

**WMGMA Medicare/Medicaid Workgroup  
June 9, 2008 Meeting**

**MEDICARE QUESTIONS**

**DEAN HEALTH SYSTEM**

1. We have been receiving an increasing number of Medicare denials COB-14. When we contact Medicare Customer Service we have been told that the following departments billed by us are considered Internal Medicine. Is that correct?

Diabetes Management	71
Family Practice	08
Internal Medicine	11
Preventive Cardiology	06
Sports Medicine	??
Urgent Care	??
Weight Management	71
Hospitalists (providers who handle only hospital patients)	??

?? = depends on physician specialty

- a. Can these charges be sent for reconsideration, with documentation to support both charges on that date?
- b. Is this a WPS Medicare issue or is it a CMS guideline?
- c. Can we get documentation to support this determination?

*Answer: The providers are categorized differently by specialty. The list of provider specialties is available on our Website at*

*[http://www.wpsmedicare.com/part\\_b/business/prov\\_specialties.shtml](http://www.wpsmedicare.com/part_b/business/prov_specialties.shtml)*

- a. *Providers have the right to request a redetermination anytime they disagree with an initial claim determination.*
- b. *It may be a CMS definition of "same physician" or the number of specialties listed on the provider enrollment system. I am unable to determine whose "issue" this is with the general information given.*
- c. *If it is how a provider is listed in PECOS, we do not offer documentation, for all other issues I need more information to complete the response.*

*The question is not a general question, it relates directly to how your organization and its provider are enrolled in the system. Provider Enrollment may be able better explain how the provider's files are built. Please contact them for further assistance, or us the contact us by e-mail function on our website.*

**MILE BLUFF CLINIC**

1. Will Medicare pass the taxonomy code to Medical Assistance?

**Answer:** Medicare Part B does not require taxonomy codes. We can pass this information if it provided for Part B claims. In most situations the information is not available.

## **AGNESIAN HEALTHCARE**

1. Is code 99291 (initial hour of critical care) allowed to be billed by two different specialists for different time period within the same calendar day? An example would be if a critical patient is treated by an Emergency Room Physician who provides 30-74 minutes of critical care and then transfers the patient to ICU and an Intensivist (different specialty) continue to provide critical care for another 30 – 74 minutes. Can both physicians bill 99291 since they are providers of different specialties and the critical care is not concurrent?

**Answer:**

*CPT Code 99291:*

*There are some situations where a critically ill or critically injured patient requires **unique initial care** on the same date of service from more than one physician specialty. Thus they may each bill the initial critical care code 99291;*

*In these instances the group of physicians are providing care that is unique to his/her individual medical specialty and managing at least one of the patient's critical illness(es) or critical injury(ies). For such situations the **initial** critical care service may be payable to each. Concurrent critical care services provided by each physician must be medically necessary*

*CPT 99292:*

*Critically ill or critically injured patients may require the care of more than one physician medical specialty. Concurrent critical care services provided by each physician must be medically necessary. Medical record documentation must support the critical care services provided by each physician were necessary for treating and managing the critical illness (es) or critical injury (ies) of the patient. Each physician must accurately report the service(s) he/she provided to the patient in accordance with any applicable global surgery rules or concurrent care rules. (Refer to IOM 100-04, Chapter 12 and §40 and IOM 100-02, Chapter 15, and §30)*

## **PREVEA HEALTH**

1. In reference to PHYS-079, if a mid-level personally performs an initial skilled nursing facility visit, is it appropriate to bill this as a subsequent nursing facility visit seeing as mid-levels cannot bill the initial codes (99304-99306)?

**Answer:** *Further, per the Long Term Care regulations at 42 CFR 483.40 (c)(4) and (e) (2), the physician may not delegate a task that the physician must personally perform. Therefore, as stated in S&C-04-08 the physician may not delegate the initial visit in a SNF. This also applies to the NF with one exception. The only exception, as to who performs the initial visit, relates to the NF setting. In the NF setting, a qualified NPP (i.e., a nurse practitioner (NP), physician assistant (PA), or a clinical nurse specialist (CNS), who is not employed by the facility, may perform the initial visit when the State law permits this. The evaluation and management (E/M) visit shall be within the State scope of practice and licensure requirements where the E/M visit is performed and the requirements for physician collaboration and physician supervision shall be met. Under Medicare Part B payment policy, other medically necessary E/M visits may be*

*performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit. A qualified NPP may perform medically necessary E/M visits prior to and after the initial visit if all the requirements for collaboration, general physician supervision, licensure and billing are met.*

### **Medically Necessary Visits**

*Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial visit in both the SNF and NF. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B. CPT codes, Subsequent Nursing Facility Care, per day (99307 - 99310), shall be reported for these E/M visits even if the visits are provided prior to the initial visit by the physician.*

**Yes, they can.**

2. L codes for custom fabricated orthoses. Is CMS interpretation that the L codes include fabrication, fitting, adjustments, training and evaluation? If evaluation and treatment is included along with the orthosis order in the therapy prescription, the evaluation CPT code 97003 for OT and 97001 for PT and the L code may be billed as long as the orthosis is included in the written treatment plan. Is that a correct statement?

**Answer:** *The code should be billable as long as all requirements are met.*

### **REEDSBURG PHYSICIANS GROUP**

1. We are experiencing denials when we bill multiple lesion removals or destructions. Billing example (in this order) 99213-25 (approved)  
11301 – denied with a CO-97 (M80)  
11301-59 – approved  
11200-59-51 – approved  
Why is the 11301 denied?

The denial indicates the 11301 was included in a pmt allowance that was already adjudicated? Where, when the patient had nothing else done?

We have received several denials for this same issue for awhile now and would like to know how is this to be submitted so it can be paid the first time around? We are paid after we submit for a review. Our coders are confused.

**Answer:** *This is a question that should be posed to customer service or contact us by email. The claim examples are important to the question, as we can not guess what happened with the audits and edits.*

### **MARSHFIELD CLINIC**

1. When the new codes for MOHs surgery were created in January, CPT Assistant published an article advising coders that when a MOHs procedure is performed on a single tumor, but is carried over to a second day, the first layer (stage) on the second day should continue with the next code in the series. The article states it is not correct to use the initial stage again on the second day because no debulking is necessary on the

second day. They recommended that all the services provided be submitted on the same claim, so the sequence of events was evident to the payer.

We have encountered problems when we submit claims to Medicare. We were advised that we would have to have these services paid on appeal. However, our success in getting the services paid is sporadic.

Could you give us some advice on what we need to do to get both dates of service paid?

*Answer: Please provide claims examples in your request to customer service or contact us by e-mail. Appeals and claims are unable to help without them.*

## **UW MEDICAL FOUNDATION**

1. The "Coding and Billing Article" attached to policy INJ-018 (Botulinum Toxin Type A & Type B) includes a chart which crossmaps diagnosis codes to injection/administration codes to determine whether the Botox will be covered in a given situation. If a claim is submitted that does not meet these specific combinations, the Botox will be denied, but the injection service is often still paid. We believe that to be an erroneous payment because services related to non-covered services are generally not covered. We feel that either the policy or the processing edit should be revised so that we don't have to make refunds in cases where the combination of the injection service and the diagnosis do not support medical necessity under the published guidelines. The Botox in these cases is being administered for a medical condition (not cosmetic) and so the GY is not an appropriate option.

On the same policy, we would like to know how we should submit a claim if a certain number of units of Botox are administered for a covered injection/dx combination, and in the same session a number of units of Botox are administered for a medical purpose not covered under the policy (but not an excluded service). Split the Botox to two lines? How do we ensure that the units of Botox done for the non-covered injection/dx combination aren't paid? How do we ensure that the injection service itself (not covered under the policy) is not paid, since it would have been performed to administer the non-covered units of Botox?

*Answer: There is no system fix for this. Our systems team continues to check on this, but at this time they do not anticipate any changes.*

2. I had recently submitted the initial part of this question through "Contact Us" on your website, but not received an answer yet, and I have a follow-up question regarding this topic.

Original question: "Transmittal 1157 (dated 01/19/2007) informs us that Medicare will capture and process up to 8 diagnoses submitted with a claim. Does this mean that the priority of the linked diagnoses is not relevant for processing? If the primary linked diagnosis does not support medical necessity for a service, but the second (or later) linked diagnosis does support payment, will the service be approved?"

Follow-up questions: If you are using all submitted diagnoses in claim processing, what would the result be on a multiple item claim if one of the diagnoses is a covered indication for a service and another diagnosis is a statutorily excluded diagnosis for the

same service. For example, labs done on a patient in for a routine physical, but who has current symptoms that support the testing. The claim would have V70.0 plus covered dxs.

**Answer:**

*Part 1: The linked diagnosis is relevant in the system, after an initial dx edit occurs. Essentially the system looks at all dx codes and then the linked dx codes if needed. The service will be approved based on all dx codes on the claim.*

*Part 2: It appears the V-code would cause the claim to deny. The system is set to read the v-codes before they read the other dx codes.*

## **MEDICAID QUESTIONS & ANSWERS**

### **MILE BLUFF CLINIC**

1. How will Medical Assistance recognize DME claims when your legacy number goes away?

*Answer: If the legacy number to which this question refers is the provider number, then Wisconsin Medicaid will cross-reference numbers in the system to assure providers are paid correctly. If the legacy number to which the question refers is the member ID changing to a randomly assigned number not based on the SSN, the system also will cross-reference the new number to the legacy number. Either way it shouldn't affect payments. The R&S reports will only state the new numbers to help providers with their conversions. (-Matt Fanale)*

2. When a Medicare- Medicaid patient receives a prophylactic tetanus immunization or a zostivax immunization, which is covered by Medicare Part D, we cannot bill Medical Assistance as you have stated. How are we to be paid for the service? Can we bill the recipient and ask them to take the bill to their Part D carrier? Please note, we are not, nor are most providers, contracted with Part D carriers which precludes us from billing them directly.

*Answer: If the recipient is dually eligible, the provider cannot bill the recipient. The provider will have to contact Medicare Part D and ask them how they are to bill for the immunization. (-Rita Hallett)*

3. How will Medical Assistance recognize Rural Health clinic claims when legacy numbers go away?

*Answer: Medicaid will be accepting the new UPIN numbers and the taxonomy that is required for rural health. Please watch the Medicaid Updates for further information. (-Chris Wolf)*

### **AGNESIAN HEALTHCARE**

1. We were just informed that the Mirena IUD (J7302) Medicaid fee schedule amount was recently changed from \$412.73 to 468.71 because the cost of the product increased in September, 2007. The new fee is retroactive to 9/24/2007 and that providers can resubmit claims for the additional reimbursement. How is this information communicated to providers and the HMO plans?

*Answer: Providers should bill their usual and customary charges. If the max fee is increased and it is applied retroactively, then Wisconsin Medicaid will adjust claims for those dates of service. The adjustment made will be for the difference between the amount previously reimbursed and the amount billed up to the new max fee, whichever is less.*

*HMO's are to refer to the max fee schedules posted on the Departments max fee web page, <http://dhfs.wisconsin.gov/medicaid4/maxfees/maxfee.htm>. Providers under contract with an HMO should consult the HMO for adjustments to claims that the HMO might make.  
(-Liz Scudder)*

## **MARSHFIELD CLINIC**

1. Does BadgerCare intend to reimburse an oral surgeon for IV antibiotics administered by an oral surgeon in his/her office? Does it make any difference if the oral surgeon is a DDS or a DMD?

*Follow-Up Question: Does this question pertain to place of service or to the provider type?*

*General Answer: Further follow-up on this question can be done later. Perhaps the following information will provide some guidance. (-Liz Scudder)*

*Wisconsin Medicaid reimburses the physician-administered drug codes ("J," "Q," and "S" codes) listed in the Physician Services Maximum Allowable Fee Schedule.*

*From the Dental Handbook (p. B1)*

*Dental providers who choose the oral surgery and oral pathology specialty use the American Medical Association's Physicians' Current Procedural Terminology (CPT) procedure codes for billing most oral surgeries. Dentists who want different oral surgery billing than assigned to their specialty must complete a form requesting a change. Refer to Appendices 2 and 16 of this handbook for further information. (Refer to subsequent publications for changes to codes listed in the handbook.)*

*From the Physician Handbook (p. 15)*

### **Prior Authorization/"J" Code Attachment**

*The purpose of the PA/JCA is to document the medical necessity of physician-administered drugs requiring PA. The completion instructions and PA/JCA are located in Appendices 21 and 22 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site.*

2. We are currently working on the recertifications that were mailed to us in April. It would seem that the State could reduce paper and postage costs by returning all of the forms together to one provider enrollment department address if we provide it to you. We have received more than 1000 individual mailings as part of the recertification process. Perhaps this is an enhancement to consider for the new ForwardHealth system.

**Answer:** Yes, with the new system Wisconsin Medicaid plans to complete recertifications on line unless a provider chooses to recertify on paper. (-Kathy Zimmermann)

3. Are there plans to implement an on-line provider enrollment process in the near future?

**Answer:** Yes, on-line provider enrollment will also be available with the new system (-Kathy Zimmermann)

4. Does the new ForwardHealth system allow providers and their staff on-line access to provider enrollment information?

**Answer:** Yes, there will be access to provider enrollment. Updates will be coming with all the information regarding the new system and its features. (-Kathy Zimmermann)

## **GUNDERSEN LUTHERAN**

1. Could you provide us with information on some of the features of the new system to be live in October?

**Answer:** In early May, Wisconsin Medicaid presented many of the new systems features with provider associations.

The Department of Health and Family Services (DHFS) is offering information and training sessions to all providers on the ForwardHealth interChange system in July 2008. These training sessions will provide an overview of the following features of the new ForwardHealth interChange system:

- Claims processing.
- Prior authorization processing.
- Enrollment verification.
- Financial processing.
- New Web portal.

Providers are encouraged to register for the sessions at <https://www.wisconsinedi.org/medReg/register/sessionlist.htm?seriesId=2>  
(-Liz Scudder)

2. Will the recertification paperwork collected in May carry over to the new system?

**Answer:** Yes. (-Liz Scudder)