

WMGMA Medicare/Medicaid Workgroup

December 7, 2009 Meeting

MEDICARE QUESTIONS

MARSHFIELD CLINIC

Submitted by: Judy Papke (papke.judy@marshfieldclinic.org / 715-221-9873)

1. In some cases, Anesthesiologists implant perineural sheath catheters, under ultrasound guidance (into the brachial plexus, the sciatic nerve, or the femoral nerve) to provide post surgical pain control via continuous infusion of the anesthetic agent. The catheter is not placed into the wound. The CPT codes for these services would be:
 - 64416 - Injection anesthetic agent, brachial plexus, continuous infusion by catheter (including catheter placement)
 - 64446 - Injection anesthetic agent, sciatic nerve, continuous infusion by catheter (including catheter placement)
 - 64448 - - Injection anesthetic agent, femoral nerve, continuous infusion by catheter (including catheter placement)
 - 76942 - Ultrasonic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), imaging supervision and interpretation

The descriptions of CPT codes 64416, 64446, and 64448 were changed in 2009 to reflect that the codes no longer included the daily management of the anesthetic agent. The global surgery indicator in the MPFSDB for these codes is 000. CPT has advised that the provider should use the subsequent hospital visit codes for following the patient.

However, if the anesthesiologist also provided anesthesia services related to a surgical procedure, the subsequent visits are denied as included in the allowance for another service. In researching this, we have been told that anesthesia CPT codes have a 5-day global period.

We cannot find a reference to a global period for anesthesia CPT codes in the MPFSDB. The Medicare Claims Processing Manual Pub 100-04 Chapter 12 Section 50 indicates the fee schedule for physician anesthesia services furnished on or after January 1, 1992 is, with the exceptions noted, based upon allowable base and time units, multiplied by an anesthesia conversion factor specific to that locality. I can find no reference to indicate anesthesia services are intended to have a global period.

Could you please provide the reference for a global period associated with anesthesia CPT codes?

Claim examples: ICN 2209244512070 2209260429880 2209253464360

WPS RESPONSE:

The five-day global period assigned to these codes was a decision made by our Carrier Medical Directors, as the payment for the anesthesia also includes "indicated-post-anesthesia care".

2. Is there a resource for providers to use to find out what CPT codes require an ordering/referring provider?

WPS RESPONSE

Unfortunately, there is no single resource that will provide this information for specific CPT codes.

UW MEDICAL FOUNDATION

Submitted by: David Ruff (david.ruff@uwmf.wisc.edu / 608-828-1809)

3. Mastectomy coverage

A few years ago, we were told that Medicare could cover bilateral (or unilateral) mastectomy and reconstruction in cases when only one breast was known to have the disorder that supports the direct need for surgery. In essence, the contralateral breast is removed as a prophylactic measure, based on the patient's and the provider's risk assessment.

Can Medicare cover mastectomy and reconstruction based on provider and patient judgment (probably family history and/or BRCA) when neither breast has proven disease? If not, what about reconstruction after non-covered mastectomy?

WPS RESPONSE –

Medicare will pay for a medically necessary mastectomy. The physician and patient may decide that it is medically necessary to have a mastectomy due to a family history of breast cancer and her having the BRCA gene.

Per the NCD, reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is considered a relatively safe and effective non-cosmetic procedure. Accordingly, program payment may be made for breast reconstruction surgery following removal of a breast for any medical reason. See GSURG-032 V code.

4. New ICD-9 code

ICD-9 added code V72.62 (Special investigations and examinations; laboratory examination; laboratory examination ordered as part of a routine general medical examination) effective 10/01/09. This appears to be an appropriate choice for use with screening lab work done in conjunction with a routine physical exam. (The exam itself would likely get diagnosis V70.0 assigned.) However, the descriptor for the V72 heading in ICD-9 notes that this section includes routine exams of specific systems, but excludes most other routine and general exams. Would Medicare expect V70.0 when routine lab services are submitted at patient request to receive a denial for the next payer's use? Or would Medicare want us to use V72.62 for these? Of note, V70.0 is on the Lab NCDs list of statutory exclusions, and V72.62 would be in the "doesn't support medical necessity" category, giving rise to ABN questions.

WPS RESPONSE

Based on CMS Publication 100-09, Chapter 6, section 30.1.I, providers are responsible for determining the correct diagnostic and procedural coding for the services they furnish to Medicare beneficiaries. Medicare contractors shall not make determinations about the proper use of codes for the provider. When providers inquire about interpretation of procedural and diagnostic coding they shall be referred to the entities that have responsibility for those coding sets. There are four places that Customer Service Representatives (CSRs) shall refer callers with questions about coding and those are included in this IOM reference at this CMS Website location:
<http://www.cms.hhs.gov/manuals/downloads/com109c06.pdf>

Based on this Internet-Only Manual instruction, ICD-9-CM related questions are handled by the American Hospital Association's Coding Clinic. Details about this resource are available at <http://www.ahacentraloffice.org/>.

You may wish to contact the above resource for resolution to your question. Our recommendation is to use the ICD-9 code description that appropriately describes the information that is documented in the patient's medical record.

5. Deceased patient

Lab work and diagnostic testing (including imaging studies) are sometimes performed and preliminary reads are done for patients who sometimes expire before the formal report is completed and signed. I believe I had read that these professional services could not be reimbursed because they lack medical necessity once the patient is deceased. Is that correct? If so, are these services non-covered if signed after the time of death, or if they are dated later than the date of death? Is there a regulatory citation that you could point out for us?

WPS RESPONSE

Transmittal 1727 Date: October 15, 2001

Change Request 1882

Section 7100, Overpayments - General, updates and clarifies the requirements that Medicare contractors conduct post-payment reviews to identify and recover payments for services billed after the beneficiary's date of death. The following represent brief highlights of the changes:

7100. OVERPAYMENTS - GENERAL

"Overpayments" are Medicare funds a physician or beneficiary has received in excess of amounts due and payable under the Medicare statute and regulations. Once a determination of overpayment has been made, the amount so determined is a debt owed to the United States Government.

Payment for items or services rendered after the beneficiary's date of death.

Contractors must conduct post-payment reviews to identify and recover payments with a billed date of service that is after the beneficiary's date of death. The identification of improperly paid claims must be performed at a minimum on an annual fiscal year basis, starting fiscal year 2001 for beneficiaries who died the previous fiscal year. In addition, the associated overpayment recoupment must be performed as soon as administratively possible, but by no later than 1 year after identification.

Contractors are not required to perform medical review for paid claims with dates of service after a beneficiary's date of death. The "post-payment claims review" should simply be an identification of the service that has been rendered after the beneficiaries date of death, and the subsequent notification to the provider that an improper payment has been made, for which recovery is now being sought.

Based on this information, services with a billed date after the beneficiary's date of death cannot be paid by Medicare.

6. Home Sleep Studies

We are contracted billers for a Sleep Clinic that has been providing test equipment and instruction for home sleep studies to patients under HCPCS G0399-TC. These have been denied with PR172 - PAYMENT IS ADJUSTED WHEN PERFORMED BY A PROVIDER OF THIS SPECIALTY. Although MPFSDB has these as carrier-priced (status C), under section 240.4.1 of IOM 100-03 (Medicare National Coverage Determinations (NCD) Manual) it appears these can be paid for OSA if other conditions have been met. Provider type or specialty is not listed in the NCD. Would you please check ICN #2209257368040 and ICN# 2209208366170 as examples and let us know what seems to be awry?

WPS RESPONSE

Each IDTF is supposed to have specific MD and tech requirements associated with their Provider Enrollment file. If these requirements are not met and the IDTF doesn't report the code as a service they intend to submit to Medicare, the code/service will deny. This is what occurred for these ICNs. You will

need to contact Provider Enrollment to verify what the IDTF meets credentialing requirements and will need to inform Provider Enrollment that you intend to submit this code for payment. In other words, you will need to consider making applicable changes to your Provider Enrollment records. Our Policy staff has received queries on sleep codes from various IDTFs and has informed the IDTFs they need to have have the following credentialed staff in an IDTF in order to have sleep codes added to their file.

MD: Pulmonologist, Neurologist or Certified by ABSM	TC: Credentialed by BRPT, NBRC, or ABRET (Polysomography)
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MEDICAID QUESTIONS

MARSHFIELD CLINIC

Submitted by: Judy Papke (papke.judy@marshfieldclinic.org / 715-221-9873)

Follow-up Issues from the September Meeting:

1. Do you have an update on when we can append the U1 modifier to vaccine codes other than just the HPV and Influenza codes? We were told at the last meeting that Forward Health hoped to implement the revision soon but we haven't heard anything new.

We understand that you are working on a Provider Update, however, we have submitted claim adjustments for HPV vaccines with the U1 modifier that have not been reprocessed. Are there other processing issues?

ANSWER

This initiative was temporarily delayed for technical issues. ForwardHealth will be issuing a Provider Update that will inform providers that they will not be required to use the "U1" modifier to receive complete reimbursement for vaccines and the corresponding administration fees. Instead, ForwardHealth will automatically reimburse providers the correct amount based on a member's age, as indicated in ForwardHealth's member files.

2. What is the status of all of the claims listed in the portal with a paid status but we never received the payment? We still have not received payment for these claims. Claim examples can be provided upon request.

Has a system issue been identified?

Who should we contact to research the individual claim problems?

ANSWER

The number of claims in the portal with a paid status for which providers have not yet received payment has been reduced to 3,000 claims, all of which are being actively worked. However, this will continue to be seen as new issues are discovered. Providers should contact Provider Services regarding specific claims.

3. We still have outstanding denials on E/M services billed with another service, i.e. x-ray, preventive medicine exam, EKGs. All services were billed appropriately but the E/M is denied as bundled. We were told at the June meeting that the bundling edit for the preventive exam with an E/M was fixed but those services are still denied when appealed.

We understand that you have addressed the Preventive visit + Problem visit issue, but there are still other issues, such as an E&M with an EKG, or an E&M with an xray. It appears the E&M is only paid if there are no other services being provided on the same date. This isn't reasonable. Also, claims submitted through the adjustment process are still being denied.

The Laboratory/Radiology section of the Physician Handbook contains the statement *"The attending physician's clinical interpretation of radiology services is not separately reimbursed because it is included in Wisconsin Medicaid's reimbursement for the physician-recipient encounter (i.e., the evaluation and management service)."* We understand that if the attending physician reads the xray, but does not prepare a written report, the service would not be separately billable. However, if the attending prepares a written report, and there is no other billing for the interpretation of the xray/diagnostic test from another provider (e.g., a radiologist or cardiologist), the service should be separately payable. If you received a separate bill from a radiologist or cardiologist for the interpretation, in addition to the bill from the attending for the technical component, we believe you would pay for both services. What is the difference?

ANSWER

ForwardHealth uses McKesson ClaimCheck, an automated procedure coding review software, to monitor and process claims within its claims processing system. ClaimCheck denies E/M services as incidental when billed with those services that Medicare defines as major or minor procedures.

ForwardHealth is in the process of reviewing its policy to determine whether these ClaimCheck denials should be overridden when the provider appends modifier 25 to the E/M services.

4. We continue to receive denials on code 96375, which is a subsequent drug administration code that must be submitted to EDS. The code is denied because the initial administration code is not included on the claim. The initial code is typically 96413 which cannot be billed to EDS and must be billed to the HMO carrier. We were given tracking # 993388 from EDS. When will this problem be resolved?

We would also like to remind DHS to keep all of the drug administration CPT codes in mind for 2010 contract negotiations with the Medicaid HMO carriers. Submitting all the drug administration codes to one payer would eliminate this problem.

ANSWER

EDS is in the process of making the appropriate modifications to the claims processing system to fix this problem. ForwardHealth will notify WMGMA when the systems fix has been completed.

5. Why does anesthesia code 00840 (Anesthesia for intraperitoneal procedures in the lower abdomen, not otherwise specified) deny for submission of medical records. The surgical procedure is paid but the anesthesia code is suspended until a copy of the medical record is submitted. This is the only anesthesia code that we have ongoing problems with. We have been appealing one claim since July 2008 even though medical records were submitted – the claim is still not paid. Claim examples can be submitted upon request. Why does the processing of this code differ from the processing of CPT code 00790 (Anesthesia for intraperitoneal procedures in the upper abdomen, not otherwise specified)? We do not receive similar record requests for this CPT code.

ANSWER

CPT procedure code 00840 is identified as a potential anesthesia hysterectomy code. Therefore, this code requires submission of medical records in order for the consultant to determine (1) whether the procedure was for a hysterectomy and (2) , if so, whether the rendering surgeon has submitted a completed Acknowledgement of Receipt of Hysterectomy Information Form. If the surgeon does not complete the appropriate Form, ForwardHealth will deny all claims directly related to the surgery, including claims for anesthesia.

6. We bill WI MA outpatient Behavioral Health therapy services with either HO (counselor has Masters Degree) or HN (counselor has Bachelors degree). Cindy Drury, Eric from WI MA Provider Rep, and we have looked at the fee schedule on the portal and cannot find the HN modifier listed? Cindy didn't know of any changes that excluded the HN modifier and asked for ICN examples of denied claims with HN modifier. The following ICN#s include both denied and paid claims were also given to Cindy but we have not heard back yet. Eric also thought the HN modifier was no longer accepted. Can you clarify?

Please clarify whether the HN is acceptable and the discrepancy on rates paid?

A second part of this issue is that La Crosse County is contracted to pay the WI MA rate for individual and group therapies. We have the rate for counselors billed with the HO modifier but have not been able to find the rate of counselors billed with the HN modifier? Where or how can we obtain that rate?

Lastly, Eric mentioned that WI MA was having system issues with mental health claims rendering providers processing correctly. Can you provide us with information on these issues?

You Responded: The "HN" modifier is an allowable modifier. The above claims denied because ForwardHealth could not correctly identify the provider file under which to process the claims. The provider should resubmit the claim with the appropriate 9-digit ZIP code.

Can you:

- provide us with a reference for the use of the HN modifier and
- explain any claim processing problems that have been identified for mental health claims and
- provide a fee schedule reference for the HN modified services

NOTE: The 2003-60 Mental Health Update provided crosswalks codes that are no longer valid to HCPCS codes H0005, H0022, and T1006 and listed the HN modifier as a valid modifier. However, these codes and modifiers are not included in the 2007-09 Mental Health Update. Perhaps this was an oversight. These codes are included in the downloadable Mental Health Fee Schedule, and there is a reference to the HN modifier at the beginning of the display document. If you search on these codes on the portal, the response says there are no matches

ANSWER

Information about the use of the HN modifier can be found in various ForwardHealth Provider Handbooks, including the Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults Handbook, the Outpatient Substance Abuse Handbook, the Community Support Program Handbook, the In-Home Mental Health/Substance Abuse Treatment Services for Children Handbook, and the Crisis Intervention Handbook.

HN-modified services can be found in the following downloadable fee schedules:

**-Mental Health and Mental Health for Alcohol and Other Drug Addictions
-In-Home Psychotherapy**

7. Is there any update regarding implementation of the Payment Error Rate Measurement (PERM) program?

ANSWER

The Payment Error Rate Measurement (PERM) review for Wisconsin has started, and the CMS contractor, Livanta, has been requesting documentation for sampled payments. Unless providers receive a contact from Livanta, their payments were not selected in the sample.

Wisconsin's review will consist of four samples. Two of the reviews have begun with record requests already out to providers. The other two reviews still need to be completed.

8. Will Medicaid/BadgerCare accept the H1N1 flu administration/vaccine codes – G9141 and G9142 or do you want to see CPT codes 90470 and 90663? Will coverage be extended to all members, or just specific programs?

ANSWER

Wisconsin Medicaid and BadgerCare Plus cover the administration of the 2009 H1N1 influenza vaccine under CPT code 90470. Reimbursement for 90470 is only for the administration of the 2009 H1N1 vaccine since the vaccine itself is supplied to providers at no cost from the federal government. Wisconsin Medicaid and BadgerCare Plus will not cover HCPCS codes G9141 and G9142.

Medically necessary influenza services, including administration of the 2009 H1N1 vaccine, are covered under the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan for Adults with No Dependent Children, the BadgerCare Plus Standard Plan, Express Enrollment for Children, Express Enrollment for Pregnant Women, Medicaid, and Wisconsin Well Woman Medicaid.

The following limited benefit programs do not cover administration of the H1N1 vaccine: the Family Planning Waiver, Tuberculosis-Related Services Only Benefit, the Wisconsin Chronic Disease Program, and the Wisconsin Well Woman Program.

Please see the ForwardHealth Update No. 2009-73 (“Overview of ForwardHealth Coverage of 2009 H1N1 and Seasonal Influenza Services”) for complete information about ForwardHealth's influenza policy. The Update is available at <https://www.forwardhealth.wi.gov/kw/pdf/2009-73.pdf>

9. Is there any update on the HPSA payment error problem that was identified in March? Has the problem been corrected? When will payment adjustments be made for underpaid claims?

ANSWER

HPSA adjustments began almost three weeks ago, with the majority having processed at this point.

New Issues:

10. Will you consider coverage for HCPCS G0250 - Physician review, interpretation, and patient management of home INR testing for a patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes face-to-face verification by the physician that the patient uses the device in the context of the management of the anticoagulation therapy following initiation of the home INR monitoring; not occurring more frequently than once a week?

Medicare has coverage provisions for this and related services, and many commercial insurers will also cover the services.

ANSWER

ForwardHealth will review its coverage policies regarding HCPCS code G0250. Thank you for this suggestion.

11. Are there any plans to allow completion of a discrepancy report via the portal? If not, can we request that it be considered as a portal enhancement?

ANSWER

ForwardHealth will consider portal submission of the Insurance Discrepancy report as a portal enhancement. This enhancement will be prioritized with other enhancement requests. Thank you for this suggestion.

12. Does Medicaid/BadgerCare have any plans to eliminate coverage for consultation codes in 2010, as Medicare is doing?

ANSWER

Medicaid and BadgerCare Plus currently do not have plans to eliminate coverage for consultation codes in 2010. Any future changes in policy regarding consultation codes would be communicated to providers through a ForwardHealth Update.

13. The Physician Fee schedule indicates an assistant can be reimbursed for CPT 28304 with modifiers 80, 81 or 82. We have received denials and when we contacted customer service, we were told that a Claim Check edit indicates it is not payable. The Customer Service representative told us that the Claim Check edit takes precedence over the fee schedule information.

At the last meeting, we were told that the Interactive Fee Schedule search was current, but the Downloadable Fee Schedules may not be current. Now, we have been told the Interactive Fee Schedule may not be valid either.

Providers must have access to current, accurate coverage information. It would seem that the fee schedule information available on the portal should be current, regardless of the format, and that claim check edits such as assistant at surgery billing should be cross-walked to the fee schedule information to correctly reflect coverage.

ANSWER

Could you please submit an example ICN for assistant surgery that was denied?

14. The DEFINITY® vial contains components that upon activation yield perflutren lipid microspheres, a diagnostic drug that is intended to be used for contrast enhancement during the indicated echocardiographic procedures. The HCPCS code assigned to DEFINITY® is Q9957 – Injection perflutren lipid microspheres, per ml. Is Q9957 to be submitted to the FFS carrier or to the HMO carriers? The Q codes for oral drugs have to be submitted to FFS Medicaid, but we were told that radiology contrast services were excluded from the requirement. HMO carriers have denied the services indicating we should submit to FFS.

ANSWER

HCPCS procedure code Q9957 should be submitted to Fee For Service. ForwardHealth will confirm that Q9957 is on the list of FFS payable drug codes.

PREVEA

Submitted by: Dean Cravillion (deanc@prevea.com / 920-431-1951)

15. H1N1 - Per EDS, we are to report G9142 (following the VFC billing guidelines), per MHS we are to bill using 90470 and per Americhoice we are to bill 90470. Since the HMO plans are suppose to follow the state program - which code is correct?

ANSWER

Please see response to question 8 above.

UW MEDICAL FOUNDATION

Submitted by: David Ruff (david.ruff@uwmf.wisc.edu / 608-828-1809)

16. Remittance data problem – (This question had been sent to David Ebert previously, and a preliminary reply referred to a known issue that had been resolved. Unfortunately we continue to receive corrupted data, so we re-pose the question.)

We would like to report an issue with the Patient Account Numbers returned in our remittance files. Per the 835 Implementation Guide, the patient account number in CLP01 of the 835 electronic remittance should be the same that was submitted on the original claim (box 26 of a paper claim; CLM01 of an electronic claim).

From page 89 of the 835 remittance Implementation Guide:

Use this number for the patient control number assigned by the provider. If the patient control number is not present on the incoming claim, enter zero. The value in CLP01 must be identical to any value received as a Claim Submitter's Identifier on the original claim (CLM01 of the ANSI ASC X12 837, if applicable). This data element is the primary key for posting the remittance information into the provider's database.

This patient account number is essential for us to accurately associate the payment information received to the claim without manual intervention.

The ICNs listed below are just a few, recent examples of claims where the patient account number that was received in the remittance file was not identical to the patient account number that was submitted on the claim.

Forward Health ICN: 1009257813021

PA # Submitted on claim: 227483561; PA # returned in remittance (CLP01): 22MJ83561

Forward Health ICN: 1009252310052

PA # submitted on claim: 227131111; PA # returned in remittance (CLP01): 22713U111

Forward Health ICN: 1009257817051

PA # submitted on claim: 229813750; PA # returned in remittance (CLP01): 229813M50

Please let us know when this issue will be resolved.

Any other providers seeing this issue?

ANSWER

There was an issue with electronically submitted claims not reporting back the Patient Account Number due to a qualifier issue. ForwardHealth reported that that issue was corrected by David Ebert. Subsequently, there was a defect discovered in the Optical Character Recognition software that was inputting incorrect data for paper submissions. ForwardHealth has created an edit to manually verify the data. Therefore, claims submitted in the past two weeks should not report erroneous Patient Account Numbers.