

WMGMA Medicare/Medicaid Workgroup

March 5, 2007

MEDICARE

~ Gundersen Lutheran ~

1. Once NPI is implemented, will locum tenens provider services be reported the same; ie, billed under the absent provider with appropriate modifier? If not, how should these services be reported?

Answer: This is a question pending to CMS. The NPI will be changed with the provider, so Locum will not be able to bill under when the provider leaves a practice. If the provider is not leaving the practice, then it will be acceptable to bill under his/her NPI.

2. Is there anything you can report to us on CMS' dissemination of NPI database and who would be eligible to access it? If not, can you give us an idea as to when we might expect more information?

Answer: We do not know when to expect the information. CMS has made it clear that the paperwork has been written and it is waiting with HHS and Congress for approval. CMS does not have a final date.

~ Dean Health System ~

3. We submitted procedure code 97760, Orthotic Management and Training, without a modifier. It was denied CO-4, "The procedure code is inconsistent with the modifier used or a required modifier is missing." Per call to WPS Medicare Customer Service, we were told this code is considered Therapy and needs a Therapy modifier. The procedure was performed by an MD in the Orthopedics department and the code is listed on the WPS Medicare Physician Fee Schedule. Should this procedure be submitted with a Therapy modifier and, if so, does the charge need to go to United Government Services?

Answer: 100-2 Chapter 15 Section 250 prohibits Part B payment for hospital services reimbursable by Part A. CORR 96-10-472.B clarifies that this applies to PCTC 7 only when furnished by independently practicing PT/OT. Services personally furnished by a physician may be paid under Part B.

PHYSMED001: When a "sometimes therapy" code is billed by a physician/NPP, but as a medical service, and not under a therapy plan of care, the therapy modifier shall not be used, but the number of units billed must not exceed the number of units indicated in the chart in NCP PHYSMED-001 per patient, per provider/supplier, per day.

4. We submitted charges as a global surgical package, and received payment from Medicare. Later we became aware that the surgical package was to be divided as surgical only with 54 modifier and post operative care with modifier 55. We made the corrections in our system and began the process to refund Medicare. We are unable to do a reopening by phone or in writing as it would generate an overpayment. The refiled charges were denied as COB-15, because the refund was not yet processed. We also missed the 120 day filing limit because the refund was not processed. How can we get these charges reprocessed?

Answer: As discussed in the meeting, there are two options available to correct this type of situation.

The first option is to refund Medicare the entire amount paid for the procedure, then verify the money was correctly applied to the claim. Once this is done, the claim is adjusted as “service not rendered”. This creates a “clean slate” so to speak and you can submit the claim again, submit the surgical care only (54 modifier) or the postoperative care (55 modifier) as appropriate. It is very important that you verify that the original claim submission has been correctly adjusted before you resubmit another claim. You can do this by viewing the adjustment on a remittance or by calling the Financial unit of WPS Medicare (866) 463-8207.

The second option is to request a re-determination in writing. The re-determination unit can add the 54 or 55 modifier as requested. This will generate an overpayment request for the difference.

In the scenario outlined in your question above both options appear to have been blended causing delays.

Finally, a reopening is never allowed in situations where an overpayment will result.

5. Our patient resides in a Skilled Nursing Facility. We performed a 70450 (CT scan of the head or brain without contrast) at our clinic. We billed Medicare Part B, who paid and then recouped the payment stating we needed to bill Medicare Part A. Medicare Part A denied stating the code is on their excluded list. Who is responsible to process this charge for a SNF patient?

Answer: The answer to question comes in two parts. 70450 professional components should be billed to WPS Medicare Part B for payment consideration. 70450 technical components should be billed to the SNF for payment consideration.

The information in is located on the following CMS Website Carrier update files http://www.cms.hhs.gov/SNFConsolidatedBilling/01_Overview.asp#TopOfPage

~ Agnesian ~

6. We have recently received a greater number of refund requests from WPS. All of these refunds were requested because the patient was a resident in a skilled nursing facility. We refunded Medicare and the secondary insurance, corrected the billing so the professional portion is billed to Medicare and the technical is billed to the nursing home. We confirmed that the patient was indeed in a Part A stay. Then within a few weeks, the refund check is sent back to us from WPS. Why is this happening? So far we have had approximately 5 of these refund requests/refund returns.

Answer: The Financial Department would be able to indicate why the check return occurred. (866) 463-8207 is the number for the WI financial unit.

Thanks for the additional information.

Of the three examples sent, two already taken in offset, so the funds were returned to you.

The third appears to have been refunded to twice to WPS Medicare. The returns were processed correctly with the data we have.

FYI: There was a Common Working File (CWF) problem related to Skilled Nursing Facility. CWF showed the patients enrolled in a SNF so we requested a refund, the SNF information was updated and the refund closed. When you sent in money, it was returned as the request had been closed.

7. Quantity billed services were discussed at the last WMGMA meeting and Ann Kelly mentioned that she had just reviewed and adjusted several radiology services to be quantity billed. We have received denials for the use of multiple units on code 75960-26 which is to be coded for each vessel. Can this code be classified as a quantity billed code?

Answer: This will be discussed at the meeting.

~ Marshfield Clinic ~

8. HCPCS code G0377 was established to allow Medicare Part B to reimburse providers for administering a vaccine that will be covered under Medicare Part D. We have been advised that we are only to use that code for the administration service when we know the drug will be reimbursed by Part D. However, we do not maintain Medicare Part D eligibility or coverage information in our system, so we won't know at the time the drug is being administered if it will be covered by Medicare Part D or not. Part D eligibility information is not available to us through CSNAP. Having to resubmit the service at a later date, when the patient receives reimbursement for the drug would be a costly process for both of us. What is your recommendation for implementation of this requirement?

Answer: You are correct Part D information is not available through C-SNAP. Providers should check the formularies to verify the drug is covered for the specific part D plan. If the drug is covered bill the administration to WPS Medicare, and if it is not covered bill the administration with a GY modifier.

~ Prevea ~

9. How does Medicare handle assigning global days to unlisted procedures such as 44799? We recently have been told that Cpt code 44799 has a 10 day global period for one patient but another patient we have been told that the global period is 90 days. Is this done by individual consideration - depending on the individual patient?

Answer: All NOC codes have global periods assigned on an individual case review basis. The days are assigned after review of the documentation.

10. Foot Care Policy-FT-001- Will Medicare reimburse procedure G0127.Q9 (modifier Q9 indicates one class B and two class C findings) if performed by a PA if diagnosis meets medical necessity?

Answer: PA's meeting all the criteria stated in Pub. 100-02 Ch.15 sect 190; Pub.100-04 Ch.12 sect 110-110.3) and PHYS-026 may only perform these services when supervised by a MD or DO. A podiatrist may not supervise a PA as they do not meet the definition for a supervising physician for PA services. In addition, all the medical necessity exceptions for payment of routine foot care must also be met.

11. According to policy RAD-033, CAT scans are a covered service and listed within the policy are numerous dx codes to support billing the CAT scan. We routinely draw a creatinine clearance (CPT code 82575) or a serum creatinine (CPT code 82565) on patients before having a CAT with contrast to assess renal fx, due the risk of nephrotoxicity associated with the contrast media. Currently we are using a V code (eg. V81.6: screening for genitourinary condition) and getting denials for the labs.

Answer: Is there a medical necessity for this draw? What is the medical necessity? Patient surgical clearance does not justify medical necessity to Medicare; therefore, a routine code is the correct code and Medicare may deny the code.

12. Codes 99221-99223 and 99231-99233 state 'physicians typically spent XXX minutes at the bedside and on the patient's hospital floor or unit'. I assume that the time a physician spends documenting in the chart, reviewing lab and other coordinating of care equates to 'floor time'. If the physician states just the total time would that be considered sufficient documentation? What documentation is necessary for the physician to bill on time in the inpatient setting? Does he need to specifically list all the activities and/or do they need to state 'that greater than 50% of their time was spent in counseling and/or coordination of care'.

Answer:

1995 and 1997 E/M Guidelines both state the following:

D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) of the

physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

!DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.

Website for guidelines:

<http://www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf> - 1997 Guidelines

<http://www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf> - 1995 Guidelines

WPS' advice: The best thing to do is provide documentation that is as thorough as possible include a time break down of face-to-face versus coordination of care. In the coordination of care area include all services provided outside the face-to-face.

13. On the Medicare Part B website under the FAQs section, there is a question that reads, 'Can a consult for preoperative clearance be billed when the patient does not have a dx other than needing the clearance for surgery?' A 'yes' or 'no' answer was not stated. We continue to receive surgeons requesting that we clear their patients for surgery without an underlying chronic condition and/or co-morbidity. If the patient presents needing a surgical clearance without an underlying condition, there is no HPI needed and no reason for visit.

Answer: A pre-surgical consultation is not billable to Medicare if it is a routine screening. The pre-surgical consultation must be medically necessary in order to be paid. In the scenario outlined in the question above, the diagnosis should be the reason for the surgical procedure. The appropriate office consultation codes (CPT 99241-99245) or initial inpatient consultation codes (CPT 99251-99255) should be used. The reason for the consultation must be evident in the consulting physician's written report or in the request from the referring physician. NCP PHYS-006 governs the Consultation benefit.

14. The CMS information that I have indicates that the Zoster vaccine (90736) is considered preventive and therefore not covered by Medicare. We are looking at stocking the Zostavax vaccine for our patients, however it can only be billed to Medicare Part D. Can a patient send in a claim to Medicare Part D to get reimbursed? I thought the drug rep told me the patients could do this.

Answer: WPS Medicare does state in policy ALRG-003 this is a routine service and is not payable by WPS Medicare. Each part D will have to determine the coverage for the drug. The plan may work with a physician for billing the drug, but the WPS Medicare is not able to tell a definitive answer on whether a given plan will cover a given drug.

~ UW Health – UW Medical Foundation ~

15. Please share whatever information you may about the incentives that will be offered to support the “2007 PHYSICIAN QUALITY REPORTING INITIATIVE”.

Answer: The following information can be found on the CMS Website at the address below.

http://www.cms.hhs.gov/PQRI/01_Overview.asp#TopOfPage

On December 20, 2006 the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorizes the establishment of a physician quality reporting system by CMS. CMS has titled the statutory program the Physician Quality Reporting Initiative (PQRI).

PQRI establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program. Eligible professionals who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment, subject to a cap, of 1.5% of total allowed charges for covered Medicare physician fee schedule services.

Note that this initiative applies to the traditional Medicare fee-for-service program only and is not applicable to the Medicare Advantage Plans, including the private fee-for-service plans.

Eligible professionals who participate in the 2007 PQRI program will have access to a CMS analysis of their reported data. Those who successfully report quality measure data on claims for services between July 1 and December 31, 2007, will be eligible for a single consolidated incentive payment in mid 2008.

The bonus payment, subject to a cap, is the equivalent of 1.5% of total allowed charges for covered physician fee schedule services provided from July 1 through December 31, 2007. TRHCA section 101 specifies that, for 2007, CMS must use the taxpayer identification number (TIN) as the billing unit, so any bonus incentive payments earned will be paid to the holder of the TIN.

16. How about some help with HCPCS code G0260. There seems to be very little information online from WPS/Medicare or CMS about when its appropriate to use this code. Our Medical Imaging department is asking “... tell me if this code applies to professional, technical and global billing? Any special considerations that we need to be aware of?”

Answer: The Medicare Physician Schedule Database (MPFSDB) indicates that the PC/TC concept does not apply to G0260. There are no special circumstances to consider except those for an ASC below.

G0260 (Injection procedure of sacroiliac joint; provision of anesthetic, steroid and or other thera puetic agent with or without arthrography), and G0259 (Injection procedure of sacroiliac joint; arthrography) have an E status on the mfsdb. E status states: Excluded from physician fee schedule by regulation. Payment for them when covered continues on a reasonable charge basis.

**CMS Manual System Department of Health &
Human Services (DHHS)
Pub. 100-20 One-Time Notification Centers for Medicare &
Medicaid Services (CMS)
Transmittal 42 Date: JANUARY 16, 2004
CHANGE REQUEST 2979**

A. Background: CMS published a Final Rule in the Federal Register on March 28, 2003 (CMS-1885-FC) to update the list of Medicare approved ASC procedures effective for services furnished on or after July 1, 2003. HCPCS code G0260, sacroiliac joint injection of anesthetic agents or steroids, was added to the ASC list. CR 2574 issued February 28, 2003 provided instructions regarding implementation of the updated ASC list.

CMS has recently become aware that some carriers are not paying the ASC facility fee for G0260 when performed in an ASC. Since G0260 was added to the list of Medicare approved ASC procedures for services furnished on or after July 1, 2003, carriers need to make sure G0260 is added to their list of ASC approved procedures.

B. Policy: HCPCS code G0260 is not payable under the Medicare Physician Fee Schedule. Rather, physicians use HCPCS code 27096 to bill for sacroiliac joint injection of anesthetic agents or steroids.

HCPCS code 27096, Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid, is not on the list of Medicare approved ASC procedures because ASCs are to report HCPCS code G0260 when a therapeutic sacroiliac joint injection is administered to a beneficiary in an ASC.

Because HCPCS code 27096 is not on the list of ASC approved procedures, under current Medicare physician fee schedule rules, carriers would pay the non-facility rate for HCPCS code 27096 when performed in an ASC. However, this results in an overpayment for the service because the ASC is also paid for facility services furnished in connection with a sacroiliac joint injection of anesthetic agents or steroids under HCPCS code G0260.

Therefore, we are instructing carriers to add CPT code 27096 to their file of ASC approved procedures, to ensure that claims from physicians that perform 27096 in an ASC are paid the lower "facility rate" under the Medicare physician fee schedule.

17. HCPCS code G0365 - Vessel Mapping Of Vessels For Hemodialysis Access (Services For Preoperative Vessel Mapping Prior To Creation Of Hemodialysis Access Using An Autogenous Hemodialysis Conduit, Including Arterial Inflow And Venous Outflow)

Let me begin by noting that the bilateral indicator for this code in the MPFSDB is "0", which may render our question moot. The description uses "vessels" but is not clear if that is intended to refer only to the necessary artery and vein in a single extremity, or is it meant include mapping of two extremities, which is sometimes done to determine the very best site for access.

Prior to the creation of G0365 one might have used 93970 for bilateral and 93971 for unilateral vessel mapping. The 2007 RVUs for global G0365 are just a little higher than

they are for global 93971; the professional component of G0365 carries only half the RVUs of the professional component of unilateral procedure 93971.

The LCD which mentions code G0365 (CV-033) is unrevealing in this aspect. The November 15 2004 Federal Register where G0365 was introduced (page 66281) notes that respondents requested separate codes for single and multiple extremities, and for a different RVU crosswalk than originally proposed. On the following page the RVU change is honored, but there is no further mention of separate codes or the single v. multiple extremity issue.

May this code be billed as 2 units when to extremities are mapped?

Answer: You noted that the bilateral indicator for this code in the MPFSDB is “0”, which may render our question moot. Which it does. We have copied below the final rule info and you are right they do not specifically address the question in their comments but we believe by giving us the 0 indicator they are saying this cannot be billed bilaterally.

Federal Register

6. Venous Mapping for Hemodialysis

CMS-1429-FC 190

In the August 5, 2004 rule, we proposed a new G-code (G0XX3: Venous mapping for hemodialysis access placement (Service to be performed by operating surgeon for preoperative venous mapping prior to creation of a hemodialysis access conduit using an autogenous graft).

Autogenous grafts have longer patency rates, a lower incidence of infection and greater durability than prosthetic grafts. Use of autogenous grafts can also result in a decrease in hospitalizations and morbidity related to vascular access complications. We stated that creation of this G-code will enable us to distinguish between CPT code 93971 (Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study) and G0XX3 in order to allow us to track use of venous mapping for quality improvement purposes.

We also proposed that this G-code be billed only by the operating surgeon in conjunction with CPT codes 36819, 36821, 36825, and 36832 and that we would not permit payment for CPT code 93971 when this G-code is billed, unless code CPT 93971 was being performed for a separately identifiable clinical indication in a different anatomic region.

We proposed to crosswalk the RVUs for the new G-code from those of CPT code 93971 and also assigned this new G-code a global period of “XXX,” which means that the global concept does not apply.

Comment: Commenters representing specialty societies and individual providers were generally supportive of the proposal for this new code, but expressed the following three primary concerns:

- Commenters did not agree with restricting this code to the operating surgeon, stating that such a restriction could limit access and serve as a barrier in providing this service. They also stated that this proposed restriction is not reflective of current practice, since nonsurgeons often perform this procedure.

- Commenters did not agree with the proposed descriptor. They indicated that the proposed descriptor did not reflect the procedure as it is now performed and suggested (a) alternate wording, such as “vascular mapping,” “autogenous AV fistula,” and “prosthetic graft,” “vessel mapping;” (b) that two G-codes should be created to distinguish between a complete bilateral and unilateral or limited studies. Other commenters noted that the proposal did not distinguish between mapping by venography or ultrasound (duplex), and some commenters suggested creating an additional G-code to distinguish between these procedures.
- Commenters stated that the comparison to CPT code 93971 in the proposed rule undervalues the service. While there are differences, the closer analogue in terms of time and resources required is CPT code 93990, Duplex scans of hemodialysis access.

Response: We proposed the G-code to create the opportunity for us to analyze the relationship between venous mapping utilization and fistula formation.

Based on the comments we received, we are revising the code descriptor to enable clinicians, other than the operating surgeon, who provide care to ESRD patients the opportunity to bill for this service.

We believe that vessel mapping requires the assessment of the arterial and venous vessels in order to provide the information necessary for the creation of an autogenous conduit. Therefore, we are also revising payment for this code and will crosswalk it to CPT code 93990 for work, malpractice, and practice expense RVUs because these RVUs more appropriately reflect the work and resources of this new G-code. The G-code and descriptor for this service will be G0365, Vessel mapping of vessels for hemodialysis access (Services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow). This code can only be used in patients who have not had a prior hemodialysis access prosthetic graft or autogenous fistula and is limited to two times per year.

We will not permit separate payment for CPT code 93971 when this G-code is billed, unless CPT code 93971 is being performed for a separately identifiable indication in a different anatomic region. We also note that other imaging studies may not be billed for the same site on the same date of service unless an appropriate “KO” modifier indicating the reason or need for the second imaging study is provided on the claim form.

We will follow the utilization closely this year to better understand whether this code is used as intended.

LCD Title

Noninvasive Vascular Testing (N.I.V.T.) [Revision]

Contractor's Determination Number

CV-033

Coding Guidelines

- *5. *We will not permit separate payment for CPT code 93971 when G0365 is billed, unless CPT code 93971 is being performed for a separately identifiable indication in a different anatomic region.*

*Other imaging studies may not be billed for the same site on the same date of service unless an appropriate **“KX” modifier indicating the reason or need for the second imaging study is provided on the claim form.*

When documentation justifies the performance of a repeat procedure on the same date of service for any reason, the procedure code G0365 is not able to be quantity billed. If you are billing two units bill on two separate lines with the appropriate modifier. The code multiple extremities are mapped, if the documentation justifies, you are able to bill a separate line of service for each.

MEDICAID

~ Dean Health System ~

1. We submitted procedure code 11720, debridement of nail(s) with diagnosis code 250.70. Medical Assistance denied reason 749, "Routine foot care diagnosis must be billed with valid routine foot care procedure codes." The diagnosis code listed in the Wisconsin Medicaid Podiatry Handbook is 250.7. Per ICD-9-CM guidelines, the fifth digit in the diagnosis code is appropriate. What is our recourse when MA has not updated their system to reflect ICD-9-CM coding changes? Please confirm that the validity of the codes is based on the date of service of the procedure.

Answer: It looks like these claims are denied appropriately. According to EDS adjudication policy POD 02.001, "Certain CPT-4 procedure codes have been identified by the Bureau of Health Care Financing as routine foot care procedures. These procedure codes cannot be billed with routine foot care diagnoses"

The issue is not that ICD-9 code 250.70 is not on file (it is) but rather that routine foot care should not be billed with code 11720. Instead, it should be billed with another procedure code (e.g., an E&M visit – we will be adding them for podiatrists) or the 11720 procedure should be billed with another diagnosis code that is not on the list for routine foot care

~ SVA Healthcare Services ~

2. If Medicaid is unable to accept NPIs until 2008, what will happen to Medicare crossover claims?

Answer: Recent national surveys indicate that the health care industry will not be ready for NPI implementation by May 23. Advisory groups to the Centers for Medicare and Medicaid Services (CMS) are recommending a minimum of six to twelve additional months beyond May 23 for the industry to make the transition. Wisconsin Medicaid's approach is consistent with industry recommendations.

Our contingency plan, as described in the Medicaid and BadgerCare Update, is to require providers to continue to use their Wisconsin Medicaid provider number on claims and other transactions submitted to Wisconsin Medicaid. This is the contingency plan endorsed by the health care industry for providers and payers who cannot accommodate the NPI by May 23, 2007.

We will continue our efforts with CMS to have Medicare pass the proprietary Medicaid provider number to Medicaid on crossover claims. If this does not occur, it may be necessary for providers to submit paper crossover claims to Medicaid. We are preparing contingency plans in the event we experience an increase in the volume of paper crossovers.

~ Agnesian ~

3. Do you know when the updated FPWP covered services list for providers will be available?

Answer: *The list of FPWP covered services was posted to the Web in January. It is Update 2007-01.*

4. Can you explain the reimbursement expectations for the HMO Medicaid plans? Is it mandatory for them to provide reimbursement for Medicaid covered services or can they establish their own coverage policies? For example, can they decide not to pay for an eye refraction (92015) even though it is a covered Medicaid service? Are they required to reimburse us the amount that is listed in the State Medicaid fee schedule?

Answer: Medicaid HMO Contracts

Medicaid/BadgerCare managed care policies are found in the Medicaid HMO contracts on the web at: <http://dhfs.wisconsin.gov/medicaid7/providers/index.htm> While Medicaid has multiple HMO contracts, the policies outlined below are essentially the same for all contracts.

Reimbursement

The Medicaid HMO contracts do not specifically address the amount that HMOs should pay providers in their network, in most instances. They are not required to pay the reimbursement listed in the state fee schedule. Their payment methodology usually is specified in their contracts with providers.

The HMO contract, under Article III - D in the Family Medicaid /BadgerCare Contract, has requirements for some types of payments such as for:

- HMO referrals to non-affiliated providers,
- Primary and emergency care services provided to a recipient living in a Health Professional Shortage Area (HPSA) or by a provider practicing in a HPSA,
- Physician services to pregnant women and children under age 19.

Coverage

The Medicaid HMO contracts do specify that HMOs must provide at least the same benefits as those provided under fee-for-service arrangements in the benefit areas that they cover.

The contract specifies in Article II-E of the Medicaid/BadgerCare Contract that HMOs must:

Promptly provide or arrange for the provision of all services required under s. 49.46(2), Wis. Stats., and HFS 107 Wis. Adm. Code as further clarified in all Wisconsin Medicaid and BadgerCare Provider Publications and HMO Contract Interpretation Bulletins, and as otherwise specified in this Contract except.....

As with fee-for-service, all services must be medically necessary.

HMOs are not restricted to providing Wisconsin Medicaid covered services. Sometimes HMOs find that other treatment methods may be more appropriate than Medicaid covered services, or result in better outcomes.

In this case, since FFS Medicaid would pay for both the exam and the refraction, the HMO should also.

Provider Appeals

It is usually difficult to answer a specific question about whether a particular service should be covered by an HMO. In this case, the provider should work with the HMO to resolve the issue using FFS coverage criteria as the basis for the discussion with the HMO. If the provider is unable to resolve an issue, a provider may appeal the HMO decision.

Medicaid and BadgerCare providers must appeal first to the HMO and then to the Department if they disagree with the HMO's payment or nonpayment of a claim. Article III-G of the Medicaid/BadgerCare contract outlines the appeal process.

~ Marshfield Clinic ~

- 5. Medicare Part B provides coverage for a limited number of immunizations. CMS has indicated that vaccines that are not eligible for coverage under Part B can be considered under a Part D plan. If a patient is eligible for a Medicare Part D benefit and WI Medicaid, we are having difficulty determining where to go for reimbursement for the service.**

Answer: The following e-mails indicate how reimbursement can be obtained from the PDPs:

**From: Schuchat, Anne MD (CDC/CCID/NCIRD)
Sent: Thursday, December 14, 2006 7:59 AM
To: Johnson, Tony (CDC/CCID/OD)
Cc: Cohen, Mitchell L. (CDC/CCID); Khabbaz, Rima (CDC/CCID/NCPDCID);
King, Lonnie (CDC/CCID/NCZVED)
Subject: FW: IMPORTANT NEWS: Medicare Payment for ID Physicians Will
Increase by 9 Percent in 2007**

On our recent conference call, Dr Lemon raised the question about Reimbursement for Zoster vaccine, and the situation at that point was that it was to be covered by Medicare Part D (instead of Part B, which covers influenza and pneumococcal polysaccharide vaccine for medicare recipients), and in addition to reimbursing max of 75% of the cost (instead of 100%) Medicare Part D at the time did not pay an administrative fee for vaccines. However, the congressional action below changes that latter item so there is reimbursement for admin fee for vaccines including zoster. This is good news as it increases the chances the recommended vaccines will be administered and will ease the burden on providers for their role in delivery.

Anne Schuchat, MD

**RADM, US Public Health Service
Assistant Surgeon General
Director, National Center for Immunization and Respiratory Diseases
(proposed)
Mailstop E-05
Centers for Disease Control and Prevention**

Medicare Will Pay Physicians for the Administration of Part D Covered Vaccines

Beginning in 2007, the Centers for Medicare and Medicaid Services (CMS) will reimburse physicians (or non-physician providers) for the administration of vaccines covered under Medicare Part D. Currently, the following vaccines are covered by many (if not all) Medicare Part D plans but there is no reimbursement for their administration by providers:

Anthrax	Japanese Encephalitis	Pertussis	Tetanus	
Diphtheria	Measles	Poliovirus	Typhoid	Haemophilus Type B
Meningococcal Disease	Rabies	Varicella	Hepatitis A	Mumps
Rotavirus Disease	Yellow Fever	Hepatitis B	Papillomavirus Disease	
Rubella	Zoster			

*****Coverage of these vaccines could vary by Medicare Part D plan. Physicians and/or beneficiaries should contact their plans to verify coverage.**

6. WI Medicaid has indicated they are to be the payer of last resort for most co-ordination of benefits issues.

Answer: See #5

7. Most physician offices are not "Participating Providers" in a Medicare Prescription Drug Plan (PDP). We do not have the ability to submit a "drug claim form" to request reimbursement. In addition, the PDPs I have spoken to indicated they will issue their payment directly to the beneficiary because we are not a network provider.

Answer: See #5

8. WI Medicaid doesn't allow us to send a statement to the patient so they can forward the statement to their PDP for consideration.

Answer: See #5

9. Is there any way that physicians can continue to bill these services to WI Medicaid for reimbursement and the Medicaid Program can seek reimbursement from the PDPs?

Answer: See #5

~ Gundersen Lutheran ~

10. With this weeks publishment of the February 2007 update No. 2007-12 can you tell us what plans are being put in place to handle crossover claims as of 5/23/07 when providers will no longer be sending legacy numbers?

Answer: See #2