

# WMGMA Medicare/Medicaid Workgroup

## December 10, 2007

### MEDICARE

#### Prevea Clinic

1. What is Medicare's policy on applying voluntary refund checks received from the clinic? Prevea has issued voluntary refunds and included the voluntary refund form on patients and are then receiving refund requests from Medicare for the amount of the voluntary refund. When we contact Medicare Financial we are told that the original voluntary refund we issued was applied to an outstanding balance that Prevea owes Medicare and not to the intended patient. This causes a lot of rework on the clinic end to make sure that our accounts reflect the same information as far as refunds and recoups as Medicare's system. Will or can Medicare inform the clinic if they do not apply the refund as intended?

**Answer: Money refunded voluntarily will be applied to the claim that it was intended. If you are receiving a refund request for claims you refunded voluntarily, the refund request must have been initiated before the voluntary refund was received and processed. If the voluntary refund was not clearly indicated, then our Financial department may apply the funds to other open accounts receivable for your group. Excess money returned voluntarily for a claim will be applied to other open accounts receivable. Excess money returned a request refund will be returned to the provider.**

2. What is the Under Tolerance policy? Prevea has been told that any refund check under \$10.00, even if Medicare has requested it, is considered Under Tolerance and is applied to any outstanding balance that Prevea owes Medicare. Is this the correct policy and where can we find this policy?

**Answer: Medicare accumulates all overpayments under \$10 and sends the request at the end of the month. The provider will receive a spreadsheet with this request that outlines all the patients and the services including the reason for the refund request. This is the under tolerance policy. The claims are usually SNF or Medicare Advantage related.**

3. Is there a law that Medicare follows regarding refunds sent by the clinic to Medicare in error? Prevea has been informed that any money that we send to Medicare in error cannot be returned to Prevea. According to the Financial Dept. this is a law that Medicare follows. Is there a policy regarding this law?

**Answer: Medicare will apply excess money returned to Medicare voluntarily to other accounts receivable. Money returned to Medicare in excess of the requested amount will be returned to the provider. In the situation where, money is returned**

**to Medicare when it should have been returned to Railroad Medicare, then Medicare will send the money back to the provider.**

4. Who should we be contacting regarding coverage disputes between Medicare Advantage plans and Medicare? We have accounts that we have received payment from Medicare and are then notified by the patient that they are covered by a Medicare Advantage plan. When we bill the charge to the Medicare Advantage plan, they also make payment. We are sending the original payment back to Medicare and receiving back indicating that Medicare is the primary. Who should we be refunding or who can we contact to resolve the coverage disputes?

**Answer: The Fee-for-Service Medicare contractor or MAC can make payment for beneficiaries enrolled in a Medicare Advantage Plan considered a “Cost Plan”. However, if the situation is such that beneficiary is enrolled in a “Risk Plan” and the fee-for-service carrier has paid a claim. Refund the money to FFS Medicare and notify the MA plan. The MA plan will notify SSA.**

5. Does Medicare reimburse CT/MRI's performed by NP's when there isn't Physician Supervision?

**Answer: A physician is expected to be in attendance for clinical decisions during imaging procedures which require a level of supervision greater than the general category as defined in the physician's fee schedule database. Services with the “02” indicator under the “Physician Supervision of Diagnostic Procedures” column requires that procedure “be performed under the direct supervision of a physician.” Services with an “01” indicator in this column require that the procedure “be performed under the general supervision of a physician.” The technical component of the procedures governed by RAD-024 all either require direct or at least general supervision based the MPFSDB.**

## **Gundersen Lutheran**

6. At the time I am submitting this question, I have not heard if 0056T will have a new CPT code in 2008, however, I am wondering if Medicare has given consideration for payment of this code. At this time these are being denied as "not medically necessary." With a waiver on file would patients be responsible for payment? Most other insurance carriers consider this "investigational".

**Answer: The 0054T, 0055T, and 0056T series are being replaced by CPT 20985, 20986, and 20987. Only 20985 have been priced by CMS: the other two are C status codes.**

**There is no peer reviewed medical literature that shows that these services (muscular-skeletal navigational systems) have any positive outcome in the long-term. Only about 10% of orthopedic surgeons use these. WPS Medicare is considering them not proven. At this time, we will not assign values to 20986 or 20987.**

7. A quick question regarding "additional information available upon request". Could you please explain the process of claims received with this information on them. Is the claim automatically developed?

**Answer: The system will review (through edits) the claim and if the claim does not need to be further developed the processing will complete. If one of the edits requires a stop and review, then the claim is reviewed by a person. The person will review all information available on the claim (anything in Item 19 or the extra narrative field) and make a decision based on that. If the information in this area is sufficient to complete processing, then reviewer allows the claim to continue through the system. If the information is not complete a documentation request may be sent or the claim may be denied. The best way to ensure a documentation request is sent is to indicate "Documentation available upon request" in item 19 or the extra narrative field.**

8. Has there been further discussion as to the provider address for development letters? Can we request they be sent to the same place as payments rather than to individual providers?

**Answer: At this time it appears to be a system limitation.**

9. We are seeing codes 73140-radiology exam of finger(s) and 73660-radiology exam of toe(s) denied as "invalid modifier" when finger and toe modifiers are utilized. We are assuming Medicare would only like to see RT and LT. Could you please confirm this? Based on the code description it seems reasonable.

0703	070307	11	0	73660	T9	174.60	0.00	0.00	0.00
CO-4	174.60		0.00						
SUB NOS:	1		REM:	M20					
PT RESP	0.00		CLAIM TOTALS			174.60	0.00		
0.00	0.00		174.60	0.00					

**Answer: The assumption is correct.**

10. Long time staff remembers a Medicare guideline stating that after three attempts to obtain a signature on file without success, the patient could be billed. We are not finding that in writing and Medicare Customer Service felt that this was an old guideline no longer in effect. What is the guidance for billing patients when they are non-responsive to our SOF requests?

**Answer: I am unaware of any specific guidance about "three attempts" this could previously have been in the IOM or somewhere else. IOM 100-04 Ch.1 Section 50.1.5 Refusal by patient to request payment under the (Medicare) program is the area that covers this. The following paragraph would cover you if the patient is not signature on file which is a refusal to request payment.**

**In any event, there is no provision that requires a patient to have covered services paid for under Medicare if the patient refuses to request payment.**

**Therefore, a provider may bill an insured patient who positively and voluntarily declines to request Medicare payment. However, if such a person subsequently requests payment by Medicare (because another insurance will not pay or for another reason) and requests payment under the health insurance program within the prescribed time limit, the provider must submit a Medicare claim, and refund to the patient any amounts the beneficiary paid in excess of the permissible charges.**

<http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>

11. Can you give us any guidance in the following situations, other than to not provide services, in order to bill appropriately to carriers?

Scenario is that we have a patient come in for lab work with orders from a Canadian provider who does not have an NPI. Those orders came to us from an entity (International Assisted Reproduction Center) located in Maple Grove, MN. That entity does not have an NPI either. Is there anyway we can bill this to the carrier?

I can provide an example if needed.

**Answer: If the entity does provider services in the United States, then they should receive an NPI. Until May 23, 2008 you could continue to bill these services with OTH000 generic UPIN. After May 23, 2008 the foreign provider is eligible to receive an NPI; therefore, CMS has indicated that the foreign provider does need to get an NPI. If he/she does not get an NPI after May 23, 2008 then the claim is not billable to the carrier. At this time CMS has indicate the claim will be patient responsibility.**

## **Agnesian**

12. We submitted a claim with a date of service of 02-12-07 and it was paid but it was the wrong DOS. We informed WPS that the DOS was incorrect. In August we received a refund request for this claim. The money was refunded and we submitted a corrected claim...which was denied. I filed a re-determination and it was dismissed because more than 120 days had passed since the initial determination (which is when we receive the initial payment). But less than 60 days had passed since the refund request (August). Shouldn't the clock start over again when Medicare requests a refund or otherwise makes adjustments to the outcome of a claim?

**Answer: We will need to look at this claim specifically.**

13. We employ hospitalists that provide the majority of our inpatient care. How are we supposed to submit claims for the following scenario which was recently denied: A hospitalist will see a patient in the morning. Because of the patient's condition, another hospitalist may see the patient for at least 30 minutes later in the same calendar day. We will bill the E/M service under the first hospitalist and bill prolonged care (30 minutes) under the second hospitalist. The prolonged care is

denied because it wasn't submitted with an E/M. Since both physicians are of the same specialty, Medicare looks at the services as being performed by one provider group. Why is the prolonged care denied? How should these services be submitted?

**Answer: The prolonged care (99356) is denied because it was submitted before the initial Evaluation and Management code (99233) was billed. There is a system edit that looks for the E&M code in history before paying the prolonged care.**

14. We have recently submitted conscious sedation claims. Code 99145, which is for each additional 15 minutes, is being denied if more than one unit is submitted. According to customer service, this code cannot be quantity billed. Can this be corrected in your system to allow quantity billing?

**Answer: We are currently waiting for a system response on this matter.**

15. There has been recent education on consultation billing by Provider Outreach and Education. An example of car engine problems was included in your power point presentation, which is not consistent with practices within the medical field. A physician may be asked to see a patient by another provider for advice but the consulting physician will typically initiate treatment of the patient at the time of the visit without contacting the requesting physician prior to the treatment. Did POE develop examples for consultation documentation that apply to the medical world? Is WPS planning on requesting copies of documentation from both the consultant and the requesting physician when reviewing consultation billing to verify that the request is documented?

**Answer: The analogy provided within the presentation is applicable to all specialties. The author felt a specialty specific examples would not apply equally to all providers.**

**The determination of whether a service is a consultation is based on the intent of the service, both from the originating provider and the performing provider's expectation. If the documentation shows the request is for the advice, opinion, recommendation, etc, for the originating provider's use in treating the patient and the other requirements are met, then the service may be a consultation. The expert's office may initiate diagnostic tests and that does not negate the use of the consultation codes. If the request is for the expert (your office) to treat the patient, the service is not a consultation. Medicare can request documentation concerning the intent of the request from both the originating and performing provider should we believe we need it to determine the appropriate payment.**

**You provided us with a description of your experiences. Based on your description, it appears your physician understands the intent of the request is for treatment of the patient's problem. This corresponds to the second example in our analogy. The Primary Care Physician refers the patient to the expert for treatment. As the expert, you expect to treat the patient. The primary care physician is not expecting to continue treating the medical condition for which they referred the patient. Therefore, the service is not a consultation. Your office has an initial or subsequent care visit as appropriate.**

## SVA

16. Medicare accounting department received a new or upgraded system that caused checks not to be issued to many providers in IL and WI. Why were providers not notified as to the delay in payment? We understand that checks are being reissued already.

**Answer: There was a brief hiccup in the system a few weeks back. Providers were not issued valid checks (Check Numbers were all 9's). This was due to the HIGLAS implementation. It affected 24 providers. Valid checks have been issued and this should only have resulted in a very minor delay. However, another payment schedule variation is upcoming due to this system change. We did a mass mailing to all providers during the last week of November regarding this payment schedule change as it may impact cash flow temporarily.**

## UWMF

17. Independent Sleep Lab POS

We had asked the following at the March 2007 meeting:

The following is a three part question from our Compliance department regarding sleep studies.

- 1) What is the proper way to bill for a sleep study in an IDTF setting: Patient has been "set up" but gets anxious and needs to leave. No recording has taken place but anywhere from 1-2 hours of time has elapsed. Is this a billable service? If so, what code/modifier(s) would be used?
- 2) What is the correct place of service for an IDTF that will be a sleep disorder center?
- 3) Polysomnograms are diagnostic tests that require general supervision. Who should be listed on the claim (paper-box 24k) when one supervising physician may be responsible only for the operation and calibration of the equipment, while other supervising physicians are responsible for test supervision and/or the qualifications of the non-physician personnel and yet another may be interpreting the test?

The answer we received said to bill with the correct POS for the IDTF. There does not appear to be a POS code whose description indicates it is for IDTF. That leads us to interpret the answer to mean that an IDTF may use different POS, depending on their location. We are acting as a billing service for an independently-owned freestanding Sleep Lab. Under our business arrangement we bill the technical component of the sleep studies under their provider number and TIN. We also bill the professional components of these studies under our TIN and the number for our interpreting physician. For the professional component we use the POS of wherever our physician is when they do the interpretation and report. We want to be sure we are using the correct POS for the technical components we bill for the lab. It's been difficult to find any relevant program guidance, but a couple of the New York Part B carriers have local policies which advise use of POS 11 (Office). Would

WPS/Medicare agree with that instruction for our situation, or are there other aspects that need to be considered?

**Answer: The Place of Service (POS) for the interpretation is billed correctly as described above. A variety of POS can be correct for this type of service. For the technical component please use the most appropriate POS where the IDTF is located. Example: If the IDTF is a mobile unit then use POS 15, if the service is performed in an office POS 11, or outpatient facility POS 21.**

18. Bone Mineral Density Studies:

When patients are referred for covered baseline BMDs because of osteoporosis risks identified by their primary care providers, it is customary for us to perform axial skeleton studies at two points (usually one at a hip and one spine) billed as CPT 77080. If the study confirms osteoporosis, the study is submitted with a diagnosis code that reflects the findings. On occasion, it is determined that either the spine or hips are not appropriate for the study due to implanted instrumentation or severe osteoarthritic changes to the bone. At that point a peripheral point is added to the study to ensure two valid points are used to confirm the findings. Again, if osteoporosis is diagnosed, the diagnosis code would reflect that finding. Recently we have been receiving denials of the peripheral study (77081) when performed in this situation. The paradox is that subsection D of the Indications section of policy MS-004 seems to specifically condone our reason for performing the peripheral study. We have appealed the denials with supporting documentation and received notice of unfavorable decision because the axial and peripheral studies cannot be billed the same day (which contradicts the policy section I have identified). Additionally, a change to the policy in August makes it appear that peripheral studies can't be paid if the findings are osteoporosis, without exception or consideration of the conditions listed in subsection D. So, our question, are we submitting something incorrectly, or is the intent to not allow two points of study for patients with implanted instrumentation or arthritic changes that preclude a complete and valid axial study?

**Answer: The intent is to deny procedure codes 77078, 77079, 77081, 77083, 76977 and G0130 when billed with ICD-9-CM diagnosis codes 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0. This supersedes the indications subsection D.**

19. Hospital Inpatients treated at Outpatient Locations

I think we may have discussed this in the past, but I haven't been able to locate any notes. We have two situations where hospital inpatients may be treated at hospital outpatient or freestanding office locations and returned to the inpatient setting the same day. We are hoping for guidance on the appropriate POS and "box 32" information to use in these situations. Would it be appropriate to bill globally for tests performed at the outpatient or freestanding office location? Also, may we assume that the procedure coding will have to agree with the POS used? In the first situation, a hospital inpatient is taken to a hospital outpatient office within the same building because of staff and/or equipment availability. (Both the staff and equipment are outpatient "clinic-owned", in this case.) In the second situation, the patient is transported from their inpatient hospital setting to a nearby free-standing office location, again because specific equipment and/or

staff are available at that location but not available at the hospital. Following the visit the patient is returned to the inpatient location.

In each of these situations, what is the appropriate POS, what would be the appropriate Box 32 location, would we use outpatient/office CPTs when there is a distinction, and would we bill globally for tests that have professional and technical components?

**Answer: In both the situations cited below, the correct POS is inpatient hospital. For Medicare purposes, if a patient is inpatient, they are inpatient for all services rendered. This is based on the PPS reimbursement. The provider must bill using the POS 21 along with the appropriate procedure codes. In the case of procedures with both a technical and professional component, only the professional component can be billed to us. The entity would look to the hospital for payment of the technical component. In the case of E&M services, they would use the inpatient procedure codes. Box 32 is the physical address of where the services are performed. This allows for correct payment.**

**We published an article in the Communique on this situation in April 2007. The article starts on page 36 and is titled "Inpatient, Outpatient, Office; Where in the world is my patient?"**

20. Conscious Sedation Services at ASC

This question is from our Medicare Appeals team:

MC is denying procedure 99143 & 99144 for Conscious Sedation as CO5-the procedure is inconsistent with the POS. We are billing POS-24 Ambulatory Surgical Center. See ICN#2207296324680, ICN#2207296324640 & ICN#2207296324660 for examples. The only thing I find in the policy states that these procedures are not payable in a non-facility setting. POS-24 ASC is considered a facility, so I'm not sure why they are denying. I called & spoke with Linda at MC CS. She stated that their system states procedure 99143 & 99144 are not payable in POS-24 ASC. She suggested sending a redetermination request with the policy to get them to look at it & possibly change the system to allow POS-24 for this procedure.

Would you please be so kind as to comment on this situation and provide some guidance as to whether these services should be payable?

**Answer: <http://www.cms.hhs.gov/ASCPayment/> provides the procedure codes that are payable in an ASC. If the code(s) are not on the list, Medicare will not pay them with POS 24 ASC. The codes in question are not on the list; therefore, they are not payable in an ASC.**

21. General POS Questions

What is our best resource for general questions about Place of Service codes and their appropriate use? There doesn't appear to be much program guidance aside from the rather short descriptions that are on the POS code list. I have submitted questions to the email address provided by CMS ([posinfo@cms.hhs.gov](mailto:posinfo@cms.hhs.gov)) on occasion, but never received any response.

**Answer: WPS Medicare has provided multiple resources for providers to use in regards to POS. If CMS is not responding, please continue to use your carrier for these questions.**

**WPS Resources:**

**CBT: [http://www.wpsmedicare.com/part\\_b/education/cbt.shtml](http://www.wpsmedicare.com/part_b/education/cbt.shtml)**

**POS 34 Article: [http://www.wpsmedicare.com/part\\_b/education/pos.pdf](http://www.wpsmedicare.com/part_b/education/pos.pdf)**

**POS List: [http://www.wpsmedicare.com/part\\_b/business/pos\\_code.pdf](http://www.wpsmedicare.com/part_b/business/pos_code.pdf)**

**Facility Based Differentials:**

**[http://www.wpsmedicare.com/part\\_b/publications/place-of-service.shtml](http://www.wpsmedicare.com/part_b/publications/place-of-service.shtml)**

# WMGMA Medicare/Medicaid Workgroup

## December 10, 2007

### MEDICAID

#### SVA

1. If a patient is eligible for TB coverage and MA denied the services indicating that they were not TB related can the patient be billed? No waiver has been signed.
2. If a patient is eligible for Emergency services only (report is filed with the claim) and MA denies that service as not being an emergency, can we bill the patient? No waiver has been signed.

**Answer: In both cases, you may bill the patient if the service is not a Medicaid benefit and you have given advance notice that a service may not be covered. We do not require documentation, but you may wish to develop a waiver of liability for the recipient to sign prior to delivering a service.**

#### UWMF

3. When does WI MA anticipate they will be ready to do NPI testing? The web site does not have any updated information other than NPIs will not be accepted May 23, 2007.

When does WI MA anticipate they will be in production with NPI only?

**Answer: Wisconsin Medicaid has not yet established a date for production with NPI only. Providers will be notified via a Medicaid and BadgerCare *Update*.**

4. My question would be, is Medicaid considering coverage for the new telephone E&M codes (99441-99443) or online E&M code (99444)?

**Answer: Not at this time. It is something we are considering for future use.**

#### Mile Bluff Clinic

5. Can you please explain the mandatory HMO enrollment requirement and how it relates to Badger Care Expansion?

**Answer: HMO enrollment is the same for BadgerCare Plus as it is now. Members have up to 6 weeks to choose an HMO, if there are two or more HMOs serving a zip code or if an area is designated by CMS as rural. If members don't select an HMO in 6 weeks or less, one of the HMOs serving the appropriate zip code is randomly and automatically assigned to them. Members have up to 90 days to change HMO and then they are locked-in for 9**

**months. If there is only one HMO, the zip code is voluntary and members may remain in FFS or chose an HMO at any time.**

## **Gundersen Lutheran**

6. Can you give us any guidance in the following situations, other than to not provide services, in order to bill appropriately to carriers?

Scenario is that we have a patient come in for lab work with orders from a Canadian provider who does not have an NPI. Those orders came to us from an entity (International Assisted Reproduction Center<sup>0</sup>) located in Maple Grove, MN. That entity does not have an NPI either. Is there anyway we can bill this to the carrier? I can provide an example if needed.

**Answer: According to FAQ #7967 on the CMS website, a provider with either a business mailing address or a practice address that are foreign addresses is permitted to apply for a NPI. Therefore, it would be possible for a provider to submit a standard claim transaction or a paper claim with NPIs for provider identifiers.**

**Wisconsin Medicaid is aware that there may be situations where a provider does not wish to obtain an NPI, and is evaluating whether any exceptions will be made to the program requirement that all health care providers obtain and use an NPI.**