

## **CIGNA**

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

Operator: Good day, everyone and welcome to the CIGNA Ask the Contractor conference call. Today's conference is being recorded. At this time, I'd like to turn the conference over to Mr. Mark Loney. Please go ahead.

Mark Loney: Thank you. Good afternoon, everybody. Thank you for joining us on today's Ask the Contractor teleconference. I have just a couple of things – just two things, really, before we go ahead and open for questions. So I'll work through those here fairly quickly and then we'll get to your questions this morning.

It is a general – this afternoon, excuse me. It is a general act call so there's not – the questions can be about anything dealing with the DME Medicare program. As always on this kind of call, this arena, we ask that you – no claims specific questions or PHI be talked about. First thing I want to talk about is a listserv message that we sent out last week on December 4.

It's an electronic funds transfer scam alert that we want everybody to be aware of. CIGNA Government Services has become aware of a scam where perpetrators impersonating CGS, or the Centers for Medicare and Medicare Services, CMS, are sending letters via fax or mail to Medicare suppliers.

These letters, which may include the CGS and/or the CMS logo, tell suppliers that there were problems identified with their electronic payments and that the supplier should expect to receive paper checks. In the letter, the supplier may be instructed to fill out a form releasing sensitive information. Please be cautious with this type of request.

If you receive a request for information in the manner described above, please check with CIGNA Government Services before submitting any information. In addition, Medicare suppliers should only send information – regardless of what's being asked for – to the addresses and fax numbers listed on our Web site, which is [www.cignagovernmentservices.com](http://www.cignagovernmentservices.com).

You can always give our office a call if you feel suspicious regarding the correspondence that you've received. Our provider customer service number is 866-270-4909.

The other thing I want to talk about real quickly is the delay of change request 6417 and 6421, which deal with the Provider Enrollment Chain and Ordering System, or PECOS. The warning edits on your electronic billings that you are receiving. The second phase of that, which would actually be a rejection of those claims, was delayed until April 5 of 2010.

The delay will give the physicians and non-physician practitioners who order those items and services for the Medicare beneficiaries more time to enroll in the PECOS system, take any necessary action that they need to do. So phase 1 will continue, which is simply the warning message and not the full rejection until April 5 of 2010.

That's all I've got for updates. Sherlon, if you will go ahead, we will take any questions that you might have. Again, let me remind you nothing claims specific no PHI please other than that this is a general (at) call so any questions dealing with the DME portion of the Medicare program we

can take.

I do have – want to make mention I've got several subject matter experts and several other provider outreach team members here with me. So if somebody else responds to your question they'll probably introduce themselves, they might just be whoever's most qualified to answer your question. Sherlon, go ahead.

Operator: To ask a question please press the star key followed by the digit 1 on your key pad at this time. Again, that's star 1 to ask a question a voice prompt on your phone line will indicate your line is open to ask your question. Please state your name before posing your question.

Again, that's star 1 if you'd like to ask a question at this time. We'll take our first question.

(Louis): Yes hello, this is (Louis) from Fort Lauderdale, Florida. I have a question regarding the (CO-182) denials, that's when you use the wrong KH, KI, KJ modifier. And I just want to confirm something that we've been told, I'll give you a scenario.

Mark Loney: OK.

(Louis): Where we deliver an item that requires the KH modifier. We actually get paid and then later on there's a recoupment because they were in a SNF or in the hospital so we recoup it. By the time we issue the refund the two KIs and the KJ have already gone out. Can we on the very next claim put the KH modifier on it and extend the cap period?

Mark Loney: Once the recoupment has been done on that original one if like in your example the patient was in a SNF and we found that out after the claim had been paid. Once that recoupment has processed you're entitled to the KH modifier and that payment again. Make sure though ...

(Louis): But we already – but technically we've already been paid for the second and the third month. So we have any OB with two KI modifiers on it.

Mark Loney: That's fine. What we're looking for is to pay one KH, two KIs and then the rest KJ. So, if the KH or one of the KI modifier months had to be taken back for an unrelated reason we can pay that month again.

(Louis): So it doesn't necessarily have to be in sequential order.

Mark Loney: No.

(Louis): OK, thank you.

Mark Loney: OK, thank you.

Operator: Again, star 1 if you'd like to ask a question at this time and we'll pause to see if there are additional questions. Again that's star 1 for questions we'll take our next question at this time.

(Steven): Hi yes, my name is (Steven) and I've got two questions in relation to insulin pump supplies.

First, we have many patients where they've received the insulin pump prior to enrollment into Medicare and so then they come to us just to get their supplies every 3 months.

When something like this occurs do we need to go ahead and get the DIF form? Because at the top of the DIF form it's a DIF form for insulin pumps.

Mark Loney: The simple answer is yes, I'm going to get a longer explanation bear with me here just a

moment.

(Steven): OK.

Mark Loney: You know what we're going to go ahead and we're doing a little research there. Why don't you go ahead with your second question and we'll cycle back to it.

(Steven): OK. Now I saw on November 5 there was a reminder of policies sent out. For example, the IAA or IA2 tests are not acceptable for the you know (basil cell) autoantibody tests.

Mark Loney: OK.

(Steven): And so my question is are we able to get – you see we've got some customers that they don't fully understand the policy. We've tried to explain to them that there are no – patients cannot be grandfathered out of that. Say if they had an IAA test that was positive that they used in the past that they no longer can use that to qualify anymore.

And we're just not able to find anything in writing that really explains that you know that this is a current policy and that there's not grandfathering. Because like that notice said on November 5 there are at least three if not five tests that suppliers used to use to qualify patients on that requirement. And you all now no longer accept those tests.

Mark Loney: OK and basically what you're looking for you say you're not able to find it in writing where we're not grandfathering.

(Steven): Yes, like individuals that used to use those tests. I mean, I know it's a – if it's very clear to me

that those are no longer excepted but it's – we're just having difficulty communicating it to some of our customers. And so yes, we would want that – see if there's any further you know places where you all elaborate on it or (just the) grandfathering.

Mark Loney: I don't know where there's anything that we've addressed grandfathering in relation to those tests. It's certainly something I can have as a take away. You know as you're moving forward with those patients, though anytime there's you know there's new testing if that's (gotten) for any reason if that's testing is done then obviously we'd need to go with the tests that are accepted now. But no, I don't know where we've given any grandfathering.

(Steven): OK. What about just a general – just some type of general assessment of how Medicare doesn't grandfather? Do you have anything about that that you all don't normally do that?

Just something to show because whenever we can explain it in the most concise and clear language we've still gotten push back and doubt tried to be you know shed upon what we've said even though we've explained it as perfectly as possible.

Mark Loney: Right.

(Steven): So we just want you know the next step is just to produce something from the actual people making the decisions.

Mark Loney: No, I can tell you that when we do allow some grandfathering that those instructions are specific and they're either in article or actually right in the policy. But no outside of that I don't know of anything where we will have a general blanket statement or anything like that.

(Steven): Right, OK. And as far as getting some – like a transcript of today's teleconference. Is that

possible?

Mark Loney: Yes transcript will go out off the top of my head I don't remember what the timeline is for the service. But they usually have it back to us within just a couple of days and I'll post it on our Web site. I'm getting 5 days from those in the room, 10, 10 days, my bad.

(Steven): OK.

Mark Loney: So yes, we'll have today's transcript out there.

(Steven): OK, will that be CIGNA government services or CMS?

Mark Loney: CIGNAgovernmentservices.com.

(Steven): OK.

Mark Loney: Click on Education and then look for Ask the Contractor Teleconference and all of the transcripts are out there.

(Steven): OK.

Mark Loney: But this most recent one should be at the top.

(Steven): OK and you'll be getting the ((Inaudible)) question as we move through the teleconference?

Mark Loney: Well I'm getting a – give me just a moment here and I think I'll have an answer.

(Steven): OK, thank you.

Mark Loney: Hold on just a moment. All right, thanks for your patience. What I'm getting is that we would need a DIF in the case where maybe the patient had it prior to Medicare coverage – something like that.

The benefit is for the pump and we have to prove medical necessity for the pump before the supplies can be provided. And we do that with the DME Information Form. So we'll need a DIF even if they've had it already when their coming to Medicare and you're just doing supplies.

(Steven): OK.

Mark Loney: OK?

(Steven): All right thank you.

Mark Loney: Thank you.

Operator: Again star 1 for questions. We'll take our next question.

Female: This question is in reference to enteral nutrition. If a beneficiary has diagnosis of severe Alzheimer's or dementia and they can't complete a swallow eval, or swallow study, or barium swallow. They're spitting it out. They will not cooperate. And as we take things to review they're looking for these functional impairments.

How do we qualify somebody that's got more of a mental impairment that does not allow them to swallow when they've got weight loss, and NTO, and risk of aspiration but no functional

impairment documented?

Mark Loney: OK, bear with me here just a moment.

Female: OK.

Mark Loney: OK, again thanks for your patience. In that LCD there's not any way around the functional limitations. We don't have the ability on you know like claims (processing) in the first level of appeals to have any kind of you know clinical infirms or anything around that.

So unfortunately the answer is there's not really a way to qualify that patient outside of those functional limitations.

Female: What happens though if like this is a new customer to us and they've been getting it paid for since 2007 and then we come in and say you know it's not qualified. I mean is there any grandfathering or anything if they've had it covered for a period of time?

Mark Loney: No unfortunately there's not. You know I could I guess, guess that whatever the previous supplier was doing and I won't but yes if there's not – basically in LCDs there's not much wiggle room for us to go around them. Once you get to a certain level of appeal – certainly not the first two – those are bound by LCD.

Once you get up into the higher levels appeal – but that obviously takes a lot of time – but yes there's not any grandfathering. So if it's something that is not good by policy then that's you know a business decision to make whether to set that patient up or not.

Female: Isn't it true that each case is supposed to be considered individually in enteral though? I mean

because they don't list the – you know there's not a list of diagnosis codes that covers somebody, or to help you.

And it's my understanding in the LCD is that each case is considered individually. Somebody that that's their only form of nutrition, their NPO, they've got documented weight loss and they would die without that tube fitting. Does that not go through the individual consideration process?

Mark Loney: There is – well you're correct – that policy is not diagnosis code specific or diagnosis code driven. There's still the qualifications that are listed for it. And we're bound by those qualifications we have to process the claim against those qualifications.

Yes there is individual consideration and you know as always there is the appeals process for some of those really one-off considerations that ultimately where it ends up because we have to – we're bound by those LCDs. We have to process the claim and consider it against those LCDs. But yes you're correct, it is not diagnosis code driven.

Female: OK thank you.

Mark Loney: Thank you.

Operator: Again star 1 for questions. And Mr. Loney we have no other questions in the queue at this time.

Mark Loney: OK, we'll give it just a couple minutes. See if anybody else has anything.

Operator: Again star 1 for question. And we have a few questions that have queued up. We'll take our next question.

(Jeanne): Yes thank you for taking my call. This is (Jeanne) with (Amerita). I have two questions regarding the beneficiary signatures. First is if the beneficiary is unable to sign their name so they sign with an X, my understanding is that can be accepted if it is signed by a witness or a representative who is signing for witness? That's the first question.

And second question is what if the beneficiary expires prior to claim submission and has not signed the assignment of benefits, or has not returned it and the patient is now deceased?

Mark Loney: The first question I'll answer – that one is the one I can do off the top of my head. Yes we do allow for patients that can't sign to make a mark – whatever their mark may be – an X, or something like that and then have somebody sign as a witness.

Probably best in your records to note the relationship of that witness to the beneficiary. That would be best in any case of an audit situation – something like that – note that relationship.

Bear with me here just a moment. So the case is you've delivered something and then you're now in the process of gathering the paperwork for it and the patient has used that for a period of time but then expired and is not able to sign any of the AOB paperwork or delivery paperwork?

(Jeanne): Correct.

Mark Loney: OK, bear with me here just a moment. OK, I'm going to make an addition to the answer of the first question. I'm being told that we also require an address for the witness, not only the relationship to the beneficiary but an address as well if you could note that in your paperwork.

And the second question, I want to make I guess a clarifying question to make sure I understand.

What paperwork have they not signed because the delivery paperwork, the AOB would be signed at the time of delivery, so the patient would still be alive. Are we talking about custom items maybe where you're doing some work?

Female: I'm talking about IV therapy or parenteral, enteral and sometimes what happens is everything gets sent out to the patient along with the home health nurse. And generally we do get the delivery ticket back.

Sometimes they don't go through the entire packet although we explain everything to them, there have been situations where they'll say we need times to go through and read everything. We'll sign it and send it back, we leave them with a return addressed envelope.

Mark Loney: Right.

(Jeanne): Patient dies, we don't have an assignment of benefit, which my understanding is I can't bill. So we haven't even dropped a claim, I don't have an assignment of benefit by the beneficiary. So my question is can we go back to a family member, to the spouse, to a son, to a daughter for the assignment of benefit and what would that documentation need to look like?

Mark Loney: Yes, we discussed that here. I guess the issue though is legally, in order for us to conduct business on behalf of the beneficiary's estate, we'd have to have power of attorney. But in this case when it was delivered, the beneficiary was alive, so the power of attorney probably wasn't in effect on that date.

So I don't think I've got a solution for that situation. You're doing everything mail order, delivery, correct?

(Jeanne): Well in some cases, some we will have one of our employees deliver and in that case we have a driver or someone who sits down and goes through all of the documentation that's required with them.

Mark Loney: Right.

(Jeanne): When it's a rural patient and although we've gone over everything over the phone with the patient, so we've talked about their financial liability, we've reviewed everything that's going to take place. And the shipment is being sent today for delivery tomorrow when the patient is discharged.

I have no control of getting that paperwork at that time of admit. So we send a letter, we talk to them on the phone and now you know patient gets extremely ill, they expire. And I don't have my paperwork back. So my question is can I hold the family responsible to sign the you know the assignment of benefits?

Mark Loney: On the AOB, unless they have a living power of attorney or somebody like that that is signing for them, that's got to be the patient's signature. If we're talking mail order delivery, the AOBs been signed, it's the same item so the AOBs in effect a couple months down the road maybe.

(Jeanne): I'm specifically talking about the AOB.

Mark Loney: The AOB, that's got to have – there's not a way for us to get around the patient or if they're alive, somebody with you know the witnessed signature, whoever that was delivered that first set up order to. If it wasn't received or it was completed at that time, I don't see a way how we can get somebody else to sign it later down the road.

(Jeanne): OK, so then let me ask the second part of that question of that then, if the beneficiary is too ill to sign at the time that it's delivered, it is acceptable to have a spouse or a caregiver sign, indicate their relationship and date it.

Mark Loney: Yes, same thing as with the first question is we can have a witness, note that relationship.

(Jeanne): OK.

Mark Loney: You're trying to prove a couple of things when you do – when you're signing a witness.

They want to know who it is, it's got to be legible. In the case of an audit, that person might be contacted and we also want to make sure that it's not your employee that's witnessing it or something like that.

So that's why we're looking for that relationship. And you know a legible signature and address so we know who it is.

(Jeanne): So witness would be same as designee perhaps?

Mark Loney: Sure.

(Jeanne): And does not have to be power of attorney.

Mark Loney: No.

(Jeanne): OK. Thank you very much.

Mark Loney: Thank you.

Operator: And we'll take our next question.

Female: Yes, my question is concerning a new-capped rental. Recently there was a change made where Medicare will not correct modifiers anymore and this is to do with negative pressure wound therapy. Prior to this change if a KH was billed for a new-capped rental, it bumped up against and sometimes was paid at a reduced rate.

Or if it bumped up against another provider, there was another provider indicator on the denial. At this point in time, it looks like Region C is denying new billing that bumps up against a KH with a 182. But are we losing visibility of the other provider denials?

Mark Loney: Yes when the change was made, instead of – it is getting that – what it is, the CO 182?

Female: Yes.

Mark Loney: Is that the denial code? I'm not sure you're losing – I'm not sure what you mean, you're losing visibility as the other supplier. So are there – is this a case where there are two suppliers actively billing?

Female: It could be. In the past if it was just – it seemed like if it was just one company doing the billing, the modifier would be changed to a RRKH and paid at a reduced rate, if it was bumping up against another provider billing ...

Mark Loney: Right.

Female: ... it would be denied with a 50 and a M3 remark code.

Mark Loney: Right.

Female: And at this point, with the change, have we lost that visibility?

Mark Loney: Yes, it's going to – the new denial code, the CO 182, if we already have paid specific modified, either the KH or the KI, that's the denial it will get instead of whatever the other one was where there's another supplier active.

So you might have – it might have to do that research you know finding out what else is on the record, that's – I guess that's kind of the, I don't want to say the point but that's kind of the reason for why we implemented that change is instead of changing them and assuming that the other supplier wasn't going to bill anymore.

We're now asking that whoever's doing the billing know what month they're in, even in the situation where you're taking it over from another company.

Female: OK, now another piece to that question, if we previously billed negative pressure wound therapy and then we've met the break in therapy policy and we're starting on a new wound billing in our RRKH at times our HAO comment for the break in service is going to contain the same ICD-9 code.

For instance if we have a pressure ulcer on a right hip and then go to a pressure ulcer on a left hip and then those claims will reject I'm thinking because of the same ICD-9 code. And we're being told that we need to establish a new CMN.

Negative pressure wound therapy doesn't require a CMN so I guess what I'm asking is, it must be the initial billing that starts the CMN in your system for the first round of therapy. Then as that stops and we try to bill a new cap, how do we stop the old CMN and begin a new one other than the break in service comment. Is there ...

Mark Loney: OK, that's a multi-answer. There's a – that's a great question. There's a lot going on there.

Yes, Break in Medical Need. So the medical need ceased to exist and then came back, and especially in the situation that was negative pressure. Wound therapy it could be the same ICD-9 code. That's very reasonable.

I think if you've talked to somebody and they said we need to set up a new CMN, that might have been a little bit of a – the wrong terminology. That we don't use a CMN in that policy. It is how we track payments systematically.

So while we will have to do that on our end, though it's not a paper CMN that you and the physician has to fill out. So the best thing to do is put a detailed HAO record in there. There might be times, yes, especially in the case where you have the same ICD-9 code as the first set of medical need that the claim might still deny.

That can go to redeterminations because more than likely you're going to get a medical necessity denial. And at that point then – but looking at the documentation, we can establish a new capped rental and start over.

Female: OK, so what you're saying is there's really no way that we can bill and get payment out of that initial billing when we have the same ICD-9 code.

Mark Loney: With the same ICD-9 code, no, there's no way I can tell you 100% you're going to do that on

initial claim submission.

Female: OK.

Mark Loney: OK?

Female: Thank you.

Mark Loney: Thank you.

Operator: We'll take our next question.

Female: Yes, on a capped rental oxygen, is there a certain modifier that you use for the accessories?

I'm getting rejection saying, invalid code or modifier.

Mark Loney: There's not a certain modifier. With oxygen, though, past the – I guess I'll call it the base equipment. Either your stationary or your portable equipment, whatever the case, though, the modality or the method might be, there's not separate reimbursement for the accessories. So the rejection ...

Female: (Even after) ...

Mark Loney: ... or the denial is speaking of the HCPCS code itself and not necessarily a missing modifier.

Female: Even after the 36 month's cap to ...

Mark Loney: Right, even after the 36 ...

Female: ... (cannula).

Mark Loney: There are some payments for contents, but not for any accessories.

Female: OK.

Mark Loney: OK?

Female: Thank you.

Mark Loney: Thank you.

Operator: We'll take our next question.

(Peggy): Hi, yes. My name is (Peggy) and the question that I – I have two questions, actually. The first question is regarding something that we heard of about the NPI being merged with the P code. Do you guys know of a Web site that is coming out for that?

Mark Loney: Yes, with the – the CR that I spoke of in the narrative at the beginning, where you're getting some warning messages now. If the referring physician – the physician that wrote the prescription – is not in the PECOS, Provider Enrollment System, there will be a Web as well. It's going to be on CMS's Web site.

But there will be a public file made available at some point. When the deadline was going to be January 1, they were looking at some time in late December to put that file out there, now that it's

been extended I have not heard an updated time period.

But there will be a public file out there. So you'll be able to search that public file and know if the referring physician is in the PECOS system or not before you build a claim.

(Peggy): OK and my next question is regarding being able to use the KX modifier and the GA modifier together on a piece of equipment?

Mark Loney: Whether that's allowable or not?

(Peggy): Yes.

Mark Loney: Sure. The KX modifier, in most cases outside of diabetic supplies, is telling us the documentation to prove the medical necessity is on file. The GA modifier means you had the patient sign an ABN for whatever reason. And you can certainly use those together, if both of those cases are true.

(Peggy): OK, well my situation is, with all of the four jurisdictions that we submit our claims to, I have gotten denials, all except for Region C, because we have combined those two modifiers together.

Mark Loney: Yes, I can't speak for the other contractors, but that's you know just going by what those two modifiers, separate from each other, tell us – what the KX tells us and what the GA tells us – there are several, many instances where they can be and maybe should be, used together.

If the patient signs an ABN, you put the GA modifier on there. If the patient's claim meets the medical necessity criteria against the LCD, then you use the KX modifier. So I don't see, as far as we're concerned from a Jurisdiction-C perspective that those are mutually exclusive at all.

(Peggy): OK, thank you very much.

Mark Loney: Thank you.

Operator: Again, star 1 if you'd like to ask a question at this time. We'll take our next question.

(Steven): Yes, this is (Steven) again. I have one additional question about insulin pumps. On a letter C on the LCD, it says the patient has completed a comprehensive diabetes education program. Has been on the program, multiple daily injections events, someone with frequent self-adjustments events, (someone) dose release 6 months, and it goes on to say some other things.

But my question is, in regard to them completing a comprehensive diabetes education program – we have a question on our physician order that just says has this patient completed a comprehensive diabetes education program? That's yes or no. Now if they mark, yes, is that sufficient proof that they have completed this program, or do we need something beyond that?

Mark Loney: OK, bear with me just a moment.

Female: ((Inaudible)).

Mark Loney: OK, thanks for your patience. The education is the responsibility of the physician. You've got the checkbox there on your paperwork. And the requirements about what the education has to entail are also on the physician's part-B side.

So to me the base level of the qualification that the education was done – and the physician has said it's done – yes, your checkbox is fine. However, our CERT coordinator is in the room and

some of the other folks here in appeals – that do appeals – are saying that when it comes to looking at the documentation, more is always better.

So if the physician's got record of that education, whether it be chart notes, whether it be a training course provided by the manufacturer that the physician takes the beneficiary through.

Any of that paperwork is going to do nothing but bolster your case. So if you could make that part of your routine information gathering, that's good.

(Steven): OK.

Mark Loney: OK?

(Steven): Thank you.

Mark Loney: Thank you.

Operator: And we'll take our next question.

(Maribel): Yes, hi, this is (Maribel) from (Echo Rentals) down in Miami, Florida. My question was the following, regarding support service that we have out in the patient's home, and right now it's in maintenance though we haven't built any more maintenance because of the purpose that the patient does not have any ulcers present.

Are we entitled to pick that mattress up or we have to leave it in the patient's home?

Mark Loney: You are – I mean, if it's a maintenance in service then based on that rental purchase agreement it's still your property, so if the patient no longer needs it for any kind of medical

necessity reason, yes, that's your equipment and you can pick it up.

(Maribel): OK, because the patient's mom had called us and told us that she called Medicare and Medicare had told her that the mattress already belonged to her and since we're billing maintenance, we would have to fix it if it had any problems.

But the thing is we only billed maintenance until April of this year because she has no ulcers present. And she's telling us that Medicare told her that we can't pick it up because it belongs to her.

Mark Loney: Well, if you were getting paid for maintenance and ...

(Maribel): Yes.

Mark Loney: ... service that means it's continued on a rental agreement so it's still yours if it was a maintenance and service.

(Maribel): OK and if there's no ulcers present we would have to pick it up.

Mark Loney: Right.

(Maribel): OK, thank you so much.

Mark Loney: OK, thanks.

Operator: And we currently have no further questions in the queue at this time.

Mark Loney: OK, let's do one more call and if then there's none, we'll be done.

Operator: Again, star 1 if you'd like to ask questions. And we'll take our next question at this time.

(Francine): Hello.

Mark Loney: Hi, how are you?

(Francine): Hi, good. My name's (Francine). I'm with Mobility Solutions here in Florida, and I just have a question. I have a rental piece of equipment that I know has been out before, let's say 3 years ago they had it because they had a fractured hip.

And now they've turned it in you know 3 years ago. They've fractured their ankle this time so it's a new – it's definitely a break in need, it's a new diagnosis. I've put that information you know that the pickup was on such and such a date, break in need, new diagnosis. I put that in my HAO record.

When I submit those claims electronically, how is that record read? Is it kicked out and somebody manually reads it, or what happens there?

Mark Loney: Yes, if the claim has an HAO record, in most cases somebody's going to read that HAO record and make a decision on the claim. Now there are times when if everything else is OK, the note alone is not enough to make that claim fall out for somebody. So there could be that you're putting something in the HAO record and it does get processed automatically.

(Francine): But if it would bump up against something then it's ...

Mark Loney: In the case of break in service and, again, I don't – it was 3-1/2 years ago, that kind of thing – I'm not sure exactly what would happen with that specific claim, but if you're putting all the information in the HAO record, that's the best thing to do.

(Francine): OK, so it doesn't necessarily kick it out for somebody to manually look at it.

Mark Loney: Not automatically just because of an HAO record. Now in the case of a 3-1/2 year break in service, there's a lot of other things in play there that might stop it, but an HAO record alone, no, was not reason to stop it.

(Francine): Oh, OK, thank you.

Mark Loney: OK? Thank you.

Operator: And we'll take our next question.

Female: I have a quick question, and I will apologize if it's been asked before. I've been disrupted several times while I've been trying to listen.

Mark Loney: OK.

Female: One of my questions is the new PAP policy where you have to have a copy of the face-to-face evaluation with the physician prior to ordering the sleep study, is there anything in process that may eliminate that from the DME provider and make it a requirement of the sleep study?

Female: Not at this time.

Mark Loney: No, not at this time. That's definitely not been asked on this call. I actually thought we might get out of here without talking about PAP today. That is certainly – as we're doing our education face-to-face and the webinars and things, that's something that gets asked a lot.

There is a lot that has to happen before the DME supplier gets that order and gets involved so to speak. But there's ...

Female: Then it's too late by the time we get it. I mean, we're out there educating the doctors. We're out there educating the sleep labs and we're trying to get them to make sure they get that ...

Mark Loney: Right.

Female: ... prior to doing a sleep study to make sure the equipment's going to get covered, but it's not their responsibility so typically it's not happening. So we're chasing paper way after the fact and then I'm being told that then Medicare's going to go ahead and pay for another sleep study which really surprises me.

I mean, if they don't want to pay for the equipment unless the face-to-face has been done – it's just a total backwards policy. That should be a requirement of the sleep lab before they do a sleep study.

And then for us to provide the equipment, they should qualify based on the LCD with the sleep study and everything else. It's just that the last person to see it is the person that's required to have the first step which nobody's paying attention to and it's a horrendous burden on the DME providers.

Mark Loney: Yes, it is some of the feedback that we get the most. And I realize that policy after it's redo,

well, I guess October of last year – it does have a lot of documentation involved in it. The physician does have some general clinical decisions to make before they prescribe a sleep study.

And that's where the PAP policy is headed is that we want to make sure that some of these other kind of decisions were made before the sleep study was ordered. I understand that to the supplier who's getting it on down the road, that's a very imperfect process. But I ...

Female: Well, it would cost Medicare a lot.

Mark Loney: ... can't in faith tell you that there's a change underway to change that.

Female: Why would Medicare want to pay for another sleep study?

Mark Loney: Now I don't mean to sound sarcastic, but as a rule I can't answer why questions.

Female: OK.

Mark Loney: That's a rule I you know I – we can educate on the policy. There are times I know when Medicare has paid for a second sleep study. There is definitely – I've talked with my counterparts on the part B side and they definitely – there is a way for that to happen if the medical necessity is there and it's ordered that Medicare can pay for that second one.

Female: Is the fact that they didn't qualify for their DME equipment, is that medical necessity for another sleep study? That's the part I'm struggling with and the sleep labs typically can't answer that real well. It's just such a unique ...

Mark Loney: It is.

Female: ... situation.

Mark Loney: And I understand there are a lot of cases – or not a lot – but there are cases that I've seen, cases that I've heard about where the patient does fully qualify based on the sleep study but the legwork wasn't done before.

Female: The face-to-face prior documenting that it's being ordered, right.

Mark Loney: Out of order, the policy does not have a way for us to get that information in any kind of arrears or backdated process if you will. So like I said, I don't have – I like to have good answers and answers that make people happy but I – in this situation, in this policy, I don't.

It's a pretty airtight process as far as the policy is concerned and there's not much way we can get around it.

Female: Is anybody voicing the problems with it? I mean ...

Mark Loney: Yes, yes. Forums like this happens quite frequently. I you know it is ...

Female: Is there anything else we can do?

Mark Loney: ... it is one of the biggest pieces of feedback that we get.

Female: All right.

Mark Loney: Thank you.

Female: I understand why. Thank you. Bye.

Operator: And we'll have our next question.

Female: OK, I have a question concerning negative pressure wound therapy.

Mark Loney: OK.

Female: There are instances where we'll get a – maybe a denial code like a 96 and it doesn't have a remark code to lead us to the specific denial reason. We will call the CSRs and ask if maybe there's additional information that we need to process the appeal.

A lot of times we're being told to add a KX modifier. Some of these claims are claims that are for rental months passed 120 days of use and the policy does not allow us to use the KX modifier.

I just wanted to bring that to your attention because it happens quite frequently that that is the answer that we get – that we did not add the KX modifier and that's the reason the claim denied and we need to add it.

Mark Loney: OK, that's great feedback for us. I don't know that that you want to just add the KX modifier.

It could be they're leaving off the KX modifier because the patient doesn't qualify for it anymore is what caused the denial.

But the KX modifier's a decision you have to make based on the policy that you're using it in or – well, based on the policy that the claim is based against.

Female: Right, negative pressure wound therapy ICD does not allow it after the 120 days of use.

Mark Loney: So it could be that the lack of a KX modifier has caused that specific – and did you say it was CO-96 denial?

Female: Sometimes it's for ...

Mark Loney: But simply adding it is probably not the answer, especially in the negative pressure wound therapy policy.

Female: Right. It can be several different types of denials that we may need just a little bit more information. Perhaps the prescribing physician's not eligible or something like that.

Mark Loney: Right.

Female: And that seems to be a pat answer that we get. And so ...

Mark Loney: ... physician not eligible shouldn't get CO-96.

Female: No ...

Mark Loney: There can be – yes, there can be different things in play but, no, I don't know that the 100% correct answer is to simply add the KX modifier. So that's good feedback for us and something I can take away and provide that.

Female: Right. I just used the 96 for an example. It can stretch across several different denial codes that we might need to call for additional information.

Mark Loney: OK.

Female: Thank you.

Mark Loney: All right, thank you, very much.

Operator: And we'll have our next question. Caller, your line is open. Please go ahead with your question.

Female: I think we hit it by accident. Hello?

Mark Loney: Yes.

Female: OK, I think we thought we were muting ourselves and we did that when we came off the line earlier.

Mark Loney: OK, no problem.

Female: Thank you.

Operator: Again, star 1 if you'd like to ask a question. We'll have our next question.

Female: I have a quick question on the Power Mobility Documentation Checklist for the K0813 and the K0816.

Mark Loney: OK.

Female: In that checklist, there's a statement that face-to-face evaluation meeting all of the following criteria. And one of the sentences says the ability to stand up from a seated position without assistance. And that is not a requirement anywhere in the LCD that I've been able to determine and I can't figure out why it's a requirement on this documentation checklist.

Mark Loney: OK...

Female: Will you all check into that for me?

Mark Loney: Bear with me here just a moment. I'm going to grab that documentation checklist up on my computer.

Female: OK. And it's on page 1 on the right side towards the top portion of that checklist.

Mark Loney: Yes. It says history of the present conditions and past medical history that is relevant to mobility needs and that looks like it's got, I don't know, a dozen bullet points or so, 10 or 12.

It's an information-gathering form. There's a lot of different things that cover a lot of different ground underneath those bullet points. And so for each piece of mobility equipments, the criteria is a little – can be a little bit different. So, yes, it might not mention that in the LCD specifically for power wheelchairs.

Female: And it's not a requirement. Even if they need assistance, as long as they can use it once they get in it for their activities of daily living ...

Mark Loney: Right.

Female: ... if they meet all the other criteria to qualify, it's covered. That was my understanding. Is that not correct?

Mark Loney: It is. I think that probably even though this is – this documentation checklist says it's specific to power wheelchairs and power-operated vehicles, we've got some other mobility items where this specific criteria comes into play like the seat-lift mechanism. Things like that.

So I – and they're looking that an entire mobility assessment has been done. And even though it's on the one for this power wheelchair, we're looking to make sure that the correct piece of equipment was prescribed if that makes sense.

So there are some other pieces of equipment that you know could be considered if a wheelchair isn't the right thing. And so they want to make sure that a full mobility assessment that includes all of these bullet points was done.

Female: OK, all right. Thank you very much.

Mark Loney: You're right. That's not a requirement in the LCD for power wheelchairs. I think it – the only place it mentions that specifically is seat lift mechanism.

Female: That's correct. So that's why it seemed real out of place for me that that was in this documentation checklist so. OK, thank you.

Mark Loney: OK. Thank you.

Operator: Again, star 1 for questions. And we have no further questions in the queue at this time.

Mark Loney: OK, I think we're probably good to finish then. Thank you everybody for joining us today at the Contractor Teleconference. Just as a final note – and this is something I do every time I'm talking to a group of suppliers – please make sure that you are signed up for our listserv.

It is the absolute best way that we communicate – the quickest way. It pretty much goes out every day, once a day. Every now and then we'll sneak a second one in there. But if you have just one person in your office signed up for it, sign up a couple more. Make sure as many people as you want, get that information.

That is really how we get the information out there quickly. It's also how we advertise all of our education. So that's important as well that you're aware of everything that's going on. Thank you today for your participation and your questions.

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