WMGMA Medicare/Medicaid Workgroup
March 13, 2006

MEDICARE

Marshfield Clinic:

1. When can we expect to have access to an updated list of the CPT codes that do allow unit billing or the CPT codes that do not allow unit billing? I've been told that the last one published isn't correct any longer and that the only way to find out is to call on each individual code.

   Answer: WPS has decided not to republish this list due to the frequency of change to the information. The best way to determine if a code can be quantity billed is to reference past experience with that code or call customer service at 866-359-1599. Medicare Customer Service Representatives will be able to tell you if a particular code can be quantity billed.

2. Is there any update on Medicare coverage of the new psychiatric testing codes and neuropsychiatric testing codes 96102, 96103, 96119 and 96120?

   Answer: The medical policy staff confirms that Wisconsin Physicians Service (WPS) Medicare does not cover CPT code 96102, 96103, 96119 and 96120. WPS Medicare published an article in the January 2006 Communiqué addressing CPT codes 96102, 96103, 96119 and 96120. The article states that WPS Medicare would deny these codes until WPS Medicare receives contrary directions from the Centers for Medicare & Medicaid Services (CMS). WPS Medicare has not received any information from CMS regarding coverage of the psychiatric and neuropsychiatric testing performed by a technician or using a computer. CMS central office is reviewing the issue. When WPS Medicare receives a response, the information will be placed on the WPS Website and publish in the Communiqué. Please refer to the WPS Medicare Local Coverage Determination (LCD) PSYCH-014 for moreinformation on these guidelines at: http://www.wpsmedicare.com/policies/illinois/psych014.pdf

3. CPT has new codes for orthotic and prosthetic management. (97760 – 97762) It appears these codes can be covered when provided by a physical therapist or an occupational therapist. Does Medicare intend to provide coverage for the services performed by an orthotist or prosthetist to determine what item is the most appropriate for a patient, or to provide extended training in the use of the item? Can this be covered incident to a physician?

   Answer: Therapy services, meeting all the therapy benefit criteria, performed by a physicians/NPPs qualified auxiliary personnel (staff who may or may not be licensed as therapists who meet all the requirements of a therapist with the exception of licensure) under the physicians/NPPs direct supervision should not be thought of as "incident to" services but separate Physician's Services, (services paid under the physicians fee schedule) that may be billed to Medicare by the supervising physician, depending on the qualified auxiliary personnel's licensure.

   Qualified Personnel is defined as staff (employee/auxiliary personnel) that have been educated and trained as occupational/physical therapists or therapist assistant, meet all the requirement for therapists but may or may not be a licensed as therapist, and qualify to furnish therapy services under direct supervision of a physician, NPP or therapist.

4. Where can we access the Medicare Part D eligibility information for our patients? Is it available through a batch eligibility query?

   Answer: To be eligible for Part D and to enroll in a PDP, an individual must be entitled to Medicare Part A or enrolled in Part B, and must be entitled to Medicare Part A or Part B benefits as of the effective date of coverage under the PDP. In general, an individual is eligible to enroll in a Medicare prescription drug plan (PDP) if:

   - *The individual is entitled to Medicare Part A and/or enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and/or Part B as of the effective date of coverage under the plan; <u>and</u>*

   - *The individual permanently resides in the service area of a PDP.*

   The HIPAA compliant 270/271 provides health care eligibility inquiries and responses on a real-time basis. Information on receiving eligibility information through an electronic transaction can be located at: http://www.cms.hhs.gov/ElectronicBillingEDITrans/09_Eligibility.asp#TopOfPage

5. A Medicare patient is scheduled for chemotherapy and we prepare two bags of drugs for the patient, but during the administration of the first bag, the patient has a reaction. We understand that Medicare would intend to cover the remainder or the first bag because it is "wasted" and cannot be reused for another patient. Does Medicare also intend to cover the second bag, which has not been used during the chemo administration, but was mixed specifically for the patient and can't be used for anyone else?

   Answer: If one vial of the chemotherapy drug is opened and put into 2 different bags then we would pay for the one vial of chemo agent. However, if one vial is placed in one bag and then a second vial is opened and placed in a second bag, we would not pay for the second vial since it should not have been mixed until the first bag was infused.

6. In the information published regarding the changes to the appeals process, we are told that we can request a claim reopening for minor errors, clerical errors and omissions. Can you provide examples of the types of things that can be handled through the reopening process?

   Answer: We are unable to provide examples. When the call is placed to WPS Medicare appeals the representative will determine if the reopen is able to be done, if not they will instruct them how to proceed with the appeal.

7. In September we submitted a question for the WMGMA meeting relating to billing for a biopsy on the same day as a MOHS procedure. The answer indicated it was billable if it was performed on a separate lesion and a 59 modifier should be added. One of our providers would like clarification on wording in the policy that indicates it can be covered if it is a different operative session. Could you please tell me what Medicare would consider a separate operative session for Mohs procedures?

   Answer: Policy DERM-004 indicates the following:
   If a skin biopsy is performed on the same day the Mohs' surgery was performed, the physician's documentation should clearly indicate:

   - *the biopsy was performed on a lesion other than the lesion in which the Mohs' surgery was performed*

~ OR ~

- *if the biopsy is performed on the same lesion in which the Mohs' surgery is performed, the biopsy is performed during an operative session separate from the Mohs' surgery.*

The definition of an operative session is a patient enters an operating room, the scheduled procedure is performed, and the patient is removed or leaves.

8. There is a new code assigned for additional physician services required for Power Mobility Device Assessment (G0372). Some of the information I've seen indicates it is an add-on code, to be used in addition to the E&M service for the actual evaluation. Does this mean G0372 must be on the same claim as the E&M? Providing the supplier with information will probably be done some time after the actual evaluation, it might be close to the 30 day limit. If we had to put it on the same claim, we would have to hold the E&M claim until the supplier requests the documentation. It doesn't seem like that would be the intent of indicating it is an add-on code, but rather to inform providers that it can be billed in addition to the E&M.

   Answer: G0372 is an add-on code for the E&M service and should be billed on the same date of service. It is not required however, to be on the same claim submission. G0372 must be billed after the PMD supplier has received the prescription. G0372 can be payable if the E&M service has already been billed on a previous submission.

   Medlearn Matters article MM4121 indicates the following:

   The new G code is only payable if all of the information necessary to document the PMD prescription is included in the medical record after a face-to-face examination of the beneficiary, and the prescription is received by the PMD supplier within 30 days after the face-to-face examination.

9. The Medicare Carrier's Manual contains a section regarding the Electronic Data Interchange enrollment form that indicates that by signing the EDI enrollment form the provider agrees that it will ensure that every electronic entry can be readily associated with the original source document. It goes on to indicate that the Secretary of Health and human Services or his/her designee or the contractor has the right to audit and confirm information submitted by the provider and shall have access to the original source documents and medical records related to the provider's submission, including the beneficiary's authorization and signature.

   Since the government is promoting conversion to EMR and other electronic media, can you tell me if they allow providers to use scanned documents to satisfy the "original source document" requirements?

   Answer: We understand that this is a complicated area. It is the feeling or WPS Medicare EDI staff that this question would have to be answered by legal staff of the specific entities concerned about it.

UWMF:

10. Regarding billing for a Preventive Medicine visit and a medically necessary visit on the same day, the WPS/Medicare website information appears contradictory. Question number 12 in the Evaluation and Management (E&M) section of the Frequently Asked Questions (FAQs) page (linked from the Provider Education page) addresses this situation. It instructs providers to subtract the <u>Medicare</u>

allowed amount for the medically necessary visit from the provider's usual fee for the preventive service. It goes on to reference NCP PHYS-001 "for more information", but both PHYS-001 (section G, #3) and IOM 100-4 (Ch 12, section 30.6.2) clearly state that the reductions should be based on "…his/her current established charge for the covered visit". Nowhere in either does it refer to the Medicare allowed amount or the amount the provider usually accepts, or any other terminology that would imply the use of that amount. Please be so kind as to specify which covered services (medically necessary E&M, G0101, G0102, Q0091?) must be "carved-out" of a preventative visit and whether these reductions to the Preventive Medicine fee should be at our usual fee, or the Medicare allowed amount.

Answer: Due to the number of questions we receive regarding the amount to charge for carve out services, WPS staff sought and received clarification from CMS.

- *First, select the most appropriate code for the preventative (routine/physical visit) visit (codes 99381-99387 or 99391-99397).*
- *Next, select the most appropriate Evaluation and Management (E&M) code for the medically necessary portion of the visit.*
- *Subtract the appropriate Medicare Allowed Amount for the medically necessary E&M visit from your charge for the preventive exam.*
- *The remaining balance is what you will charge for this portion of the exam. This portion will be a "non-covered" service.*

The provider can bill the beneficiary for the deductibles, co-pays and non-covered portion of the visit. CCI edits bundle G0102 into all E & M codes except preventive medicine services. Modifier 25 will not allow payment of G0102 with any non-preventive Evaluation and Management code. This is only the case with G0102.

All deductibles and co-pays still apply for those services that are covered by Medicare with the following exceptions:

- *HCPCS G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) and G0102 (Prostate cancer screening; digital rectal examination). For these services, the deductible, **but not the coinsurance**, is waived.*
- *HCPCS code Q0091 (Screening papanicolaou smear; obtaining, preparing and conveyance of the cervical or vaginal smear to the laboratory). The Pap test, itself, is a clinical laboratory service, and, therefore, is subject to section 1833 of the Act, which requires 100% reimbursement. As the coinsurance applies to HCPCS Q0091 (handling of the specimen) but not to the actual test, the provider may bill the patient for the coinsurance for Q0091.*
- *Actual lab tests HCPCS G0103 (PSA), P3000/30001 (Pap smear) and G0107(Fecal-occult blood) have neither deductible nor coinsurance applied.*
- *Pages 116-118 of the General Medicare book address this issue in detail. The book is located at: http://www.wpsmedicare.com/provider/pdfs/general_medicare.pdf*

11. What is the status of code 90714 (Decavac)? The January Communiqué contains notice of revisions to LCD ALRG-003, including the addition of 90714 for Decavac preservative free tetanus and diphtheria toxoids effective for use on July 1 2005. We have continued to receive denials as "code not effective on DOS" for services. For service dates after 12/31/05 we have received requests (ADRs) asking for invoice copies. Will 90714 claims for services between 07/01/05 and 12/31/05 be processed? Will we be required to wait for ADRs and submit invoices? Will 90714 be in the April ASP file, and if it is, will that pricing only be applied for DOS 4/1/06 and later?

Answer: According to the fee schedule, this code is effective for services 01/01/2006 and after. We anticipate that this time frame will change and be retroactive back to 07/01/2005. Until we can notify you otherwise, please hold claims for 2005. If you have received denials, the claims can be resubmitted at a later date if and when the fee schedule is updated. We apologize for any inconvenience this has caused. The tetanus/diphtheria injection is subject to rules outlined in policy ALRG 003.

12. Our Compliance staff has questioned the instruction in GI-008 that tells providers to bill certain lower GI scopes as "*the appropriate diagnostic procedure*" if a lesion or growth is found, and removed or biopsied, during a procedure which had been begun as a screening. While it seems appropriate to bill the procedure code for the service which was actually performed, as opposed to that which had been planned, diagnosis coding for this situation is not discussed. We would presume that such a service would be adjudicated under the GI-006 guidelines and edits, based on the diagnostic procedure code used to replace the screening procedure code.

    At issue is instruction from the AHA's "Coding Clinic" publication, which, as a designated adjunct to "Official ICD-9-CM Guidelines for Coding and Reporting ", is considered part of the authoritative instruction for use of the ICD-9 code set under HIPAA guidelines. Based on the following excerpt, it appears that in this situation we would be required under HIPAA to use a screening diagnosis as the primary linked diagnosis for the diagnostic procedure.

    "Coding Clinic, First Quarter 2004 Page: 11 to 12 Effective with discharges: April 20, 2004
    Question:
    Coding Clinic, Fourth Quarter 2001 advises the assignment of code V76.51, Special screening for malignant neoplasms, Colon, as the first-listed code when a patient with no personal history of gastrointestinal disease and no signs and symptoms has a screening colonoscopy performed that reveals a polyp. Is the code assignment different when the polyp is removed during a screening colonoscopy? It would seem that when a condition is found and treated, the procedure becomes a definitive procedure and is no longer a screening test.

    Answer:
    Whenever a screening examination is performed, the screening code is the first-listed code. The fact that the test is a screening examination remains, regardless of the findings or any procedure that is performed as a result of the findings.
    A screening is the testing for disease or disease precursors in a seemingly well individual so that early detection and treatment can be provided for those who test positive for the disease. The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test. A screening code may be a first listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done during an office visit for other health problems. Should a condition be discovered during the screening then the code for the condition may be assigned as an additional diagnosis."

    If WPS/Medicare processes a claim for a diagnostic colonoscopy with biopsy (e.g. 45380) with a primary linked diagnosis code of V76.51, will the secondary diagnosis link (e.g. 211.3) be considered when deciding whether the service may be allowed?

    Answer: Yes we would consider 211.3 when paying the claim. (Policy GI-008)

13. For 2006, CMS has made changes to HCPCS descriptions of units of service for some drugs. For example, code A9502 (Myoview) has become "Technetium Tc-99m tetrofosmin, diagnostic, **per study dose, up to 40 millicuries".** In 2005, this same code was described as "supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m tetrofosmin, **per unit dose**." What is the significance of this change, especially the phrase "per study dose"? If a patient is dosed with (less than 40 millicuries) of this drug and two studies are done, would that be two units of service? What about if the patient is dosed for an at rest study, and again prior to an induced-stress study?

    Answer: Since the code says per study dose, up to 40 millicuries … if they use 20 millicuries for one test and another 15 for the other test then only one unit of A9502 should be billed to us since code states it is up to 40 millicuries. (Beth Scanlon). The drug should be sent to WPS Medicare in the increments used. Each 40 millicuries will be billed separately and only as 1 unit.

    If the provider is splitting the 40 millicuries between 2 patients we are not sure how this will be handled. Pricing for this drug has not yet been finalized. We may do a manual price and do a break down. More information on this is to come.

Prevea Clinic:

14. For Medicare patients, can a PT on site supervise a COTA or does the supervision need to be an OT?

    Answer: Per NCP PHYSMED-001 Section I A Qualified Professional states:

    … Qualified professionals may also include physical therapist assistance (PTA) and occupational therapy assistants (OTA) when working under the supervision of a qualified therapist, within the scope of practice allowed by state law. Assistants may not supervise others.

    A PT can supervise an OTA providing state law allows the PT to perform the service.

15. For NPI numbers, there is indication that they will have an electronic capability of sending the information on group providers versus doing individuals for groups sometime this summer. Is that correct?

    Answer: The latest information released states late spring to early summer of 2006. The Newest information on NPI is located on the CMS Website http://www.cms.hhs.gov/NationalProvIdentStand/01_Overview.asp#TopOfPage.

16. August 2005 Communique: ABN - clarification on date of service. Can we list several dates of service on ABN for lab tests? Example: 1/5/06, 3/15/06, 6/7/06 for lab tests that a provider would like tested every 3 months?

    Answer: There are two parts to this answer. First, it will depend on the physician's orders. If the physician orders the services as a series, then it would be appropriate to include them on a single ABN. Second, an ABN cannot cover a time span larger than a year. If the series will continue beyond a year from the signature a new ABN is needed.

17. What criteria do you utilize when auditing by the 1995 guidelines for the exam? It is clear that one organ system is focused and that 8 organ systems would be comprehensive, but there is not a very clear delineation between and expanded and a detailed exam. Several organizations state that

"industry standard" would apply the 2-4 for expanded and 5-7 systems for detailed, but that is only "their" interpretation, so how would Medicare interpret expanded and detailed exam?
Answer: The standard by which Evaluation and Management services should be coded are the 1995 and the 1997 guidelines for E/M coding. These guidelines can be found in Chapter 6 of the Medicare resident and New Physician Guide (7th edition), which can be obtained from the CMS website. Medicare would interpret "expanded" and "detailed" examinations as they are described in the 1995 and 1997 guidelines, and documented E/M services must meet the guidelines' criteria.

The 1995 Guidelines describe a detailed examination as "Detailed--an extended examination of the affected body area(s) and other symptomatic or related organ system(s)".

The 1997 Guidelines for the general multi-system examination state "Detailed Examination-should include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet is expected. Alternatively, a detailed examination may include performance and documentation of at least twelve elements identified by a bullet in two or more organ systems or body areas".

18. Would Medicare allow using the status of 3 chronic conditions from the 1997 guidelines with the 1995 exam guidelines?

    Answer: We are able to use the three chronic conditions for both 1995 and 1997 guidelines. The assumption is that it would carry over.

19. Medicare Approved Facilities for Cpt Codes - recently received a denial (CPT Code 33979 ICN 2205354379220) and was unaware the procedure/procedures needed to be performed at a specific facility. Is there a way to find out all approved facilities for a procedure or which procedures require a facility to be approved prior to performing the services?

Answer: IOM 100-3 Chapter 1 Part 1 Section 20.9 indicates the facility requirements for this procedure. There is a list of the approved facilities on the CMS Website at: http://new.cms.hhs.gov/MedicareApprovedFacilitie/VAD/list.asp

Agnesian Healthcare:

20. Do you know the status of the surrogate UPIN number OTH000? I thought it was mentioned on the last physician open door forum that the status of this number was unknown, possibly won't be eliminated in April.

    Answer: CR 4177 indicates that the surrogate UPIN OTH000 will not be accepted for dates of service after April 1, 2006. The exceptions to this are claims submitted by the beneficiary and mass immunizations. Medlearn Matters Article MM4177 details this change.

    http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4177.pdf

Mile Bluff:

21. Medicare Remit Easy Print: We would love to use this function, but cannot. Because we use a clearinghouse for our electronic remits and because they reformat them before sending them to our computer vendor and into our clinical software program, we cannot dump or download the reformatted remit file into the desktop holding the Easy Print software. Currently we are trying to work with our software vendor to somehow get the true electronic file sent to us before it is

reformatted. Are other clinics using clearinghouses having this problem? Is Medicare intending to do anything about this?

Answer: The information that is being transmitted between a provider and a clearing-house is not under Medicare's control. The provider and clearinghouse agreement will indicate what information being communicated.

22. Are branch clinics considered a subparts under the NPI system? Currently, we have a Medicare Provider Number for our main Clinic (group) and a Medicare Provider Number for our branch Clinic (same group). I would think we would have a NPI for each of our clinics. Is there a difference in a number for a Subpart than a number for a group/branch clinic? Perhaps, WPS cannot answer this. What experience do other clinics have in getting group NPI numbers?

    Answer: The answer on subparts is not a clear cut case. CMS has provided the following paper to help providers determine if the subparts within the organization need a NPI. WPS can not give you direct guidelines to follow as CMS has not supplied them to WPS.

    http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Medsubparts01252006.pdf

Dean/St. Mary's:

23. After months of waiting for a response, we just lost the person in our organization that was researching this issue. I understand if the request cannot be accommodated, but we would really like to know what procedure code should be used when billing the endoscopic Harvesting of Upper Extremity Artery. The open procedure is defined as procedure 35600 and I believe this is what Medicare and Medicaid would like to see. However, both the description and illustration of the 35600 only describe the open procedure. We have been reimbursed by Medicare when submitting procedure code 33999 along with the medical notes at the allowable rate assigned to 35600.

    Answer: 35600 states it is the open procurement of the artery, so it should only be billed if the procedure is performed that way. The endoscopic procedure should be billed the NOC code 33999 and will be price accordingly.

Gundersen Lutheran:

24. Q9957 is a per cc code, but Definity is a 1.5cc vial. How would you like to see this on a claim?

    Answer: Based on our research, Definity is only available in a 2ml unit dose, meaning 2ml of drug per vial. Further information might be required to see how one arrived at the 1.5 cc amount to really make an informed determination on that.

    We have looked at the Redbook, Definity package insert and CMS website and these sources all indicate that Definity comes in a unit does of 2ml per each glass vial. The volume may be 1.5 cc, but the information indicates that the vial contains 2 ml of drug. That 2ml unit dose is the criterion that was used to establish the fee. We verified this by looking at the ASP files on the CMS website. There is one file that gives the pricing and another that provides the back up sources that CMS used to determine the fee. The ASP files can be found at the following location:

    http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/02_aspfiles.asp#TopOfPage

    The CMS sources indicates the fee for Definity is based on 1 ml of drug so to bill the entire 2ml vial, they would need bill 2 services in the units field. Call Placed to Gunderson Lutheran on 3-1-06

25. If this does result in being eliminated, Gundersen Lutheran gets referrals from a very large number of providers who are dentists who do NOT have a UPIN. In many of those cases, our dental specialists provide consults and treatments for conditions/diseases that are covered by Medicare. How would we report this type of referring provider for the services requiring UPINs?

    Answer: At this time WPS Medicare does not have the final answer for providers who are not required to get a UPIN. Please watch our Website for further information on this topic.

MEDICAID

Dean/St. Mary's:

1. Our podiatrists bill Medicaid for fracture care using 2830 thru 28470 and then supply the patient with a foam walking splint (L4360). Our coding staff has indicated to us that supplies are over and above the global fee for fracture care and that we can bill for those separately. We would like to know how we should bill for the supply. Right now we are not recognized by you to dispense DME.

   Answer: Podiatrists cannot be directly reimbursed for DME/DMS codes unless they get a separate medical vendor provider number. They can be reimbursed for the cast supply procedure codes in the Q4001 – Q4051 series without receiving a separate provider billing number.

Marshfield Clinic:

2. Can you tell us what the plans are for keeping providers appraised of your plans for the new Medicaid processing systems?

   Answer: Wisconsin Medicaid is still in the process of developing the new claims processing system, so any training or informational materials would be premature at this time. When details are more final, there will be numerous special Update publications describing the new system and its impact on providers. There will also be provider training sessions that will be announced sometime this summer.

   To assure that relevant and timely information gets out to providers, Wisconsin Medicaid will be working closely with the industry associations. We will be scheduling meetings with those groups in the next few months.

3. Our Obstetrics Department is seeking approval for coverage of items and services related to the off-label use of misoprostal as a means of treating women for early pregnancy failure in lieu of D&C.

   This request is based upon recent literature that has concluded the treatment of early pregnancy failure with misoprostal vaginally is a safe and acceptable approach with a success rate of approximately 84%.

References:

- A Comparison of Medical Management with Misoprostol and Surgical Management for Early Pregnancy Failure; Jun Zhang, Ph.D.; N Engl J Med, 353; 8, pages 761 - 769
  http://content.nejm.org/cgi/reprint/353/8/761.pdf

- Pregnancy Failure and Misoprostol - Time for a Change (editorial); Beverly Winikoff, M.D.; N Engl J Med, 353; 8, pages 834 - 836
  http://content.nejm.org/cgi/reprint/353/8/834.pdf

- Medical vs. Surgical Management of Early pregnancy Failure (correspondences); N Engl J Med, 353; 22, pages 2403 - 2404
  http://content.nejm.org/cgi/reprint/353/22/2403.pdf

Will WI Medicaid cover misoprostal for treatment of early pregnancy failure?

Answer: Non-label use of misoprostol requires prior authorization and is reviewed on a case-by-case basis. The current approved uses are for abortions (under the S-codes based on standard abortion policy) and as an antirheumatic.

4. The Physician's Handbook indicates a prescription from a physician or physician's assistant is required for coverage of DME or DMS items. Can these items be prescribed by an NP or CNS and be considered for coverage?

   Answer: If it is within their licensure and scope of practice, a prescription by these providers is acceptable.

5. Does WI Medical Assistance cover the new orthotic and prosthetic management codes 97760 – 97762? What provider types can be reimbursed for these services? Do you intend to cover the services of orthotists and prosthetists as a delegated medical act if the service meets the guideline outlined in the Physician's Handbook?

   Answer: Allowable providers include physicians, physician assistants, nurse practitioners and, as billing providers only, FQHCs/RHCs. These codes are covered and appear on the new physician fee schedule with max fees, with an effective date of 1/1/06. Orthotists and prosthetists are not eligible providers under Wisconsin Medicaid. The ancillary rule applies only to E&M codes 99211 and 99212.

Prevea Clinic:

6. Is there criteria or a definition of what is considered "emergency for patients covered" by Emergency Medicaid?
   Answer: Emergency services are defined in HFS 101.03(52), Wis. Admin. Code, as "those services which are necessary to prevent the death or serious impairment of the health of the individual." Wisconsin Medicaid does not reimburse for emergency services unless they are Medicaid-covered services.
   All claims for emergency services are reviewed by a medical consultant to determine compliance with this regulation, based on the diagnoses used on the claim or on documentation supplied by the provider, if needed by the consultant to make a determination.

7. For CPT Codes 90465 & 90466 - what do you consider or require appropriate documentation for the codes?

   Answer: Since Medicaid does not cover administration codes, but instead includes administration in the reimbursement for the vaccine, no special documentation is needed. The new claims processing system will allow us to link vaccines with administration codes, so both sets of codes will be payable next year. Under the new system, a vaccine administration code will not be payable unless it is also billed with a vaccine.

Agnesian Healthcare:

8. When will the Family Planning drug administration codes be updated? We continue to receive 2005 denials for code G0351 (administration code for Depo-Provera injections) & now are receiving 2006 denials for 90772.

   Answer: This has been fixed. An amendment will be sent over in early March to have EDS identify and adjust claims improperly denied for this reason.

9. We are currently receiving denials for POS 14 (Group Home) for services provided in a convent for nuns. According to the August, 2005 Communique, it is recommend that POS 14 is used for a convent. We are coding domiciliary E/M codes (99324 - 99328) for these services. Why is this not allowed by Medicaid?

   Answer: The problem is that the current claims processing converts HIPAA compliant two-digit place of service (POS) to pre-HIPAA single digit POS so that the claim can be paid within the original claims processing system. There was no logic posted for POS 14 (or 20) for electronic claims, so the edit checking POS was set to autodeny. We had an internal meeting to review the conversion logic and have drafted a directive to EDS to correct the logic for this and a few other national POS (e.g., POS 20.)

   The problem will not exist with the new claims processing system since it will directly accept two-digit POS. However, because EDS does not keep the original POS that came over from the Medicare Carrier, providers will have to re-submit these claims once the fix is made (scheduled for sometime in May 2006) or use another place of service.

10. Anemia due to chronic disease (dx code 285.29) is not a covered condition for Aranesp and Epogen injections. This is a common reason for these medications and is allowed by Medicare. Do you know if this will be added as a covered diagnosis?

    Answer: Wisconsin Medicaid will not be adding dx code 285.29 for these drugs. Providers must use the more specific 285 dx codes currently allowed or submit PA.

Mile Bluff:

11. Is there an update on the adoption of "97" E&M guidelines by MA?

    Answer: Medicaid has had a couple of meetings with the Wisconsin Medical Society (WMS) to discuss the 1995/1997 E&M guideline issue. WMS has provided additional information from the AMA regarding proper use of guidelines. DHCF staff will present these materials to its management. A decision is still pending.

Gundersen Lutheran:

12. Q9957 is a per cc code, but Definity is a 1.5cc vial. How would you like to see this on a claim?

    Answer: According to our pharmacy staff, providers should bill what they actually use. So if you use 1.5 cc, bill a claim for 1.5 units.

Aurora Health Care:

13. Eemergency Medicaid (for undocumented aliens) coverage includes birth and also includes any services when the life is in danger. What about any pre and post partum care? (ie., blood work, labs, etc.) We need more clarification on what services the Emergency Medicaid program pays.

    Answer: Pre and post-partum care are explicitly excluded by CMS from coverage under the Alien Emergency benefit. CMS has defined all births as included under the benefit. All services must meet the definition of emergency in order to be considered for coverage under the Alien Emergency Benefit. Note: Pregnant undocumented aliens are eligible for coverage under the New Prenatal Care Benefit. This offers full reimbursement for all Medicaid-covered services, including prenatal care. Post-partum care is covered only if provided as part of global OB.

14. According to the January Medicaid Update 2006-01, "Postpartum care is *only* reimbursable if provided as part of OB care". Does this mean that if the antepartum visits, delivery, and postpartum care are billed ala carte, you would not reimburse the postpartum only code?

    Answer: That is correct. The program was set up consistent with state and federal directives that stated that postpartum is not a benefit under the Prenatal Care Benefit. The reason is that eligibility is linked to pregnancy. Once birth has occurred, the woman is theoretically no longer eligible. From a practical standpoint, a woman with this benefit remains covered until the end of the month in which she delivers. So if a postpartum visit occurred in that narrow time frame and the procedure code was separately billed, the claim would pay and reimbursement would have to be recouped by Medicaid on a post pay basis. Since most postpartum visits occur 4 to 6 weeks following delivery, the woman is no longer eligible unless they fall under Emergency Medicaid, for which postpartum care is specifically excluded.

    CMS allowed global billing for obstetrics since that is standard billing practice among physicians.

15. Later in the same Update it states "if fewer than 6 antepartum visits have been performed for these women, the provider will not be reimbursed for global OB care or for postpartum care". Does this mean if the 5 or less antepartum visits are billed with code 59425 and the delivery and postpartum care is billed separately as well (59409 and 59430 or 59410) you would not reimburse the postpartum care?

    Answer: Yes, for the same reason stated above.