

CIGNA

Moderator: Taveo Perry
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1:00 p.m. CT

Operator: Good day, everyone, and welcome to CIGNA Conference Call. At this time, I'd like to turn the call over to Mr. Taveo Perry. Please go ahead, sir.

Taveo Perry: Good afternoon and welcome to the CIGNA Government Services Acts to Contractor Teleconference from DME MAC jurisdiction C. Again, I'm Taveo Perry with the Provider Outreach and Education Team. I would like to thank you for participating on today's call. Your participation helps us to identify issues that are important to you so we may better meet your needs.

This (specialty call) is dedicated to suppliers or pharmacists (and) bill medications to Medicare. Because today's call is specialized for pharmacists, we ask all of you who are not pharmacists that we are not to make claims of the pharmacy component. So please, disconnect and plan on participating during next general act call.

Today's call, we'll get pharmacy updates to the policies that are relevant to the pharmacy community. The policy that we dealt with are as follows: Immunosuppressive drugs, nebulizer drugs – specifically DuoNeb, the October 2008 quarterly average sales price or ASP updates. Joining us today are (CGS) representatives from our Provider Outreach and Education Department and our Technical Department.

Please keep in mind that we're not able to answer questions about individual claims issues. If you have specific issues, please contact our provider contact center at 866-270-4909. To check claim status, call the Interactive Voice Response or IVR system at 866-238-9650.

Let's begin with an update on changes within the immunosuppressive drug policy. The immunosuppressive drugs LCD has been revised to include a requirement for the supplier, to obtain the date of the qualifying transplant and affirm that the transplant date precedes the date of service for the immunosuppressive drug claim. If these criteria are met, the KX modifier must be added to the claim.

Medicare covers a beneficiary immunosuppressive drugs following an organ transplant, provided that the beneficiary receiving the drug was enrolled in Medicare part A at the time of the organ transplant procedure. Moreover, Medicare will pay for medically-necessary immunosuppressive drugs for such a beneficiary whether or not Medicare paid for the transplant itself.

Prior to April of 2006, the Durable Medical Equipment or DME regional carriers received information about the date of a beneficiary's transplant (do a) DMERC Information Form or DIF which included a field in which the supplier could enter a transplant date. However, on February 17th, 2006 the Centers for Medicare and Medicaid Services otherwise known as CMS issued a transmittal 867, changed request 4241, which number one, eliminated the DIF; number two, implemented and (edit at) the Medicare's Common Working File or CWF system to search the Medicare's master beneficiary record for transplant upon receipt of a claim for immunosuppressive drug. If the CWF system does not find evidence of a transplant in the MDR, the claim line for the immunosuppressive drug is rejected.

And CWF does not have a transplant record for beneficiary as Medicare did not actually pay for the procedure. The DME MAC, Medicare Administrative Contractors have been inappropriately

denying claims, even with such beneficiary were enrolled in the Medicare part A and at the time of that transplant. To resolve this issue, change request CR5916 implements an automated process for adjudicating claims for immunosuppressive drugs when the beneficiary was enrolled at a Medicare part A at the time of the transplant, but Medicare did not pay for the transplant.

Specifically, CR5916 requires that for claims filed on or after July 1, 2008, suppliers (from furnishing on) immunosuppressive drug to a Medicare beneficiary, in association with the previous organ transplant must number one; secure from the prescriber at the date of the organ transplant; two, retain documentation of the transplant, date and its files and; lastly, annotate the Medicare claim for the drug with the KX modifier to signify both that the supplier retains the documentation of a beneficiary's transplant date, and that the transplant date proceeds the date of service for furnishing the drug.

Also effective July 1, 2008, the Local Coverage Determination effective for date of services on or after July 1, 2008 is being revised. This revision applies to the least costly alternative to Levalbuterol or Xopenex is being withdrawn upon further review by the Centers for Medicaid and Medicare Services. The effective date for applying the least costly alternative to the unit dose combination solutions of Albuterol and ipratropium, Duoneb, HCPCS and the J7620 is being revised. The effective date is delayed and will be implemented for claim for days of services on or after November 1, 2008.

The medical necessity for administrating FDA approval unit dose combination of Albuterol and ipratropium HCPCS and 7620 compared to separate unit dose of Albuterol and ipratropium has not been established. Consequently, effective for claims with dates of services on or after November 1, 2008 when one unit of service of code J620 (bill) covers (criteria met), ((inaudible)) will be based on the allowance for the least costly medically-appropriate alternative which is 2.5 units of HCPCS, J7613 and 0.5 units of HCPCS J7644.

Next as many of you are aware there has been updates to the October quarterly average sales pricing or ASP for drugs and biologicals, change request CR6175, instructs Medicare contractors to download and implement the October 2008, ASP drug pricing file for Medicare part B drugs, as well as revised prior ASP files.

Section 303C of the Medicare Modernization Act of 2003 revised the payment methodology for part B covered drugs and biologicals that are not paid on the cost or perspective payment basis.

Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on cost or perspective payment basis are paid best on the average sales price or ASP methodology and pricing for compounded drugs have been performed by the local contractor. The ASP methodology is based on quarterly data that drug manufacturers submit to CMS, which CMS then provides quarterly to Medicare contractors to the ASP drug pricing files for Medicare part B drugs.

On September 16th 2008, the October 2008 ASP files were available for download along with revisions to prior ASP payment files. If CMS determines that revisions are necessary, the October 2008 ASP NOC files will be available for retrieval from the ASP Web page along with the prior revisions.

I want to turn the call over to (James Herren) with additional updates also with Provider Outreach and Education.

(James Herren): Thanks, Taveo. I (want to) wrap this up with a little bit more information.

On September 3rd of this year, September 3rd 2008, CMS announced a list of DMEPOS suppliers who are exempt for meeting the quality standards for DMEPOS accreditation. CMS did later clarify that pharmacists and pharmacies were not included in this provider exemption. Therefore, pharmacists and pharmacies do need to obtain accreditation – that is pharmacists and

pharmacies will need to obtain accreditation, they were not exempt from the rules that CMS issued recently.

And you do want to make sure you are accredited by September 30th of 2009. You will want to make sure you have your application in by January 1st, or 31st. Make sure you have it in by January 1, of 2009 to assure that you will have gone through the accreditation process. They cannot guarantee that your accreditation will be complete by September 30th of 2009 if you do not have that form in by January 1st, of 2009.

For more information on DMEPOS Accreditation, please visit the CMS Web site. You can go to [cms.hhs.gov/medicare provider supplier enrollment](http://cms.hhs.gov/medicare%20provider%20supplier%20enrollment). And let me read that again. It's cms.hhs.gov/medicareprovidersupenroll. So I'm going to read it all up to you again. It's Medicare, M-E-D-I-C-A-R-E, provider, P-R-O-V-I-D-E-R-S-U-P-E-N-R-O-L-L. That's all in one word, medicareprovidersupenroll. That doesn't make much sense to me either but that's what they came up with.

Also just to let you know, CIGNA government services is continuing on Maximizing Your Reimbursement Workshops that will be Provider Outreach and Education for CIGNA government services will be in Denver, Colorado on the 15th of this month. On October 15th, we'll have a Maximizing Your Reimbursement Workshop in Denver. We'll follow that up in Baton Rouge, Louisiana on November 11th. We'll be in Houston, Texas on December 1st and Dallas, Texas on December 3rd. Maximizing Your Reimbursement Workshops are all day workshops and we do cover a lot of topics that will assist in the billing of Medicare.

Also, members of the Provider Outreach and Education Department at CIGNA government services will be attending; Medtrade East at the Atlanta World Congress Center from October 27th to October 30th at the Medtrade Conference in Atlanta. For more information on that, go to medtrade.com and we are in the exhibitors list.

This does include the update portion of today's act call for pharmacies. We'll now open the phone lines to 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 866-270-4909, again, that's 866-270-4909. Again, we would like to take this opportunity to thank you for participating in today's call. We'll go ahead and take your questions now, and we'll go ahead and turn this back over Taveo Perry.

Taveo Perry: Thank you, (James). We're ready for our first question.

Operator: Thank you, sir.

Today's question and answer session will be conducted electronically. If you'd like to signal to ask a question, please press star one on your touch-tone phone. If you're using a speakerphone, please make sure your mute function is turned off to allow your signal to reach our equipment. A voice prompt will come on your line to let you know when it's open. Again, that's star one for any questions.

And we'll go to our first question.

Taveo Perry: Great.

Operator: Please go ahead, your line is open.

Female: Yes. I had a question about pharmacies needing to be accredited.

Taveo Perry: OK.

Female: If a pharmacy is not doing diabetic supplies and only doing part B drugs, do they still need to be accredited?

Taveo Perry: Well, if you're going to be doing glucose supplies or any type of DME, you would need to be accredited. You're not billing any type of equipment or supply, is that correct?

Female: No, we're just doing part B medications, immunosuppressive, anticancer, antiemetics, nebulizer meds, but just the meds, nose strips, no lancets, no diabetic supplies.

Taveo Perry: One moment please.

Female: OK.

Taveo Perry: OK. Sorry about that. So, if you are going to be billing items that we cover at the DME med, you would have to have accreditation.

Female: OK, even if it's just the oral meds and not actual supplies?

(James Herren): Ma'am, do you have an NSC billing number?

Female: Yes.

(James Herren): Yes, you will need to obtain accreditation.

Female: OK, thank you.

(James Herren): You're welcome.

Taveo Perry: Thank you.

Operator: And we have no further questions. But as a reminder, please press star one if you'd like to signal for a question.

And Mr. Perry, it appears we have no further question, sir.

Taveo Perry: We'll give them a couple of minutes, (Dana).

Operator: Thank you, sir.

Taveo Perry: OK.

Operator: And we do have somebody queued up. We'll go to our next question.

(Carolyn Fogel): Yes. I have a question regarding the B4185 lipids.

Taveo Perry: OK.

(Carolyn Fogel): We do quite a few TPN patients and the B4185 is billed separately. We calculate the number of units that the patient receives per the date span and send that in. And approximately 75 percent of our EOBs that come back, those line items for the B4185 are paid incorrectly. We send them back through re-openings, give them once again the DIF, the number of units that were billed and we always get additional payment on it.

Is there any way that we can get that additional payment upfront so that it reduces our workload?

Taveo Perry: Sorry about that. It actually does depend what type of information is on the DIF. But we will take this information back to our claims department for feedback to have them be aware that we are receiving issues with that B4185 paying at a reduced level, but when you go to reopening, they're just paying at a higher level.

(Carolyn Fogel): We certainly would appreciate that. Like I said, it would reduce our workload considerably.

Taveo Perry: Right. And this is with a variety of patients and not just one specific patient, correct?

(Carolyn Fogel): It is across the board on majority of our TPN patients? We always have to send that one line item back through to re-openings to get it paid correctly.

(James Herren): Hi, ma'am, this is (James Herren).

(Carolyn Fogel): Yes.

(James Herren): I have a question for you.

(Carolyn Fogel): Sure.

(James Herren): Before you go to re-openings, by any chance, are you contacting customer service to see what we have on file as far as you know to make sure it does match the DIF form that you're selling to re-openings?

(Carolyn Fogel): Yes. As a matter of fact, we do.

(James Herren): What response are receiving from customer service? Are they telling you that we don't match what you have by any chance? Or are they saying we do match?

(Carolyn Fogel): No, they say that you do match.

(James Herren): They do match. Perfect.

(Carolyn Fogel): Right. We will go in, have them pull up the DIF and have them – let us tell them what we have on our DIF, and they tell us whether or not it agrees. The majority of the time, it does agree. So, then we have to send it in to re-openings. Sometimes they're gracious and we'll send it to a tier-2 rep, but I think the appropriate place to route it is to re-openings.

(James Herren): OK. If you don't mind, can we get your phone number and your name?

(Carolyn Fogell): Sure.

(James Herren): We wouldn't mind getting a few examples on this that we can share with claims.

(Carolyn Fogel): OK.

(James Herren): That way, we can educate, make sure that all the departments are on the same page here.

(Carolyn Fogel): OK. That will be fine.

(James Herren): What's your name again ma'am?

(Carolyn Fogel): It's (Carolyn Fogel)

(Carolyn Fogel): Correct.

(James Herren): OK. And what we'd ask of you is that maybe we'll get a few of those examples that are paid incorrectly that you can later send to re-openings that have been paid at the correct rate.

(Carolyn Fogel): OK. We'll be glad to get several of those for you, (James).

(James Herren): OK. Thank you.

(Carolyn Fogel): Yes.

Operator: And once again, if you'd like to ask a question, please press star one.

And we have no questions on the queue, but just a reminder, it's star one.

And we do have a question. Please go ahead, your line is open.

(Carolyn Fogel): Yes. This is (Carolyn Fogel) again. I just asked the question about the B4185 ...

Taveo Perry: OK.

(Carolyn Fogel): and I do have another question about the antibiotics. We do a lot of antibiotic therapy and a lot of times, that crosses over from Medicare with the PR204 denial to the secondary, and the secondary will pay on the crossover. However, if there is not an NDC number that is on the Medicare claim, the secondary does not pay of course that drug. Is it possible to put the NDC number in the HOA seal and have it crossover to the secondary so that secondary can go ahead and pay?

Taveo Perry: I'm sorry. You said antibiotics?

(Carolyn Fogil): Yes. Like we have a vanco patient.

Taveo Perry: OK.

(Carolyn Fogel): We will bill a J3370

Taveo Perry: OK.

(Carolyn Fogel): And then we will bill – if it's a claim that we are going to be billing the secondary, we will bill the 809270 as a non-covered item, tell you what it is. Or if it's just the kits, we will bill maybe A4223, I believe it is.

And we get the PR204 denial from Medicare which is what is needed for the secondary to pay. It will crossover to the secondary, but if that NDC number is not on the crossover information, the secondary will not pay the drug, they will pay the other insurer, but they don't pay the drug. If we have that NDC number in the field, will that crossover for us to the secondary?

Taveo Perry: (Carolyn), have you tried that previously?

(Carolyn Fogel): I think we did and I don't think we had any success with it.

Taveo Perry: Yes. I don't think that it is going to crossover the NDC number.

(Carolyn Fogel): Yes?

Taveo Perry: The only time the NDC number is going to crossover is going to be with oral anticancer meds.

(Carolyn Fogel): OK.

Taveo Perry: You can try again, but I don't think that it's going to crossover actually.

(Carolyn Fogel): Right. Well, we were just you know we're trying to tighten up processes and it's always difficult to maybe track everything, have the secondary pay a partial claim and then go back and re-bill. So, we just wanted to make certain that that was something that we might try to tighten it up.

All right, thank you very much. That's the end of my questions and that's it.

Taveo Perry: One moment, please, (Carolyn).

(Jon Bergey): (Carolyn), this is (Jon Bergey) with our technical team. One of the things, those are non-covered items that you're talking about, correct?

(Carolyn Fogel): Right.

(Jon Bergey): You might want to check with the secondary and see if they even require that they get the Medicare denial first. They may, depending on the secondary.

(Carolyn Fogel): Yes. The majority of the ones we have are with Humana and Tri-care. CIGNA, all of those, yes, they do require that PR204.

(Jon Bergey): OK. Well, yes, if that's the case, then it is – because we don't require that NDC. There's probably not a way for you to ...

(Carolyn Fogel): To have a crossover?

(Jon Bergey): crossover

(Carolyn Fogel): Yes, OK, all right. Well, we'll try to come up with something else to streamline our process in.

(John Barry): OK. Thank you, (Carolyn).

(Carolyn Fogel): All right. Thank you.

(Jon Bergey): You're welcome.

Operator: And once again, that's star one for questions.

And sir, it appears we have no further questions.

Taveo Perry: OK. We (are ready to) answer questions from you guys if you anymore questions, we'll hang around for a couple of minutes or so. So again, we're here to answer questions. If you have any, please request the floor.

OK. We'll go ahead and wrap the call up unless we have any other questions at this time, we will end the call in another couple of minutes or so.

Operator: And once again, if you would like to ask a question, that's star one.

And we do have a question and we'll take. Please go ahead, your line is open.

Female: Yes. My question has to do with our crossover claims with our Medicaid and the part B medications . Our claims are crossing over but the Medicaid aren't processing them, they're denying them. they need the NDC number. And is Medicare ever going to cross that information over to the Medicaid?

Taveo Perry: Not the NDC numbers, only for all anti-cancer drugs.

Female: OK, all right, thank you.

Taveo Perry: OK.

Operator: And we do have another question. Please go ahead, your line is open.

Female: Hi. I have a question about the KX modifier and the external infusion pump policy.

Taveo Perry: OK.

Female: Is the KX modifier only to be used on the Ambisome and amphotericin B with lipids and lipid complex?

Taveo Perry: One moment. Thank you.

Female: Yes.

(James Herren): Give us one moment. we need to look at the policy really fast, OK?

Female: Not a problem.

(James Herren): Again, give us a moment. We have the policy here real fast. We're just trying to pull it just to make sure we give you the right information here. We just want to double check something.

Female: I appreciate that.

(James Herren): Thank you. It's a good question by the way.

Female: OK. Thank you for your question. Actually according to the Local Coverage Determination for all claims for the J0287, J0288 and J0289 that meet the criteria that are outlined in section 5C of the Local Coverage Determination, would include the KX modifier. So that is the only item within the Local Coverage Determination for external infusion pumps that require the KX modifier.

Female: Thank you very much.

Female: You're welcome.

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

Taveo Perry: Go ahead.

Operator: Please go ahead, your line is open. If you heard the voice prompt on your line, please go ahead, your line is open at this time.

OK. I'm hearing no response. Once again, I'd like to remind everyone, it's star one if you'd like to ask a question.

Female: And can I add something to the last question also before we take the next call? Just as a clarification, the only drug specific that requires the KX – I think everyone who provides the external insulin pumps are aware of the KX modifier requirements there.

But I just wanted to mention those just in case there was someone on the call that is providing external insulin pumps who was not aware of the KX modifiers there. Those are the two items within the Local Coverage Determination for external infusion pumps with the KX modifier requirement. Thank you.

And we'll take our next call.

Operator: Thank you and we do have a question we'll go to. Your line is open, please go ahead.

(Shannon): My question is concerning the paying for the Least Costly Alternative. So, if we're billing DuoNeb which is the J7620, they're going to pay us for separate Albuterol and ipratropium after November?

Taveo Perry: Yes, ma'am. That is correct.

(Shannon): OK. And then also I also have a question about our crossover claims. For some reason, my provider for my Durable Medical Equipment – our clients are crossing over to Blue Cross Blue Shield, but under my pharmacy, my neb meds are not crossing over to Blue Cross Blue Shield of Mississippi, and we seem to be having a problem with that in the past several times that we have and claims were happened to send them over, they're not crossing over.

Female: Is it just for – do you provide other items to those patients that are crossing over?

(Shannon): Under our durable medical equipment provider number, we did and they are you know crossing over. But just under my pharmacy provider number, they're not crossing over to Blue Cross Blue Shield Mississippi for some reason.

(Dante Thomas)Female: Have you checked with Blue Cross Blue Shield of Mississippi to determine if they have your information on file as the pharmacy to accept these claims?

(Shannon): Yes. They did. We're a provider with Blue Cross Blue Shield of Mississippi.

(Dante Thomas) Female: Under the pharmacy number as well?

(Shannon): Yes.

(Dante Thomas): Have you contacted them on the receipt of those and what exactly are they advising?

(Shannon): They haven't, but they're just not getting the clients. They don't meet. So, I didn't know if they have stopped crossing over for Medicare or if they had all quit sending them, or if there was a problem on your side.

(Dante Thomas): No, we're not currently experiencing any difficulties with crossovers. As long as the patient's record is on files with the coordination of benefit contractor – agreement contractor. Then the information will crossover automatically from Medicare to Medicaid. So, it could be a situation where perhaps that patient's records or using all of your patients. Do you?

(Shannon): All the patients that's getting the neb meds from the (fed) do have Blue Cross Blue Shield as a secondary are not crossing over, and it's strictly under my pharmacy provider number.

(Dante Thomas): Bear with us just a moment. We're just trying to see if we can determine a reason that will cause just that particular carrier to have these issues. Bear with us just a moment.

(Shannon): OK.

Taveo Perry: All right. Sorry about that. We're going to have to check on it. Is it OK with you if you call back on that?

(Shannon): I guess.

Taveo Perry: What was your name?

(Shannon): It's Shannon.

Taveo Perry: (Shannon), may we have your telephone number, please?

Taveo Perry: That's a direct line?

(Shannon): Just ask for me.

Taveo Perry: Shannon, your last name or you're only Shannon there?

(Shannon): I'm only Shannon here.

Taveo Perry: OK. We'll give you a call back and I'll check that for you.

(Shannon): OK. Thank you.

Taveo Perry: OK. Thank you.

Operator: Once again, it's star one for any questions.

Taveo Perry: OK. We'll conclude the call with that final question. Dana, thank you. We'll go ahead and end the call.

Operator: Thank you so much, sir. Again, thank you everyone for your participation. You may disconnect at this time.

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