

**WMGMA Medicare/Medicaid Workgroup  
March 10, 2008**

**MEDICARE**

**UWMEDICAL FOUNDATION**

1. It is common for patients to be referred to specialists at UWHC for treatment after they have received initial diagnosis elsewhere. For example, a patient diagnosed with cancer may be referred to our oncologists. In turn, our oncologist would review documentation and results of diagnostic tests from the other facility and in some of the more complicated cases they may request that our radiologists review all relevant imaging studies and produce an integrated consultation report specific to the diagnosis and treatment options. Generally, this consultation report is prepared as an integration of relevant information from all studies with the most definitive study being dominant. There are also occasions where a certain study (or studies) may warrant a consultation report separate from the integrated report. Because these consultations are for complicated cases, they are often more time-consuming than an initial interpretation and report would be for a straightforward study. They usually involve multiple studies and specific questions about treatment planning and they necessitate a coordination of findings from separate studies into an integrated format. In reviewing policy PHYS-006 (Consultations), there is an absence of instruction regarding our situation. The E&M consultation codes don't apply, nor do the clinical consultation codes 80500 and 80502 which are limited to pathology consultations. The Medicare Physician Fee Schedule database lists CPT code 76140 (Consultation on X-ray examination made elsewhere, written report) with status "T", indicating that the code is invalid for Medicare submission. How would WPS like to see these consultations reported?

**Answer: Will be handled between the Carrier Medical Director (CMD) and UW Medical Foundation representative.**

**PREVEA**

2. There seems to be a discrepancy in how Medicare processes procedure 97039-Fluidotherapy. There are cases in which we bill 97110 & 97039 with dx code of 715.94 and receive reimbursement. However, we have also receive denials of "noncovered" or "not medically necessary" when billing the same procedures and diagnosis codes. Please provide clarification.

**Answer: We are still researching this issue.**

3. Medicare Claims Processing Manual 30.6.9.2 Can discharge services 99238-99239 be reported prior to the actual day the patient goes home? Example: attending physician sees the patient on Friday but the patient does not actually go home till Saturday, they could be waiting for lab results and they won't have it till the next day. The instructions by the

attending is if the labs are ok, patient released to go home. (this happens in a covering situation)

**Answer: Assuming no further service the next day, the 99238/39 would be billed for the last day that the physician actually saw the patient. Thus, it would be appropriate for the Friday service.**

4. Medicare Claims Processing Manual - A. Initial Hospital Care From Emergency Room - The patient is seen in the ER and the provider does a consult, that turns into an admission. I am correct in interpreting this as the provider has a choice, they can bill the consult or admission. If choosing a consult, since the POS is ER, shouldn't we bill as outpatient consult?

**Answer: Typically one is not providing a consultation in the emergency department if the patient is being admitted. However, it is possible that a true consultation can turn into an admission. The problem using a consultation code (rather than an admission CPT code) is that most likely the consultation code will pay less. The consultation would be an "Office or other outpatient consultation" with the payment being reduced for being at a facility. Most likely, the admission code would pay more. If CPT 99244 or 99245 were used, these would reflect 60 and 80 minutes respectively of physician time. Thus, most likely a physician would be financially better off billing an admission.**

5. According to Policy PHYS-004: Incident to a Physician's Professional Service in the Office or Clinic, it states that "The physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary."

Our interpretation of 'office suite' would be the same location and/or same address. What is the definition of 'office suite.'?

**Answer: An Office suite is considered to be the same area of the building the service is being provided in. It does not necessarily mean the same address. I.E. If the patient is being in family practice, the Supervising should also be in the family practice area, not in radiology, the lunch room, or a different area of the building. Simply put, the physician must be THERE where the service is being done. Typically a medical center has the same street address all the various departments, offices, and even the cafeteria. Thus the "same address" is irrelevant.**

## **GUNDERSEN LUTHERAN**

6. There have been 3 articles published on the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC). None of these give the date when providers can access the enterprise applications online. Could you provider us with any additional information as to the date these will be available?

**Answer: Please see the updates information provided.**

7. Do you have any other updates regarding IACS-PC?

**Answer: See above.**

8. When will the IA Medicare provider numbers be added to CSNAP so that we can do claim status checks?

**Answer: We are happy to announce the CMS have recently approved the usage of C-SNAP for providers in Iowa, Kansas, Missouri, and Nebraska otherwise know as J5. Please note that even though CMS has approved C-SNAP WPS does have work to do in order to make it available for these new customers and at this time, WPS has not determined the official go-live date. Additionally, C-SNAP functionality will be limited to claim status and eligibility for our J5 providers at this time. Make sure to watch our Website and sign-up for our ListServ in order to receive information on C-SNAP availability and functionality.**

#### **DEAN/ST MARY'S REGIONAL CLINICS**

9. We have physicians that will do comparison x-rays of unaffected limbs in or to determine if the x-ray of the affected limb is within normal limits for that patient. These are not considered screening, so why does Medicare feel these are not medically necessary?

**Answer: Medicare pays for medically necessary services that are allowed by policy (local, Federal, and national), that is billed properly and coded properly. The issue is "why is it being done?" Is it done because of protocol? If so, then there is no medical necessity. Is it being done because the patella on x-ray is unusual on the left side, and the radiologist wants to see if the abnormality is bilateral? If so, then there is medical necessity for the other side. Medical necessity is always the deciding factor for the payment of claims, assuming that the service is properly billed and coded, and allowed by policy, law, or regulation.**

#### **SVA**

10. This question is about dialysis for transient patients. We have been getting denials as another provider was paid for a similar procedure. In the past we have had to write these charges off as the home center was billing monthly charges. We received a call from Barb at Medicare who was following up on a "Contact Us" question about this issue. She stated we should add "transient services" to the description/comment field of our claim as that is what Medicare looks for. We want to know if this is correct, and if any other providers have come across this problem and how they have handled it or if they already put in the comment and get payment?

**Answer: Below is the answer compiled from the Medicare Documentation on this situation. The appeal is always the appropriate action when you do not agree a claim determination. The remaining information is given as a suggestion, I would also agree with the suggestion**

**on Additional Documentation and Transient Patient in the Extra Narrative filed of the electronic claim.**

*Thank you for our conversation yesterday regarding the inquiry you sent to Wisconsin Physicians Service (WPS) Medicare concerning a claim denial for the End Stage Renal Disease (ESRD) monthly capitation payment for a transient patient.*

*In our telephone call, you indicated you billed ESRD services for a transient patient. We reviewed your denied claim and found Medicare denied code G0327 (ESRD related services for home dialysis (less than full month), per day; for patients twenty years of age and over). WPS Medicare denied the claim because the Centers for Medicare & Medicaid Services (CMS) permits reimbursement for only one ESRD capitation code per month. I regret that this also applies when one provider submits a claim for a monthly capitation code and someone else submits a second claim or subsequent claim for a daily ESRD related dialysis service for a transient patient. Medicare reimburses the claim first received in the Multi-Carrier System (MCS) claims processing system. For additional information on the CMS program manual instruction for ESRD, please refer to CMS' Internet Only Manual (IOM), Publication 100-04, Chapter 8, Sections 100.2 and 140 located at the following CMS Website:  
<http://www.cms.hhs.gov/Manuals/IOM/list.asp>*

*In your situation, you may wish to submit a redetermination regarding the denied claim with documentation. When submitting the appeal, be sure to identify the service is for "transient services." WPS Medicare published a couple of helpful tip sheets that you may find useful when requesting a redetermination. The first sheet, titled, "Fact Sheet: Which Form Should I Use?" will help you determine whether a reopening or a redetermination is appropriate for your situation. The second sheet, titled, "How to Appeal a Claim Determination," provides additional information about the redetermination process. You can find these tip sheets on our Website at the following addresses:*

*[http://www.wpsmedicare.com/part\\_b/business/appeal\\_fact\\_sheet.pdf](http://www.wpsmedicare.com/part_b/business/appeal_fact_sheet.pdf)*

*[http://www.wpsmedicare.com/part\\_b/business/appeal\\_howto.pdf](http://www.wpsmedicare.com/part_b/business/appeal_howto.pdf)*

*When submitting future electronic claims, you may wish to add the comments, "Transient Services" and "Documentation Available Upon Request." Please add your comments for electronic claims in the appropriate electronic narrative field. By making these changes, this may assist in the payment of code G0327. You may find additional information regarding electronic claim submission on the following WPS Medicare Websites:*

*[http://www.wpsmedicare.com/part\\_b/business/electronic\\_notes.shtml](http://www.wpsmedicare.com/part_b/business/electronic_notes.shtml)*

*[http://www.wpsmedicare.com/part\\_b/business/cms1500\\_xw.pdf](http://www.wpsmedicare.com/part_b/business/cms1500_xw.pdf)*

*I hope this information is helpful for you. Please reference the Correspondence Control Number (CCN) below if you need additional assistance from WPS Medicare about this matter. If you need immediate assistance with this or any other question, please contact our Provider Customer Service department at 866-359-1599.*

**Mile Bluff Clinic**

11. In the February Communique on page 6 it states that, "If after several unsuccessful attempts to obtain the NPI from the referring, ordering provider.....requires that the provider or supplier who is furnishing the service or items report their own name and NPI in the claim's ordering/referring...provider field. Could you further explain this?"

**Answer: The article is a reprint of CMS MM5890, and CMS is requiring providers receiving a referral attempt to get the referring providers NPI for the claim. CMS recognizes that not all providers are willing to give out an NPI, and does not want the patient to suffer; therefore, providers performing the service can use their own name and NPI in item 17 and 17 B after several attempts to get the NPI have been made.**

**CMS does not define what several attempts consist of; however, your carrier recommends that you check the NPI directory before billing your own providers name and number.**

12. Does this mean that if we cannot, after several attempts, get the NPI of a referring provider when we bill for a consultation, we fill in our own?

**Answer: Yes, it does mean that. You should also check the NPI directory before using your own name and number.**

**NPI Directory: <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>**

## **MEDICAID**

### **UWMEDICAL FOUNDATION**

1. When will WI MA be ready to test NPI only transactions?

**Answer: After DDI Implementation- Tentatively October 2008.**

### **GUNDERSEN LUTHERAN**

2. BadgerCare+ Update December 2007 No. 2007-111 states providers are to report their NPI numbers to BadgerCare+. If we have already submitted our NPIs to WI Medicaid, we expect that covers the requirement stated in the Badgercare+ Update from December? Can you please confirm?

**Answer: Yes**

3. When a patient is admitted and discharged within the same day, we are to bill the claim as an outpatient claim (131 bill type). How does WI MA want us to report the bed and nursing charges? Do we report these as non-covered, not report them at all, or bill them as a 762 rev code as observation?

**Answer: Observation code is best one to use.**

**MILE BLUFF CLINIC**

4. What is the status or update on the new computer system?

**Answer: October 2008**