

June 12, 2006 WMGMA Follow up information

During the June 12, 2006 WMGMA meeting, members requested further information on several items. Below are summaries of the issues or a status of the resolutions.

Question #2 on the original document

WPS Policy PSYCH-015 states that health and behavior assessment, reassessment and intervention services can be covered if the patient has not been diagnosed with mental illness. The companion article specifies that the focus of the health and behavior services relates to a diagnosed physical health problem or illness and not to a mental health issue. These services are often provided as part of an interventional pain management program, and the patient may have been seen by another provider for depression. Is it your intent to deny coverage of the health and behavior services if the patient is seeing a different provider for depression?

If you would intend to cover the services described above:

If a behavioral health provider has to consider treatment of the depression (what meds are being used, etc) in determining the best plan of care for the physical health problem, would including depression as a secondary or tertiary diagnosis cause the claim to deny?

Answer: Health and Behavior Assessment/Intervention services identify psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment or management of physical health problems. The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments.

If there is a known mental health disease, then the appropriate mental health service, not Health and Behavior Assessment/Intervention, would be billed.

Follow up information

Medicare will not consider the diagnosis codes billed on other claims when adjudicating claims for Health and Behavior Assessment/Intervention. There are, however, CCI edits that may preclude separate payment for services provided on the same day.

Question #6 on the original document

At the March meeting we asked the following: A Medicare patient is scheduled for chemotherapy and we prepare two bags of drugs for the patient, but during the administration of the first bag, the patient has a reaction. We understand that Medicare would intend to cover the remainder of the first bag because it is "wasted" and cannot be reused for another patient. Does Medicare also intend to cover the second bag, which has

not been used during the chemo administration, but was mixed specifically for the patient and can't be used for anyone else?

After group discussion, we were told the question would be reviewed again because they did not take into consideration that these drugs are not usually mixed in the physician's office. Is there an update?

Answer: The answer previously given is correct. WPS will not pay for the extra bag even if the bag is mixed at a location other than the provider's office.

Follow up information

WPS is going to pose the question to CMS for clarification on whether or not the provider may bill the patient.

Question #16 from the original document

Screening tests for occult blood in the stool, billed as G0107, may be covered under the Colorectal Cancer Screening NCD (210.3), which includes the language "The beneficiary completes the existing gFOBT by taking samples from two different sites of three consecutive stools; the beneficiary completes the iFOBT by taking the appropriate number of stool samples according to the specific manufacturer's instructions."

Coverage of diagnostic hemoccult tests is defined in NCD 190.34 (one of the "23 lab NCDs"), which was recently changed with the removal of code 82270 and the addition of code 82272. This, along with the revised description for 82270, seems to indicate that Medicare intends to pay (the same amount) for a single diagnostic specimen in the office and three screening specimens collected at home, but not for three diagnostic guaiac specimens collected by the patient. Is that truly the intent of this change, and if not, could you provide clarification?

Answer: Medicare Learning Network Matters article in our CQ acknowledges 82270 code was deleted from NCD but did not explain why. We can not speak for the lab NCDs per se, but the description changed and states in the definition of this code that it is for colorectal neoplasm screening making it not applicable to the diagnostic NCD.

Follow up information

There is ongoing discussion occurring on this issue.