

CIGNA

**Moderator: Ronja Roland
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1:00 p.m. CT**

(Ronja Roland): Good afternoon, and welcome to the CIGNA Government Services Ask The Contractor Teleconference for Jurisdiction C DME MAC. I am Ronja Roland with Provider Outreach and Education. I would like to begin by extending thanks to those suppliers who are participating today. Your participation in this call 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 call.

We are joined on the call today by representatives from CMA; we also have representatives from Palmetto GBA, the EDI Contractor for Jurisdiction C. Also, with us are representatives are 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 questions regarding a specific claim, you may contact our provider contact center at 866-270-4909. You may also check claims status through our IDR unit. That number is 866-238-9650.

I would like to begin the call by providing an update on our DME MAC operational performance. Following the update, we will also (discuss other) important topics affecting Medicare suppliers. After that, we will open the line to your questions.

CIGNA Government Services is committed to providing excellent customer service to all of our Jurisdiction C suppliers. We recognize that our Jurisdiction C customers are experiencing service issues including busy signals when trying to reach customer service agents as well as concerns with claims processing, redeterminations and re-opening. CIGNA Government Services is taking the necessary steps to improve these operational areas.

The first operational area that we would like to address is our customer service area. Actions that we are taking to address the problem includes, CIGNA Government Services continues to add and train customer service staffs. We are continuing to provide refresher training for our existing staffs to improve call handling efficiencies and knowledge.

We have made outbound calls to those customers who are making frequent, high-volume calls to the call center, and these inquiries represented a significant portion of the daily call volume. We are pleased to report that our efforts are continuing to yield a positive result. The additional staff has resulted in the reduction of blocked calls and we expect to see results continue to improve as we add training resources to the call center.

The next area we will discuss is the re-openings area, which has a higher than expected volume of reopening requests to correct clerical error. CIGNA Government Services is shifting its resources to address this work load. Additional resources are also being added to the telephone and re-opening lines to enhance service provided over the phone. The re-openings department is continuing to see the following trends.

The KX modifier is the primary reason for many denials. Omission of the KX modifier is on a clerical level omission. So, most of these denials can be corrected in the re-opening process. We expect to see the number of KX modifier re-opening requests to decline as providers begin to submit correct claims. CIGNA Government Services is receiving multiple requests for the same reopening requests.

For example, some customers are faxing in their requests and then calling the reopening unit for corrections. Duplicate requests increase processing time for re-openings. We are beginning to receive erroneous re-opening requests for claims denied for maintenance of service. It is important to differentiate the scenarios that require recent omission of new claims from those that require reopening. We will discuss the appropriate corrective actions for maintenance and service claims a little later in today's call.

Our claims processing area continues to exceed CMS expectation for claims processing timeliness. In November 2007, over 2.6 million claims were processed. We have identified the following trends upon analyzing the claims work load.

As previously mentioned, CIGNA Government Services continues to see the omission of the KX modifier. Analysis of the claims data also 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 – is on our web site at www.cignagovernmentservices.com/jc. Click on the archived 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 some paper claims. Please refer to the Jurisdiction C Supplier Manual Chapter six on Claim Submission for detailed instructions on submitting NPI and PTAN numbers.

Special attention should be paid to the requirements of blocks 33-A and 33-B. Also verify that your NPI number is on the NPI crosswalk by accessing the NPPES web site and reviewing your records at <https://nppes.cms.hhs.gov>.

Suppliers submitting claims for maintenance and service are reminded that 15 months must be paid before the first maintenance and service claims can be paid. CIGNA Government Services has identified a number of claims that were improperly paid for maintenance and service before completion of the 15 billing months. We have been notifying suppliers and recovering those overpayments. We will discuss appropriate submission of maintenance and service claims later in today's call. Now, (James Herren) from Provider Outreach and Education will discuss redeterminations, reopening, maintenance claims and medical review.

(James Herren): Hello everyone. Thank you, Ronja. As Ronja just said, my name is (James Herren), and I'm going to discuss a few issues with you. Let's start with redeterminations.

Some of the current issues that we are experiencing in our redeterminations department include re-determination decisions not processed within the expected time frame and customers who are unclear whether a re-determination request was received and whether it is in process.

Why this issue is happening? CIGNA Government Services received an unexpectedly high volume of re-determination cases at the cut-over of the DME contract. Although that work load has been completed, our current work load was impacted.

This is what we are doing to address this issue. We are completing work on a first-in, first-out basis. We are offering supplier education on determining when to request a re-determination versus a re-opening. If you are unsure of the difference in redeterminations and reopenings, we recommend that you complete the Reopening and Appeals Online Education course found at cignagovernmentservices.com/jc.

That web site is www.cignagovernmentservices.com/jc. You can find that link under the education header in the online education center. Again, that course is called Re-Opening and Appeals Online Education. We are sending acknowledgment letters – our acknowledgment letters now include the date of service of the claim being appealed.

We have provided refresher training to customer service agents on retrieving and reviewing the status of the re-determination requests. Please note that once an acknowledgment letter is received, it is not necessary to call to confirm receipt of the re-determination. The cases are being worked on a first-in, first-out basis. So, if you do receive an acknowledgment letter, that does indicate that we have your re-determination request.

We are providing clear instructions and online education to suppliers on the redetermination process. As we mentioned, we invite you to register for the Reopenings and Appeals Online Education course. You may also review chapter 13 of the Jurisdiction C Supplier Manual for further details on reopenings and redeterminations.

How our efforts are yielding positive results in the re-determination work load? With the resources we have added to process all re-determination requests, we have completed all cases submitted prior to June 1st. 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 system for claims status inquiry and the now recent beneficiary eligibility and payment information.

The customer service line should be used for complex inquiries that cannot be answered from the IVR. Please report to our web site at cignagovernmentservices.com/jc for a complete listing of IVR options. That information can be found under the Contact Us section of the Jurisdiction C web site.

Please do not send duplicate redetermination and reopening request. CIGNA Government Services is sending acknowledgment letters for all redetermination cases received. The letter serves as your confirmation that the redetermination case was received and will be processed.

Also note that redetermination acknowledgment letters are sent to the supplier's physical address and not their billing address. Now, we are going to discuss the differences between redeterminations and reopenings.

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 diagnosis code and inaccurate data entry. Other examples can include computer filing errors, incorrect data service, missing modifier or incorrect PTAN. A PTAN is your provider transaction access number, which is formerly known as the NSC supplier number.

Also, addition of a missing KX modifier is included within the reopenings department. Remember that if you are adding the KX modifier to a claim, you must have the documentation on file that the

KX modifier indicates. For instance, if you leave the KX modifier off of a claim for a wheelchair, you may go to the reopenings process to get this corrected. Please remember that a reopening can be submitted for denied claims and underpaid claims or to report an overpaid claim.

Also note, if you are challenging an overpayment recovery case, you must send that to redeterminations. Reopenings cannot assist you on an overpayment recovery case. You may submit reopenings 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 you have a significant number of pages in your request, please mail that into us as opposed to faxing.

To avoid unnecessary delays or returns of re-opening requests, we strongly recommend the use of the reopening request form, which can also be found in our web site at www.cignagovernmentservices.com/jc. That is in the front page and it's in the middle of the site under the Forms section. Please note some reopening requests may require additional information beyond what is – 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 options for claims correction – the first option is reopening – the second option is to go through a redetermination.

A redetermination is the first step in the appeals process. Redeterminations are necessary for denials that involve over-utilization, insufficient documentation, items that require CMN, but do not meet medical necessity and/or denials as a result of a development letter with insufficient documentation submitted. Redeterminations must be submitted in writing within 120 days of the initial claims determination. To avoid unnecessary delays or rejection, please use the redetermination request form located on our web site in the forms section of www.cignagovernmentservices.com/jc.

Next on the list, I'm going to talk about maintenance and servicing denials. Changes to the capped rental rules based on the Deficit Reduction Act of 2005 are effective with new rentals on or after January 1, 2006. Capped rental items provided before this date are still subject to the 15 paid rental months followed by maintenance and servicing period. For capped rental items falling under the old policy, CIGNA Government Services will deny maintenance service claims with ANSI (reason CO179) and remark code M6, if 15 rental payments have not been paid.

Any maintenance and service claims previously paid in error will be sent for recoupment. There are two options to obtain maintenance and service payments for these. For further details on this, please review the 'Archived News' section of the Jurisdiction C web site for an article published on July 10, 2007 titled "Maintenance and Servicing Denial." I will discuss the two options now.

Option one: 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 haven't been paid 15 rental months on Medicare should follow the appeals process for overpayment. Please include documentation of 15 paid rental months by Medicare with the appeal request.

Option two: 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 the rentals using dates of service within the current filing time. Refer to Jurisdiction C DME MAC Supplier Manual chapter six, page 26, titled, "Timeliness for filing Claims." This will indicate to you when you can file a claim. You'll need to indicate in block 19 or in the line note on

electronic claims something that says, to the effect, "Please extend for remainder of rental months."

If the remaining rentals are within the timely filing requirements but outside of the original 15 months, suppliers will need to submit the remaining rentals as claims and not as reopenings and indicate in block 19 or in the line note on electronic claims, again, "Please extend for remainder of the rental months." So, you can put those on the end of your last paid rental month, as long as it is within the current timely filing. We would like to update the maintenance and service recoupment process. Per a CMS directive, there should not be recoupments for maintenance service claims that are over four years old.

The overpayments team at CIGNA Government Services is aware of providers in which maintenance and services payments were recouped erroneously. The overpayments team is in the process of issuing refunds for those providers. Going forward, no claims for maintenance and service over four years will be recouped by CIGNA Government Services.

Also, CIGNA Government Services would like to remind suppliers that the medical review department will be transitioning back to the Jurisdiction C DME MAC on March 8, 2008. Implementation activities have begun. CIGNA Government Services will use the Listserv and the Jurisdiction C web site to provide updates and news regarding the implementation in the months ahead. Medical review and support of benefit integrity activities will still be performed by the PSC/Program Safeguard Contractor, which is TrustSolutions for Jurisdiction C. There will be minimal changes for providers on where to submit certain items such as ADMC request, returning responses for some developments requests, et cetera. But suppliers should not make any changes until they receive instructions to do so. This should occur closer to the March 1, 2008 date. (Dante Wynn) will now speak about NPI issues and other Jurisdiction C matters.

(Dante Wynn): Good afternoon. Since October 2, 2006, providers have been encouraged to submit both the NPI and Medicare legacy identifiers, also referred to as PTAN or legacy numbers or PIN. During this time frame, providers were allowed to submit invalid NPI legacy ID combinations. Effective October 29, 2007, CIGNA Government Services began editing the NPI legacy identification combination for validity against the NPI crosswalk file. Where a match could not be located on the crosswalk, claims are being rejected or returned to the provider.

As of this date, all claims must be submitted with a valid NPI legacy match. Even if only the legacy number is submitted, the NPI on the crosswalk must match for the claims processing to occur. 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 the issues with the NPI legacy combination.

Please verify the following to make any necessary corrections before claims are rejected. First, if you have a claim that is returned, verify that the correct NPI was submitted. If the correct NPI was submitted or if you require an application for an NPI, you would access the National Plan and Provider Enumeration System or NPPES web site at <https://nppes.cms.hhs.gov>.

Verify or submit all of demographic information in NPPES and compare against your National Supplier Clearinghouse record for consistency. The most common issues that we have identified with rejected NPI claims is the omission of the National Supplier Clearinghouse legacy number from the NPPES file. If the 10-digit National Supplier Clearing House issued supplier number is not listed under the other provider identifier list, ask the National Supplier Clearinghouse to please update your NPI file to reflect that legacy number.

Another common issue identified with NPI rejection is the entity type registered with the National Supplier Clearinghouse does not match the entity type registered within NPPES. If the supplier

type with NPPES is an organization, the type with the National Supplier Clearinghouse must also be an organization. Likewise, if one is listed as an individual, so must the other.

Please review the NPPES record to verify that the correct type is listed. If it is, you may contact the Jurisdiction C customer service to verify that the same information is listed on the NSC record. To update NPPES, make corrections through the NPPES web site. To update the NSC, complete a CMS 855S form.

For companies with multiple NPI, make sure that the NPI that you're using is compatible with your Medicare enrollment. If all the records in NPPES are correct and there is incorrect information on-file with the NSC, again, please complete the CMS 855S form and make the necessary corrections. When updating any information with the National Supplier Clearing House, please include all of the national provider identifiers that will be used in place of legacy numbers. Likewise, if you are applying for an NPI, please make sure that all of your Medicare legacy numbers are listed in the NPPES file.

Effective March 1, 2008, your Medicare fee for service claims must include an NPI in the primary provider field on the claim. And that is, The Billing, Paid to Provider and/or Rendering Provider field. You may continue to submit the NPI legacy pairs in these fields or submit only your NPI. The secondary provider field, that is your Referring and Ordering and Supervising Physician field may continue to include only your legacy number, if you choose.

Failure to submit an NPI in the Primary Provider field will result in your claim being rejected beginning March 1, 2008. In addition, if you are already billing using the NPI legacy pair in the Primary Provider field and your claims are currently processing correctly, now would be a good time to submit to your contractor a small number of claims containing only the NPI and the Primary Provider field. This test will serve to assure your claims will successfully process when only the NPI is mandated on all claims.

It is also imperative that providers immediately look at their NPPES records to ensure that they did not inadvertently report their or someone else's Social Security Number in a Freedom of Information Act disclosable field. If a Social Security Number is listed on one of those fields, please delete that Social Security Number immediately and, if appropriate, replace it with the correct information. And, again, the web site to view your NPPES record is <https://nppes.cms.hhs.gov>.

In May 23, 2008, in compliance with the Contingency Guidance issued on April 2007, CMS will list its NPI contingency plan, meaning that the NPI may be accepted and sent on all HIPAA electronic transactions, paper claims and standard paper remittance advices. This also includes all secondary provider fields. So, the referring physician identification number should include the NPI only to avoid costly claim rejection.

Next, we will discuss crossover. Effective October 1, 2007, the processing of Medigap crossover's transitioned to the Coordination of Benefits contractor from the individual Medicare claims contractor. This transition caused a change in the submission of claims from participating suppliers for Medigap crossovers. Participating suppliers servicing any beneficiary who hold Medigap plans will now identify these claims for crossover by including the new five-digit claim-based Medigap COBA identification number in the field NM109 of the NM1 segment in loop 2330B of your electronic claims. Again, that is field NM109 of NM1 segment on the electronic claims or in – if you're submitting claims on paper that would be in block nine of the CMS 1500 form.

Next, we will talk about the Medicare Contractor Provider Satisfaction Survey or MCPSS. This is designed to measure provider satisfaction for all fiscal intermediaries, regional home health intermediaries, carriers, and durable medical equipment Medicare contractors and all (AB MACs) included as (fee-for-service) contractors. This survey is sent to approximately 33,000 Medicare

providers and suppliers. Providers may respond via secure Internet site, telephone interview, paper copy or fax.

Providers will rate contractors on seven functions and data collection has begun for the survey. Westat, a survey research firm will conduct the survey for CMS. If you are contacted by Westat for the survey, please participate. If you are contacted and you have questions regarding the survey, you may contact Westat at 888-863-3561. That telephone number again is 888-863-3561 or you may e-mail them at mpss@westat.com.

Next, I would like to discuss the Comprehensive Error Rate Testing or CERT. This is a process implemented by CMS to measure paid claims errors. The CERT program is not administered by CIGNA Government Services. CMS created a separate entity called the CERT contractor to carry out an independent quality review of processed claims.

Claims submitted to Medicare on a yearly basis are in the excess of two billion claims per year, and that's billion with a B. The CERT documentation contractor is responsible for requesting and receiving the medical record documentation from providers. The CERT documentation contractor randomly samples approximately 200 claims each month. The CERT documentation contractor or CDC will call the suppliers to provide information about the CERT program and advise of the documentation requests that are coming. They will answer questions about the process and advice of what steps will be taken.

CIGNA Government Services also has a CERT coordinator who will assist suppliers with complying with any CERT request. The CIGNA Government Services CERT coordinator is Judy Goins and she also makes the outreach calls to assist suppliers with these requests.

For that purpose, the CERT contractor randomly requests claim information and then reviews these claims using the following criteria. Does the item meet Medicare benefit categories? Is the

equipment statutorily excluded from coverage? Is the equipment medically necessary? Is the item coded and billed correctly? There are items that they will verify to ensure that the claims were paid appropriately.

If you receive a CERT request, it is very important to respond to those requests. If a supplier does not reply to a CERT request, an error against both the supplier and the contractor is recorded. CERT results are important to the suppliers, the contractors and CMS. Anytime a non-response occurs, an immediate denial decision is made, which results in a request for refund from the supplier if a claim had been paid originally.

Please note that providing information to the CERT contractor is not a violation of HIPAA standards. The CDC contractor is also a part of the Medicare claims system and, therefore, is legally authorized to request this information and the beneficiaries have consented to this as part of the claims payment process. This concludes the CERT section. I will now turn the call back over to Ronja Roland. She will discuss the Jurisdiction C, DME MAC upcoming events and the (Listserv).

Ronja Roland: Thank you, Dante. The Cigna government services Provider Outreach and Education team is excited about the educational opportunities we have in scheduled in 2008. Please make plans to participate in one or more of the following activities.

The Provider Outreach and Education team will participate in the Mississippi Association of Medical Equipment Suppliers on January 8, 2008 in Jackson, Mississippi. James Herren will be representing the Jurisdiction C DME MAC in Puerto Rico at the SEMA. That meeting will be held in January. I will be representing the Provider Outreach and Education team at the Mesa All-Star Conference in Austin, Texas February 27 through 29.

The DME MAC Provider Outreach and Education team is also working with the North Carolina Part B Outreach and Education team to conduct a joint workshop in Spring 2008. Please continue to visit the Education section of our web site for more information. To receive the most current news and Medicare update, please enroll on the Cigna government services Jurisdiction C Listserv. The process is very easy.

Just go to our web site at www.cignagovernmentservices.com/jc. Select the Listserv link, complete the form and click the submit button. Please make sure that your firewall is programmed to accept e-mails from CIGNA Government Services. We have identified that some firewalls will block at least some of the attributes as spam. This concludes the update portion of the 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, you may contact our provider contact center at 866-270-4909. If you wish to check claims status, you may call 866-238-9650. Again, we would like to take this opportunity to thank you for participating in today's call and we will now take your questions.

Operator: We will take our first question.

(Andrea Jones): Yes. We have two questions. We have a question about capped rentals, which is a maintenance and service part. What is the status of getting everything corrected because we're still getting erroneous denials?

Ronja Roland: OK. Let me just make sure I have your question correct. You have a question on the capped rental recoupments and you want to know the status of recoupments that were done incorrectly?

(Andrea Jones): No, it's not just recoupment. It's ongoing claims submission that are denying erroneously because they have been paid the full 15 months and we're sending all the documentation that's required or have sent at all, and they're still denying them even though they shouldn't be.

Ronja Roland: Did you request that through a re-opening or re-determination, or just submitted claims?

(Andrea Jones): Some – most of the claims were just submitted because they had been paid 15 months and we hadn't had any problems before we sent that. The maintenance and service were verifying 15 full months of payment before we sent the amount to the door now because we had so many that came back for recoupment for that reason. But we're having some of those. We're having some that we've sent through re-openings and those, I think, are in the works of being re-processed. The new claims submissions that we're having problems with because we have them paid full 15 months and we're getting (CO50) denials as well as, other capped rental denials with them for not being paid for 15 months when we have them.

Ronja Roland: OK. If you're indicating that you already had proof of the 15 paid months and you are getting maintenance and service denials, but you do have that proof. If we are denying your claims, option one in the article discussed on our web site titled "Maintenance and Servicing Denials" indicates that if there is proof of 15 months, that is when you would submit a re-opening request and you – I think I hear you said that the ones that you submitted to re-openings are in process. Are you indicating that re-opening requests that you received positive that they were completed, possibly are also denying, is that correct?

(Andrea Jones): Some of them are. What they're doing is denying them. We're using your form, and they're stating the beneficiary information was not on the form.

Ronja Roland: You completed the form with all of the beneficiary's information and we're rejecting your form, is that what you're saying?

(Andrea Jones): Yes.

(Samantha Coleman): This is (Samantha Coleman), the supervisor over the re-opening team. Can I get your name and your contact number because I would like to get some of those examples from you so I could follow up after the call with you?

(Andrea Jones): OK. That's great. My name is (Andrea Jones). And it's 423-624-8281 extension 3532.

(Samantha Coleman): OK. I will definitely follow up after the call with you, (Andrea).

Female: All right. The other question that we have is we do home infusion therapy here and we do a lot of antibiotic therapy with some new beneficiaries. We realized that for non-covered service and we bill to have their secondary pickup and pay. And the problem we're having now is we're billing for vancomycin, which is J3370, we're adding a GY modifier, making sure they know we are just looking for the denials. And they're coming back denied for no-CMN when it's a non-covered service. And it happened with one patient. I was worried it was a re-opening, then I reprocessed it and send it back there and it denied correctly. But now, I've had two other patients with several dates of service each doing the same thing, and they wouldn't want to look into systems. Now, all of a sudden the system is kicking out these strange denials on something that is non-covered.

(Ellen Edenfield): This is (Ellen Edenfield) from the Claims area and I will also give you a call. You're not (Andrea) though, are you?

Female: No, ma'am. We have three people in here.

(Ellen Edenfield): OK. And what is your name?

Female: My name is (Lisa).

(Ellen Edenfield): Same number different extension?

Female: Yes. It's 3506.

(Ellen Edenfield): OK. Because we do have instructions in place how those should be processed and it looks like something has gone wrong. So, I have to get some examples and see if I can track that down for you.

Female: OK. That will be lovely. That was it. Thank you.

Ronja Roland: Thank you.

Operator: We'll move on to our next question.

Female: Hello?

Ronja Roland: Go ahead.

Male: Yes, ma'am

Female: My name is (Diana), calling from Medical Equipment Distributors. We had a couple of questions regarding reopenings. We are concerned about the – reopenings and redeterminations – we're concerned about the 120-day time limit on the re-determinations. We are looking at our extension to adhere to the timeline. However, with the payer changing from Palmetto to CIGNA, the claims aren't being processed timely and they were having problems conveying to you all the

issues we're having with receivables. We've got two claims and one is at least denied in error, that's 170 days old. Do you understand my question?

Ronja Roland: Yes. I'm going to repeat it. you have a question about the redetermination. You're saying providers are required to submit within a certain time frame. However, they are not being processed within the specific time frame as indicated – the 120 days – and you currently have a specific example– it has been above 168 days.

Female: Yes. And then we have another one that's 150-day that were denied in error and these are ones that we were told from the customer service that it was denied in error.

(James Herren): And you have not filed your appeal. Is that your concern?

Female: No. We were not told to file an appeal. These are denied in error from CIGNA.

(James Herren): OK.

Female: And I was told not to do anything. That this would be processed. But if then, like I said, one is 100 and almost 70 days and one is 150 days. And that's a huge concern to us.

Ronja Roland: May I ask what the item or the code that was billed that ...

Female: K0823.

(James Herren): And what was the denial specifically for.

Female: It said it was same or similar. But it was not.

(James Herren): OK. And we have confirmed in speaking to customer service that this is in fact our error.

Female: Yes, sir. I mean we've got – I've got documentation of every person I've spoken with after you're last call, I even faxed some of these to (Dante Wynn) and she also confirmed that these were denied in error from CIGNA..

(Dante Wynn): You said your name is Diana?

Female: Yes.

(Dante Wynn): Hi, Diana. This is Dante. Let me go ahead and get your telephone number and take a look because if it was something that was denied in error, I need to take a look at it to see what exactly happened with it.

Female: OK. I'll be happy to give that to you. But I still don't understand. I mean we've already been through this with you and I'm going to do it again. But I just kind of feel like if it's out of your hands, what happens next? I mean we just keep – every time we call, they keep saying that it's still being adjusted. It's still being adjusted. And I've got every customer services person's name down that has told us that.

(Dante Winn): OK. (Diana), let me do some further research on this. So, I can go ahead and get your telephone number.

Female: Sure. 919-873-9168

(Dante Wynn): OK. Let me – let me give you a call back. And I'll take a look at it.

Female: OK. We have another question too.

(Dante Wynn): OK.

Female: We're having some concerns too with the crossover claims. We called EDI when – it shows some of the EOB that it is crossing over and we – and these are specifically Medicare-Medicaid crossovers. When we called Medicaid, they said there's no claim. But EDI says that – when we called the service line, they're saying they're all crossing over. And I didn't know whether there was something going on with Medicare that it is not crossing over or can you me with that.

(James Herren): What state are you in, ma'am?

Female: North Carolina.

(James Herren): Bear with us one moment.

Operator: And do you have any other questions?

Female: Yes, we do.

Ronja Roland: Yes. We aren't aware of any problems with not crossing to Medicaid. On your remit, is it giving the remark code that it has crossed?

Female: Yes.

Ronja Roland: At that point, if it actually showing on your remit that it crossed over, the error may be on the Medicare end. We actually crossed over the claim information. You may want to verify, with

the Medicaid office to make sure that your supplier number – all your information there is correct so that they can update their records.

Female: We have done that. They're saying that claim is on file when we talked to the customer service people there. They're saying it's coming over. So, we don't know whose error it is. Both Medicare and Medicaid are telling us it's not their problem. And, obviously, it's a problem for us.

Ronja Roland: You can also contact the coordination of benefits contractor, the COBC.

Female: Yes.

Ronja Roland: And they may be able to verify your information to make sure that it is also correct.

Female: OK. And do you have their phone number ?

Ronja Roland: We can get it for you.

(James Herren): We'll get you a phone number. And I'm also going to check on something, too. I think the beneficiary has to contact the COBC.

Female: All right, then.

(James Herren): I will get you that phone number and I'll also verify that information for you.

Ronja Roland: So, when (Dante) gets your call back, we'll have that information for you.

Female: All right. Another thing I have. I know you're all having problems and backlogs and that sort of thing – I have tried to call the re-opening line many, many times. And never have been able to

get through. In late, we have been trying to fax. Those faxes are rejected. So, of course, we're resulting into sending hard copies, which takes longer. When do you all anticipate that being a little better for us?

(Dante Wynn): As far as the telephone re-opening line ...We are actually adding additional staff. So, some time around late January, we should have that staff trained and available on that line.

Female: OK. You don't anticipate opening the lines longer during the day because a lot of times I'll call, units are also closed for lunch... Isn't there going to be an extended hours?

(Samantha Coleman): At this time, we are not ...

(Samantha Coleman): We are not required to have a set time frame on when those lines are available. It is an additional way for you to reach the re-opening team besides just doing it in writing or via fax. We are just giving those three options to you. So, I would encourage you, if you're not able to get through it at this time, just to continue sending those in either via fax or mail. And I'm absolutely aware of the busy signal that's part of our receiving with the fax machine. It is due to the high volume of faxes that we're actually receiving, which is causing that.

Female: OK. I will make some note there you say by the end of January, right?

(Samantha Coleman): we will add an additional staff, yes.

Female: I do have a question. Being in Region C, we were used to having our ombudsman and we now we don't. Is there anyone that if we cannot --to get any recourse? What do we do? I mean, is there somebody we can call? Is there any type of provider relations person that is willing to help us?

Ronja Roland: OK. Let me make sure I understood your question. with the previous contractor you had an ombudsman?

Female: Right.

Ronja Roland: One thing we do want to clarify, with the change to the DME MAC – the DME MAC contractors now must follow the requirements of change request 3376. In that change request, it actually shows a tiered approach to customer service.

Female: Right.

Ronja Roland: So, therefore, regardless of who would have won the contract, the ombudsman position would have been eliminated.

Female: OK.

Ronja Roland: There is, of course, your tier one, your tier two customer service, your provider relations, PRS specialists and then we do have a Provider Outreach and Education team. If you have a question or an issue that cannot be resolved through the appropriate tier or appropriate levels of expertise ...

Female: Yes.

Ronja Roland: At that point, that information will be forwarded, if it is an education issue, to the Provider Outreach and Education team. And then, you will receive a callback from one of the representatives in the Provider Outreach and Education.

Female: OK. Just one last question. Do you know what your turnaround time is on a (clean claim)? So, claim comes in electronically. How long does it take to get through your system?

Ronja Roland: We do have 30 days to process a clean claim.

Female: OK. So, and just to get back and I'm very anxious for you all to look at these couple of claims that we have. If they're denied in error and it is your error – then that seems like a long time to me. I mean, if it's 30 days, I have claims that are 170, 150 days.

Ronja Roland: We do apologize. And (Dante) is going to look into that and give you a callback. We do, however, need to allow other callers to ask their questions.

Female: Sure.

Ronja Roland: So, we appreciate your questions and you will hear back from Dante.

Female: OK. Thank you so much.

Ronja Roland: Thank you.

Operator: We'll move on to our next question.

(Candy Childers): Hello?

Ronja Roland: Yes. Go ahead.

(Candy Childers): Yes. My name is (Candy Childers) and I'm having trouble with trying to work on this CPAP masks. If they've had a CPAP and their 15 months has gone by and they get new masks,

tubing and head gear and we are billing for it and being denied. I'm not sure why they're denying it.

Ronja Roland: OK. Your question is that you are billing for a CPAP accessories or masks.

(Candy Childers): Right.

Ronja Roland: And you're getting a denial. one thing to remember with the CPAP accessories as well as the CPAP unit, the KX modifier is required. So, make sure that when you're looking at either your EOB or your claims submission that you are attaching)the KX modifier on that.

(Candy Childers): OK. And if they have had the CPAP for 15 months, then it should already – it should reflect the accessories, is that correct.

Ronja Roland: Yes, we will pay for the accessories on patient-owned equipment. So, if the patient rents or owns the CPAP and needs the accessories, it will be considered for payment. But, do remember to make sure that they do meet the requirements and the KX modifier is attached to the accessories.

(Candy Childers): OK. And then I have one other question. If you have a patient that's on oxygen, and they've been with a company for say, two years, and then they come over – they moved from another supplier and with the new guidelines of 36 months), do you – and we supply them with oxygen – do you start from the beginning or do you start from that 24 months and go to the 36 months.

Female: This is Ellen Edenfield. Start with the 24th month and you'll get the remainder of the 36.

(Candy Childers): OK. So you're only – so you're only going to get the – a year's worth of it.

Ellen Edenfield: Correct.

(Candy Childers): Excuse me?

Female: You're only going to get the remainder of the 36 months.

(Candy Childers): OK. That's what I thought. Thank you, ma'am.

Ronja Roland: Thank you.

Operator: We'll go to our next question.

Ronja Roland: Go ahead.

Female: Yes, ma'am. I'm billing enteral nutrition and I'm wondering how long are these appeals? I didn't hear the answer earlier. We're looking at how long for the appeals to be processed and paid? Is it still over 120 days?

(Debbie Elder): This is (Debbie Elder, re-determination supervisor, and we are currently just running over about 120 days for redetermination.

Female: Do we have hope in the future?

(Debbie Elder): We do. In fact, we are trained and on-production, we have reduced our inventory and, hopefully, you'll be seeing those requests processed quicker. And our inventory will be reviewed quicker.

Female: OK. Well, that's good to hear. So, will there be a notice on that like there was a moment ago when you all declared the wrong phone number for this telephone call?

(Ronja Roland): We do apologize for that. We, again, our sincerest apologies for the incorrect information for the call. As we conduct our upcoming outreach and ACT calls, we will continue to provide updates on the operational areas for CIGNA Government Services.

Female: OK.

Ronja Roland: Thank you.

Operator: We'll move on to our next participant.

Female: Yes, ma'am. Can you hear me?

Ronja Roland: Yes we can.

Female: OK. My name is (Janice), and my question is when a wheelchair and qualifying items are billed on the same date of service, why are the qualified items such as the batteries, the armrest, the footrest, things like that, being denied for no proof that the patient owns the equipment even though the chairs have been approved and paid for on the same date of service.

Ronja Roland: Let me make sure I have your question correct. You have a question that when you're submitting claims for mobility items and the accessories, and are being billed on the same date of service but the accessories are denying before the chair. Correct?

Female: Yes. And what it is, the chair is being paid for on the same date of service, but it's showing that the patient doesn't own the equipment.

Ronja Roland: OK.

Female: And so, we're not getting paid for things such as the batteries, the leg-rest, the armrest and things like that.

(Ellen Edenfield): This is Ellen again. And we did have an issue early on where if a chair came in with accessories and the accessories are processing before, what we call a dummy CMN is set up for the equipment. They were denying incorrectly. But we did put some corrections in the system to alleviate that. So, if you're still having that issue – are these current claims or ...

Female: Yes, ma'am. In fact, over the past week-and-a-half, I have probably called at least about 10 with the same problem that the batteries are being denied. They're showing that the patient doesn't own the equipment even though the patient actually owns the equipment.

(Ellen Edenfield): OK, (Janice), if I can get your number I will give you a call and see if I can get some examples.

Female: OK. It's 423-478-7433 and my extension is 1223.

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

Female: OK. Thank you very much (Ellen).

Ronja Roland: Thank you.

Operator: We'll go to our next question.

Female: Yes. Can you hear me?

Ronja Roland: Yes. We can.

Female: My question is – I have a couple of questions here. That if I am calling into IVR and their name has a Q or a Z in it, I am getting a message that it's an invalid ID and then we have to call Customer Service. Which takes a long time, and I'm just wondering if there's any solution to that.

Ronja Roland: Let me verify your question. You – when you're contacting the IVR and you have a beneficiary whose name has a Q or a Z ...

Female: Yes, ma'am.

Ronja Roland: It is saying that that is not valid?

Female: Yes, ma'am. And IVR is great, by the way.

Ronja Roland: Thank you.

(Tricia Luna): This is Tricia Luna. Let me give you a call and I'll research it because that should not be occurring the way that we have our name search setup. So, what's your name again?

Female: I'm calling for (Wilma Gutatas) and my number is 575-257-7174, and if you could call tomorrow, I would appreciate it.

(Trisha Lane): OK. I'll call you tomorrow then.

Follow-up response: The IVR is programmed to reflect the letter Q on the 7 key and the letter Z is on the 9 key.

Female: And then I have two other questions.

Ronja Roland: Go ahead.

Female: We're also having tremendous problems with crossover claims, particularly with AARP and we used to not have any problems with it. And I'm wondering if there is any specific problem with AARP because it just changed since – the news of the new contractor.

Ronja Roland: So your question is since the transition, you've been having problems with the crossover to AARP.

Female: Yes, ma'am. That's correct.

Ronja Roland: Once you receive your EOB, is it showing forwarded claim information at the bottom of that EOB – claim information?

Female: Yes, ma'am. And it's showing that it's been crossed over but it – we're just getting a denial from AARP on the secondary, saying that that person isn't a valid person. And we've had them on for quite a while.

Ronja Roland: OK. If this is actually shown on your remit and then AARP is saying that person is not valid, at that point, you may want to contact AARP. That seems like that is an error on their and not necessarily CIGNA Government Services.

Female: OK.

Ronja Roland: All right. Thank you.

Female: My last question is – I'm just wondering if it's going to be necessary with a reopening on every person that has a break in need. It used to not be that way and if they haven't had a break in need longer than 90 days, it was necessary. But it wasn't if it was less than 90 days. And I'm wondering if that really is necessary to stay with it that way. Because reopening are so time-consuming and they're backlogged.

Ronja Roland: OK. Let me make sure I have your question correct. You are questioning when there has been a break in need, submitting those for a reopening?

Female: Yes, ma'am.

Ronja Roland: You're following the appropriate process for that?

Female: Yes, ma'am.

(Ellen Edenfield): OK. This is (Ellen) again. And we do have a process in place for break in service.

Your claims should edit and if you will put that information in the narrative field that there is a break in service and when it ended, the things we need – as much as you can in the narrative – we have a special team that processes those claims.

Female: OK. So, we shouldn't have to go through reopening on that?

(Ellen Edenfield): Yes. They should be handled on the front end.

Female: OK. They haven't been, but thank you.

Ronja Roland: Thank you.

Female: Hopefully, they will be.

(Ellen Edenfield): That's right.

Ronja Roland: Thank you.

Operator: We'll move on to our next participant.

Ronja Roland: Go ahead.

(April Howard): Hello? This is April Howard DME here in Arkansas. And I have several inquiries.

Ronja Roland: Go ahead.

(April Howard): First of all, we have to wait almost two weeks for our remittance advice. You know, we get it electronically into our account, and we would like to know if there is a better way to find out that information earlier than waiting 10 days or more for our remittance advice. Do you know if there is anything available?

Ronja Roland: Let me verify your question. Your question is in regards to the claims, the have processed, and you're receiving the payment electronically. You just have not received the remit?

(April Howard): Right. We have to wait quite a while, you know, 10 to 20 days for that.

Ronja Roland: Let me ask this. Are you receiving your remittances electronically?

(April Howard): No, ma'am. How do I do that? I wasn't aware of that.

Ronja Roland: You were not aware of how to receive your remittances electronically?

(April Howard): No, ma'am.

Ronja Roland: OK. You can actually contact EDI. You may also go to their web site, which is palmettogba.com, and there should be a link for the JC EDI.

(April Howard): OK.

Ronja Roland: And their toll-free number is listed. But the information should be available on their web site.

(April Howard): OK. Another question I have is about these clients enrolling with another insurance, and they're not really aware of what they're doing. So, when I'm billing CIGNA Medicare for something and it gets denied, you know, I have to research these plans – these Medicare Advantage plans and addresses and phone numbers. And it takes up a lot of my time. And, you know, on your automated system, it says you can go to your web site, but when I get to your web site, it says temporarily unavailable or this is no longer available. So, is there an easier way to find out these different plans and addresses?

Ronja Roland: OK. Let me make sure I understood your question here.

Patients that have either updated or changed their insurance, they now may be Medicare advantage ...

(April Howard): Right.

Ronja Roland: You are trying to check their eligibility on the web site?

(April Howard): Well, no. I'll call the eligibility on the IVR.

Ronja Roland: OK. I'm sorry.

(April Howard): And it tells me, you know, they have an advantage plan and this is a contract member.

And if I would like the advantage plan's addresses and phone numbers, they're available at the web site. But when I logged on to the web site, they're no longer available.

(Tricia Luna): This is (Tricia Luna) and again let me check to make sure that that link is still valid because it goes out to the CMS web site.

(April Howard): OK.

(Trisha Lane): And I'll just verify on our web site if that link is still a valid link.

(April Howard): OK. Also, I have always known it to be true that we have to have an original doctor's signature on all orders when the Medicare is the primary payer. Is that still true or can we accept, you know, a fax or, you know, a photocopy signature or online signature or electronic, I mean.

Ronja Roland: I'm going to repeat your question. In regard to physician's order for a full – (DME) items, you want to know is a signature stamp, fax or copy accessible?

(April Howard): Right.

Ronja Roland: Yes it is. You can refer to chapter three of the Jurisdiction C Supplier Manual. And we recently –did a Webinar on documentation requirements. We will be repeating that in the upcoming year. So, again, you can refer to chapter three of the Jurisdiction C Support Manual.

That chapter is titled "Supplier Documentation requirements." And that information is available on the website.

(April Howard): I have one last question. It's regarding these power wheelchairs group two, three and four. We got a memo from TrustSolutions, Incorporated that now they will require a physical therapist and the physician is no longer – his order is no longer acceptable. And that's coming soon. I don't think we got it ...

Male: Not March. April 1st.

(April Howard): April 1, 2008. It's when that's going into effect. And I just want to make sure, you know, is that really going to happen or does that usually happen once they say it's going to happen. Because everyone we've spoken to, they have no idea of this – of this ruling.

(James Herren): Yes. we've seen the letter and it doesn't say that only a physical therapist or occupational therapist is going to be the one to write the order.

(James Herren): So, it's no. You can use a physical therapist or occupational therapist notes.

Female: That is not what that says. It says that it's an RSP or in that – and then they'd list an occupational or physical therapist has to evaluate him or a rehab physician and we're in a rural area and there's no way that you could have enough physical therapist to go out and evaluate someone and it's not clear if it's just the high-end wheelchairs or – which we don't sell – or just you know, a standard, you know ...

Male: Power chairs.

Female: We're not talking about scooter chair. We're talking about an electric chair. But it says that it – they would have to be evaluated by one of these people. It didn't matter what the doctor orders, it's – if he ordered it, they would still have to be evaluated by one of these people.

And it's supposed to go in effect April of '08. So we don't want to be sitting here, waiting and then get a memo. And when we try to find something about TrustSolutions, they referred us back to your phone number and your people said TrustSolutions disconnected their phone line and we could not get any information. So, we don't want to be sitting here, waiting until April, and then they're saying you have to have somebody.

Ronja Roland: We do appreciate your proactive approach. What we will do is research this a little further just to ensure that we are giving you the correct information. We are looking over that article as we speak. What we will do to ensure that everybody gets the correct information, we will include the answer in the minutes, which will be posted shortly after the call.

Female: But what is, you're looking at the memo. What's your take on it ma'am.

Ronja Roland: I'm really not at liberty to make that statement at this moment. We want to confirm that our take is the correct take. So, we will include that information in the minutes.

(James Herren): We can also – we can actually – we can discuss this with the Jurisdiction C Medical Director and just give you his opinion on this as well. And then will put that in the minutes.

Please refer to the Jurisdiction C website (www.cignagovernmentservices.com/jc). Under the section "Latest News" is the article titled "ATP Requirements." The article explains what requirements have been removed from the Power Mobility Devices LCD. The requirements that will be removed from the LCD, were scheduled to be implemented April 1, 2008.

Female: OK. In the (HMD) data reference book that I received – I receive quarterly updates – and the K0823 is the highest in wheelchair that we are dealing with at this time. And there were some contradictory information that states that this is a power – I mean a group two and then, you know, and then in another section it says that it's not a group 2. Could you tell me right now what the K0823 is considered? What group is it considered in?

Ronja Roland: OK. Your question or your comment is in regard to, I believe, a handbook that references the K0823 as a different group.

Female: Right.

Ronja Roland: Because that is not a publication that was produced by CIGNA Government Services, I cannot confirm any information in that particular handout.

Female: Right.

Ronja Roland: For coding issues, you can always go to the SADMERC web site. Which is through Palmetto GBA. They also have a product classification list.

Female: OK.

Ronja Roland: Where you can use the durable medical equipment coding system or DMECS online. You can actually put in the code and it will allow you to see the manufacturers and it should provide also the category. So, that would be your best reference as far as coding. We thank you for your questions. We're going to move on. Thank you.

Female: Thank you.

Operator: Moving on to our next participant.

Female: Hello?

Ronja Roland: Go ahead with your question.

Female: Hi. I'm calling from a DME Company. And, actually, I have two questions. The first question goes back to the recoupment of overpayments more than four years, and I understand that you all are going to go through a process and refund back those payments that are more than four years old. Is that correct?

Ronja Roland: That is correct.

Female: That is correct.

Female: OK. Now, once that has been resolved – if there are active claims out there – for those services, how are we handle moving forward on getting paid. Where – what is the conclusion on that? How would that be handled? I mean ...

Ronja Roland: OK. For the current maintenance and service claims, we would, again, refer you to the maintenance and servicing denial article on our web site under archived news and there are – if you have proof of the 15 months, then you may request the re-opening. If you do not have proof of the 15 payments, then you may request an extension of the rental ...

Ronja Roland: So, you would just go through either of those options, whichever applies to your situation. And that is how you would – you would fix even claims beyond the four years.

Female: OK. So in the event that you are – I have patient who we had to recoup – we had to initially – we give you all – we refund their payments – the services that happened, it's 2001 to 2002. Now, 2001 through 2003 is going to be refunded back to me. According to your information, Medicare had – did not have the 15 rental payments on file. So, now, you all are saying in order for us to continue the maintenance and servicing fees, we need to be able to provide to you guys 15 rental payments that have been made, and then we can take it from there.

If the 15 rental payments have not been made, do we start a new cap rental? Are we going to request for the remaining rentals to be added in there? And with the refund – with the refund of the payments that were made, are those going to be included in the rental payments?

Ronja Roland: OK. To answer your question, if there is not proof of 15 months, a new capped rental will not start. What you would do is to request an extension of the capped rental period and submit the remaining months and once we have the 15 months on file, at that point, six months from that 15th month the maintenance and services can resume.

Female: OK. My second question is, I understand that you all are indicating that you all are going to be calling the providers for calls – you all will be given providers office to call for information that could initially be found on the IVR while we get the information from the customers service rep? is that correct?

Ronja Roland: Let me make sure I understood your question. You are asking are we going to be contacting providers that can that can access information through the IVR?

Female: That is correct.

Ronja Roland: No, in that statement – I do apologize. We did make calls to providers that were heavy hitters to our call center to let them know that the IVR system is available to check claims status.

Female: OK. I think that was it.

Ronja Roland: OK. Thank you.

Female: Thank you.

Operator: Going to our next participant.

Ronja Roland: Go ahead with your question.

Female: This is (Theresa) with (Ascot) Medical, and I got a couple of questions. Are you there?

Ronja Roland: Yes, we are. Go ahead.

Female: OK. I'm sorry. We're having a problem. We have got two or three patients who either give us reasons like maybe he had a Workman's Comp claim or clerks that we were trying to supply with them with the things that do not pertain to that – that these were something that happened a long time ago. And we have several that had been working for, you know, two or three months trying to get this straightened out and they're still being told it's going to be 30 to 90 days for it to show the change that their Medicare is primary. Do you know why it's taking so long?

Ronja Roland: OK. Let me make sure I understand your question. You have some claims for patients that were originally under Workman's Comp or car accident, and Medicare is now primary, but that information is not updated?

Female: Correct. And one of my patients who is actually on the phone with Medicare, almost four-and-a-half hours about three weeks ago. And they told her it would take anywhere from 30 to 90 days,

and this is something that happened like earlier in the year. It has nothing to do with what we're trying to supply her with.

Ronja Roland: OK. What we're going to do – we're going to give you the information for the coordination of benefits contractor.

Female: Yes.

Ronja Roland: And their toll-free number is 800-999-1118 and the beneficiary will need to contact them.

Female: Well, that's the number we have been given ma'am. They have already been contacting Medicare through COB.

Ronja Roland: Are they – are they calling 1-800-Medicare or the actual COBC?

Female: I've been given the 999-1118. For instance, 101 is an (auto edit) but what we've been ordered by the physician is for diabetic testing supplies. It has nothing to do with that.

Ronja Roland: OK. We do apologize but, unfortunately, we cannot update those records.

(Ellen Edenfield): I will take it. This is (Ellen). As far as Medicare processing of those claims, if it's Workers' Comp, the liability or an (auto record), we do not normally deny those claims. We pay them conditionally, waiting for settlement of that accident or whatever it is. So, if you're getting denials from Medicare over Workers' Comp, then that's a totally separate issue. Are we denying your claims or is this secondary denial of claims?

Female: Medicare.

(Ellen Edenfield): Medicare DME contractor?

Female: Yes.

(Ellen Edenfield): Then, I'll need to get some examples. Because if it's Workers' Comp, that should not happen.

Female: OK. Is there a number I can reach you?

(Ellen Edenfield): I – Let me just get your number and I'll give you a call.

Female: OK. It is – excuse me – 591-372-4444.

(Ellen Edenfield): And your name is (Theresa).

Female: Yes, ma'am.

(Ellen Edenfield): Is there an extension?

Female: No, ma'am. Just ask for me.

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

Female: And I have another question.

Ronja Roland: Go ahead.

Female: A totally different thing. The question I have is can DME company lease bought supplies and equipments such as canes, walkers, chairs, diabetic supplies at a physician's location or clinic for them to issue to the patients and then send the appropriate paper work back to the DME company. They used to call it the supply closet.

Ronja Roland: OK. Your question is that can a medical equipment company leave equipment at a physician's office.

Female: Yes. Sort of...

Ronja Roland: OK. That is something we'll actually have to research. We can give you a call back about that as well. I believe you need to do a little further to see – to make sure that is something that is not acceptable.

Female: OK. Well, I know some time ago, it was frowned-upon but I could not find anything in writing and not that we're doing it, but you know, we know several in a kind of – well, it kind of corners the market, if you know what I mean.

Ronja Roland: OK. Thank you so much. For you, we will get that – we will research that information and get back to you.

Female: OK. Can I ask one last question?

(James Herren): We will put that – we will put also that in the minutes as well, so everyone else can get that answer as well.

[A provider may not leave any DMEPOS \(Durable Medical Equipment, Prosthetic, Orthotic and Supplies\) in the physician's office for dispensing to the beneficiary for home use. The provider must dispense all items directly to the beneficiary. Please refer](#)

to the Code of Federal Register section 424.57, which can be found on the CMS website at www.cms.hhs.gov. It is also noted in the DMEPOS Supplier Standards (#4), “A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order.”

Female: How cool! Thank you.

(James Herren): Thank you very much.

Ronja Roland: Thank you. We’re going to go ahead with the next question.

Female: Oh.

Ronja Roland: Oh, I apologize. Did you have one more question?

Operator: Moving on.

Female: Hi my name is (Roxanne) and I’m calling from a home infusion company and I had a question.

We’re having a really hard time getting our TPN claims paid correctly. I called in and talked to a senior leader regarding this and was told the matter would be referred to your Provider Relations area or to Research and someone would get back with me within 10 to 25 days. That was back in October, and I’ve never heard from anyone.

And in the meantime, we do send re-determinations on these and they’re coming back unfavorable. But, yet, in the explanation of the decision, it’s saying that you’re finding that the units that we’re billing can be covered as billed. But, yet, the decision are unfavorable and we’re

not getting the additional payments and I'm wondering if there's maybe someone on your team – in your claims or re-determination area that I could speak with to try and get this resolved.

Ronja Roland: OK. Let me make sure I understood your question. In regards to home infusion claims, you have had some that have been denied. You have sent them to re-determinations and the re-determination is coming back as unfavorable.

Female: Right.

Ronja Roland: Correct. OK. What we're going to do – as we do apologize that you have not received the callback. We will – we're going to take your name and your number and we'll have someone get some examples from you and we'll research that for you.

Female: Oh, that would be great. Thanks.

Ronja Roland: What's your number? You're name is Roxanne, correct?

Female: My name is Roxanne, yes, and my telephone number is 303-561-5034

Ronja Roland: Is there an extension?

Female: That's actually it.

Ronja Roland: OK. Thank you.

Female: Thank you very much.

Operator: Going to our next participant.

Female: Hi. This is (Crystal). I'm calling from a home care in San Antonio, Texas, and I have several questions. I'll start with – many times we send it hard copy of claims or re-determinations or different types of correspondents that are scanned in, but if there's an issue with the processing of those documents, the customer service representatives can't ever – they don't ever have access to view these documents and I was just wondering will that ever be resolved?

Ronja Roland: Let me make sure I have your question correct. When you're sending in hard copy documentation – whether it be claims submission, appeals or any correspondence – if there is a discrepancy? Or you have a question regarding that hard copy information. You're being told that the customer service associate cannot access that?

Female: Yes. That is correct. And then I say, well, if you can't, is there anyone else that can. And they would say, no. Nobody can.

Ronja Roland: OK. When that situation arises – we do apologize – a tier one customer service associate is unable to access that information. However, you can request a tier two representative and that – at that point, they can research on this issue with that.

Female: OK. And I'm sorry. May I ask who's speaking?

Ronja Roland: This is Ronja Roland.

Female: OK. My next question is concerning – I believe it was (Dante Wynn) that mentioned earlier that if we're putting the NPI and the legacy numbers on claims, that the information does need to match and they do need to crosswalk. My question is, if the information is not crosswalking, is it necessary to have the NPI currently on the claim? Can we just still have the legacy ID numbers?

Dante Wynn: Actually, you can, but it's still not going to avoid the crosswalk, we are verifying every claim against the crosswalk. So, even if you submit the claim with the legacy only, we will still view the crosswalk with that legacy number to verify that the correct NPI is linking to it. So, it's not necessarily what's on the claim that's causing the issue. There is probably a problem in the crosswalk. So, what you would want to do is to review your NPPES records to ensure that the correct legacy number is in your NPPES files and if you're not the person who can update those records, you would want to definitely get with the person who can.

Female: OK. My next question, if – can I ask another question?

Ronja Roland: Go ahead.

Female: OK. We have some claims where we do upgrades on claims and we used the modifiers – the GA, which indicates the (ABN) on the file. And then, the GK, which is the actual item or service used by the physician. But what happens is I'm getting the same or similar denials, and my suspicion is that they just – they are using their discretion in the claim. Are they not scrutinizing the claim enough? Because they're just denying all of those that we submit like that – the same or similar equipments against each other. Like, for example, if we gave a total electric bed, but what the doctor really ordered was a similar electric and the patient agreed to the upgrade, they're denying everything as same or similar equipment. And then, denying the total electric for not a covered benefit. We're using all the current modifiers.

(Ellen Edenfield): This is (Ellen). And what – if you're getting a same or similar denial it's not – it should not be – I'm not saying it's not – but it should not be because of you upgrade situations. It should be against another piece of equipment we have on file. So, if you're getting same or similar denials against the upgrades, the edits don't work like that. So, I would need to see some of those.

Female: OK. Well, I have several. But I should probably be a little more insistent with the customer service representative into finding out whether or not they're actually the same or similar equipments.

Ronja Roland: Right.

Female: OK. I had one more question, if I'm allowed.

Female: We do a lot of wheelchair cushion before with the previous carrier. We would just cut in the line note that the patient owned the manual wheelchair. But, now, the customer service representatives are instructing us throughout the manufacturing information, the date of purchase. And, yes, I was just wondering, I guess, provided I need to know that and where in the manual that it says that we have to obtain that information?

Ronja Roland: OK. Let me make sure I have your question correct. You're submitting clients for wheelchair cushions and you're sending with the previous contractor, you did not have to include any information about the patient owning a chair?

Female: No, we did have to put that the patient owned the manual wheelchair. But as far as the manufacturing and the date they purchased it and where they got it and how, well -- you know, just all -- I don't understand why we need all that.

James Herren: part of that -- for us as well is that, you know, there may be two chairs, for instance, on this beneficiary's record. One they received back in 1995, for instance, and then there is one they received in 2005. So, we need to know what chair you are providing a cushion for. For instance, whether the one you were providing in 1995, then we wouldn't be paying that claim. We will be denying the cushion. So, we do need to know the information on what chair you're providing this cushion for.

Ronja Roland: And what we can do – we can actually – if you – on our web site, we do have frequently asked questions, as well as this information will be included in the ACT call minutes.

Female: OK.

Ronja Roland: Thank you.

Female: Thank you.

Operator: Moving on to our next question.

Female: This is (Vicky). We have – we provide procedures that require span dates. And Medicare has recouped some of those services back because the patient's HMO went into effect during that time when the span dates were effective. I had to send those in to re-determination. Do you know how is that going to work? Do you know if Medicare only going to pay us up to before that HMO went into effect? And then, I have to bill the HMO for the rest of that?

Ronja Roland: OK. Let me make sure I have your question correct. You provide items that require span dates. You have billed the dates of service with span dates. However, you are getting recoupment for part of those – of that date of service because the patient is under an HMO?

Female: Actually, Medicare is recouped in the full amount because the patient HMO went into effect, saying that date of service was July of 2007 with the span date through October and the HMO went into effect September 1. Then Medicare recoups, all of my money. And, now, I have to send it in to redetermination so that I can at least get part of my payments back.

Ronja Roland: Let me ask you this. I do know we had a problem in reopenings where we were having claims that were HMO identified and we were recouping money that we should not have been. Are these things are still occurring currently with you right now?

Female: Yes, ma'am.

Samantha Coleman: Let me get your name and number, so we can resource those.

Samantha Coleman: Actually, those are contractor errors and you should not have to go through the re-determination department in order to get those corrected.

Female: Oh, God. Thanks.

Samantha Coleman: I would also want to continue to do education with the re-opening staff as well.

Female: Oh, fantastic. My phone number is 901-312-3150 extension 5187. And my name is (Vicky).

(Samantha Coleman): OK, (Vicky) this is (Samantha). I will give a call back so we can get that issue resolved for you.

Female: I appreciate it. Thank you.

(Samantha Coleman): Thank you.

Female: All right. Bye.

Operator: Going to our next participant.

Ronja Roland: Go ahead with your question.

Female: Hello?

Ronja Roland: Yes. Go ahead.

Female: Yes. This is (Lisa), and I have a question regarding denial, which is a CO18 duplicate denial.

And I was wondering if you could explain to me. I received this denial on a piece of – actually with a concentrator that I billed. When I actually called in to find out we never billed a duplicate claim, and then when I called, I spoke to a representative, I was told that our claim denied against the claims for the same date of service that was billed by another company in our area. And I was wondering why I got that denial as opposed to a same or similar denial.

Ronja Roland: Let me make sure I understood your question correctly. You received a duplicate denial, CO18, for an oxygen concentrator. When you contacted the provider contact center, you were told that another provider had billed for the same date of service?

Female: Yes.

(Ellen Edenfield): This is (Ellen). And, actually, those claims fall out in suspect duplicates, if the supplier numbers are not equal. And you really should have gotten a same or similar denial rather than a duplicate denial.

Female: Yes. Well, when I – that was my point because when I called in, the representative that I initially spoke told me that she could not send it back for just to have our records correct. So, she could not send it back to have the claim adjusted so that they would deny correctly, as same or similar. And I had to inadvertently ask for a tier two representative before I could get that claim sent back for reopening.

Female: Was the claim resolved for you?

Female: Well, the tier two representative sent it to re-opening to have it reviewed and re-processed ...

Female: They have. To deny correctly. But, initially, I was then told that I was going to have to submit it to re-opening myself, which I didn't agree with when this claim was denied incorrectly, in the first place.

Ronja Roland: Thank you. It sounds like it has been corrected. But we thank you for bringing that to our attention as well.

Female: OK. I do have another question. Also, I wanted to – just kind of a general question – because I wanted to know, when you do submit things to reopenings say, for example, when the CMN is missing or you don't have the CMN on file. I wanted to know when those claims are re-processed because they denied in error and once you receive the CMN. Do they automatically load the CMN if you submit the CMN to re-opening? Do they automatically reload those? Is that usually the standard procedure?

(Samantha Coleman): Yes. This is (Samantha). That would be correct. If your claims were denied for missing a CMN and you're submitting that to re-opening, we would load those CMN into our system and then the necessary adjustments on claims.

Female: OK. Well, see, I don't know if this is – if this is a (fluke) because I did receive a denial of such and I actually did receive a letter stating – acknowledging receipt of my re-opening request. The CMN was sent then and about two weeks later, I received another denial for the same reason, for the same claim. So, I didn't understand if the same didn't – wasn't loaded or -- I just couldn't understand what was going on. Because when I spoke to a representative on that particular

claim, I was told that the claim denied incorrectly. They were paying off of another CMN that was in the system from another company. It wasn't – I don't even believe that was our CMN.

(Debbie Elder): This is (Debbie), with redeterminations. You should not be getting acknowledgment letters on reopenings. You will be getting letters through redetermination. So are you sending these through redetermination?

Female: I did receive a letter. It might have been sent to redetermination because I did receive a letter stating that you were acknowledging that you have received this.

(Debbie Elder): And when we received your re-determination request, we will load that CMN and process it and pay it correctly -- whether paid or denied.

Female: OK.

Ronja Roland: Thank you.

Female: All right. Thank you.

Operator: Going on to our next question.

Ronja Roland: Go ahead.

Female: Hello?

Ronja Roland: Yes. Go ahead.

Female: Hi. Yes. My name is (Helen) from American home patient. I have a couple of questions. First, I need to find out about your CMN. We're getting a lot of oxygen CMN's that we submit claims on. And then, we would call in, they'll deny for no CMN. And then we'll call in, and then they'll say, "Well, now, your CMN is on file. You can re-submit the claims." So, we want to know what your process is for oxygen CMN's. How you load them, because all -- most of our claims are denying for no CMN.

Female: Are you submitting your CMN's electronically?

Female: Yes.

Female: Are they getting rejected?

Female: No.

Ellen Edenfield: Then, if you are sending the CMN, and it's not rejected and we are accepting it, then we shouldn't deny it for no CMN.

Female: Or we're getting denials -- they're saying they have no CMN but when we call in, they say, "Oh, we just loaded your CMN like a week ago. You can go ahead and re-file the claims now."

Ellen Edenfield: I can't explain how that happens unless it is like accounting issue, you have multiple claims, one has the CMN, one didn't. One got into the system first, and denied. And then, the second claim came in with the CMN. But once it's submitted and that claim did work, the CMN is loaded.

Female: OK. We have another question.

Ronja Roland: Go ahead.

Female: We're being told -- when we do our re-openings and we send them in, and we're being told, when we call in 130 days from the time we send them in, they're saying they're not on file. I'm to send them in again. That's what the representatives are telling us to do. And this is going on like two or three times, sometimes we're mailing redeterminations like, three times. And we call them (months) later because we follow up every 30 days, and they're still saying it's not on file and to send it in. I want to know why so many claims are denying in error. Is it a coincidence?

Ronja Roland: Let me ask this question. Are you receiving an acknowledgment letter for the re-determination?

Female: No.

Debbie Elder: This is (Debbie). I'm going to get your number. This is (Helen), correct?

Female: Yes.

(Debbie Elder): And give you a callback. I'll try and get some examples. Because if you sent those into us, we should have those on file. You should not have to re-submit those.

Female: OK. My number is 229-257-0075 extension 101.

(Debbie Elder): OK. This is (Debbie) and I'll give you a callback tomorrow.

Female: OK. We have one other question. We want to know why we're getting so many denials for claims that are denying in error. I mean, we have so many patients that are out there that we've submitted claims. And then, we call and they said, "Oh, it's denied in error." And then they give

us a confirmation number, and then two or three months later, that confirmation number is still open, and we're still not getting anywhere with these claims. When we called back, and the representative tells us that it was denied incorrectly. We need to re-submit that. That the (CMN) number was rejected.

(Debbie Elder): I'm sorry. We could not here the last part of that question.

Female: There are certain things that apply. What she's talking about. We would get a (DCN) number. And then, when we call back to check on it 30 days later, We're showing that the (DCN) number was denied or basically kicked out because it was keyed in error. You have to resend it – send that in for re-determinations. It would not be sent as (re-corrected) with the phone if it was due to a typing error on your (PIN) because it was supposed to be corrected over the phone at that time. And then starting over.

Ronja Roland: Let me ask this. Are you talking from the general customer service standpoint or re-opening?

Female: Customer service. For when we call, and they're telling us that's denied in error. They give us the (DCN) number and they tell us to (send) it up. Then, we called back. And then, I've been told on claims, "Well, that was keyed incorrectly. You're going to have to resend that." And, I mean, that's just, to me, it's – I ought to understand what's going on with that. Why they would start us back over. If it was keyed incorrectly per the person that gave us the (DCN) number to begin with.

Ronja Roland: Is this happening currently? Or was this some time ago?

Female: No, this is (being) current. This has been for within the last 30 days.

Ronja Roland: OK. I do apologize. What we would do – we do have your number. We would probably request a few examples from you once we give you a call to see what is going on with those and to research some of those (DCN's) as well.

Female: OK.

Ronja Roland: OK. Thank you.

Female: All right.

Operator: Going to our next question.

Ronja Roland: Go ahead.

Female: Hello?

Ronja Roland: Yes.

Female: Yes. This is (Darlene), and I work with Ashley Medical Equipment in Louisiana. We are – well, we finished an E0217 audit for the – what we call a water circulating heat pump. And asked the lady who was speaking earlier about not receiving the confirmation letters that you guys have received them. They need to give you my phone number as well.

(Debbie Elder): OK, Darlene. This is (Debbie). Go ahead.

Female: 318-220-7584.

(Debbie Elder): And do you have an extension or is that direct number?

Female: It's my direct line. And as this for re-determination where you have not received acknowledgment letters, correct?

Female: That's correct.

(Debbie Elder): OK. I'll give you a callback.

Female: And I have a couple of other concerns. We have a few patients that have been admitted into hospice who have rental equipments. And by the grace of God, they've been released. And we're getting denied as same or similar. And I'm wondering, we've even put narratives in and block 19 and I just need to know what else we can do.

Ronja Roland: OK. Let me make sure I understood your question. You have patients that have been released from hospice. But once they're out, your claims are denying same or similar?

Female: Yes.

Ellen Edenfield: Are you providing the same types of equipment you did before they went into hospice?

Female: Yes, ma'am. Not with the same serial number, obviously, because it's been claimed up and put out on another patient.

Ellen Edenfield: If it's the same code, it shouldn't be – oh, though, I have to see some examples of that.

Female: I understand.

Ellen Edenfield: OK. We do have your number and we'll get some examples from you on that as well

Female: OK. And I have one other question, if you have time?

Ronja Roland: OK.

Female: OK. On sales of walkers with seats, if we're – we have billed for routine labor for an hour, general wiring issues, the wheels needed to be changed, let's say tightening of the bolts and cleaning it and delivering back to the patient and we've been denied as it not being medically necessary. Is there anything – do I just need to go through the re-opening process to aver the same narrative as I did on my original claim?

Carolyn Helton: This is (Carolyn). When you are billing repair, you said it was a walker, is that correct?

Female: Yes, ma'am. With a seat.

Carolyn Helton: OK. And you were saying that you were repairing wiring.

Female: Well, actually, the brakes on it needed to be repaired.

Carolyn Helton: OK. So, when you're doing that labor, are you indicating that that's routine maintenance on that walker or there is something actually wrong with the walker that required you to make repairs to it.

Female: Routine maintenance. That would be maintenance, wouldn't it? Now, that you've made that clarification, that makes sense.

Carolyn Helton: OK. And routine maintenance is the beneficiary's responsibilities not covered by Medicare on that. So, if there was something wrong with the walker that required labor, you

would have to indicate that within your labor. It's -- what was actually broken on the walker why you did that labor. Because routine service is not covered.

Female: Wonderful. Thank you very much.

Female: Yes. Thanks.

Ronja Roland: Thank you.

Operator: Moving on to our next question.

Ronja Roland: Go ahead with your question.

Female: Yes. This is (Wanda) with (Home Oxygen Care). And I have a few questions. One of them is on the oxygen CMN.

Ronja Roland: All right.

Female: Hello.

Ronja Roland: Yes. Go ahead.

Female: Are you hearing me?

Ronja Roland: Yes.

Female: OK. On the oxygen CMN (inbox), can that be left blank if the order is for two liters? Because that's the question that applies to -- if it's four liters or more. Or does the physician's office send it to (NA).

Ronja Roland: Your question on the oxygen CMN question (six), can that be left blank?

Female: If the patient's order is for two liters.

Ronja Roland: Oh, if the physician only ordered two liters, not the four liters.

Female: Because that really is going to apply can it be left blank?

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

Female: Or do we need to send it back to the physician and have them (NA) it?

(Ellen Edenfield): I don't have a copy of the CMN in front of me but this question six, the question regarding if over four liters was prescribed?

Female: Yes.

(Ellen Edenfield): That's the information? Then, it doesn't apply to your claim and it can be left blank.

Female: OK. If it doesn't apply. OK. Just a general statement on the CMN. Somebody else just said earlier about the CMN not being on file -- we're having situations like the portable and concentrator denying but it's on the same CMN.

(Ellen Edenfield): This is (Ellen) and it could be that one of your CMN is getting in and one is not. Are you getting CMN rejects?

Female: If it's sent together up on a claim and it's sent electronically.

(Ellen Edenfield): Well, I'm not sure how your electronic format works but each of those items requires a CMN. It's the same CMN but they each require one.

Female: OK.

(Ellen Edenfield): And, normally, if one gets them autocopied. I not sure why you would get a CMN on one code and not the other.

Female: OK. We've had that happen several times so that

(Ellen Edenfield): OK, (Wanda), what is your number. And if you have an example for me, I'll see if I can trace it down.

Female: OK. Our number is 870-561-8424.

(Ellen Edenfield): OK.

Female: OK. And then I have a couple more of questions. On B code 4595, which is the suppliers for (TENS) unit, what is all-inclusive in that code? That's electrodes and the gel and the batteries or what specifics is it?

Ronja Roland: Your question is in regards to the A4595 of the (TENS). The (TENS) supply – you're questioning what is included in that code?

Female: Yes.

Ronja Roland: You can actually reference what is included in that code in the actual LCD for the TENS unit or you can also go to the SADMERC web site that I referenced earlier, and it will give a definition of what is included in that particular hit code.

Female: OK.

Ronja Roland: OK.

Female: But, one more. On batteries for powered wheelchairs that our patients own, will Medicare pay for replacement batteries for the wheelchair?

Ronja Roland: Yes.

Female: For the patient-owned equipment?

Ronja Roland: Yes. We will.

Female: And how often can they get new batteries?

The second part of your question is how often can they get batteries for the patient-owned chair.

Female: Yes, ma'am.

(Ellen Edenfield): This is (Ellen Edenfield) and there's not a written parameter for batteries that I'm aware of but as long as the medical necessity is there, if -- when batteries -- I mean, if it's no longer

working, you would have to replace it. It's not, like every year or two years, it's nothing like that.

It's based on the medical need of the patient.

Female: OK. And would we need a prescription from the doctor or how would the doctor know that their batteries are dead?

(Ellen Edenfield: You do not need an order for accessories.

Female: OK.

Ronja Roland: Thank you.

Female: We would just put in the narrative that it's patient-owned and battery is beyond repair.

(Ellen Edenfield): If Medicare did not pay for the wheelchair; you'll have to give us that wheelchair information.

Female: Yes. What type of chair, date of purchase.

Female: Right, so that you can reference it.

(Ellen Edenfield): That is correct.

Female: OK. All right.

Ronja Roland: Thank you.

Female: Thank you very much.

Ronja Roland: OK. We're going to take our last call.

Operator: Going to our last question.

Male: Hello?

Ronja Roland: Go ahead.

Male: Hi. My name is (Jim). I'll be real quick here. Processing of power wheelchair claims. If you have a signed ABN and capped rental modifiers. Of course, the software set up to only four. Per the Jurisdiction C, we should be using the over four modifier of 99 in the fourth modifier field, then putting the third and fourth modifier in the HAO record.

However, when you do that, and the two modifiers in the HAO record end up being the KX and the GA, then They are denied because they're not picking those two modifiers in the HAO. When I called I was informed, "That's not how we did it. That's how Palmetto did it." You don't use the 99 modifier and you end up only with the GA modifier in the HAO record. The claim will get paid but it'll be getting paid with a contractual obligation code. What is the correct procedure? We followed what was in writing and it didn't work.

(Ellen Edenfield): This is (Ellen), and these are our claims that you're talking about, right? Current claims?

Male: Yes.

(Ellen Edenfield): OK. So, we do have a special status that those claims go to and the instructions are that certain modifiers are required to process their claim and some of them we can manually the

information so that we can take care of that, like your VP modifier, and those like things. So, if they're leaving off the KX or GA, which is causing you to get an incorrect denial, then I need to see some of this.

Male: OK. I have seen just a few of those. We got them corrected. I mean, it's just that you have a manual that says it should be working. It's not working.

(Ellen Edenfield): I understand. You had them corrected. But I want to make sure we have our instructions corrected so it doesn't happen in the future.

Male: OK. I'll be quick because I know everybody wants to go. Walker claims.

(Ellen Edenfield): I'm sorry. We needed your – let me get your contact number before you go to your next question.

Male: 813-928-6101.

(James Herren): OK. Thank you.

Male: Walker claim.

Ronja Roland: OK.

Male: And most – not most – many beneficiaries don't want standard-issued wheeled walkers. They want the nice pretty one with the color in the basket and all. OK? We were selling these as an upgrade with the same HCPCS. And we even received a few letters for a while from TrustSolutions verifying the upgrade. Then, I was informed by the CSR, we couldn't bill those in upgrades because it was non assigned claim, we could not charge the beneficiary the difference

between the allowable and the price that we sold – sell the walker to the bank for. That doesn't sound right to me. We're using two line items. We're using GA on the first line items. We're using GK on the second line items.

Ronja Roland: OK. Let me make sure I have your question or concern. In regards to Walkers?– let me make sure I understand this correctly – the patient is requesting something different, correct?

Male: Correct.

Ronja Roland: OK. At that point, yes. We do apologize for the incorrect information given to you by the customer service associate but you can do that as an upgrade if the patient has chosen the upgrade.

Male: OK. And real quick. I'd like a clarification, please. In the past, we have been told that – OK – we're talking about a non-upgraded item. An item where the allowable is too low to -- for our cost. We told them to pass and we're non-par. We're not limited to charging beneficiaries on the allowable. Previously we've been (charged) with adding on par. If we want to do an upcharging on that because we need more than the allowable to cover the cost as long as we obtained a signed (ABN) from the customer. If they are acknowledging that Medicare doesn't pay for the difference between the price for selling and choosing for, and the allowable that we are OK. And I'm being told by CSR's we cannot upcharge any beneficiary for an item, even as a non-par. Can you clarify that, please?

Ronja Roland: OK. Let me make sure I understood your question correctly. On a non-upgraded item, you're saying you're charging the beneficiary an upcharge?

Male: Yes.

Ronja Roland: For example, let's use a power chair as an example. OK? Let's say that the allowable is roughly \$3,000. OK? And, really, we need \$3,500. The (bene) wants that chair, the (bene) we think the doctor the (bene) qualified for that chair. In the past we've been told you can charge that upcharge of \$500 as long as you have (ABN). Again, we're not doing this as an upgraded item because it's truly not an upgraded item.

(Ellen Edenfield): OK. This is (Ellen). And, number one, you should charge Medicare beneficiaries the same that you charge anybody else for that piece of equipment coming in your door.

Male: Yes.

(Ellen Edenfield): OK. If the beneficiaries agree that they would pay the difference between what Medicare allowed and what you submitted on the claims, you would have to get an advance beneficiary notice and this is signed by the beneficiary that says they will accept that.

Male: And that's what we've always done. But, again, I was told by two CSR's that they won't allow us to do that.

(Ellen Edenfield): Have you added the GA modifier to your claim and gotten a CO denial?

Male: I – well, this just came up recently. We've been – I have not had a problem in the past. We're getting the claims paid and we always, always, always gotten an (ABN) signed. You know, we don't – we don't want any surprises. We don't to want have any surprises. And, you know, we thought we were following correct protocol on these. And then I'd thought within the last 30 days, it said, "No, you cannot do that." And I'm going, "Wait a minute, something is very wrong here."

(Ellen Edenfield): OK. One thing we do want to suggest -- any time you're calling the customer service center or the provider contact center, we do ask that you always get the name of the associate

that you spoke with. In that way, when situations arise such as this, and you've been given a misinformation, we can actually go back and educate that associate properly.

Male: OK.

(Ellen Edenfield): So, do you have any names, that way we can make sure – or excuse me – we do have your contact number. If you have specific names, once we give you a callback, if you'll provide that to us.

Male: OK.

(Ellen Edenfield): So we can make sure that we are educating correctly.

Male: OK. And I'm going to second the first – the couple of people that you ((inaudible)) that fact that when you do call in – when an error has been made by the contractor on processing the claim, first level is ((inaudible)) but that's your problem. You have to resubmit or you have to present it to re-opening or re-determination. And I'd like, like everyone else, if the contractor is making the error, I'd like to see the contractor correct the error and not put the resolution on the supplier. We just had that happen on our power wheelchair, denied as an M3. It was eight prior. CSR admitted, "Yes, that was our mistake. But that's your problem." You know, so, if you folks could address that, that would make a lot of us more happy.

Ronja Roland: OK.

(Ellen Edenfield): OK.

Male: I appreciate your time. Thank you.

(Ellen Edenfield): Thank you, (Jim). Actually, if it is a carrier error, you would report that to the customer service department. They would verify that it is carrier error. Once it is verified that it is carrier error it will then be processed – it will then be forwarded to the appropriate department for correction. So, we will take care of those items that are carrier error. And you want to make sure that you do obtain a confirmation number from the CSR and/or the tier two or (PRS), whomever it is that you are speaking with.

Ronja Roland: And with that, we thank you again for attending Cigna Government Services ACT Call. Please be sure to check our web site for upcoming ACT calls, Webinars, or any educational events. Again, thank you for your attendance.

Operator: And that concludes today's conference. We thank you for your participation and wish you a wonderful day.

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