

# WMGMA Medicare/Medicaid Workgroup

## September 18, 2006

### MEDICARE

#### Mile Bluff Clinic

1. Can you review the WPS status/chances of becoming a Medicare Administrative Contractor? What year will this happen? I understand all Contractors will be named and the process fully implemented by 2011.

**Answer:** WPS recommends bookmarking the following CMS web address for the most up-to-date Medicare Administrative Contractor (MAC) information. The following answer is from the CMS Website at:

[http://www.cms.hhs.gov/MedicareContractingReform/02\\_WhatsNew.asp#TopOfPage](http://www.cms.hhs.gov/MedicareContractingReform/02_WhatsNew.asp#TopOfPage)

**"On July 31, 2006, CMS announced it has awarded the first contract for a Part A/Part B Medicare Administrative Contractor (A/B MAC) to Noridian Administrative Services (NAS). NAS will be the A/B MAC for Jurisdiction 3 (J3) comprised of Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming. As the J3 A/B MAC, NAS will immediately begin implementation activities and will assume full responsibility for the work no later than March 2007. A Background Sheet and Qs & As related to the award are available below."**

**CMS has announced that their goal is to complete all MAC transitions by the Fall of 2009. The Medicare Modernization Act of 2003 requires that all transitions to a MAC environment be completed by 2011.**

2. In a recent Monday morning Medicare alert, you addressed Cert Provider Compliance Error Rate (CERT). It was stated that the most frequent error was "procedure code submitted is a non - covered service." Is it understood that we send uncovered services in for a "denial?" We are intentionally doing this.

**Answer:** WPS Medicare recognizes that there are some circumstances that will require you to submit a claim for a Medicare denial (i.e. patient request, secondary insurance, etc.). If you submit a claim for a non-covered service, the CERT process does assess a Provider Compliance Error. If the service you are billing is statutorily non-covered or is not a Medicare benefit, you should append a GY modifier to the CPT code for the service you are billing. In this case, no CERT Provider Compliance Error is assessed.

## **Marshfield Clinic**

3. We previously (in March and in June) asked about storing the patient's authorization to release information in an electronic format and whether or not that would satisfy Medicare's requirement for an original source document. I believe this was sent to the CMS central office for clarification. Is there any update?

**Answer: CMS is reviewing the issue. We do not have further information to share at this time.**

4. 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?

We were told that the question was being submitted to CMS for clarification. Is there any response?

**Answer: There will be information on this issue provided at the meeting.**

5. At the June meeting, the following questions was asked: 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?

We were told that there were ongoing conversations on this topic. Is there a final response?

**Answer: Medicare does not pay for three diagnostic guaiac specimens that the patient takes home and returns to the physician's office. Medicare does cover screening guaiac testing the beneficiary does at home. Providers should bill using G0107 for the screening guaiac. The diagnostic NCD clearly states that FOBT is reported once. "The FOBT is reported once for the testing of up to three separate specimens (comprising either one or two tests per specimen)." We believe the change to the NCD was due to an oversight. The description of**

**82270 is for screening and doesn't belong in the diagnostic lab NCD. G0107 should be used for Medicare patients and 82270 could be used for screenings performed on non-Medicare beneficiaries.**

### **Dean Health System**

6. We are waiting for a written response to the following issue discussed at our 06/12/06 meeting. Tom Ryan and Mark Kirchberg planned on emailing updates by June 26, 2006. (In follow up we contacted Tom Ryan and Mark Kirchberg through the contact us portion of the WPS website, and by leaving telephone messages on 07/12/06).

We have been told verbally to bill the Harvesting of a Radial Artery by Endoscopic Approach as 35600. The description in CPT states "Harvest of upper extremity artery one segment, for coronary artery bypass procedure," there is no written indication for either approach (open, endoscopic). Charges for this service were billed as unlisted 33999, and have been denied by Medicare with indication that a valid CPT code exists for this procedure.

**Answer: CPT Code description – Harvest of upper extremity artery, one segment, for coronary artery bypass procedure**

**The descriptor for the CPT code 35600 does not describe the method used for the harvest, this code can be used whether the artery is obtained via an open or an endoscopic approach. Providers should not bill CPT code 33999 as the 35600 is the true to use.**

7. We have received denials for temporary code 0064T for a CLIA number. A CLIA number is not needed when a charge is not laboratory related, how do we get these charges processed? ICN #2206202130632

**Answer: 0064T is a T-code. With rare exceptions, T-codes are not paid since most are experimental/investigational. Medicare does not pay this code. You may use a signed Advanced Beneficiary Notice (ABN) and receive payment from the beneficiary.**

8. We have received COB15 denials for CPT 69990-59 (operating microscope). This is an add-on code often used by our neurosurgeons during an operative session when more than one procedure is being performed. For example: codes 61601, 61751, 62272 and 69990, per CCI 69990 is bundled with 61751, but not with 61601 for which the operative microscope was used. What logic is used to assign the COB15 denial when multiple codes are billed? Can this denial be appealed with operative notes? Would the documentation need to indicate when use of the microscope was initiated and terminated, or would documentation of "operating microscope used during (name of procedure)" be sufficient? ICN # 2205363107580.

**Answer: The CCI edits for Column 1 61751 and Column 2 69990 do not allow for a modifier 59 to added and a payment made. The system cannot overlook that the two codes**

**are on the claim together. You do have appeals right on the claim if you feel 69990 should be payable.**

### **Gundersen Lutheran – Point of Discussion**

Could we discuss the implications and issues related to access to individual provider numbers for large practice groups with numerous physical locations and addresses as well as the correspondence issues?

It is our understanding there was to be some CMS clarification issued? If so, can you share with this group?

Do you have any recommendations for recourse from this workgroup?

### **Prevea**

9. Would you consider the decision to administer chemo on an established patient as straightforward, low, moderate or high in decision making. The GYN/ONC association is stating based on chemo administration, it should be considered moderate decision making. Please clarify CMS stands on this issue.

**Answer: CMS does not render an opinion in a scenario such as this. Rather, CMS provides a description of the decision making component and lists those factors to be considered when choosing the appropriate level of decision making. CMS recently published an *Evaluation and Management Services Guide* which is offered as a reference tool and does not replace content found in the *1995 Documentation Guidelines for Evaluation and Management Services* and the *1997 Documentation Guidelines for Evaluation and Management Services*. The provider is responsible to choose the appropriate level of decision making, based on various factors considered and the information he/she documents in the patient's medical record.**

**To view the *Evaluation and Management Services Guide* and for links to the *1995 and 1997 Documentation Guidelines for Evaluation and Management Services*, see:  
[http://www.cms.hhs.gov/MLNProducts/downloads/eval\\_mgmt\\_serv\\_guide.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf)**

10. Is the modifier 76 appropriate to use on CPT code 88305 (Tissue Exam) for Pathology? According to Medicare Customer Service staff, we should bill with the 76 modifier instead of the 59 modifier, but we do have cases where Medicare has paid when the 59 modifier is utilized and do not use the 76 modifier. What is correct and is there a policy that we can reference? Would you like this quantity or each specimen billed on a separate line? An example we were told from Customer Service on how to bill:  
88305.26 First specimen  
88305.26.76 Second specimen  
88305.26.59.76 Third and all subsequent specimens

**Answer: Medicare does not use the modifier 59 with this code. The use of modifier 59 is only for CCI edits in the Medicare world. Check the CCI edits to verify if a Modifier 59 is needed. The procedure code should not be quantity billed to Medicare. The example given above would be correct if billed as follows:**

**88305.26 First specimen**

**88305.26.76 Second specimen**

**88305.26.76 Third and all subsequent specimens**

**Medicare does not cover the procedure code 88305 for the same reason on the same specimen done on the same day.**

**The information is available from the 4/26/2006 teleconference question 1 at the following Website:**

**[http://www.wpsmedicare.com/provider/pdfs/clin\\_lab\\_qa.pdf](http://www.wpsmedicare.com/provider/pdfs/clin_lab_qa.pdf)**

11. At the time of a prevent medicine service, (ie annual exam), on a menopausal women, the provider discusses Hormone Therapy; would that discussion of Hormone Therapy qualify as a separate billable service? The documentation would support the discussion of the Hormone Therapy issues probably based on time.

**Answer: A preventive service is a non covered service. However, if at the time of a Preventive Medicine Service (Routine Annual Check-up) a significant issue was addressed, the significant issue maybe “carved out” from the preventive service if it would normally be covered if done independently. A significant issue would be considered a new or different abnormality/medical problem or change or exacerbation of a pre-existing condition which revealed in the process of examining the patient and the physician determines it is significant enough to require additional work to perform the key components of the appropriate level office E & M.**

**Generally, the standard of medical practice in our jurisdiction has been to only utilize Hormone Replacement Therapy (HRT) to treat another significant condition and not as a preventive therapy due to the serious side effects associated with its use. However, all preventive services include age appropriate counseling and anticipatory guidance. If counseling were performed to review the use of HRT to treat a new or an exacerbation of a pre-existing condition and documentation supported the other elements needed, it could be carved out from the preventive service. Without reviewing notes for the specific situation, we can not make a broad determination.**

**Normally, when billing the level of an E&M service based on predominance of counseling, more than 50% of the time of the face-to-face encounter has to be spent providing counseling and/or coordination care. However, preventive services do not have an associated time listed with them. Further, the total time of the visit should not count toward the level of service carved out as many of the elements performed during the visit were for non-covered preventive services. Therefore, the length of time spent in counseling for the covered condition would generally be the only criteria available for use in determining the level of service to be carved out.**

**In these types of situations, we would encourage you to review the documentation to determine what elements in the history, exam, and/or medical decision making were performed to address the new or exacerbated pre-existing condition requiring HRT. These elements might better reflect the level of service performed. If predominance of counseling is used, the counseling and/or coordination of care performed must be relevant to the issue addressed and the documentation must support the length of time spent in counseling.**

**CMS has a preventive medicine website. The website address is <http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp>**

### **References**

**IOM 100-04, Ch 12, Section 30.6.2  
NCP Phys-001**

12. Would CPT code 57061 be appropriate to bill when using TCA to treat HPV lesions on a female in the vaginal area? Should we be using different CPT codes if some of the lesions are in the vaginal area, versus the rectal area, versus the labial area 56501 or 46900? It seems silly to bill different CPT codes, but they are different anatomical areas. I would assume that the first time the patient presented that an E/M could be billed along with the destruction code(s), and at following visits, billing only the destruction codes (s).

**Answer: CPT code 57061 (simple) or CPT code 57065 (extensive) CPT 2006 pg. 232: Destruction of vaginal lesion(s); (eg., laser surgery, electrosurgery, cryosurgery, chemosurgery) would be appropriate to bill when using TCA ( trichloroacetic acid) to treat HPV lesions on a female in the vaginal area. The extent of the lesions treated is the main factor when determining whether to use 57061 or 57065. The method of destruction can imply the level of service performed. However, the documentation must support the level of service billed regardless of the destruction method used. See also “Destruction” on pg. 67 of the CPT 2006 Professional Edition for coding instructions. Also, reference LCD DERM-008 for Medicare coverage regarding destruction of benign lesions.**

**Appropriate CPT codes should be used for procedures performed in different anatomical areas. Depending on the location, it may be appropriate to bill for CPT codes 57601, 56501, and/or 46900. However, due to the proximity of these anatomical sights, the notes would have to clearly describe both the location of the lesions and that each of these separate sights was treated. If there is no clear delineation in a different anatomical area, then only the sight(s) where the lesions are clearly established should be billed.**

**All procedures have an inherent amount of E/M built into them. If a physician has to diagnose a new problem and develops a plan of care (which can include the procedure performed) to address this problem, this generally is a separate and distinct E/M service. To bill any E/M service with a procedure, the documentation must support that a separate E/M service was performed. Due to the broad statement above, to make a definitive determination, documentation must be reviewed on a case by case basis. Also, reference**

**LCD DERM-008 for further guidance on billing E/M procedures with destruction of lesion(s).**

13. If a patient is being seen for surveillance every 3 months following completion of treatment for their cancer, it is still appropriate to use the cancer diagnosis for the visit. We are getting denials when using any V codes. The reason for the visit is to continue to monitor them for any reoccurrence of their cancer or long term effects from the cancer therapy. It is standard for the oncologist to follow patients in 3 month intervals, then extend to 6 month intervals and annually. The ICN # is 2206040364310, DOS 1/12/06

**Answer: The ICN provided in this example finalized on 02/21/06. The E/M code (99214) was allowed for the diagnosis used (V10.42). This claim was not denied. The diagnosis reported indicates personal history of malignant neoplasm, other parts of uterus. If the physician is following the patient for this reason, it is appropriate to use this ICD-9-CM code, as long as the documentation in the patient's medical records substantiates its use.**

**It appears that on the claim in question the primary diagnosis code billed was V7231 with the secondary diagnosis being V1042. V7231 is a routine gynecological exam. If truly a routine gynecological exam is given, G0101 should be billed. Please refer to Policies GU-003 and PHYS-001 for elements needed for this code and the frequency which it may be billed. It also appears in history that when the appropriate V code for cancer is the primary code billed, the service was paid.**

**When a patient is being seen for surveillance following completion of treatment for their cancer, it is appropriate to use the cancer diagnosis for the visit. If this is the reason for the visit, this should be the primary diagnosis on the claim. When to start coding with personal history of cancer versus the active diagnosis is generally based upon survival rates and local medical practice.**

14. For multiple labs which use the same CPT code, which modifier should be utilized. Example: 87400 (Influenza A or B, each) is done twice, once to test for A and once to test for B. Which modifier is appropriate for the second code? The second code with the 59 modifier has been denied. We are wondering, based on the path example, if the 76 would work. We think the 59 is the correct one to use, but need clarification because it is denied, 91 would not be because it technically is not a repeat lab. Modifier 59 seems the most appropriate because we have two separate test with two separate results.

**Answer: The Medicare system considers this procedure to be a repeat lab if it is billed more than once to Medicare for the same date of service. Doing the procedure once for Influenza A and once for Influenza B on the same day and billing the procedures to Medicare, is considered a repeat procedure and modifier 91 appropriate to bill in this situation.**

**Line 1: 87400**

**Line 2: 87400.91**

**It is not appropriate to bill modifier 59 as the situation above is not a CCI situation. Check the CCI edits to verify if a modifier 59 is needed. The use of modifier 76 is not appropriate on a clinical lab procedure.**

15. Is it acceptable for the Medicare Replacement Plan of Network Platinum Plus to require us to follow Network Health Plan's policies as well as Medicare's guidelines.

We have been told that if a patient has a CT Scan, MRI/MRA, Nuclear Cardiology, or PET Scan - we must have this precertified through NIA per the Network Health Plan policy. Medicare does not require precertification for any of these tests.

**Answer: WPS Medicare is only able to speak to traditional Medicare; therefore, we do not have an answer for this question.**

### **Agnesian**

16. We have been working with Mark regarding many dialysis claims that were not paid appropriately under code 90999 (this code must be used per Med Learn Matters article MM3414 for transient patients or patients treated in dialysis w/o a physician visit). Can you please give us guidelines on how we can get reimbursement for these services with code 90999, without having to go through all of the hassles we have been going through? What information is required in the documentation in order for this service to be paid?

**Answer: CPT Code 90999 (Unlisted Dialysis Procedure, inpatient or outpatient) is deemed a NOC (Not Otherwise Classified) code which requires medical review. When billing CPT Code 90999, "Documentation available upon request" must be placed in box 19 or the equivalent field on the electronic claim form. The provider is responsible to submit all documentation to support the code and quantity billed. Here are some helpful reminders to ask before submitting documentation for CPT Code 99099:**

- A. Is it legible?**
- B. Is the beneficiary's name on the documentation?**
- C. Are the date(s) of service the billing provider was responsible for the beneficiary on the documentation?**
- D. Is the supervising providers name on the documentation?**
- E. Is all other pertinent documentation during this timeframe included to support the code and quantity billed?**

17. We continue to have problems with updating CSNAP with eligibility information. Currently we have a couple of patients with services dating back to January. One of the patients is enrolled with WPS Medicare effective 1/1/06 but your system is still not updated. Both the patient and we have call numerous times with enrollment information. We have contacted the patient's previous Medicare Part C plan and their system is indicates disenrollment on 12/31/05. What can be done to get your system updated properly and promptly?

**Answer: The problem is with the Common Working File (CWF) and is a national issue. Providers are receiving claim denials because the beneficiary was enrolled in an HMO at one time and the CWF has not yet been updated to reflect the disenrollment. If the beneficiary has disenrolled from the HMO and has documentation from the HMO that is at least 30 days old and they have contacted 1-800-MEDICARE and their file has still not been updated the provider has three options:**

**Have the beneficiary fax the documentation to the national HMO disenrollment contractor**

**Copy the documentation and fax it to the national HMO disenrollment contractor**

**Be patient and wait for the October fix to be put into place - once the system has been fixed providers will need to resubmit claims that were denied in error**

**The national HMO disenrollment contractor is:**

**Intergrigard, LLC**

**2121 North 117<sup>th</sup> Avenue, Suite 200**

**Omaha, NE 68146**

**Fax Number: (402)995-2789**

**The eligibility information in C-SNAP is also affected by the HMO disenrollment error because information that is loaded to C-SNAP comes from CWF. The information between January, 2006 and May, 2006 may not be accurate because of the CWF system error. The C-SNAP is on target to have live eligibility at the end of September, 2006; however, this may not fix the problem. *Per CMS* the disenrollment problem is targeted to be fixed in October, 2006.**

18. Why do we need to send an invoice for Cytoxan which is code J9093? A fee for this drug was established earlier this year but I noticed that it is not on the current drug fee schedule which became effective July 1<sup>st</sup>. According to the previous schedule, Medicare was already paying us less than our cost for this drug - now we have assumed the additional cost of submitting a separate invoice each time the drug is used. We have received very few payments for Cytoxan for dates of service after April, 2006.

**Answer: An invoice is needed if the drug/biological is not listed on the ASP pricing file. This file contains lists for NOC and true codes. This file can be located using the following web link.**

**<http://www.cms.hhs.gov/providers/drugs/asp.asp>**

**Additional information is available in Change Request 4149, (Section B4) available at the following web link.**

**<http://www.cms.hhs.gov/Transmittals/downloads/R856CP.pdf>**

**CMS did not include Cytoxan in the ASP pricing file effective July 1, 2006 through September 30, 2006. Since Cytoxan does not appear on the ASP pricing file, a invoice continues to be needed.**

## UW Health

19. We recently submitted a claim that included a Seidel Test, which was submitted as CPT code 92499 with the comment “documentation available upon request” in the appropriate NTE segment. A development letter requesting information for the unlisted code was received, and the visit notes were returned with the letter in timely fashion. We subsequently received a denial (ICN #:2206152522090) for this service as CO-125 (DENIED/ REDUCED DUE TO A SUBMISSION/ BILLING ERROR(S)). One of our staff contacted WPS/Medicare Customer for help in deciphering this denial, and they were told that a “true code” exists for this service and that it was not appropriate to submit as unlisted. Our staff person was also told that Medicare could not offer further assistance with regard to submission of this service.

We have not been able to discover which code WPS/Medicare considers “true” for this service. A search of WPS/Medicare and CMS websites fails to reveal any specific instruction regarding the Seidel Test.

The denial code and our subsequent CS inquiry were not much help with this. Was the correct denial code used, and was the information from CS accurate? It’s my guess that the person who reviewed the documentation may have felt the Seidel test was a component of the intermediate ophthalmologic exam (92012) billed on the same day.

Either way, it would be in our mutual interest to have the reviewer’s rationale available for us to consider. Once we understand the unwritten guidelines we are better able to accommodate them within our coding and billing process. Any insights into this issue?

**Answer: Generally, the Seidel test is included in the ophthalmologic exams as its components are associated with these services. The nurse reviewing this claim was not able to determine what the NOC code was for and linked it to the procedures listed in the documentation.**

**20. Please note that Mark Kirchberg has already begun looking into this question**

Which POS code would be appropriate on a claim submission for professional services provided to a beneficiary who is confined in a Long Term Care Hospital? There are a couple of different scenarios which we like addressed for a LTCH inpatient in this situation.

It appears that POS code 21 (inpatient) would be appropriate if we provided professional services to the patient at the LTCH. Would that be correct?

What if the technical portion of a study or test is performed by the LTCH, but the result is sent to our doctor for interpretation and report? There is an item in the WPS/Medicare FAQ page that implies provider location is the key:

**“ The patient had a radiology service at ABC Hospital on 10/1/05 as an outpatient. Dr. Jones read the radiology services in his/her office on 10/2/05. What date of service**

**and Place of Service code should Dr. Jones use when submitting a claim to Medicare for the professional component?**

Answer: The date of service is reported on the date the service was actually performed. Dr. Jones should report 10/2/05 as the date of service. **The place of service is reported as the actual place where the provider performed the services.** Dr. Jones should report place of service office. Box 32 and the electronic equivalent should report the actual physical location of the office. “

I understand that the "box 32" address should reflect the physical location where the provider was when they performed their part of the service. And past advice from the carrier seemed to tell providers that the POS code should agree with the Box 32 entry. That is to say, if a provider reads and reports an Xray in their free-standing office, they would use that address in Box 32 and POS code 11, even if the patient was confined in a hospital. I find some apparently conflicting advice as well:

A "Q&A" in an article on page 40 of the December 2005 Communique notes patient status as the determining factor:

**“2. My patient is admitted to the emergency room, outpatient department, or inpatient floor. The facility sends the patient to my office for a visit or service. Can I bill POS office?**

**a. No. The appropriate POS code is the status of the patient. Inpatient is 21, Outpatient is 22, and Emergency room is 24. “**

Another source of information that supports the patient status as defining appropriate POS code is from the December 2005 Communique. From page 26 of that publication, as an excerpt from the IOL 100-4 included in the article on transmittal #735 (CR#4097), is the following excerpt. I've added the underlining.

**Item 24B - Enter the appropriate place of service code(s) from the list provided in section 10.5. Identify the location, using a place of service code, for each item used or service performed. This is a required field.**

**NOTE: When a service is rendered to a hospital inpatient, use the “inpatient hospital” code.**

If a beneficiary had an Xray done while an inpatient at UWHC (University of Wisconsin Hospitals and Clinics), and it was read by our radiologist in their office in the same hospital, we would use POS 21 for the professional component billing, correct? The examples in the WPS/Medicare FAQ section don't include a situation where a beneficiary is a registered inpatient at a facility, and test results are sent out to a doctor at a different facility for interp and report. If our provider reads and reports a study at their hospital office that is in a different facility that the LTCH in which the patient is confined, which POS code and box 32 address do we use when filing a claim for our professional services?

I'm also curious if there would be any CWF agreement issues with the "TC" coming from an inpatient hospital bill and the "26" coming from us with an outpatient POS, or both components coming in with POS 21, but different box 32 addresses.

**Answer: The information we provide in both the FAQ on the Website, and the example from the Communique are correct. This is based on the particular service performed. Medicare reimbursement for E&M services performed in the office include expenses for maintaining the office, including overhead, auxiliary personnel etc. Medicare reimburses the facility for these expenses when the patient is an inpatient, outpatient or an emergency room patient. Medicare's reimbursement for E&M services performed in a facility setting are lower than those performed in the office setting. In addition, services generally provided by auxiliary staff such as administration of injections etc, are part of the facility charge and Medicare Part B will not make reimbursement.**

**Medicare does not make a difference in reimbursement for the professional component of diagnostic services based on the place of service. Medicare's allowed amount is the same whether performed in the office or in the hospital. Therefore, the POS code chosen should reflect the physical location of the physician when performing the services. Physician offices located in the same building as the hospital are still physician offices. If the physician provides the service in the radiology department, as an example, the correct POS code to choose is 22, outpatient hospital.**

**This will not cause any CWF problems. There would only be problems if the TC portion is billed with POS 11 and the patient is inpatient.**

## MEDICAID

### **Mile Bluff Clinic:**

1. Can you share with us the reimbursement for Gardasil (HPV), 90649? I understand it will be administered in three doses.

**Answer: Gardasil is reimbursed at \$130.50, effective 6/9/06. This and all other new vaccines (Zoster, ProQuad, and Rotovirus) were posted on our website in the fee schedule section for physicians at the end of August 2006.**

**Note: there is a good possibility that Gardasil will be included in the VFC program. If that is the case, it will be provided free to providers and we will pay only administration fees (bill using the vaccine code). Providers will receive separate instructions on the VFC status and how to bill and be reimbursed for adult patients.**

### **Marshfield Clinic:**

2. Is any information available relating to system changes that will need to be implemented for 2007? We were originally told there would be information sessions available in early 2006.

**Answer: Information sessions with providers are tentatively scheduled for January/February 2007. There are still a number of policy issues that need to be resolved before written and oral communications with providers can commence.**

3. Is any information available regarding NPI requirements for WI Medicaid?

**Answer: Not at this time. Providers will receive notification and training when formal decisions are made.**

4. Is there updated information available regarding the Family Planning Waiver Program? Is there a new list of covered services? CPT has been updated several times since the last list was made available.

**Answer: An Update is in the works detailing the covered services. It will hopefully be ready in September.**

**If providers feel there are procedures that should be added to FPW, they need to write a letter to Jim Vavra, Director of the Bureau of Fee-for-Service Health Benefits, explaining which codes they would like to see added and the justification for the addition. DHFS is preparing to submit a waiver renewal in June 2007, and at that time a revised list of procedure codes will be submitted to CMS for approval.**

5. We have heard that WI Medicaid is considering requiring providers to submit the NDC on the claim when submitting a claim for an injectable drug administered in a physician's

office. This would require substantial changes in our systems. Is this true, and if so is there any information available on this?

**Answer: The federal Deficit Reduction Act of 2005 requires states to collect the NDC code for single-source physician administered drugs by January 1, 2007 and for multiple source physician administered drugs by January 1, 2008. The Department is awaiting additional guidance from CMS before it determines how best to implement this requirement.**

### **Agnesian**

6. When will code Q0091 be added to the FPWP procedure list? We are currently receiving a denial for all of these services. Code 99000 is a covered service.

**Answer: See answer to #4 above.**

7. Why are we receiving denial for some of our anesthesia codes with the denial code of 7 - "Information inadequate to establish medical necessity of procedure performed"? We are required to submit documentation. Examples of anesthesia procedure codes denied are: 00790 & 01961.

**Answer: A review of the claims involved found that the procedures were billed with quantities greater than 30 (7.5 hours of anesthesia). There is an edit that requires an anesthesia report if the number of 15-minute time units exceeds 30.**

**Note: in the new claims processing system, we will be requiring billing in minutes rather than units. This edit will be turned off at that time.**

8. We have received a denial of an E&M code when a patient sees two different providers - different specialties - on the same day (providers both billed 99213). One of the E&M services is paid and the other is denied as a duplicate. We appeal the denial and send in notes explaining that the services were provided by two different physicians with different specialties and it still is denied. We were told that it is denied because their system can only read procedure code and patient ID. Since the same code was billed by both providers, the system rejects one charge as a duplicate. How can we get this service paid?

**Answer: According to EDS, the provider should adjust their original *paid* claim. When adjusting, they should indicate the performing provider number on detail 1 and add another detail which includes the other performing provider number. The claim in question had the clinic as both performer and provider on one detail and the physician as performer on the other request for E&M reimbursement. The system found this to be duplicative (biller & biller), since there was no way to make a distinction between performers for the two E&Ms in question.**