WMGMA Medicare/Medicaid Workgroup
June 12, 2006

MEDICARE

Agnesian Healthcare:

1. One of our Medicare Coding Specialists called customer service and verified that a claim she was working with was denied because the patient was enrolled in a Medicare C plan. CSNAP was not showing any Medicare C information for this patient. The Customer Service Rep verified that the patient did indeed have a Medicare C plan. When our coding specialist asked for the insurance code (which is information that is available on CSNAP) she was told by the CSR that this information could not be given out. Our coding specialist was told that she would have to get that information from CSNAP, (which she already knew to not be updated.), the IVR (which she was told **sometimes** gave that information if it was available), or to contact the patient. Why couldn't the CSR give her that information if it was readily available?

   Answer: CMS allows different levels of information release over the phone versus by C-SNAP. The representative was correct in not releasing the Medicare HMO information over the phone. C-SNAP does not provide the name of the plan; however, C-SNAP will provide the effective/termination dates and the plan code. The plan code looked up at http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/claims_processing_20060120.pdf will provide the name and address of the plan.

   The Customer Service Representatives are bound by *Disclosure Desk Reference for Providers found in Pub 100-9, Chapter 6, Section 80.*

Marshfield Clinic:

2. 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.

3. PATH-001 indicates that an independent lab (Lab A) that is also a referring laboratory may bill for tests sent to another laboratory (Lab B) which is approved for such tests and CLIA certified in the necessary specialty. The Coding Guidelines section (C.1.c.) indicate the appropriate procedure code with the modifier 90 needs to be used when lab tests are beyond the independent lab's (Lab A) certification level and are referred to another lab (Lab B).

   Does this mean that if Lab A has the CLIA specialty certification for the referred test, they would not add the 90 modifier (they may have the certification but it is not a test they perform), but if they do not have the CLIA specialty certification, they would add it?

   Answer: Modifier 90 can be added in both instances, including the instance where the referring laboratory has the necessary CLIA certification and is referring the test anyway.

   <u>Independent Laboratory A is submitting the claim for the referred tests.</u>

   Independent Laboratory A (because they do not meet CLIA certification requirements) refers clinical laboratory services to Independent Laboratory B who meets CLIA certification requirements for tests referred to them.

   Independent Laboratory A appends modifier 90 to the clinical laboratory procedure code(s).

   Independent Laboratory Lab A:
   1. List the appropriate procedure code with modifier 90 when lab tests are beyond the independent lab's certification level and refer to another Independent laboratory.

   2. The <u>CLIA certification number</u> for the performing/reference laboratory (Lab B) <u>must be entered in Item 23</u> of the CMS-1500 form or the electronic equivalent.

   3. The <u>reference laboratory's (B) name, address, zip code and carrier assigned provider number*</u> must be entered in Item 32 of the CMS-1500 form or the electronic equivalent.

   In cases when a laboratory service is referred from one independent laboratory to another independent laboratory, to identify the laboratory actually performing the test.

   4. Only bill one <u>unique facility number</u> per claim.

***WPS will obtain fee from the state and zip code where laboratory B is located.**
Pub. 100-4, Chapter 16, Section 40.1
http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf

40.1.1 Claims Information and Claims Forms and Formats

(Rev. 85, 02-06-04)

Claims for referred laboratory services may be made only by suppliers having specialty code 69, i.e., independent clinical laboratories. Claims for referred laboratory services made by other entities will be returned as unprocessable.

Independent laboratories (Laboratory A is billing and referring to Laboratory B) shall use modifier 90 to identify all referred laboratory services. A claim for a referred laboratory service that does not contain the modifier 90 is returned as unprocessable if the claim can otherwise be identified as being for a referred service.

The name, address, and CLIA number of both the referring laboratory and the reference laboratory shall be reported on the claim.

4. Policy GU-020 – Diagnostic Pap Test was published in the September 2005 Communique (Pages 132-139). There are some payable diagnoses included in that publication of the policy that are not included in the current online policy. They are 079.4, 099.53, 617-0 – 617.4, and V67.01. I can find no revision to the policy after the September publication. Can the on-line policy be updated to include these diagnoses?

   Answer: The September Communiqué reflects the correct information. The correct information is posted to the Website.

5. At the March meeting we asked the following: CPT has new codes for orthotic and prosthetic management. (97760 – 97762) It appears these codes can be covered when provided by a physical therapist or an occupational therapist. Does Medicare intend to provide coverage for the services performed by an orthotist or prosthetist to determine what item is the most appropriate for a patient, or to provide extended training in the use of the item? Can this be covered incident to a physician?

   The response we received related to services provided incident to a physical or occupational therapist. Our question was whether an orthotist or prosthetist working incident to a physician could be reimbursed for these services.

   Answer: No. Therapy services provided incident to a physicians services must be performed by personnel meeting the qualification of a therapist according to the following from CMS Pub.100-4 Ch. 15 section. 230.5. or WPS NCP PHYSMED-001 section X

<u>Qualifications of Auxiliary Personnel</u>. Therapy services appropriately billed incident to a physician's/NPP's service shall be subject to the same requirements as therapy services that would be furnished by a physical therapist, occupational therapist or speech-language pathologist in any other outpatient setting with one exception. When therapy services are performed incident to a physician's/NPP's service, the qualified personnel who perform the service do not need to have a license to practice therapy, unless it is required by state law. The qualified personnel must meet all the other requirements except licensure. Qualifications for therapists are found in 42CFR484.4 and in section 230.1, 230.2, and 230.3 of this manual. In effect, these rules require that the person who furnishes the service to the patient must, at least, be a graduate of a program of training for one of the therapy services as described above. Regardless of any state licensing that allows other health professionals to provide therapy services, Medicare is authorized to pay only for services provided by those trained specifically in physical therapy, occupational therapy or speech-language pathology.

That means that the services of athletic trainers, massage therapists, recreation therapists, kinesiotherapists, low vision specialists or any other profession may not be billed as therapy services.

6. 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 or 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.

7. The National Diabetes Education Program (NDEP) has produced a manual titled, "Feet Can Last A Lifetime: A Health Care Provider's Guide to Preventing Diabetes Foot Problems". See http://ndep.nih.gov/diabetes/pubs/Feet_Kit_Eng.pdf.

   On page 8 of this manual, foot exam instructions are provided. The instructions for the visual foot inspection indicate, "A physician, nurse, or other trained staff may complete this inspection".

   Based on this information, would it be appropriate for a nurse or other trained staff - as delegated by the treating physician - to record a patient history, perform the foot exam, and provide education, reporting the service as G0246 (Follow-up physician evaluation and

management of a diabetic patient with diabetic sensory neuropathy with LOPS) incident to the treating physician?

Answer: No. The reference cited described only visual inspection of the feet. It may be appropriate for the physician's staff to complete the history, visual exam of the feet and the education under the physicians direct supervision, but in order for the follow-up examination service to be billed and paid by Medicare the remaining four elements of the examination must also be completed and documented. The six-month interim for evaluation and treatment by the same or other physician must also be observed. See CMS Pub.100-3 section 70.2.1 and CMS Pub. 100-4 Ch.32 sections 80-80.8 or WPS NCD PHYS-073

8. Change Request 4219 states that midlevel practitioners such as nurse practitioners or other who may bill independently for Medicare services, are not eligible to participate in the 2006 Oncology Demonstration Project. However, we have a copy of a letter from Herb Kuhn to Karen Stanley, President of the Oncology Nursing Society, indicating CMS "would allow payment for nurse practitioner services associated with the demonstration that are furnished under the incident to provision". The letter goes on to say "these non-physician practitioners may provide the services/information described by the G codes as an incident to the services of the physician…. If the practice could bill appropriately for the underlying incident to service, then the practice or physician can also bill for the associated Oncology Demonstration G codes."

   Has WPS received confirmation from CMS that it is appropriate to pay the Oncology Demonstration G codes for services provided incident to a physician service?

   Online reference for letter: http://www.ons.org/lac/pdf/032906.pdf

   Answer: The CR reads that midlevel practioners cannot bill for these services. The letter mentioned and the ASCO website have statements from CMS that some of these services can be billed as incident to services. The letter or the ASCO website does not constitute guidance we can follow so we have recently requested that CMS clarify this directly with the carrier and we have not received an answer yet.

9. In March we submitted the following question: The Medicare Carrier's Manual contains a section regarding the Electronic Data Interchange enrollment form that indicates that by signing the EDI enrollment form the provider agrees that it will ensure that every electronic entry can be readily associated with the original source document. It goes on to indicate that the Secretary of Health and human Services or his/her designee or the contractor has the right to audit and confirm information submitted by the provider and shall have access to the original source documents and medical records related to the provider's submission, including the beneficiary's authorization and signature.

   Since the government is promoting conversion to EMR and other electronic media, can you tell me if they allow providers to use scanned documents to satisfy the "original source

document" requirements? You indicated you had forwarded this question to CMS for consideration. Is there any update available?

Answer: At this time, CMS regional office has forwarded the request to central office. We do not have any further clarification.

Gundersen Lutheran:

10. Policy INJ-033 regarding Synvisc states "it is not expected the injections be repeated within six months." Do you interpret this as six months from the first injections or six months from the 3rd and final injection?

    Answer: The 6-month injection period begins with after the last injection. In a series of injection it would not be appropriate to start the next treatment cycle until 6 months has lapsed from the last shot.

11. Does Medicare interpret CPT 96101 and 96118 as face to face AND interpretation time or face to face AND/OR interpretation time? There is much conflicting information coming from specialty societies.

    Answer: CPT codes 96101 and 96118 describe central nervous system assessments/tests performed by a psychologist or physician AND the interpretation of these tests. The definition of these services is not met unless there is "both face-to-face time with the patient and time interpreting test results and preparing the report".

    The American Psychological Association Practice Organization and the National Academy of Neuropsychology wrote the attached information that basically agrees with both CMS central office and WPS. (See information also included)

12. With the increasing number of patients enrolled in Medicare Advantage plans, do you have some guidance on how to best manage clinical trials? No one really wants to pay us for these services and we are getting mixed messages on what services are considered in the clinical trial.

    Awaiting a call from Ann at Gunderson Lutheran before a response is generated. Penny Osmon of the Wisconsin Medical Soceity has provided the following contact for questions related to Medicare Advantage Plans.

    Michael Reardon
    michael.reardon@cms.hhs.gov

UW Health - UW Medical Foundation:

13. We continue to have problems with business correspondence from Medicare being sent to clinical settings rather than our office. This has caused delays is responding to Medicare's refund or documentation requests. When we have inquired about this in the past, we were told that this is a "system" limitation.

The newly revised enrollment form 855 solicits a "special payments" address, and notes that "Medicare will issue payments via electronic funds transfer (EFT). Since payments will be made by EFT, the "Special Payments" address should indicate where all other payment information (e.g., remittance notices, special payments) should be sent." Another provider group with whom we recently discussed this issue mentioned that they had been told they need to submit new 855 forms to have correspondence sent to the address of their choosing. Will use of this field in the new 885 forms accommodate our request that we be allowed to declare our own mailing address for correspondence from Medicare? If so, will we need to file updated 855 forms for each of our enrolled providers?

Answer: We can change the address on file to the address in question, if the address on file is correct and a signed fax statement is received. The signature must be from an Authorized Official. If the correspondence address is completed on the application, it will not resolve the problem. Contact the provider enrollment hotlines if you need assistance or to verify if the address is correct. The number is (877) 908-8476.

14. Are polysomnography (95810, 95811) and multiple sleep latency tests (95805) and pulmonary stress testing (94620) allowable when billed from a freestanding office location (POS 11)?

    Answer: Our system does allow all of the above codes to be billed with Place of Service (POS) 11.

15. 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: Medciare 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.

16. How should a Welcome to Medicare physical be billed if the beneficiary has MSP status? (Does Medicare intend to pay primary for that service? If so, do you require a denial from the primary insurer? If so, does an "unprocessable claim" denial suffice?)

Answer: Medicare would require a statement from the patient's primary insurance. A denial or unprocessable statement would be sufficient, if an explanation of the denial or unprocessable code accompanied the submission.

17. Below is a question from the March meeting, which I had thought was still pending further research. Am I mistaken, or is there an update for this?

    For 2006, CMS has made changes to HCPCS descriptions of units of service for some drugs. For example, code A9502 (Myoview) has become "Technetium Tc-99m tetrofosmin, diagnostic, ***per study dose, up to 40 millicuries".*** *In 2005, this same code was described as "supply of radiopharmaceutical diagnostic imaging agent, technetium Tc 99m tetrofosmin,* ***per unit dose****." What is the significance of this change, especially the phrase "per study dose"? If a patient is dosed with (less than 40 millicuries) of this drug and two studies are done, would that be two units of service? What about if the patient is dosed for an at rest study, and again prior to an induced-stress study?*

    Answer: If two studies are performed from one 40 millicurie vial then only one vial should be billed. If one study is performed and the remainder of the vial is wasted or is insufficient to perform a second study and a second vial is used then this code could be billed for 2 units.

MEDICAID

SVA Healthcare:

1. We bill for outpatient pathology services and have noticed that Medicaid continually denies CPT code 85097 (Bone marrow smear, interpretation) stating that it can only be used in a doctor's office. Why? Since it is an interpretation service only, shouldn't Medicaid allow this service in an office or outpatient setting?

   Answer: You are correct. We will be changing the EDS files to allow this procedure in hospital (inpatient and outpatient, home and nursing home places of service. A directive to EDS is pending.

2. Scenario: Hospital receives an order and provides the technical component of a chest x-ray. That film is interpreted by one of our radiology clients. Patient demographics from the hospital indicates the patient has MA. We submit a claim to MA, and MA denies the interpretation because the recipient only has MA under the Family Planning Waiver program. Are we allowed to bill the recipient for that denied interpretation? If so, do we need to confirm that the patient was notified in advance of non-coverage before we can bill for the denied service?

   Answer: Before a patient is charged, the provider should work with DHFS to determine why exactly the service was denied. Some Family Planning Waiver

recipients are also eligible for the TB benefit and thus a chest x-ray may be covered. The provider is responsible for notifying a patient in advance of delivering services if the patient will be liable for charges. As previously discussed with SVA, billing agencies are strongly encouraged to work with providers to ensure that patients are notified of financial responsibilities.

Dean Health Care:

3. Will they be recognizing the routine venipuncuture codes (36415, 36416) rather than the handling code (99000) for blood draws with the new computer upgrade.

   Answer: There will be no change in policy with respect to venipuncture. Reimbursement for these codes is not separately reimbursable.

Mile Bluff Clinic:

4. We currently have a Clinic DME billing number for billing Medical Assistance our DME type services, for Podiatry primarily. We understand that we will only have one NPI for our clinic and that we would use that number in billing for DME and all other medical services. Is this what MA is expecting once NPIs are used? Do you have a different plan?

   Answer: Medicaid is still developing policy regarding NPI and more information will be forthcoming in Medicaid Updates. However, as a general rule, it is up to providers to determine the number of national IDs they need for operational purposes and we will deal with certification issues separately. We have heard that Medicare may require a unique NPI for DME providers. If that is the case, we will likely match that requirement. You should check with Medicare regarding its DME certification requirements.

Marshfield Clinic:

5. Is it possible to bring Mari Ruetten to a meeting to discuss the Family Planning Waiver Program educational needs and problems we have encountered with the program?

   Answer: Mari has a commitment in Milwaukee on June 12. I will try to get her to attend a future meeting.

Meriter Hospital:

6. Is there any plan or thoughts being made to change the rule that a patient has to be in a bed over midnight to be considered Inpatient? It is happening more frequently that patients are having "Inpatient Only" procedures and are discharged before midnight. It makes it very difficult for hospitals to do this billing.

   Answer: We would be interested in knowing about which types of procedures you are specifically talking. For the situation described below, you are certainly able to bill

those claims as outpatient. The general answer is that eventually these procedures will be incorporated into the outpatient rate per visit.. For now, Medicaid isn't planning on changing rules for how inpatient services are billed.