

3rd Quarter FY09 Written Correspondence FAQs (J5)

Q1. Where can I find a definition and usage information for modifier K8?

A1. The K8 modifier was deleted from the list of valid modifiers. The modifier never was intended for use. The deletion date is April 1, 2009

Go to <http://www.cms.hhs.gov/>

Click on "Regulations and Guidance"

Under Guidance

Click on Transmittals

Under Transmittals

Click on "2009" Transmittals

Scroll down & choose "All" in the View Items per page

Click Go

Click on "R1739CP" (6480)

<http://www.cms.hhs.gov/transmittals/downloads/R1739CP.pdf>

Q2. Where can I find information on billing multiple laboratory panels on the same claim?

A2. A listing of HCPC laboratory panels codes can be found in CMS web site 100-4 Chapter 16 Section 90.2.

Go to <http://www.cms.hhs.gov/>

Click on "Regulations and Guidance"

Under "Guidance" click on "Manuals"

Under Manuals Overview on the Left side, click on "Internet-Only Manuals"

Under Publications click on 100-04

Under Downloads click on Chapter 16

Section 90.2

<http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf>

Q3. When did the Erythropoiesis Stimulating Agent Local Coverage Determination (LCD) become the same for Part A and Part B?

A3. The Erythropoiesis Stimulating Agent LCD (L26655) was effective for Part A and Part B services on May 23, 2008.

Q4. If physical therapy (PT), occupational therapy (OT) and speech language pathology (SLP) services are performed on the same date and at the same time, can we bill 2 units for the 15 minutes performed for both OT & SLP services?

- A4. Therapists, or therapy assistants, working together as a “team” to treat one or more patients cannot each bill separately for the same or different service provided at the same time to the same patient.

CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same patient(s). Where a physical and occupational therapist both provide services to one patient at the same time, only one therapist can bill for the entire service or the PT and OT can divide the service units. For example, a PT and an OT work together for 30 minutes with one patient on transfer activities. The PT and OT could each bill one unit of 97530. Alternatively, the 2 units of 97530 could be billed by either the PT or the OT, but not both. Similarly, if two therapy assistants provide services to the same patient at the same time, only the service of one therapy assistant can be billed by the supervising therapist or the service units can be split between the two therapy assistants and billed by the supervising therapist(s).

<http://www.cms.hhs.gov/>

Click on Medicare

Under Billing

Click on Therapy Services

Under Overview

Click on 11- Part B Scenario

Scroll down to 1. Billing –CPT Codes: Not Permitted

http://www.cms.hhs.gov/TherapyServices/02_billing_scenarios.asp

- Q5. We are a Method II Critical Access Hospital (CAH) and have patients that come in to see the doctor. During that same day they have reference lab performed. Can we bill two claims and what type of bill do we use?
- A5. Prior to July 1, 2009 you would bill an 85X Type of Bill (TOB) for the Hospital Physician charges and any appropriate hospital charges. The reference lab services would be billed on a 14X TOB.

For dates of service on or after July 1, 2009, an individual is no longer required to be physically present in a CAH at the time the specimen is collected. However, the individual must be an outpatient of the CAH, as defined at 42 CFR §410.2 and be receiving services directly from the CAH. In order for the individual to be receiving services directly from the CAH, the individual must either be receiving outpatient services in the CAH on the same day the specimen is collected, or the specimen must be collected by an employee of the CAH. These services would be billed on an 85X TOB.

Tests for non-patients are billed on TOB 14X, and are paid under the lab fee schedule.

Go to <http://www.cms.hhs.gov/>

Click on "Regulations and Guidance"
Under Guidance
Click on Transmittals
Under Transmittals
Click on "2009" Transmittals
Scroll down & choose "All" in the View Items per page
Click Go
Click on "R1729CP" (6395)
<http://www.cms.hhs.gov/transmittals/downloads/R1729CP.pdf>

Q6. Can we bill for a urinalysis test when a nurse collected the test and not the laboratory technician?

A6. Yes, medically necessary urinalysis tests collected by the nurse can be billed to Medicare.

Q7. We have several women come in annually to have a mammography. Some women have breast implants due to a history of breast cancer and some have breast implants and have no history of breast cancer. Should the mammogram be billed as a screening or diagnostic service for these patients?

A7. The test should be billed as a screening service if the service is for annual test and is not for complications. Screening mammographies are radiologic procedures for early detection of breast cancer and include a physician's interpretation of the results. A doctor's prescription or referral is not necessary for the procedure to be covered. If the test is being repeated due to history of breast cancer then the Diagnostic test would be appropriate.

Go to <http://www.cms.hhs.gov/>
Click on "Regulations and Guidance"
Under "Guidance" click on "Manuals"
Under Manuals Overview on the Left side, click on "Internet-Only Manuals"
Under Publications click on 100-04
Under Downloads click on Chapter 18
Section 20
<http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf>

Q8. Is it appropriate to use HCPCS codes 97110, 97112 or 97530 during speech language therapy performed in a Skilled Nursing Facility (SNF)?

A8. Therapy services according to regulations are considered skilled rehabilitative services. A SNF facility would be able to perform the therapy if they are within their scope of practice by qualified professionals or qualified personnel.

Go to <http://www.cms.hhs.gov/>
Click on "Regulations and Guidance"
Under "Guidance" click on "Manuals"
Under Manuals Overview on the Left side, click on "Internet-Only
Manuals"
Under Publications click on 100-02
Under Downloads click on Chapter 15
Section 220
<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>

A listing of medically necessary HCPCS codes for therapy services can be found in our Local Coverage Determinations (LCDs). They are as follows:
Physical Therapy- L26555
Occupational Therapy- L26574
Speech Language Pathology- L26614

Go to
http://www.wpsmedicare.com/j5macparta/policy/active/local/files/mac_a_lcd_list.pdf

To see a listing of all of our LCDs.

- Q9. We are a CAH and would like to know how to bill Medicare to utilize days for inpatients that have a Medicare Advantage Plan?
- A9. Hospitals must submit an informational only bill (TOB 11X) which includes Condition Code 04 to their Medicare contractor.

Go to <http://www.cms.hhs.gov/>
Click on "Regulations and Guidance"
Under Guidance
Click on Transmittals
Under Transmittals
Click on "2007" Transmittals
Scroll down & choose "All" in the View Items per page
Click Go
Click on "[R1311CP](#)" (5647)
<http://www.cms.hhs.gov/transmittals/downloads/R1311CP.pdf>

- Q10. I am researching coverage policies for intravascular ultrasound (IVUS). Does Medicare cover IVUS for non-coronary patients?
- A10. Yes, this is a billable service; however according to the federal register the IVUS HCPC Codes of 37250 and 37251 have a status indicator of an N so there is no separate payment they are packaged into the APC.

Go to <http://www.cms.hhs.gov/>
Click on Medicare

Under Medicare Fee-for-Service Payment
Click on Hospital Outpatient PPS
On left side click on Addendum B
Scroll down & choose "All" in the View Items per page
Click Go
Click on Addendum B for the appropriate date of your claim.

<http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage>

Q11. I have an adjustment that rejected with reason code 30960 stating that a provider is not permitted to adjust a medically approved claim. Do I have to mail in my adjustment?

A11. Yes, a provider is not permitted to adjust a medically approved claim. This reason code is assigned when the following conditions are true.

- Frequency Code is '7' or '8'
- Adjustment Req code is 'H'
- History claim current status is 'P' or 'R'
- History claim user action code is = to 'E' or 'ER'
- If the claim has the above conditions the adjustment must be sent in hardcopy or if the claim was denied for Medical Review then it must be appealed.

Q12. I work for an acute hospital and billed a same day transfer claim. Unfortunately, the claim is editing with reason code 37022 stating to submit all medically necessary days as covered days and covered charges. I am billing date of service 01/24/09 through 01/24/09 and have one day in the covered day field and one day in the non-covered day field. How should I be submitting these claims?

A12. The claims should be submitted with the days in the non-covered field, the charges in covered and the 40 condition code must also be included on the claim.

Go to <http://www.cms.hhs.gov/>

Click on "Regulations and Guidance"

Under "Guidance" click on "Manuals"

Under Manuals Overview on the Left side, click on "Internet-Only Manuals"

Under Publications click on 100-04

Under Downloads click on Chapter 3

Section 40.1 Part D

<http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf>

Q13. I have an outpatient claim (13X) that rejected with reason code C7113 stating an inpatient stay is less than 4 days from my outpatient claim. If I remove the diagnostic services from my outpatient claim, will this allow my claim to process?

A13. Yes, if all diagnostic services are removed from the claim this will allow the claim to process.

Go to <http://www.cms.hhs.gov/>

Click on "Regulations and Guidance"

Under "Guidance" click on "Manuals"

Under Manuals Overview on the Left side, click on "Internet-Only Manuals"

Under Publications click on 100-04

Under Downloads click on Chapter 3

Section 40.3

<http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf>

Q14. I have an inpatient claim (11X) that rejected with reason code C7120 stating that an outpatient claim is equal to my inpatient claim. How do I get my claim to process?

A14. If the outpatient history claim has one or more diagnostic revenue codes present you must cancel the outpatient claim and add all the charges to the inpatient claim.

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Under Manuals Overview on the Left side, click on "Internet-Only Manuals"

Under Publications click on 100-04

Under Downloads click on Chapter 3

Section 40.3

<http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf>

Q15. I have a claim that rejected for reason code W7062 stating that HCPCS code 90780 is not recognized by Outpatient Prospective Payment System (OPPS). How do I correct this claim?

A15. A new HCPC code would need to be used on the claim. An alternate code may be available for the same service.

Q16. I have a claim that is editing with reason code W7050 stating that the service is non-covered based on statutory exclusion. I am trying to bill HCPC code A9270 for a self-administered drug denial. How should I be billing this?

A16. Providers should bill self-administered drugs with revenue code 637 as non-covered charges with HCPC A9270 along with modifier GY (Item or Service Statutorily Excluded or Does Not Meet the Definition of Any Medicare Benefit).

Go to <http://www.cms.hhs.gov/>
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Under "Guidance" click on "Manuals"
Under Manuals Overview on the Left side, click on "Internet-Only
Manuals"
Under Publications click on 100-04
Under Downloads click on Chapter 1
Section 60.4.2
<http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>

Q17. Is a medically necessary ambulance service excluded from consolidated billing if the service they are going to the hospital for is excluded?

A17. Yes. Ambulance trips associated with Major Category I.A-E. and G. services are excluded from SNF consolidated billing. In addition, ambulance trips associated with Major Category II. A. services provided in renal dialysis facilities (RDFs) are also excluded from SNF consolidated billing.

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Click on "Regulations and Guidance"
Under "Guidance" click on "Manuals"
Under Manuals Overview on the Left side, click on "Internet-Only
Manuals"
Under Publications click on 100-04
Under Downloads click on Chapter 6
Section 20.3.1
<http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf>

Q18. Can Critical Access Hospitals (CAHs) bill inpatient Part B services on Type of Bill (TOB) 12X?

A18. Yes, CAHs can bill inpatient Part B services on type of bill 12X, however there are some revenue codes that can not be billed on the 12X bill type. Refer to the below section in CMS Manual for a list of excluded revenue codes on a 12X bill type.

Go to <http://www.cms.hhs.gov/>
Click on "Regulations and Guidance"
Under "Guidance" click on "Manuals"
Under Manuals Overview on the Left side, click on "Internet-Only
Manuals"
Under Publications click on 100-04
Under Downloads click on Chapter 4
Section 240.1

Q19. I have a claim that rejected for reason code 34465 stating that this beneficiary has coverage through an employer's group health plan that is primary over Medicare. We show that Medicare is the primary insurance. Common Working File (CWF) has been updated to show that Medicare is primary. How can I get my claim to process?

A19. You must adjust your claim using a condition code D8 along with the appropriate adjustment reason code (i.e., BL (Black Lung), DB (Disability), LI (Liability), WC, (Workers Compensation), WE (Working Elderly) etc...).

Q20. I have an outpatient (13X) claim that line denied with reason code W7040 stating that a component of comprehensive procedure was billed without an appropriate modifier. What do I need to do to get this line to process?

A20. To get the claim to process you will need to check the NCCI tables to see if a modifier is appropriate, and then add the appropriate modifier is allowed. The following CMS manual is in reference to the modifier explanation.

Go to <http://www.cms.hhs.gov/>

Click on "Regulations and Guidance"

Under "Guidance" click on "Manuals"

Under Manuals Overview on the Left side, click on "Internet-Only Manuals"

Under Publications click on 100-04

Under Downloads click on Chapter 23

Section 20.9.1

<http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf>

The following link is to the National Correct Coding Initiative (NCCI) tables (this table will allow you to check your codes to see if modifier is allowed), after clicking on the link you would then click on the appropriate code range for your claim.

<http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp#TopOfPage>

Q21. I have a claim that is editing with reason code 31715 stating that the units of service are in excess of the medically reasonable daily allowable frequency. How can I determine which HCPC code is over the daily allowance? What if the allowable amount has been billed for the HCPC that is editing?

A21. Providers need to check every HCPCS code on the claim to verify that the correct units are reported. A partial list of the Medically Unlikely Edit HCPCS/CPT codes can be found at:

http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp