, is anything being done about that or do we just do re-opening?

Female: OK. So your question is we currently experiencing any problems with the 13th month of a capped rental denying an error?

Teena Baber: Yes.

Female: And if so, what do you do?

Teena Baber: Yes.

Female: This is ((inaudible)) in claims and I'm not familiar with that particular problem.

Do you have examples of where that's happening?

Teena Baber: Yes.

Female: OK. Can I give you a call and get some info?

Teena Baber: Sure. It's 864-877-5600 and just ask for Tina, OK?

Female: I will.

Teena Baber: OK.

Female: Thank you.

Teena Baber: And another question is, we're getting CO16 denials, which are like missing information on oxygen stuff and we're seeing a lot of those, and I didn't know if there was a systems problem or something.

Female: So you're saying you're getting denials for missing information on oxygen claims?

Teena Baber: Yes.

Female: Are you getting remark codes that advise what was missing?

Teena Baber: I don't know about that. I do have one I could look up. One of them is one that I initially paid and then Medicare came back and adjusted it to deny with a 16. And then that's one that went through all that process to PRRS and we're still waiting on it to pay. But we have – I just – if I look at remittances, I'll see that later ones have denied that way, too, and I don't remember if it had a remark code.

(Ellen): Tina, this is (Ellen), when I give you a call, can you give some examples of that ...

Teena Baber: Sure.

(Ellen): ... as well?

Teena Baber: OK, sure. And then some other jurisdictions like jurisdiction B give the MSP company name that you all show on file. Is there any possibility you all

might start doing that soon? Your automated system says to contact the beneficiary.

(Trisha): Yes, our – this is (Trisha); our IVR is not set up to actually give that information. But if you need it, it can be furnished through customer service.

Teena Baber: OK. Thank you so much. And will we ever be able to check the status of re-determinations through the phone line?

(Trisha): This is (Trisha) again and we are working on that.

Teena Baber: OK, I didn't catch that.

(Trisha): It will be in the near future hopefully.

Teena Baber: OK, thank you. That's all. Thanks so much.

Female: Thank you.

Operator: We have a question now from Linda Jones in NEB Meds Incorporated.

Linda Jones: Hi, this is Linda Jones my question is two questions today. Mainly, I've been having a little problem with everybody's been talking about maintenance

and service, and I think everybody's like following the same procedure and I was listening to one of the reps that were on the phone earlier about maintenance and service.

My situation is, I have two claims, two major claims that I have to go back as far as 2000, I'm sorry, 1998, just to prove that this patient has had capped – has had (rental period) and to show maintenance and service starting on July 21st of '99.

Now when I first called on this claim to customer service, I was told that it was because you guys did not have the records like you stated before, and because (Palmetto) did not follow guidelines when the contract was transferred. Now this puts to me, in my mind, this puts a major in all suppliers who are on the phone now because we have to go back just to prove. And to me, if the beneficiaries are being paid and they are in the system, then the original records should always – also be there.

So what is being done? Because that means if I continue to get these, I'm going to go back and prove all the way back to almost '97, '98, '99 and do the first rental through the 15-month rental and then show those that were paid that you guys are going back to recoup.

(Ellen): This is (Ellen) again and I certainly sympathize with you, and we brought all those of issues up at the beginning of our contract stay with CMS, and tried to

negotiate some way to get around that kind of issue. And our instructions are to follow the guidelines and that we have to have proof of 15-month's pay.

So, I understand your pain and I'm sorry, but – and I am going back to CMS to ask about the timeframe if we can cut off at a certain level or something. But unless we get permission from that, we'll have to continue as we are.

Linda Jones: Because some of them, they're so – they're so large that on one of them, I had to just start at maybe showing you the 10th, 11th, 12th, you know, and 13th, 14th, 15th and then start showing you when the maintenance was actually paid. But I show at least five because some of them are so big and one of the persons that were on the phone earlier was saying something about the seven years. Where here, our situation has always been seven years, if you have an active patient that you're constantly billing and they're maintenance and service, then you do keep those. But if they're inactive patient within the seven years, of course, you can then destroy them if you're no longer billing, but it has to be, of course, seven years from whatever date that you were actually billing.

So, I mean, it's just majorly, I don't want to have to get – if I go in and get my ERN's and I constantly see all this, then I have a lot of claims that will be sitting because I have to go back and research.

(Ellen): I understand.

Female: Right.

Linda Jones: And it becomes so major, and I'm not trying to blame anything on anybody, but it just puts a big situation on all suppliers with (CMNS').

Female: Yes, (Linda) ...

Linda Jones: ((inaudible)) they're very old.

Female: Right and Linda, we do empathize with you and unfortunately, we're not – we're not in a position to make that decision. So we will definitely follow up with CMS and the answer to that question will also be included in our minutes if those answers are received pretty quickly. If not, we will send further information out on that through our list serve and on our Web site.

At this time we do not have any feedback from CMS to indicate if the current instructions may be changed so please continue to follow the previous instructions for correcting MS denials. Refer to our website at [www.cignagovernmentservices.com/jc](http://www.cignagovernmentservices.com/jc) under the Archived News for the Maintenance and Service Denials article.

Linda Jones: And I have one more question, reiterating what someone else was saying about receiving the letters, well, in my situation here, too like there, I have a letter

sitting in front of me dated July 6th (printed) and it says, "We have received your request dated June 8th, allow 60 days." Well, I'm starting to get a lot of these in. Sixty days was August 8th, and we're supposed to (go) in October. I haven't heard anything on several of my claims and I have – I'm now trying to put a list together to keep up with all my denials and past 60 days.

Female: And Linda, was this a re-determination request?

Linda Jones: This one in particular was, give me just a second here. Let me flip back.

This particular patient – this came from – yes, a re-determination.

(Debbie): This is (Debbie) with the Appeals Department, and we do recognize that we are not meeting timeliness right now. All the work that we received at cutover, we anticipate to be completed by October. And I do ask that if it's gone beyond 60 days, to still – to not send in another request because if you do that, that's just going to increase our timeliness.

Linda Jones: Yes, I don't – what I do, I just kind of check the IVR and I've been checking this particular individual and I checked it on July 22nd, and I went back on August 7th. You know, and then I just – I just keep checking it. But I'm hoping we will get at least a payment or it'll show up on the, you know, download that it was paid. So, I'll just keep an eye on it.

(Debbie): Yes. It's only going to show up as paid if your re-determination request is favorable.

Linda Jones: OK. Thank you very much.

Female: Thank you, Linda.

Operator: And as a reminder if you do have a question, press star one and if your question has been asked and answered, you may remove yourself from the queue by pressing star two. We'll take our next question from Jeana Lambert of Blunt Memorial Home Equipment.

(Patrice): Yes, this is (Patrice) asking a question for Jeana. Our software vendor, we're having some trouble with them with the (CMN's) for the hospital bed, wheelchairs and CPAPs. I know that they're no longer required, but our software vendor still wants us to use those and I know that we sent them in and we've send them in for a review process, and our review was denied because we did not have the proper documentation.

So are you accepting the (CMN's) now or do you prefer us to use other documentation?

Female: OK. Let me make sure I understand your question. You submitted a claim including a certificate of medical necessity for hospital beds, CPAPs and so forth recently since the removal of the (CMN) requirements. Is that correct?

(Patrice): Correct.

Female: So you submitted the claim. Did you include the KX modifier on the claim line?

(Patrice): Yes.

Female: You did include the KX modifier on the claim line and the claim denied for medical necessity?

(Patrice): Correct. Well, denied for some other reason, but when it was sent into review, our review was denied because of the certificate of medical necessity is no longer accepted by Medicare.

Female: What reason did the claim deny, this is going to determine what information we're looking for in the re-determination department?

(Patrice): Right. I believe ...

Female: It sounds as though the information that you provided did not address the reason that the claim was denied. I think – I think these are two different issues.

(Patrice): I believe the claim was denied initially for the (KX modifier) missing, and the person that we had on staff instead of – Medicare at the time didn't have reopenings, and this is Medicare and it will have switched over to the CIGNA, sent it into review. Once it went into review, it was denied because of the documentation we had, not because of the (KX) modifier. The (CMN) met the qualification.

Female: OK. I'm going to give this one to (Debbie) in our Appeals Department.

(Debbie): This is (Debbie) in the Appeals Department. If you submitted that request to determination to Palmetto and then we received that at cutover, if you just said, we left off the (KX) modifier an error, that's a clerical error. We would process that. But if you did not state that, then we would need that documentation supporting the (KX) modifier. So if you did not include that in your re-determination request, we would deny that.

(Patrice): OK. So, my question, are you guys going to accept – continue to accept the hospital bed (CMN), the wheelchair (CMN) and the (CPAP CMN) ...

(Debbie): No. (CMN) ...

(Patrice): ... as documentation?

(Debbie): (CMN's) are no longer required so we would not accept that as documentation.

(Patrice): That was the question that I had. OK. Thank you.

Female: Thank you.

Operator: We'll take our next question from Mandy Baldwin, Walgreens Home Care.

Mandy Baldwin: Yes, we have a couple of questions. One of them is an easy one, I noticed when I called the other day into customer service and I was listening to their hold messages, they stated that you guys were going to be closed on the 15th and the 16th, but at the beginning of this call you just said it was going to be on the 15th. Can you clarify how many days you really are going to be closed?

Female: Mandy, what you're saying is on the hold time we indicated two days closed for the EDC transition?

Mandy Baldwin: Yes.

Female: Just a moment. It is – it is – it is possible that it could be, but the transition actually occurs the 12th through the 15th. Are those the dates that you're getting on the hold message?

Mandy Baldwin: No. It specifically said they would be closed for, I can't remember if they said education or computer something, but they stated Monday the 15th of October and Tuesday, the 16th of October.

(Roc): This is (Roc) from the Claims area. We will be closed on the 15th and there is a potential that we may be closed on the 16th. What we'll do is we'll verify the hold message and make sure that it says that there is a potential that we're going to be closed on the 16th.

The EDC transition went smoothly and we were available for calls and claims on the 16<sup>th</sup> as planned.

Mandy Baldwin: OK. And I know we've discussed this a lot with other callers and whenever I had Medicare, I've had a denial on something and I've called the customer service reps and they've informed me that it was denied in error, it was a Medicare error. They're sending me through to the tier two reps to send it to provider relations for reopenings. Is that normal procedure and how long are we supposed to wait before we receive a response from provider relations about those reopenings?

Female: OK, and to answer that one, Mandy, if it's something where you have determined that a claim needs to be adjusted, you can bypass customer service altogether and just submit a reopening request.

Mandy Baldwin: Usually I don't know that it's like a Medicare error until I've called and talked to them about why it was denied and what they show on record. And so, and then at that time, they just automatically send me through to a tier two, and most of the time I'm not exactly sure why I've got the denial until I called them for clarification.

Female: OK, so you're not requesting to be sent?

Mandy Baldwin: No, I'm not requesting to be sent. They're just telling me that's the procedure of how it should be done.

Female: [Technically the current process is to request that these claims are sent to tier two for research. You may, however, request that this not be forwarded and go ahead and request a reopening of the claim.](#)

Mandy Baldwin: One other thing, let's see, I received a denial – we wanted to try a claim doing – billing for urological supplies. It doesn't state in the LCD that you can bill urological supplies in a three-month span, but I know that you can on ((inaudible)) and diabetic. So we attempted it; I received a denial. When I called

back in, they told me – the first time I talked to them about it, they told me it was a true denial, that was fine. Then we ended up having a second ((inaudible)) question about that same claim, and when I called back in, they said, oh, we denied this in error. You can do it in a three-month span. But I'm not sure exactly what to do.

I've got one customer service rep telling me you can't and one telling me you can. So, what is the true story on urologic?

Female: Are these future dated claims or past dated claims? In other words, are these for three months, this month, and then two months after this month? Or are these for this month and two months before this month?

Mandy Baldwin: It's for – say, September, October, November.

Female: OK. You are not allowed to future date three months of urological supplies. Now if it were, let's say for instance you wanted to submit a claim with this month, last month and the previous month, that could happen. But if it's for future dates, no, you would not be able to do that.

Mandy Baldwin: OK. Because what they've done now, if that claim is sitting at provider relations to go through reopening because they told me that it had denied in error and I should be expecting payment on it. What should I do about that claim?

Female: That particular claim, if they have forwarded the information over, it will – if it's, once it gets to that level, it will be forwarded over for reopening and moving forward. If you come across situations where there is an adjustment required, you may just bypass customer service altogether and just submit the claim to reopenings.

Mandy Baldwin: OK. And then the other thing that I have, it's not really a question; it's more of a comment, I called yesterday to follow up on a denial that I had received on a (CMN). They informed me what the problem was with the (CMN) for oxygen, and what I needed to correct. And while I was on the phone with the customer service rep, he explained to me that exercise is not a valid option for testing a patient for O2. That is not in the LCD and it's not a valid option.

Female: That is actually an option. We can give feedback to the trainer on that one as well just to ensure that everyone is aware that it is valid.

Mandy Baldwin: OK. And that's all I had. Thank you very much.

Female: Thank you.

Operator: We'll take our next question from Paula Young, Lincare.

Paula Young: Good afternoon – I'm calling from Lincare in Columbia, South Carolina, and I have a policy question about oxygen. We have had situations where we bill the E0431, the (gaseous) portable, and then several months later, the doctor will switch the patient to a liquid portable, the E0434. The E0434 will deny as not medically necessary or missing a (CMN). I'll call the customer service rep and the policy states that all we needed was a doctor's order to switch modality, but I've been told two different answers. One, customer service rep told me that I need to send a revised (CMN) switching the modality and the other one said I needed a new initial. So I'm confused as to what we are supposed to do. But the policy states that no new testing, no new (CMN), all we need is a doctor's order to switch modality.

(Ellen): This is (Ellen) and if there's no change to the doctor's order, you're just changing modality, we should copy the (CMN) we have on file for the E0431 to be – for the EO434 and you would not have to submit the (CMN).

Paula Young: OK.

(Ellen): If you did submit a (CMN) and it had a new test on it or something, it may have caused some confusion there. But, ordinarily you wouldn't need a new (CMN). We would take the (CMN) on file for that new doctor's prescribed equipment.

Paula Young: Well, the claims that we sent were not sent with a new (CMN). There was no testing. It was just a straight modality change.

(Ellen): And we denied it for what reason?

Paula Young: Sometimes it was a C050, not medically necessary. And others, it was a C0175, (Needing) a CMN.

(Ellen): OK. I would need to see examples of that because that is hard coded logic, so that would happen to ((inaudible)) copy it. So Paula, could I get your number?

Paula Young: 888-461-3116, extension 119.

(Ellen): OK. I'll give you a call.

Paula Young: So they are supposed to copy the (CMN) that's on file ...

(Ellen): We would take – once (CMN) has been approved and there's no changes in that order, you would not need to send us anything else when you're just changing modality.

Paula Young: OK. Thank you very much.

Operator: We'll take our next question from George Lising.

George Lising: Yes, hi – good afternoon. This is George and I have a few questions, the first one is regarding customer service. Every now and then we would three-way conference beneficiaries with Medicare to check on equipment history. And first question, why does it take sometimes over 30 minutes on the hold time?

And the second is, we know that the patient has an equipment through Medicare and it would show on your record that there's no record of that equipment with Medicare.

Female: OK. Let me make sure I understand your question. So you're saying that the patient indicated to you that we – that Medicare has paid for equipment and then you call in and the equipment is not listed in our records?

George Lising: That's correct.

Female: And your other question was about the hold time?

George Lising: Yes.

Female: OK. Let me address the hold time first, as we've mentioned at the beginning of the call, we were – we are aware of the issues, and we are taking steps to

correct that, and we are seeing major improvements in those hold times. You will continue to see that get better and better over time as we are providing additional training and staff to address the call volumes that we're receiving.

On the second part of your question as it relates to the equipment on file, it would depend on whether Medicare specifically paid for that equipment. Because sometimes patients will have equipment that was provided by a primary insurance or other insurance and that may or may not have been submitted to Medicare.

George Lising: You know how we would know that the patient have that equipment in history? We will provide the equipment and it will deny the same – and similar.

Female: So are you indicating that you checked (same or similar) and a piece of equipment, Medicare told you there was no equipment and then you subsequently received a denial for (same or similar)?

George Lising: Yes, that is correct.

Female: Just a moment. We do apologize that that occurred. That should not happen at all if – at all on the calls. I really can't speak to why that equipment was not identified initially. But when you call in with (same or similar) just make sure that you are indicating the equipment that they have and the equipment that you're

providing so that we can – so that the customer service representative can view the records accordingly.

George Lising: Next question that I have is, on the useful lifetime of the equipment other than the doctor's order, what documentation do we need for a patient to qualify on a new equipment if the one that he has or she has is over five years?

(Ellen): This is (Ellen) and if the equipment that they have is over five years old, then we may replace it with a new piece of equipment.

George Lising: Would that be automatic?

(Ellen): Yes. We have instructions to look for that.

(Josephine Lising): OK. We have cases where in the patient only had it eight years ago for a month, but I still got denied on the hospital bed saying it's (same or similar).

(Ellen): OK. I'll have to look that, but there is instructions to look for equipment on file that's over five years ago before denying it. So, it could've been denied in error. I mean, you could send it in for the reopenings or I can give you a call and take a look at it.

(Ellen): Thank you.

(Josephine Lising): Also, we are getting letters from your overpayment recovery unit that as of date we never responded to the initial recoupment letter. The problem is, we never get those initial letters from you, and they are charging us interest for not refunding you on time.

We have had like three cases of this, letters that are coming to us that we never responded to the initial letter, but we never got those letters.

Female: Those letters are going to the address where all of your correspondence for Medicare goes.

Female: Yes.

Female: Are you getting other correspondence from us?

(Josephine Lising): Yes. I do get some and I do not get. On some, I have like three, but we get the final letter from you, but I never got the initial recoupment letter.

(Rita): This is (Rita) in the overpayment area. Do you have the second request? Is that what you've gotten from us?

(Josephine Lising): It's the second request and also I noticed that on the cover letter that you all sent us, you have an incorrect mailing address to mail the check. It's P.O. Box 3029. It should be P.O. Box 30629, I believe. Can I have – call your attention to this and they said they would correct it, but I just wanted to call your attention.

Female: That has to be corrected through the (National Supplier Clearinghouse).

((inaudible)) correct address to ((inaudible)) office.

(Josephine Lising): No, I mean, your mailing address to mail our check, refund check in New York is incorrect on your letters.

Female: I've not been made aware of that. We're getting lots of checks at that post office box.

(Josephine Lising): Yes, we are getting – I called your attention, it's missing a number on the P.O. box.

Female: Where did you get the address that you are trying to – advising us to send – to correct it to? Where did you get that address?

(Josephine Lising): From the recoupment letters that we get.

Female: What does the recoupment letter indicate?

(Josephine Lising): The recoupment letter will indicate the right address ...

Female: Which is?

(Josephine Lising): ... on your second – hold on I'll get the letter.

Female: You're saying the second request letter has the incorrect post office box?

George Lising: Yes. The second letter will have an incorrect post office box. It'll say  
(JCDME) ((inaudible)) P.O. Box 3029, New York, New York, 10087-0629.

Female: Thank you.

Female: We'll look at that.

Female: We'll look into that and we'll include that information in the minutes.

[In researching this, it appears that the correct address is printing on all letters.](#)

(Josephine Lising): Yes, can you also let us know why we're not getting the initial  
recoupment letter and then we get a secondary letter that we have not  
responded?

Female: Was the second request recent?

(Josephine Lising): Yes. It's dated September 18th signed by Sokha Tok, T-O-K –  
overpayment recovery.

Female: ((inaudible))

(Josephine Lising): The first name is S-O-K-H-A and the last name is T-O-K.

Female: OK, yes.

(Josephine Lising): It's dated September 18th, '07.

Female: Yes. She is one of our recovery analysts. You should've gotten the first  
request, too. I don't understand why.

(Josephine Lising): No, ma'am. This is the – this is the second one that I got, but I  
have not received your initial letter.

Female: I don't understand why.

(Josephine Lising): Me either. So you're charging us interest for something that we never got.

Female: I'm sorry. I mean, you said you were getting some of your first request, and I just don't understand why these would not. I mean it may be problems with the post office or something, but ...

(Josephine Lising): I don't know.

Female: ... They're definitely mailed.

George Lising: That's nothing new with the post office.

Female: I'm sorry?

George Lising: That's nothing new with the post office.

Female: Thank you.

George Lising: Thank you, too.

Operator: Our next question comes from Patty Kneer, M. Davis Management, Incorporated.

Patty Kneer: Hi, thank you for taking my call. I have two questions. The first one is, we're having trouble ever since CIGNA took over, and maybe this goes to the EDI person rep there from Palmetto, we are not getting our Medicaid Florida – I'm in Florida – Medicaid of Florida is not paying any secondary claims.

The Medicare EOB indicates that it's crossed over and I have talked with EDI at Palmetto extensively and they claim it's not their fault. And then I've talked repeatedly to Florida EDI and they say that, oh, they're aware of the problem. They were going to fix it. They even sent out a newsletter, ACS did stating that it was going to be resolved within the week and that was six weeks ago. And it's – I don't understand why they – why you all changed intermediaries from whoever Palmetto was using is how Medicaid of Florida has explained it to me.

I'm quite concerned because it's very time consuming to go back and paper claim all of these crossovers, and I wondered if either Palmetto or EDI can address that, or, you know, what I can do.

Female: Actually, probably your best contact would be the coordination of benefits contractor for that information because they are the ones that directly – if the remittance advice indicates that we crossed it over, the process is we send that information over to the ((inaudible)) benefits contractor, and ...

Patty Kneer: Who is that?

Female: Oh, gosh, just a moment. We will – actually, can I include that in the minutes for you?

Patty Kneer: Sure.

Female: The FL Medicaid office should contact the Coordination of Benefits Contractor (COBC) to determine why the claims are not crossing over to them. The Medicaid office may contact the COBC; the contact information is email: [COBVA@GHIMEDICARE.COM](mailto:COBVA@GHIMEDICARE.COM); telephone: 1-800-999-1118 or TTY/TDD 1-800-318-8782 for the hearing and speech impaired, they are available Monday through Friday, from 9:00 a.m. - 5:00 p.m., Eastern Standard Time, except holidays.

Patty Kneer: Well, why would that have changed when everything was going along just?

Female: As far as I know, we're not aware of any problems. So if there is ...

Patty Kneer: Yes, you are because I've called several times. I mean, at least EDI and Palmetto is aware of it and so is sort of Medicaid and I'm not the only one.

There's several providers that have called and complained. I'm out thousands of dollars right now.

Female: Right. And I am so sorry to hear that. But it does sound like if they've indicated – if Florida Medicaid has indicated that they're aware of the problem, it sounds like they're probably already working with the COBC. And we really can't speak to what is occurring there because they have a totally – it's a separate contract through CMS and a separate contractor. So they would be the ones to better speak to it.

Now if it were a situation where it should've crossed over and you're not getting a notice on your Medicare remittance advice that it crossed over, then that would be – that could potentially be something dealing with our office or with the supplemental insurer's records for the beneficiary. But if we're indicating that it crossed over, we are sending that documentation to the coordination of benefits contractor.

Patty Kneer: Well, I'll try that. And then also, you guys keep referring to the NPI Web site to look up numbers, it's been down for about a week and did you guys know of any time that that's going to be back up?

Female: As we mentioned, CMS is aware of the problem. They took it down because it was unstable. We did receive notice yesterday from CMS that Web site should be back up and running sometime next week.

Patty Kneer: Oh, OK.

Female: So hopefully they will be able to get that up and running at that time, but that is when they anticipate getting that fixed.

[The NPI Registry is available and functioning properly at the release of the minutes.](#)

Patty Kneer: And my last question is, we're all of a sudden getting 150 denials and when we call in, they're saying that they don't show the patient ever received the equipment, and this might be like maybe the last three or four rental periods of a wheelchair or a CPAP. And the patients – and we've been paid all along, and then all of a sudden we're getting a denial and we're being asked to fax in delivery tickets.

So, what's up with that? I mean, what would create that? And this has happened – it's just not one specific patient. It's happened several times and when we call in, the actual denial doesn't state that. The actual denial says that, you know, if you look at your glossary, it says, payment adjusted because the payer deems the info submitted does not support this level of service. But when

we call in, we're told that there's no proof that the patient ever received the equipment. We're being asked to fax our delivery tickets in.

Female: And are you getting that request from CIGNA Government Services, or is it coming from Trust Solutions?

Patty Kneer: Oh, no, this is Medicare denial on my EOB.

Female: Oh, it's on your explanation of benefits?

Patty Kneer: Right. And when we call in, because that was a new one, you know, because there's new codes and that was a new one. We were trying to figure out what that was for and that's what we were told by customer service at CIGNA.

Female: OK. Can I get your telephone number?

Patty Kneer: Sure. It's 407-539-0303 and my name is Patty and ((inaudible)) (proxy med), that's how we do business.

Female: OK, Patty. Let me look into that and I will also include the finding of this in the minutes when we post them online. And also, we did identify the telephone number for the coordination of benefits contractor.

Patty Kneer: Thank you.

Operator: We'll take our next question from (JoAnn) from Sentara Homecare.

Female: Hi, my name is ((inaudible)) with Sentara Homecare, and I have a – I have two questions actually. One is, on the – it's in reference to the (CMN's) the new annual parenteral nutrition that just came out or it came out a few months ago, at the bottom it says, supplier signature it's ((inaudible)) supplier signature. I have doctors that are refusing to sign that because they're saying that we, the homecare company, is a supplier and they're not going to sign it. Who was supposed to sign that?

(Dante'): Actually, that form is no longer a certificate of medical necessity. It is now a durable medical equipment information form (DIF) which means that you as the supplier would complete that based on the medical documentation that you received from the physician.

Female: So that will no longer have to be completed by the physician?

Female: That is correct.

Female: So we complete it and sign it?

Female: That is correct.

Female: And that's the only medical documentation that you all require because the (CMN) had not been done away for parental and enteral?

Female: The (CMN) has gone away; it has been changed to what we call a (DIF). The difference between a (DIF) and a (CMN), (CMN's) are completed by the physicians, the (DIF's) are completed by the supplier. So the parenteral and enteral nutrition form no longer has to be completed by the physician. They're now completed by the supplier based on the information that is received or the prescription that is received from the physicians.

The (DIF) does not have to be signed by the doctor. The doctor still has to prescribe the item, but it's no longer on the CMN form.

Female: OK. So, if we complete it and signed it, are we required to send a copy to the doctor for his record?

**Female: No, you are not required to do that.**

Female: OK. And my second question is, we were formerly a part of Region B, and when Virginia went to Region C, we were transferred. And we have noticed we're having a lot of problems with patients that had rental equipment before and

it was being paid by region B with no problem. But now when we started building Region C, they're denying. And when we call, they're saying, "No CMN is on file".

Aren't they supposed to have like a common working file or a share it file where if we submitted a CMM before, shouldn't they be able to go on and look at that?

Female: Yes, they should. And in those – in those situations where a claim has denied for that, if, in fact, you do receive the denial, that would be another example of when you may request a reopening and bypass customer service.

Female: OK, so we are set – we have to do reopenings about all the ones that get like that, because we have quite a few that are like that.

Female: If it is on file, that is correct.

Female: OK. So even when you call and you say you don't see us. We're still going to do a reopening.

Female: If you are aware that the – that the certificate of medical necessity is on file with Medicare, then yes, you can request that to reopen.

Female: OK. Thank you

Female: Thank you.

Operator: We'll take our next question from Karen Coursen, Lincare.

Karen Coursen: Hi, I have a couple of questions. The first one is in regards to the maintenance denials, we're being told by the CSR's that they have no record of the previous payments, that they were lost in the transition from Palmetto, that they can't see stuff in the comment file that was previously paid. So my question is, why is that having to be our problem for one thing. And then also, what can you – what can we use as proof of payment in the event that we can't come up with a better idea on how to resolve this? I mean, we have over \$150,000 in offsets at this point.

Female: OK. If – as (Ellen) explained a little earlier, in the event we went to CMS at the time that this went on and asked, what can we do to lower the impact of this – of the maintenance and service payments, we were told to follow the rules as they're listed.

So if the records are not there, the documentation that you can utilize would be a copy of explanations of benefits showing the 15 payments made by Medicare from the past. If you are unable to obtain that documentation, then you can – then you are allowed to go through the process that we discussed earlier in the

introduction section. Actually I will refer you to our Web site at [www.cignagovernmentservices.com/jc](http://www.cignagovernmentservices.com/jc) under "Archived News". There was an article on July 10, 2007 that gives you all of the options that may correct any maintenance and service denials that you're experiencing.

Karen Coursen: Is one of them – I'm just curious to be able to use ICN numbers in the event that these are so old that we're unable to produce the EOB's?

Female: No, it's not because if the information has been purged from the system, the ICN's will not give us any documentation to support that. So, one of two things would be to – option one, provide us copies of those Medicare Remittance advices. Or option two would be to bill the remaining months and then pick up the maintenance and service after six months from the last payment.

Those are actually the only two options that we can offer at this time based on the information that we received from CMS.

Now as we mentioned earlier, (Ellen) is also going to check with CMS to see if there is a possibility that they may provide us some additional options – perhaps a specific cut off, but at this item we have to continue with the decision that we were given initially which is to recoup any maintenance and service claims that were paid in error.

Karen Coursen: I know when this happened previously with region A when they was a transition, they eventually agreed to allow us to send proof of two previously maintenance payments. Is that a possibility for the future with CMS?

Female: We have requested that as an option for CMS. At this time, they have no t given us permission based on that. If that is what jurisdiction A did, we will add to our notes when we go back to CMS that jurisdiction A was given his permission. We cannot say whether or not they will or will not allow that as an option, but we will add that to the request.

Female: I have another question that I think I can probably hit several questions into one. It's a follow up regarding the common working file and documentation that's there. Also situations where there are breaks in service that are well over, sometimes well over a year where we're being asked to produce pick up tickets which is something we've never had to do before and instead of getting our new initial (CMN's) loaded. And then also, too, just – on denials that are really almost ridiculous, denials for research on nubilizers, capped rental denials oxygen and – this culminates into a huge bunch of errors that all our only answer is to go reopening and delay all of these payments by another, you know, 90 to 120 days.

Female: So you're – so what – let me make sure I understand your question. OK, you're indicating that there were several different claims that denied in error on our part, and your question is what steps you take to get those corrected?

Karen Coursen: You already answered that as far as – as far as the areas having to go through reopening. My question is, do all of these have to go through opening – reopening You know, previously if we had a claim and there was a break in service, we were allowed to resubmit the claim stating there was a break in service, and the dates, and they would load the new CMN. How we're being told that that has to go to reopening. Same thing with stuff in the common file. Previously Palmetto would be able to, as you were on the phone with the customer service representative loaded the new – load the lifetime CMNs from the common working file right there on the phone. As opposed to our having to wait for what appears to be a problem on CIGNA's part for our payment for another 120 days.

Female: It shouldn't take 120 days, but to answer your question on the first portion, if it is a denial for ...

Female: Break in service.

Female: ... break in service, then that information can be re-submitted. That is not necessarily a reopening request.

Karen Coursen: But we are submitting those with the narratives and they're being denied anyway.

And originally when this first started, we were getting them processed like that, and now we're right back to – they either don't see them, they can't see the (CMN's), they can't see our narratives, they're just not loading them.

Female: Do you know where they're placing the narratives?

Karen Coursen: In the only area that it can be placed. Right, in the (HAL) record.

Female: OK. Let me go ahead and take your – take your telephone number, Karen.

We currently require new CMNs to be submitted through our reopening department.

We will research the possibility of updating our processes to include break in service CMNs based on completed break in service narratives and completed electronic CMN's. If the process is updated, the information will be provided on our website and a ListServ.

Operator: And we'll take a question now from Beverly Rohret from Omnisys.

Female: I'm sorry?

Beverly Rohret: Yes, we had question, you had gone over the re-determination process and stated we go off the initial date of the denial. My question for you is, when we have claims, for example, that deny for one reason, Medicare's updated their

system or whatever reason we resubmit that claim, and then we have another denial unrelated to the first denial, then when we get the second denial, we have to take that to redetermination. And we filed the redetermination on one and got an unfavorable because we did not meet the timely filing.

So my question for you is, are you looking at the very first denial that we get or is it the new denial that we get when you were making this determination?

Female: It depends on what you are actually requesting the re-determination on. If the first denial is the reason for the re-determination request, then that would be the date that we would follow.

Beverly Rohret: OK, now if ...

Female: ((inaudible)) the second denial, let's say for instance the second denial is a duplicate denial, then, of course, we'd still go with the initial date as the date of determination.

Beverly Rohret: The example that we had was where the initial claim denied with PR22 stating that Medicare should've been billed as secondary but Medicare's records have since then updated, so we resubmitted the claim and got a denial that was unrelated to that. And when we got that, we did take that to redetermination and they denied it.

Female: OK, so in this situation, you're not appealing to (MSP) denial; you are appealing the second denial?

Beverly Rohret: Yes. It was because the transplant information wasn't on the file.

Female: In that situation, it would be the second denial date.

Beverly Rohret: OK. So then what do we need to do with the denial then that we got of the redetermination?

(Samantha): This is (Samantha), at this time since you've gotten a denial from redetermination for past file time limit, you need to submit that back in to the redetermination department asking for a reopening of the redetermination decision and indicate that you're appealing a new denial off of that particular date of service.

Female: Take it to re-consideration?

(Samantha): No, that is – do you have that option, but just to explain to you how that will work, if you take it to reconsiderations, they will only address the issues of timeliness. If they find that you filed it timely, then they're just going to remand it back to redeterminations. What I'm understanding is you billed the claim twice

and you got a second denial that is totally unrelated from the first denial. Your 120 days starts from that second denial.

So in this case you may bypass reconsiderations, send the request back to redeterminations requesting a reopening of the original redetermination decision, request that we vacate the redetermination dismissal (denial).

Female: OK, wonderful. So just make sure I understand for all future claims, if my second denial is unrelated to the first denial and it's not a rejected claim, you should go off that second denial date, not that first one, right?

Female: That's correct.

(Samantha): OK. I just want to make sure because we are seeing that, so we'll take that back to redetermination and ask them to reopen?

(Samantha): Yes.

Female: I believe that's it.

Dante: OK, thank you. We'll take our last question now. We are nearing three o'clock.

Operator: Our last question comes from Kimberly Williams, Gentiva.

(Kenya): Yes, my name is (Kenya); I'm calling from Gentiva Home Health Services.

Hello?

Female: Yes, go ahead.

(Kenya): OK. I have a question, I have a patient that actually as services in another region, and we're billing through "C" to get that claim billed to region A, B or D, and I'm getting denials now stating that I'm billing to the wrong carrier.

Dante Wynn: OK, so the patient lives in another jurisdiction?

(Kenya): Correct.

Dante Wynn: OK, then you would submit the claim to the jurisdiction of which the patient lives.

(Kenya): OK. Before CIGNA took over, we were told that as long as we had that other provider's address, oh, I'm sorry. We had that patient's address in another region, but all we had to do was build to region C and they would transfer the claims to whatever region the patient was in.

Dante Wynn: We do – we'll still deny those claims. We will transfer them now. If you are not signed up as a biller to that other jurisdiction, they will not process the claim even though we transferred it.

So just because you received a denial does not indicate that we did not transfer it. But was the claim submitted electronically to us?

(Kenya): Yes, it was.

Dante Wynn: OK, it was submitted electronically. We do transfer that information to the other jurisdictions, however, if you're not signed up as an electronic biller with the other jurisdictions, they may not process that claim.

So to bypass it, though, you really – the best to do it, if you know up front the patient lives in a different jurisdiction, just go ahead and submit the claim directly to that jurisdiction.

I'm sorry? Hello.

Operator: Your line is still open.

Dante Wynn: (Kenya), did you have – does that answer your question?

(Kenya): Ma'am?

Dante Wynn: Does that answer your question?

(Kenya): Well, no, because – OK, so you're telling me, I have rights to bill the other region.

Dante Wynn: Are you signed up as an electronic biller with the other jurisdictions?

(Kenya): Yes, I am, and I'm getting a denial from CIGNA telling me that I'm not able to bill that region.

Dante Wynn: We wouldn't give that denial. Let me get your telephone number, (Kenya).

If the claim is submitted to us with a beneficiary's address that is outside of our jurisdiction on the claim, the claim will be transferred to the appropriate jurisdiction. If the claim is submitted to us with a beneficiary's address that is within our jurisdiction on the claim, the claim will not be transferred to the appropriate jurisdiction and a denial for incorrect payer will be included on the remittance advice. To avoid any unnecessary denials, it is best to submit the claim to the appropriate jurisdiction initially.

(Kenya): Ms. Wynn, I'm sorry, we have one other question.

Dante Wynn: OK. Go ahead.

Female: Hi – this question is in regards to the PR60 and the OA109 denials. These are denials that we're getting on sale items. The OA109 is a denial for ((inaudible)) patient's in the hospital or is HMO. And that's the description on that denial.

PR60 has the same description, but it's the patient responsibility denial. What determines or who determines one code's being PR, patient responsibility, and the OA109 being a contractual responsibility?

(Ellen): This is (Ellen) again, and we get the ANSI code from CMS, and they give us the group code that goes with the ANSI and remark codes.

Female: Does that answer your question, (Kenya)?

(Kenya): Not exactly. We also recently are receiving denials for PR179 that's (same and similar) and the CO57 is same similar. Again, this is – one is denying for contractual and the other one for patient's responsibility. Can you repeat your ...

Female: Did you have an advanced beneficiary notice on one of them?

(Kenya): No, neither one was billed with an ABN.

Female: OK.

Female: Normally what happened prior to CIGNA is we received the OA109 denial, patient is in (SNF) and we would adjust it accordingly because it was our responsibility. But now we're getting a PR60, patient responsibility code.

Female: I would have to look at that.

Female: You would have to look at that?

Female: OK.

(Marie): I have another – my question is in regards to the recoupment, will there – will there be a statute of limitation on how far back you are recouping? I heard the questions before in regards to your files, how far you can look back, but will there be some type of statute since Palmetto paid us, rightfully so in some cases, and should you all be recouping maintenance for services that they've paid before? I understand that we have made – we have been wrongfully remitted on some, but I think there should be some type of statute.

Female: And actually that question did come up earlier in the call and as we started before, we will research further with CMS and we'll include that answer with the minutes if it is available. If not we will forward that information via our List Serve and Web site.

But at this time, there is no statute. CMS gave us instructions to take all overpayments for maintenance and service claims back once we identify that 15-paid rentals are not on our files. So we will – we will be checking into that a little further and we will definitely let everyone know of that information.

And we have now reached our three o'clock time and we do, again, appreciate everyone's participation in this call and we will also be posting the next quarterly Ask the Contractor Teleconference on our Web site, and thank you for your time and you all have a great day.

Operator: That does conclude today's conference. We thank you for your participation. Please have a good day.

END