

Mutual of Omaha - Medicare
Ask the Contractor Teleconference (ACT) - MINUTES
“Drug and Lab NCD Coding Guidelines
Wednesday, May 23, 2007
Chairperson: Janet Mateo

The “Ask the Contractor” Drug and Lab NCD Coding Guidelines Teleconference for the Northeast Region was called to order by Janet Mateo, Medicare Field Representative in the Chicago Field Office at 10:00 a.m. Central Time.

Following the introduction of participants on the call, Field Representatives from other regions, and other Provider Outreach and Education team members, Janet discussed the primary responsibilities of the Field Representatives to the provider community. An overview of the Ask the Contractor and Small Provider Teleconferences was provided and participants were encouraged to visit our website at www.mutualmedicare.com to download teleconference minutes and to view other upcoming educational activities. Everyone was reminded to pay close attention to the start time for teleconferences in different regions, which may vary depending on where facility is located and the time zone. For example, if your facility is located in the Central region but is participating in a teleconference held in the Northeast region; the time zone is based on the Eastern Standard Time zone, which is one hour later.

Each participant who registered for the teleconference received a confirmation notice, the Drug and Lab NCD Coding presentation and several handouts. The handouts included two coding example attachments, a Crossover Claim Issues document State ID Code and the Medicare Resource Card.

The conference call lasted 1.5 hours beginning with the Drug and Lab NCD Coding presentation followed by a discussion of the crossover claim issues identified by the EDI department and Q& A session. During the presentation participants were in a listen only mode, but were given the opportunity to ask questions during the Q&A session. Everyone was reminded to keep the questions general in nature and to direct any beneficiary specific questions to customer service at (866) 580-5945.

The topics covered during the teleconference included:

- ❑ Drug Coding
- ❑ Examples of Incorrect Drug Coding
- ❑ Guidance on Coding NCD Diagnostic Labs Test
- ❑ Reasons for 54 NCD Denials
- ❑ Examples of 54NCD Denied Claims/ How Claims should be billed
- ❑ Crossover Claim Issues Identified by EDI Department
- ❑ NPI/UB-04 Implementation
- ❑ Resources available
- ❑ Q & A Session

Questions Submitted with on-line Registrations

Will there ever be a diagnosis code added for pre-operative testing for Prothrombin Time (CPT 85610) or PTT (CPT 85730). A number of doctors include this in their standard order set for surgeries or other procedures where bleeding may be a concern, yet many times the patient is not on blood-thinning prescriptions or does not have one of the currently allowable diagnosis to support medical necessity of those tests.

At this time there are no pre-operative diagnosis codes covered as a medical necessary code within the NCD manual. In a circumstance where the patient is coming in for a pre-operative lab test and there are no other lab signs, or symptoms or related conditions on the medically necessary list, the test would be line item denied and an appeal would be necessary.

Please address the General Health Panel 80050. What if there is a valid diagnosis for the CBC, TSH, and CMP? How should we submit this lab service?

The General Health Panel (CPT 80050) is not covered by Medicare. Anything that is considered a general health service is not covered. There must be a reason for the panel to be done. There are other panels that are covered and those can be found in the Medicare Claims Processing Manual, Pub. 100-4, Chapter 16, Sec. 90. As far as the CBC, TSH, and CMP, if the lab test is performed and the patient has signs, symptoms and related conditions that are on the medically necessary covered list, providers can bill the diagnosis code on the claim at the time of submission to avoid denials and unnecessary appeals.

What charges are not separately billable?

Additional information is needed from the participant who submitted this question before answering it. Janet will review the on-line registration forms to determine who asked the question and follow-up on an individual basis.

Is it correct to bill for a residual amount of a drug not given to a patient? Review of appropriate use of modifier 59, specific examples of the terms of separate and distinct.

Units should be reported in multiples of the units included in the HCPCS descriptor. If the dosage given is not a multiple of HCPCS code, the provider should round to the next highest units in the HCPCS description for the code. If the full dosage provided is less than the dosage for the code specifying the minimum dosage for the drug, the provider reports the code for the minimum dosage amount.

Modifier 59 is used to indicate a distinct procedural service. It is used when a therapist needs to indicate that a procedure or service was distinct or independent from other services performed on the same day. For therapists, particularly PTs and OTs, modifier 59 is used to indicate distinct procedures in sequential time intervals at the same patient encounter or separate patient encounters on the same date of service. Modifier 59 is also used with CPT codes without specified time intervals, such as CPT 97002 or 97004 (PT and OT re-evaluation codes) when billed with other PT and OT services to indicate that the re-evaluation is a distinct service, when it is indicated. When billing for both individual (one-to-one) and group services provided to the same patient in the same day, modifier 59 is allowed provided the CMS and coding rules for one-on-one and group therapy are both met.

Questions Raised During the Teleconference

When I look at the Missouri Medicare website for Prothrombin Time, it shows that the Local Coverage Determine policy has been retired, but we are still receiving denials for not having the correct medically necessary diagnosis code with CPT 85610. Please clarify.

If the Prothrombin Time LCD has been retired on the Missouri Medicare website, you should be referring to the Prothrombin NCD in the National Coverage Determination manual – Publication 100-3. NCD always supercede Local coverage determinations. National coverage determination applies nationwide and is binding on all Medicare FIs, QIO, etc. Local coverage determination may be written to further clarify or define National coverage determination but cannot be more or less restrictive.

It is my understanding that you cannot code urine culture using the lab results without consulting with the referring physician first. Is this correct?

You can code based on the the lab report because it shows signs and symptoms. Since lab results are interpreted by the physician, the claim can be coded from these tests. If you had a finding or impression on a lab test result that showed signs, and symptoms, you can code as such.

For a patient entering the ER in an emergent situation and the physician is ordering test to attempt to diagnose the patient, and some of the test fall out as being denied under the NCD, are there any special conditions for the ER patient in this situation. In this situation an ABN is not issued prior to the test, and we do not know if there is a diagnosis to cover the service. Is there a special consideration for this ER scenario?

Are you not looking at the initial intake of the patient how they presented in the ER? If there are signs and symptoms in the order for the physician to order these test, there should be enough supporting information to have the service covered.

If a patient has a pre-existing condition that they are taking a prescribed medication for when they come into the ER, should the claim be coded with this condition?

If the patient were currently receiving treatment for a premorbid condition when he/she presents in the ER, this would be covered.

Will there ever be a training pertaining to recurring radiation, PT, OT services?

Mutual of Omaha will certainly consider this as a topic for future training if other providers express an interest in education on the same topic.

How should the GZ and GA modifier be reported to Medicare? We have reported the GZ with occurrence code 32 and the claims have rejected.

The GZ modifier is used to indicate that the provider expects the item or service to be denied as not reasonable and necessary. Modifier GZ cannot be used when an ABN is required. Occurrence code 32 should not be reported on claims with GZ modifier because an ABN is not issued. Claims should be submitted with non-covered charges. The provider will be held liable. GA modifier should be appended to those line items for which the ABN was issued. Charges should be submitted as covered and Medicare makes the determination if the line item is not covered or covered. The modifier GA is present and Medicare determines that the line item is not covered, the patient is liable.

We are having problems with crossover claims, who should we talk to?

Crossover claim issues should be reported to the EDI Department at (866) 734-6656. The EDI Department will refer the issue to GHI.

Please explain again how to bill the General Lab Panel (CPT 80050)

The General Lab Panel (CPT 80050) is not covered if billed alone on the claims. Since the General Panel is an uncovered service, it is safe for providers to bill the individual tests such as the CBC, TSH, and the CMP as coverable test. This would not be considered unbundling of panels. Please review Publication 100-4, Chap 16, Section 90. 1 – 90.4 for coverage of the individual panel test.

Please provide me with the training website for the NCD and LCD module?

You can find the NCD Computer Based Training module under the Provider Education section of our website at www.mutualmedicare.com. Currently, the NCD CBT is under review and is not available for viewing. Please check our website regularly for the availability of the training module.

Please clarify whether the FIs decision to pay on review of labs & EKGs shown on the slides for abnormal results is based on the physician documentation or did the FI interpret the results and assign codes. The coding convention specifies that we cannot code form lab results or nursing documentation. We can only code based on the physician's clinical documentation.

When the case file is reviewed, we look at everything in general starting with the physician's order to make sure it is available and to determine if test was performed as ordered. We also look at the documentation to make sure that it supports the need for the test performed. Page 8 of the Coding Policy Manual provides coding guidelines for all NCD edits.

There are some drugs that have multiple does, How should we code the claim. For example some drugs have 30 mg and another descriptor with 40 mg. If the physician gives multiples doses or more milligrams than either one of these, how would you code the claim. If there are 120 milligrams, and 30 mg are taken from one bottle, would you bill 4 units. What if they have 100 milligram with a descriptor or 30. Would you still bill 4 units because they took it from the 30mg bottle.

Yes. You should also indicate how the drug was administered in the remark section of the claim. For example, if 2 units of 30-mg tablets were administered on a certain date, all of this information should be reported. If you administered more or less units of more mg on another date, this should be reported in the remark section of the claim.

Following the Q & A session, several reminders were made relating to the NPI contingency plan and the implementation of the UB-04. Participants were encouraged to utilize all the educational resources available on our website at www.mutualmedicare.com and were provided with some of the benefits to signing up for the EML. Participants were also reminded about to register for the MSP Conditional Payment teleconference scheduled for Wednesday, May 30, 2007.

The teleconference concluded after participants were given additional resources such as the website address for CMS Medlearn matters articles and CMS Quarterly updates as well as brief updates on the topics that are listed below:

There were 77 participants from 24 facilities on the call today.

The teleconference ended at 11:31 a.m.

Respectfully submitted by Janet Mateo, Medicare Field Representative, Chicago Field Office