

**WPS Medicare
Ask-the-Contractor Teleconference (ACT) – MINUTES
Bone Mass Measurements
March 27, 2008
Chairperson: Mary Sue Gardner, RN/BSN**

The Central Region ACT, “Bone Mass Measurements” teleconference was called to order by Mary Sue Gardner, Medicare Outreach Nurse Analyst – Omaha Office, at 1:00 PM Central Time.

Mary Sue began the teleconference by introducing herself. She was joined by other Outreach Analysts and members of the Provider Education staff as well as nurses from the Medical Review Department. The introductions were followed by a brief description of the purpose of the call, including discussion on Change Requests (CR) 5521 and 5847, as well as WPS Medicare’s Part A processing of claims that have edited for medical review, and a discussion of the necessary documentation to submit if providers have claims that suspend for review.

The introductory discussion was followed by a review of the requirements for Bone Mass Measurement as listed in the Benefit Policy Manual, Publication 100-2, Chapter 15, Section 80.5. This section of the manual explains the conditions for coverage for Bone Mass Measurements. For Claims Processing of Bone Mass Measurements, providers were encouraged to review the Claims Processing Manual, Publication 100-4, Chapter 13, Section 140.

After review to the manual requirements, for Bone Mass Measurements, a review of Change Request 5521 which was implemented on July 2, 2007 with an effective date of January 1, 2007 was held. The requirements for contractor’s processing of Bone Mass Measurements was discussed. Discussion was then held regarding Change Request 5847 which was issued on January 18, 2008 and contained clarification on the claims processing instructions contained in CR 5521. It was determined by CMS that in some cases claims were being denied inappropriately as a result of CR 5521, which was contrary to the original intent of the change request. Change Request 5847 only listed the business requirements that changed from 5521 and the requirements of the Benefit Policy Manual did not change.

An overview was given as to how WPS Medicare Part A implemented an edit, as a result of the instructions in these Change Requests. Due to the complexity of the code combinations, WPS Medicare Part A chose to set this edit up as a complex medical review edit. This resulted in a large number of claims suspending for medical review. As a result of the large amount of claims that suspended, WPS Medicare Part A re-reviewed the requirements of the CRs and re-visited the edit to determine if corrections to the edit were needed. Applicable changes were made to the edit, and as a result of those changes WPS Medicare Part A chose to reprocess all claims that suspended for the Mass Measurements, 50BMM, edit. Clarification was given to the providers as to how WPS Medicare Part A would handle the reprocessing of these claims.

Important dates for providers to note regarding the changes to the edit are March 21, 2008 for all legacy providers. If a claim suspends for medical review for the 50BMM edit after March 21, 2008 for Legacy providers, those claims would then need to be submitted for complex medical review. For our J5 providers, March 23, 2008 was the date the changes were made to this edit. Any claim that suspends for Medical Review after this date will require complex medical review to determine if it is medically reasonable and necessary.

It was stressed and important for providers to note, that after all claims are reprocessed, if a claim suspends for medical review a second time, and the documentation has already been submitted to us, and the claim is showing in your system in the SB MRDOC status/location, that documentation does not need to be resubmitted for medical review.

Finally, regarding the medical review edit; It was stressed, and important for providers to note, that any Additional Development Request (ADR) that was received by providers prior to the dates the edits were updated, will not be required to be submitted for complex medical review, unless during reprocessing, that claims suspends a second time for medical review.

The final points discussed during this teleconference were the documentation requirements for medical review.

At the conclusion of the presentation, the line was opened up for questions from the audience.

OPEN QUESTION AND ANSWER SESSION:

Q1. Being a hospital, not a doctor's office, the history and physical as well as the rational for the test are probably going to be at the doctor's office, not the hospital. How do hospitals deal with that?

A1. If your claim suspends for medical review, you will need to contact the physician's office to obtain that documentation. If you are going to request reimbursement from Medicare for a service that your hospital performs, you will be responsible for supporting the medical necessity of the services and submitting all requested documentation required for review.

Q2. When you say that the frequency of this service is 2 years or at least 23 months have passed since the last covered bone mass measurement, I would like verification on the interpretation of this. For instance, if the first bone mass measurement was performed on January 14, 2006, we do not need to wait until after January 14, 2008, as it is allowable to perform the next one in the month of January, as long as it has been at least 23 months. Is this correct?

A2. Yes. That is correct.

Q3. In clarifying the first question, are you expecting hospitals to set up a separate medical records department to collect all the H&Ps and additional information that should be sent from the physician's office when requesting the DEXA scan, because our medical records department won't accept the H&Ps coming in from extraneous physicians coming in for outpatient services? That's what it sounds like you are asking us to do, in setting up separate medical records to track the H&Ps coming in for these tests. So are you saying it is our responsibility to get that information and to track it and keep it?

A3. Ultimately, if the claim suspends for medical review, and you are the facility that is performing the test, it is your responsibility to obtain the information necessary to support the services your facility provided are medically reasonable and necessary.

Updated Information: In accordance with the Program Integrity Manual Publication 100-8, Ch 4. Section 3.4.1.2:

**3.4.1.2 - Additional Documentation Requests (ADR) During Prepayment or Postpayment MR
(Rev. 179, Issued: 12-15-06; Effective: 11-29-06; Implementation: 01-16-07)**

When contractors cannot make a coverage or coding determination based upon the information on the claim and its attachments, the contractors may solicit additional documentation from the provider or supplier by issuing an additional documentation request (ADR). Contractors shall request records related to the claim(s) being reviewed. Contractors may collect documentation related to the patient's condition before and after a service in order to get a more complete picture of the patient's clinical condition. The contractor shall not deny other claims related to the documentation of the patient's condition before and after the claim in question unless appropriate consideration is given to the actual additional claims and associated documentation.

This section goes on to state in section A.

A. Development of Non-Lab Claims for Additional Documentation

If, during pre- or post-pay review, a contractor chooses to send an Additional Documentation Request (ADR) regarding a *non-lab* targeted service, they shall solicit the documentation from the billing provider or supplier and may solicit documentation from other entities (third parties) involved in the beneficiary's care. If a contractor chooses to solicit documentation from a third party, they may send the third party ADR simultaneously with the billing provider or supplier ADR. Contractors shall send ADRs in accordance with the following requirements:

Billing Provider or Supplier ADRs

- Contractors who choose to request additional documentation shall solicit such information from the billing provider or supplier and shall notify them that they have 30 days to respond. Contractors have the discretion to grant an extension of the timeframe upon request. The contractor shall pend the claim for 45 days. Contractors may cc a third party.
- Contractors have the discretion to issue no more than two (2) "reminder" notices via letter or phone call prior to the 45th day.
- If information is *automatically* requested only from the billing provider or supplier and no response is received within 45 days after the date of the request (or extension), the contractor shall deny the service as not reasonable and necessary (*except for ambulance claims where the denial may be based on §1861(s)(7) or §1862(a)(1)(A) of the Act depending upon the reason for the requested information*). These claims denials are issued with Remittance Advice Code N102/56900 ("This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely."). These denials count as automated review. Refer to PIM chapter 3, section 3.4.5 for definitions and examples of types of prepayment and postpayment review.
- If information is requested only from the billing provider or supplier and the information received fails to support the medical necessity of the service, in full or in part, the contractor shall deny the claim, in full or in part, using the appropriate denial code (see section 3.4.2). Beneficiaries cannot be held liable for these denials unless they received proper liability notification before services were rendered, as detailed in CMS Pub IOM 100-04, chapter 30. These denials would count as complex review. Refer to PIM chapter 3, section 3.4.5 for definitions and examples of types of prepayment and postpayment review.

Q4. For legacy Part A, if we received an ADR prior to March 21, 2008 we do not need to submit those, correct?

A4. You are correct. If you received an ADR as a legacy provider, prior to March 21, 2008 you do not need to submit this for medical review. You do however need to watch your system to assure this claim moves to the payment floor. If a second ADR generates after March 21, 2008 you would need to respond to that. WPS Medicare will be publishing a Listserv message stating this, as well as post the minutes to the call and audio of this call.

Q5. In regards to the G code for screening, can you repeat that code and is that used in replacement to the 77080 when you submit?

A5. That code was the G0130, and would not be used in replacement of the 77080. This code is: Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel). CMS lists this as a code that is allowable to charge for screening, but must also meet all other medical necessity requirements.

Q6. We are a J5 provider, and I just wanted to verify that any ADR that generates after March 24, 2008 would be the ones that we would have to re-submit documentation for, correct?

A6. Any ADR that generated after March 24, 2008 for J5 providers are ones that you will need to respond to. Keep in mind, that if claim also suspended prior to that date, and generated an ADR, and you responded to the ADR with medical records, you would not need to submit documentation again for medical review. These would be claims that on your system for this reason code are in the status/location of S MRDOC.

Follow up information to call: There was question on the call regarding the status location of S MRDOC, and it was verified that this will also remain the status/location of received claims for medical review for our J5 providers.

Q7. We are from Iowa, and we have not transitioned to WPS yet, but we are trying to get a jump on what we need to do in regards to these claims. We are also having a lot of problems with the Bone Mass Measurements in Iowa as well. In a meeting with WPS recently, we were given a list of CMS preventative services, and Bone Mass Measurements was on there as a covered service. It says beneficiaries can get them, but we can't get them paid for. We need to talk to our current contractor, because they are denying any Bone Density that has a screening code on it. We have chosen not to even do any DEXA scans until we come over to WPS.

A7. We cannot answer to how your current FI is handling these claims for you, however the services for Bone Density Measurement Screening are allowable under Medicare regulations if they meet the regulatory requirements to be performed. The only advice we can offer is to append your appeals rights on those that meet regulatory requirements through your current contractor.

Q8. We are also from Iowa, and when we come over to you, I wanted to verify is screening for a-symptomatic post menopausal female that there are no other issues with this beneficiary going on, can they be covered at intervals of every year based on this alone.

A8. If this patient is only postmenopausal, a-symptomatic, and there is no other documentation to support the medical need for this test at an interval of greater than 2 years, it probably would not be considered for coverage.

Q9. The CR 5847 mentions several times a local list of covered ICD-9 diagnosis codes by the contractor, and we are wondering if there will be a local list published for Part A? We see that Part B does have a list within their LCD, and wondered if you were going to publish a list for Part A?

A9. Yes, we are in the process of developing a local list for Part A. We are not sure at this time if it will come out in the form of an LCD or just a local list. You can look at the list contained in the Part B LCD as a reference at this time, but Part A is in the process of currently developing a list of these covered ICD-9 codes.

This concluded the question and answer portion of the call. The providers were encouraged to sign up for our e-News Listserv under the Self Service tab of our Website,

<http://www.wpsmedicare.com/index.html>, as well as directed to contact information for our outreach analysts and location of additional educational sources.

The teleconference was ended at approximately 1:48 PM Central Time.

The references included in this presentation are for informational purposes only. The current Medicare regulations will prevail.

There were 120 participants on 54 lines for the teleconference.