

WMGMA Medicare/Medicaid Workgroup

June 11, 2007

MEDICARE

Mile Bluff Clinic

1. In the May Communique, on page 23, you conclude your topic of GSURG-037 by stating that "Most likely when a beneficiary requires repeated debridement, CPT 97597 or 97598 is the service performed, although at times CPT 11040-11042 may also be the true service." I know you do not give coding advice, but what does "may also be the true service" mean?

Answer: The wording "may also be the true service" refers to the choosing the code that best describes the service performed. A provider should choose the code that best describes the service performed.

2. What is your expectation of what a podiatrist would be billing for debridement of foot ulcers?

Answer: This will be discussed at the meeting.

UW Health

3. Is there any restriction as to which physician specialties may perform and bill for a hospital admission based on admitting diagnosis? May a physician with the specialty of Family Medicare be paid for admitting a patient with a mental health diagnosis? (Please assume the admission has been appropriately documented, is medically necessary, and that Psychiatry has been consulted)

Answer: As long as the provider is billing within his/her state scope of practice and is a Medicare provider, there is no restriction on this. All information in the situation described above it would appear state scope of practice applies.

4. The following is a three part question from our Compliance department regarding sleep studies.

- A) What is the proper way to bill for a sleep study in an IDTF setting: Patient has been "set up" but gets anxious and needs to leave. No recording has taken place but anywhere from 1-2 hours of time has elapsed. Is this a billable service? If so, what code/modifier(s) would be used?

Answer: No service was performed therefore nothing can be billed to the program or the beneficiary.

- B) What is the correct place of service for an IDTF that will be a sleep disorder center?

Answer: If the IDTF meets the affiliation or physician control criteria the IDTF location should be reported. See POS codes and definitions. To review a complete list of POS codes visit http://www.wpsmedicare.com/provider/pdfs/pos_code.pdf

- C) Polysomnograms are diagnostic tests that require general supervision. Who should be listed on the claim (paper-box 24k) when one supervising physician may be responsible only for the operation and calibration of the equipment, while other supervising physicians are responsible for test supervision and/or the qualifications of the non-physician personnel and yet another may be interpreting the test?

Answer: The physician in control of the clinic should be reported as the supervising physician.

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MEDICAID

Mile Bluff Clinic

1. FPWP: We continue to have patients put into this program that are already sterilized. We have been told by Mari Ruetten, DHFS, that if a woman cannot contracept, she should not be on the program. However, the county workers that enroll program recipients are not allowed to ask these kinds of questions. That being said, this is definitely an area that DHFS should take a closer look at. That is what Mari told us on 4-27-07. She cc'd the e-mail to Michael Vaughn and Joyce Wells, DHFS, asking them to give my MA processor more detailed information. We received nothing additional.

Answer: A patient's eligibility for coverage is not the responsibility of the provider. If a provider is concerned that a patient is eligible, but does not really meet the criteria, the provider should encourage the patient to contact her county eligibility worker. However, the ability to contracept is not an eligibility requirement, and thus is not part of the application process for the FPWP or any of the Wisconsin Medicaid/BadgerCare programs. Therefore, county eligibility workers are unable to terminate eligibility due to a patient's fertility status unless the individual voluntarily chooses to disenroll from the program.

Covered services for the family planning program are identified in Wisconsin Medicaid/BadgerCare Update 2007-01. If a provider provides a covered service, as identified in Update 2007-01, to an individual that is eligible, the service is covered. Providers can use an on-line eligibility verification system, or use the automated voice response (AVR) system to verify eligibility.

To assist FPWP enrollees and providers in understanding the goal of the Program, DHCF is developing a pamphlet explaining the FPWP in greater detail. The target audience of this pamphlet will be persons enrolling in the FPWP. Additionally, the Department plans to modify the electronic ACCESS application Apply For Benefits tool to clarify that the purpose of the FPWP is to prevent unintended pregnancies.

2. How long will DHFS continue to waste tax-payer dollars on not having an intake question of "have you been previously sterilized?" This has been going on for four years and nothing is done about it. To make matters worse, when we call to report a patient, previously sterilized, we are told to bill annual exams and labs anyway. We then counter that we need to put the V25 diagnosis on the claim as it is a program requirement and we were told, by an Erica, that it was not necessary. Is the program supposed to pay for services of individuals previously sterilized? Or is she telling us to commit fraud!

Answer: The main purpose of the Family Planning Waiver is to prevent unintended pregnancies by providing low-income women with contraceptive services. All services covered under the Family Planning Waiver are related to the overall goal of promoting contraceptive management and reproductive health. Providers must always bill with the most appropriate diagnosis for each individual situation, as required in the instructions for submitting claims.

Services covered under the Waiver that are not contraceptive related are only covered as a follow-up to a contraceptive service, as described in the Wisconsin Medicaid/BadgerCare Update 2007-01. These services must be provided within 12 months of the contraceptive service. Following the contraceptive management exam, an individual may require follow up services that are unrelated to the V25 diagnosis, e.g. STD treatment. If the service is not a follow up service to a contraceptive service, then it's not a covered service.

3. Are there any other benefits given to these individuals as a result of qualifying for FPWP?

Answer: Please refer to Wisconsin Medicaid/BadgerCare Update 2007-01, for the most current listing of Family Planning Waiver covered services.

4. Just what do we do, who do we call when we know a patient is incorrectly placed into the FPWP? This program has been "difficult" from its inception. We can deal with "difficult." But it is not acceptable to have unqualified people benefit from it. Do we need to talk to a legislator or a TV station? Or, can this be a program fix? I have had no answers for my staff for four years now when we are confronted with additional unqualified patients.

Answer: As with all Wisconsin Medicaid/BadgerCare programs, the individual is responsible for notifying the county eligibility worker of changes that impact program eligibility. If a provider feels that a patient is inappropriately enrolled in a program, the provider should instruct the patient to contact the county eligibility worker for an eligibility review. Eligibility cannot be changed based on information reported by a third party.

Dean Care

5. Why does Medical Assistance deny CPT 99375 (Physician Supervision of patient under care of home health agency)? The physician uses his clinic as the place of service as that is where he does the review of the patient's case.

Answer: Wisconsin Medicaid covers only face-to-face patient encounters. It does not cover telephone calls between patients and doctor or other non-direct encounters.

6. Will Medical Assistance recognize the modifier 25 or 59 when the new claims processing system is in place?

Answer: Medicaid plans to incorporate a ClaimCheck module that monitors the proper use of many commonly used modifiers, including those cited above.

7. According to CPT we are able to bill 99173 (Visual Screening) with preventive medicine visits. Why does Medical Assistance determine these to be inclusive?

Answer: The HealthCheck exams are billed using the preventive medicine codes and include a visual screen in the list of HealthCheck services. The HealthCheck handbook recommends use of the Snellen test for purposes of testing visual acuity.

8. Does Medical Assistance pay for Preventive Medicine Counseling 99401-99404? If so, are there specific diagnosis codes that are required for payment?

Answer: Currently, those codes can only be reimbursed for tuberculosis case management for persons with a TR medical status code and limited tuberculosis benefits. The link to the Update that included the preventive counseling codes is at <http://dhfs.wisconsin.gov/MEDICAID/updates/2003/2003-34att1.htm>

Allowable diagnoses for these codes are:

V01.1, V12.01, V71.2, V74.1, 010, 018.9, 137, 137.4, 771.2, 795.5

9. Should we use the HCPC code G0289 for Medical Assistance when we provide a Arthroscopy, Knee, Surgical, for removal of loose body, foreign body, debridement/shaving at the time of another surgical knee arthroscopy in a different compartment of the same knee, as we do for Medicare? Currently we are billing both knee scopes, with codes 29881-RT and 29877-51-59, the second service is being denied.

Answer: Normally, ClaimCheck finds 59877 incidental to 59881. This relationship would not exist with G0289 since ClaimCheck does not monitor HCPCS codes. However, you can also request a medical consultant review and override of the ClaimCheck audit by submitting an adjustment request form, formally requesting review and supplying additional documentation of why the audit should not apply.

Prevea

10. The state reassigns the patients to an HMO if they do not complete the proper paperwork. The provider group cannot obtain an ABN and has an option to treat the patient at the clinic expense or turn them away. Is there another way of notifying patient prior to changing the assigned HMO?

Answer: Medicaid does not reassign families to a different HMO when they are already enrolled in one. We do auto assign families that fail to choose an HMO, but we do not change their assignment at our initiative once they are enrolled. So the change request would have had to come from the recipient. I am not sure why the recipient

would request a change to an HMO that does not work with Prevea if they are already going there for obstetric care.

In addition, the caseworker is not able to make any HMO assignments or changes. Recipients need to contact the HMO Enrollment Specialist (Automated Health Systems) at 800-291-2002 to make enrollment choices or changes.

Managed care suggests that a representative from the client contact Kathy Kaelin, the Project Manager for Automated Health Systems, at (414) 221-9300 extension 121 for a detailed explanation of how to deal with situations where the patient is in the "wrong" HMO. Automated Health Systems can also send one of their staff to the clinic to meet with clinic staff in person to explain HMO enrollment policy and to answer questions.

11. Infertility - follicle scans 76830.52 are not covered and patients request to pay cash for the services. Can we collect cash and/or have an ABN signed?

Answer: Wisconsin Medicaid does not cover infertility services. Therefore, providers can bill recipients for these services if they first inform the recipient of the non-coverage and resulting patient liability. Medicaid does not require an ABN or similar waiver but encourages their use.

12. Same as above, but in reference to any infertility services can we collect cash and/or have an ABN signed?

Answer: See #11 above.