

Ask-the-Contractor Teleconference (ACT) Minutes

Time: 10:00 – 11:30 am (CDT)

Date: 09/16/2009

Meeting Group:

Ask-the-Contractor Teleconference (ACT)

Attendees:

LEGACY Providers and Provider Representatives and Agents

Note Taker:

Recorded Call

Telephone Number: 877-290-9695

Pass code: 72897736

Agenda Item	Discussion	Suggestions	Outcome/Action
Note: Free Form Agenda	The following represents questions asked during this 90-minute call.	The designated operator for the phone provider welcomed everyone and reviewed procedures for asking a question. The operator then introduced the lead moderator, J. David Bozarth.	
Introductions:	POE staff introduced themselves and co-moderators and deferred to the panel of experts. Staff stated today's date, and that the call was being recorded. Anyone who had issue with this should disconnect. The goal is to answer as many questions as possible during the time allowed. For those whose questions require research, a member of the panel of experts will ask for the participant's phone number for follow-up after the call.	The designated operator for the phone provider again reviewed the procedures for posting a question, and the call began.	
Question 1:	What are the guidelines for billing the Welcome to Medicare physical? Does everyone get one?	We reviewed the guidelines for this Preventive Service, including the changes for 2009.	We reminded the participants that the Welcome to Medicare Physical must be provided within the first year of a beneficiary's eligibility, and cannot be performed after that point.
Question 2:	Should we append the GW modifier when billing for psychologists in place of service 34 for	The Medicare Internet Only Manual (IOM) 100-04, Chapter 11, Section 50	We will follow-up with this provider to get more specifics, including claim

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	procedure codes 99304-99318? Our claims for these services are being denied.	addresses this billing scenario.	examples, to best determine the nature of the problem.
Question 3:	Are we correct in appending a KD modifier to charges for compounded drugs, such as J3490?	These compounded drugs are typically provided through an implantable pump.	We referenced a <i>Communiqué</i> article from August 2009 which addresses this.
Question 4:	We receive some payments and some denials when billing for left ventricular assist devices (LVAD), procedure code Q0496, in an outpatient setting.	There are only a few facilities approved to provide this service in an outpatient setting nationwide.	We provided several follow-ups for this provider and are still working to resolve the billing issues associated with this.
Question 5:	We are interested in a proposed Local Coverage Decision for physical therapy (PHYSMED-009) and noticed that it was pulled from the Website. Was it pulled because of technical problems or because of other proposed changes? When can we expect this policy to be reinstated?	There was a reference to the previous “Active-Final” policy, but it was pulled as well. The provider was correct in that (PHYSMED-009) was pulled due to some needed revisions	We will notify providers via the Website and Listserv messaging as to when the revised policy will be re-introduced, with its corresponding effective dates.
Question 6:	How do we bill Medicare B for a shingles vaccine for a patient who has no Medicare Part D coverage, but who has a supplemental policy that will cover it if they receive a denial from Medicare? Will we violate a contract by balance billing the patient?	You do not bill Medicare Part B. This service is a coverage benefit for Part D only. You are correctly receiving a CO 50 denial (for Contract Obligation).	The provider should discuss this with the supplemental insurer to determine how to accommodate the need for a denial, when the provider should not bill Medicare Part B for this service.
Question 7:	How do we bill add-on code 90472 when we are not providing the base code of 90471? This is generating denials both when 90471 is billed and denied (PR 96) as non-covered, or when 90471 is not being billed at all.	90471 is only payable when the associated vaccine is payable. By the same token, 90472 is only payable when 90471 is payable. This provider’s claims are being denied correctly.	We will follow-up with this provider to get examples of instances where they received payment for 90472, and try to advise them on the GY modifier and getting “patient responsibility” denials.
Question 8:	We are having trouble with venipuncture services being denied and we have worked with both our clearinghouse and with WPS EDI, and still have not resolved the situation. What should we do?	We are receiving a denial message of 257, and the EDI representative says that there is missing information in field 33 of our electronic transmission.	We will call this provider to research their information specifically, and work with our EDI area to make certain we answer correctly.
Question 9:	a. Is the GW modifier appropriate for mental health services provided to Hospice patients?	Yes, GW is the appropriate modifier for when you are treating something not related to a patient’s terminal condition	
	b. I have questions about proper usage of modifier 76. How do I know when to use this, as opposed to times when services can be quantity billed?	During this discussion, the caller said that she had answered her own question.	We encouraged the caller to review the Modifier 76 Fact Sheet, and to reference the quantity billing services chart.
Question 10:	We do not understand how to bill outpatient mental health services when a patient has a primary over Medicare and the claim adjustment is not correct.		We took this caller’s name and number for a call-back with specific examples of the situation she was describing.
Question 11:	Can we bill Medicare for an attending physician seeing a Hospice patient when the patient is on a	Depending upon the contract in place, you may bill Medicare. But, whether or	We encouraged the caller to contact VA to determine if the contract in place

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	VA contract? Will Medicare pay the balance?	not Medicare will pay is unknown.	allows for any balance billing.
Question 12:	Can we bill for the services of a primary physician when a hospitalist is assuming the care of a patient and the primary has no face-to-face contact?	The caller went on to say that the hospitalist and the attending are under the same tax ID number.	Under this scenario, no services can be billed to Medicare Part B.
Question 13:	We submitted comments regarding Local Coverage Determination L30135. When can we expect to see something posted regarding a final on this policy?	This policy regards skin substitutes and has been revised. The new policy with changes should be released soon.	Look to the replacement of the original policy for this service, which was just replaced onto the WPS Medicare Website.
Question 14:	What are we to do regarding Medicare Advantage plans who retroactively disenrolled beneficiaries and recouped monies paid for their services?	We are seeking guidance from the Centers for Medicare & Medicaid Services (CMS) on this issue, as it has become widespread and is difficult for many providers.	WPS Medicare will publish any and all information we receive on this topic as soon as it is made available.
Question 15:	Can I speak to someone in Provider Enrollment regarding the deactivation of a Medicare provider number for lack of billing? Is this common?	You are correct in that Medicare is required to deactivate provider numbers when they are not used in a year's time.	The Provider Enrollment hotline for Wisconsin providers is 877-908-8476.
Question 16:	a. Is there a maximum number of services that a social worker can bill to Medicare Part B?	There is no maximum number of services that a social worker can bill Medicare Part B. However, all services billed will be considered for medical necessity, which can include frequency.	
	b. Can we bill Medicare Part B for home health care services when a patient does not have Part A?	Yes. If a patient has Medicare Part A coverage, then it would hold precedent over Part B for home health services. However, if there is no Part A, then the provider could bill Part B for this.	
	c. Can we bill for flu shots we provide? Where can we find instructions for roster billing flu shots?	Information pertaining to billing for flu shots is available on the WPS Medicare Website at www.wpsmedicare.com	
Question 17:	a. We have been paid for 95806, an unattended sleep study, which we feel should not be paid. Has the coverage for this service recently changed?	Yes, there has been a recent change in coverage for unattended sleep studies.	Look to the October <i>Communiqué</i> for more information regarding this service.
	b. How do we know whether to reference the Quantity Billing chart or the MUE listings for determining what we may bill to Medicare Part B.	For multiple services, you should reference both the Quantity Billing chart and the MUE listings.	We explained in detail how both the WPS Medicare and CMS Websites must be used as references for these determinations.
	c. What are the time limits associated with Coordination of Benefits (COB) claims that are	The Coordination of Benefits Contractor (COBC) has 120 days to	We do not believe that this information is available via C-SNAP; however, you

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	under investigation? Can we locate this information via the CMS Secure Net Access Portal (C-SNAP)?	complete reviews of claims under investigation.	may inquire with Customer Service.
	d. Does the WPS Medicare system recognize sub-specialties prior to denying multiple E/M services billed on the same day by providers of a group?	Currently, sub-specialties are not recognized; however, for such denials providers may request an appeal.	There are limited situations whereby an appeal can consider sub-specialties. It <u>is</u> important that providers be mindful of situations wherein physicians of the same group are seeing patients. The mere classification of sub-specialty does not exempt providers from denials for multiple E/M services being billed.
	e. Are there any general guidelines for refunds? Must we refund before we submit re-bills?	There is no set way to approach this. Usually you would refund first.	Depending upon the situation, you may want to request a Reopening.
Question 18:	a. Are commercial insurers bound by Medicare's guidelines for billing carve-out procedures? What do we do in situations when we are being overpaid?	There may be different approaches by different private insurers as to how they calculate payments for carve outs.	Work with the individual insurers to determine what their process may be. You may reference the carve-out guide in the preventive services section of the WPS Medicare Website.
	b. Can I bill Medicare Advantage claims for carve-out services the same way I bill them to Medicare?	We cannot speak on behalf of Medicare Advantage plans, as they are contracted by CMS just as we are.	Contact Advantage plans individually to determine their specific guidelines for processing carve-out services.
Question 19:	a. Is Medicare B doing anything to address the mental health reduction being applied to E/M services provided by internal medicine specialists for a diagnosis of dementia?	We are billing procedure codes 99213, 99214, and 99215, and receive a reduction when the only diagnosis is one of dementia.	We took this callers name and phone number for a call-back with specific examples.
	b. Do the notes in a patient's record need to reflect the amount of time a physician took to render discharge management? If so, where should these notes be placed, in the progress notes or in the discharge summary?		It is appropriate for providers to list the amount of time spent for discharge management. The discharge summary is the most logical place to report this.
	c. Is there any update on contract reform? Will WPS Medicare continue as our contractor? We would hate to lose WPS Medicare.	Thank you for this. However, we have no information pertaining to updates in Medicare Contracting Reform.	Please reference the CMS Website for continuing updates regarding contract reform and Medicare Administrative Contract (MAC) awards.
Adjournment	We thanked all participants for taking time out of their busy days to join us.	We reminded all that we host these Ask-the Contractor Teleconferences (ACTs) on a quarterly basis.	Watch the WPS Medicare Website for announcements of all upcoming ACTs.