

# WMGMA Medicare/Medicaid Workgroup

## September 17, 2007

### MEDICARE

#### Mile Bluff Clinic

1. How does Medicare reimburse a same day or a subsequent day return trip to the operating room which would be billed with a 78 modifier? (This is not a repeat procedure) In seminar information from several years ago, it was printed that we should not reduce our fees when billing. However, it was also reported that you reimburse at the intra-operative percent. Is this still correct?

**Answer: Yes, the information is still correct. The intra-operative percentage on the Medicare Physician Fee Schedule Database is the percentage paid and the billed amount does not have to be reduced.**

#### Marshfield Clinic

2. If a provider holds two CMS specialty designations (i.e. Endocrinology and Pediatrics), how would it be viewed for payment in the following scenario: The provider sees a patient in Pediatrics who self-referred. However, the patient has previously seen a Pediatric provider within the 3-year timeframe. Therefore, the patient is established to the Department of Pediatrics. However, the physician they are seeing today hasn't seen the patient before and has dual specialty designations, with Endocrine as the primary designation. Would the visit meet the requirements for a new patient visit?

**Answer: Please verify what the provider is set-up with for a primary specialty. The provider is able to see a patient as a new patient as long as that specialty has not seen the patient, but the claim may deny due to system limitations. The provider file needs to state that the provider has a dual-specialty, and the documentation should indicate which specialty the provider is practicing under. If the provider file and documentation is correct, then even if the system denies the claim will be payable upon appeal.**

3. We have recently had to submit claims for the initial dose of Darbepoetin to the Q2 contractor for reconsideration. We received a favorable decision from them, but when the claim was processed, the CPT code from J0881-EJ to J9999-CC. Claims for subsequent treatments have been denied. We think that since the initial J0881-EJ service does not appear in your claim history, the subsequent claims are not being paid. Example is ICN 5707130761000. Could you please tell us how to resolve the subsequent claims?

**Answer: This will be discussed at the meeting.**

4. We submitted claims for MOH's procedures that were performed on the same day as other procedures using CPT code 17311-79. We received a denial from Medicare for CPT 17311-79-51 indicating that the procedure code was inconsistent with the modifier used. We were advised by WPS Customer Service to submit the service without the 51 modifier. However, as far as we can tell, your system added the 51 modifier during processing and then denied the charge because it had a 51 modifier. Example for review is: 2207089458122. NOTE: This claim has been resubmitted and is currently in process. We just ask that you review the processing of the original claim to see if there is a system problem.

**Answer: The system auto fills modifier 51 when the multiple surgery indicator is a 1, 2, 3, or 4 on the Medicare Physician Fee Schedule Database. At the time this claim was processed in our system, had the multiple surgery indicator of "2" for procedure code 17311.**

**Due to CR 5528, on April 2, 2007, the multiple surgery indicator was changed to a "0". Therefore, the system no longer auto fills modifier 51 on procedure code 17311.**

### **Agnesian**

5. When we discover that we submitted the wrong date of service or place of service on a claim that has already been submitted for payment, should we notify you of the mistake if the correction has no impact on the payment? In the past we sent in a re-determination request or a request for reprocessing. The requests are dismissed because the change does not alter the payment amount. How do you want this handled?

**Answer: There is no need to inform Medicare of the information that does not cause any claim payment changes. Please note in your records for future review.**

### **Hospice Concerns:**

**WPS Medicare recognizes that Current Procedural Terminology (CPT) codes for 2007 do not have specific codes for hospice care. Providers, who are not employed by or under a financial arrangement with a hospice, may need to bill for evaluation and management services for a hospice patient who is receiving respite care in a facility. Due to that fact, we would like to provide the following guidance for billing CPT codes and POS 34.**

**The WPS Medicare system recognizes POS 34 with two types of inpatient codes. The codes are inpatient CPT codes (99221 – 99239) or a nursing facility CPT codes (99304 – 99318). WPS Medicare's system does not recognize other outpatient and observation CPT codes with POS 34.**

**A provider needs to determine the type of facility in order to determine the correct CPT code and POS 34 to submit. If the hospice is certified by Medicare and is part of a hospital or facility, then it may be appropriate to bill the inpatient hospital CPT**

**codes in POS 34. If the hospice is a free-standing hospice, or located in a skilled nursing facility, or a domiciliary care facility the provider may want to bill the nursing facility codes in POS 34.**

**If the patient is receiving hospice services in the home the correct POS is 12 - Home not POS 34. The Center for Medicare and Medicaid Services (CMS) Internet Only Manual (IOM) 100-04, Chapter 26, Section 10.5 defines POS 34 as “A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.” WPS Medicare does not accept CPT codes 99341 – 99350 when billed with POS 34 based on the definition in the IOM manual.**

**WPS Medicare’s system does not recognize Domiciliary Care CPT codes 99324 – 99340 to billable in POS 34, as the certification from part A changes the bed from a domiciliary care bed to a hospice care bed. This type of certification from part A is for a free-standing hospice facility and should follow the guidelines for that type of a facility.**

## MEDICAID

### **Mile Bluff Clinic**

1. Can you share any new billing requirements for your new computer system? Some advance warning would help us to prepare to meet new requirements.

**Answer: New billing requirements will be communicated to providers through our standard publications and training process. One of our communications and training objectives is to provide timely information to allow providers to adapt to any changes resulting from implementing a new system.**

This same answer would apply to question #5, which is very similar to this question.

2. Will your October meetings be geared toward the computer system/NDC requirements or what is the focus?

**Answer: Wisconsin Medicaid has not yet established dates for trainings involving the new Claims Processing System. The dates and registration materials will be announced via our website.**

### **Dean Health Systems**

3. The HPV injection is a series of 3 injections over a period of 6 months. Medicaid covers the injection from ages 6 to 26. If you start the series at age 26, and then the patient turns 27 before the last two injections are given, why is it they will not cover the last two injections.

**Answer: The FDA has approved Gardasil for use in females between the ages of 9 and 26. To comply with the federal guidelines, it is important that providers begin the 3 dose series in a timely manner that will allow for the series to be completed by the time the female turns 27. If something should happen that prevents the final dose in the series from being administered prior to the 27th birthday, the claim will have to be submitted on paper through special handling with a written request for an override of the age restriction. Documentation that the inoculation series should have been finished prior to the person turning 27 and why it couldn't be must be provided. A medical consultant will review the claim. You may wish to work with an EDS field representative prior to submitting claims.**

## Marshfield Clinic

4. If a provider holds two CMS specialty designations (i.e. Endocrinology and Pediatrics), how would it be viewed for payment in the following scenario: The provider sees a patient in Pediatrics who self-referred. However, the patient has previously seen a Pediatric provider within the 3-year timeframe. Therefore, the patient is established to the Department of Pediatrics. However, the physician they are seeing today hasn't seen the patient before and has dual specialty designations, with Endocrine as the primary designation. Would the visit meet the requirements for a new patient visit?

**Answer: The concept of new patient follows the rendering/performing provider, not the specialty. If that provider has not seen the patient within the past 3 years, the patient is considered a new patient.**

5. We would appreciate any information available on the new processing system currently under development.

**Answer: See responses above.**

6. We would appreciate any information available on the requirement to submit the NDC code and the HCPCS code on claims for drugs administered in a physician's office. Reference: July 17, 2007 Federal Register at:  
[http://www.access.gpo.gov/su\\_docs/fedreg/a070717c.html](http://www.access.gpo.gov/su_docs/fedreg/a070717c.html)

Hopefully those attending can discuss this requirement.

**Answer: See the responses to Agnesian questions below.**

## Agnesian

The following are questions pertaining to NDC reporting for drugs administered by the provider.

7. When will communication be sent to providers from the Wisconsin Medicaid Program?

**Answer: Medicaid will notify providers of its plans to implement this federal requirement in the coming weeks.**

**Addendum questions posed during the meeting and responded to by Carrie Gray on 9/18/07.**

**When will an updated list of manufacturers with Medicaid agreements be published on the web? ANSWER--The updated list will be posted on 10/1/07 and quarterly thereafter.**

Can Medicaid develop a list of contracted drugs, so that providers can make sure they are ordering and prescribing MA approved drugs?

**ANSWER--Unfortunately not. There are some resources available such as the SeniorCare Drug Search Tool, the CMS crosswalk and the Palmetto crosswalk that may provide some assistance.**

Does the NDC requirement for physician administered drugs apply to Medicaid HMOs? **ANSWER—Carrie Gray has sent this question to Managed Care and when response is received it will be shared.**

8. Is your computer system capable of accepting NDC numbers? If so, will this be reported back to us on a remittance so that we know you received it?

**Answer: No, because of this limitation, DHFS is seeking a federal hardship waiver to delay implementing this requirement until the new system is functional.**

9. Will your system screen for submission of NDC and if it is not submitted, what will happen to the claim?

**Answer: Screening for submission of the NDC will occur once the new claims processing system is implemented.**

How will Medicaid monitor and know if the correct NDC number is submitted?

**Answer: Once the new system is implemented, the NDCs will be verified using 2 crosswalks, the CMS crosswalk and the Palmetto crosswalk**

10. What format are we to use for reporting single or multiple NDC numbers?

**Answer: Please go to [www.nucc.org](http://www.nucc.org) for additional information on this.**

### **Gundersen Clinic**

12. Question: When procedure codes are either added or removed from the Wisconsin Medicaid computer system, why can't they also be added/removed from the online allowable fee schedule as well as the online appendixes? Staff responsible for billing, as well as individual providers, depend on the information online to be correct. When we discover after the fact that the online information is "not" correct, it is too late. We have no other option than to write off charges once billed to MA and denied.

Example 1) Procedure codes 92340 & 92341 on MD Fee Schedule coded 120,220 –Non Covered Service, Not A WI Medicaid Benefit. Yet, per a phone call with Janine on 8/22/07 these charges should be payable. These same codes are listed as covered on the OD Fee

Schedule. We have 4 RA examples of paid claims (2 MD and 2 OD) for these services. If needed, these can be faxed to you for reference.

**Answer: These two codes are not payable to physicians and the pricing action codes are correctly printed on the fee schedule. They are payable to optometrists and opticians.**

**The claims processing system identifies the type of provider who submitted the claim and processes it accordingly. While the system handles claims correctly, the reference files listing allowable providers used by Provider Services are incorrect for these codes. We are in the processing of correcting these files. In the meantime, you should rely on the applicable fee schedule for coverage information.**

Example 2) Appendix 2 – HCPCS codes for Hearing Instruments reflects P/A needed for codes V5160 and V5241. Per phone call to WI MA we were told P/A is not required. There is a December 2004 update (2004-86) posted stating PA not required; however, the appendix is not updated. Staff are being told by customer service reps to call and not go by what is posted online.

Current and updated online information would eliminate a large volume of calls to WI MA from providers' staff as well as individual providers.

**Answer: PA is not required for these codes. The requirement was lifted in 2004. We are aware that many handbooks and Appendices need updating.**

**Wisconsin Medicaid understands providers' frustrations when its publications are behind policy. As soon as a discrepancy is identified, Medicaid takes steps to clarify the discrepancy either in an Update or through revisions to the provider handbooks. Currently, the Department's greatest priorities are in developing publications for the new claims processing system and BadgerCare Plus. Other publications are being approved or updates only on a limited basis. Changes identified in Updates will appear in the next edition of the applicable handbook.**

**Fee schedules are updated quarterly. With InterChange, they will be updated in real time.**

**Wisconsin Medicaid appreciates hearing from providers when there is a discrepancy between our policy and published documentation. These contacts are sometimes our best source for identifying such discrepancies and frequently result in changes to policy, publications and/or claims processing.**

13. What is the minimum refund that will be processed by MA and what policy/regulation we should refer to when dealing with credit balances of less than \$25?

It is our understanding there is a minimum refund so we want to confirm and obtain the appropriate MA documentation for our Compliance Department.

**Answer: According to EDS, there is no minimum refund amount.**