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**Wisconsin Physicians Service (WPS) Medicare
Ask-the-Contractor Teleconference (ACT) - MINUTES
Topic: Critical Access Hospitals (CAHs)
August 27, 2009
Chairperson: Tanya Hardiman**

The J5 ACT call was conducted by Tanya Hardiman, Medicare Outreach Analyst. The topic was Critical Access Hospitals (CAHs). This was an open Question & Answer call.

Tanya began the teleconference by introducing herself. She was joined by other Outreach Analysts, Customer Service, the Claims Department, and Audit & Reimbursement. The introductions were followed by a brief description of the information available on the WPS Medicare Website. Participants were encouraged to sign up for the WPS and CMS electronic mailing lists.

The introductory discussion, the call was opened for questions.

Questions and Answers:

Q1: My question relates to the meeting we had on Tuesday with CMS and our Recovery Audit Contractor (RAC). In the meeting they related they had their automatic recoupment process ready, but they were waiting on some system changes on WPS' end. Can you tell me when we can anticipate those system changes will be made?

A1: The system changes are not with WPS but with FISS. We have not been given a date when the changes will be made.

Q2: The RAC also indicated there was a repository where claims will be put if they were already medically reviewed by WPS. I wanted to make sure WPS was using this repository.

A2: Yes, WPS will be using this repository. If your claim was ever medically reviewed by WPS, then the RAC should not be reviewing it again.

Q3: My concern is regarding the change in lab billing. If a CAH employee goes to a Skilled Nursing Facility (SNF) and collects a lab specimen, we can bill this on an 85x type of bill (TOB), correct?

A3: This is correct as long as the beneficiary is not in a Medicare Part A stay. If the patient is in a Part A stay, then the SNF will be responsible because the lab service is part of SNF Consolidated Billing.

[This change can be found in Transmittal 1782, Change Request 6395, 2009. The regulation can also be found in CMS Internet Only Manual \(IOM\), Publication 100-04, Medicare Claims Processing Manual; Chapter 4; Section 250.6](#)

For purpose of implementation of section 148 of MIPPA, a CAH employee is considered the following:

1. Employee of CAH main provider
2. Employee of a CAH provider-based department

An employee of a provider-based entity, such as an RHC, cannot be considered a CAH employee for purposes of this provision. The definitions of department of

a provider and provider-based entity can be found in the regulations at 413.65(a):
http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr413.65.pdf

3. A contracted employee of the CAH – if the individual performing the specimen collection is not employed by any other entity to provider services at the location where the specimen collection is taking place

Q4: How does this change in lab billing affect provider-based Rural Health Clinics (RHCs) if the employees of the RHC are also employees of the CAH?

A4: If the RHC is provider-based to the CAH and the collection was done at the RHC, then the CAH may bill the claim on an 85x TOB. Payment for laboratory tests performed for a patient of a RHC is not included in the RHC's all-inclusive rate and may be billed separately by the base provider for a provider-based RHC.

This regulation can be found in CMS IOM, Publication 100-04, Medicare Claims Processing Manual; Ch. 16; Sec. 30.3

Q5: Regarding the policy for Erythropoiesis Stimulating Agents (ESA), could you please clarify if the hemoglobin on subsequent injections can be between 10 and 12. Or is it supposed to be below 10? This would be with a diagnosis of chronic kidney disease and anemia.

A5: Tanya requested the provider to send her question via e-mail. Below is the answer. The Hemoglobin (HGB) 10-12 would be acceptable for chronic kidney disease for continuance. The HGB is usually below 10 for the initiation of an ESA medication for chronic kidney disease. The stipulation that the HGB has to be below 10 or Hematocrit (HCT) below 30 for initiation and continued administration of an ESA medication was specific to the cancer diagnoses and stipulations in CMS IOM, Publication 100-03, Medicare National Coverage Determinations (NCD) Manual; Sec. 110.21

Q6: If you have an employee walk over to a nursing home, are you still able to bill for the travel fee?

A6: No, if the employee is just walking to the next building, you may not bill for a travel fee.

Upon further review, we were unable to find regulation that states this may not be billed. However, travel allowance can be made only where a specimen collection fee is also payable, i.e., no travel allowance is made where the technician merely performs a messenger service to pick up a specimen drawn by a physician or nursing home personnel.

This regulation can be found in CMS IOM, Publication 100-04, Medicare Claims Processing Manual; Ch. 16; Sec. 60.2

Q7: We have to have time recorded for physical therapy on an outpatient basis. Is this also true on an inpatient basis? Does the start and stop time have to be documented in the chart?

A7: HCPCS are not required on an inpatient claim; however, you would need to document the start and stop time in the beneficiary's record.

Q8: If a beneficiary is on Medicare Part A at a SNF, and they come to our facility for a Doppler, may we bill Medicare for the procedure or would the SNF be responsible?

A8: This would all depend on if the procedure fell under SNF Consolidated Billing or not. In order to know for sure, you would need the HCPCS for the procedure and check the SNF Consolidated Billing exclusion list.

The SNF Consolidated Billing exclusion list may be found at <http://www.cms.hhs.gov/SNFConsolidatedBilling/>. On the left hand side, click the “FI/A/B MAC Update” link for the appropriate year.

Q9: In regards to documenting therapy minutes, can we just document the minutes or do we need to record the start and stop times?

A9: You always need to document start and stop times.

Q10: We have been running into a lot of new edits on the Medicare system. The issue we are having is understanding if we should be using modifiers. The specific reason codes we are getting are 31587 and 31588.

A10: The provider was asked to fax specific claim examples to Tanya for investigation.

Q11: We are having the same issue with reason code 31588 and were told by Customer Service this is a system issue.

A11: The provider was asked to fax specific claim examples to Tanya for investigation. [The issue with reason code 31588 has been referred and is currently being investigated.](#)

Q12: When can travel fees be billed?

A12: Transportation costs may be billed for mobile radiology units.

[This regulation can be found in CMS IOM, Publication 100-04, Medicare Claims Processing Manual; Ch. 13; Sec. 90.3 and 90.5](#)

Travel allowance may also be billed under certain circumstances for specimen collection.

[This regulation can be found in CMS IOM, Publication 100-04, Medicare Claims Processing Manual; Ch. 16; Sec. 60.2](#)

Q13: We bill swing bed and use an 18x TOB. We have a patient that was non-weight bearing, so we used condition code 56 because he was unable to be skilled past the 30 day transfer requirement. This claim is being denied with reason code 31513 saying condition code 56 can only be used on a 21x TOB (a SNF inpatient claim).

A13: The provider was asked to fax the claim information to Tanya for investigation.

[Information on the use of condition code 56 can be found in CMS IOM, Publication 100-02, Medicare Benefit Policy Manual; Ch. 8; Sec. 20.2.2](#)

Q14: If I have a patient come in twice a day for hydration therapy, I know we put all the charges with the appropriate revenue code on the first line then put zero dollars for the same revenue code on the second line. When does the 59 modifier apply to this?

A14: The primary purpose of modifier 59 is to indicate that two or more procedures are performed at different anatomic sites or during different patient encounters. It should be used only if no other modifier more appropriately describes the relationships of the two or more procedure codes. If using the 59 modifier, and the use is appropriate, you would put the modifier on the second line.

[More information on the proper usage of modifier 59 can be found at http://www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf](http://www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf)

Q15: I read an article in the August *Communiqué* regarding sleep studies and coverage criteria, but there is also a Local Coverage Determination (LCD) on this topic. Which one do we follow?

A15: LCDs follow Medicare regulation; therefore, you may use the LCD as your guidance.

The article the provider was talking about is based on MLN Matters® Number: MM6534. The official instruction (CR6534) issued to your Medicare MAC, carrier, and/or FI may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R103NCD.pdf> on the CMS Website.

Q16: We are a CAH that does billing for our ambulance, also. If we have more than one ambulance run on the same day we are now required to bill both runs on the same claim. This becomes an issue when the ZIP code destination is not the same for both runs.

A16: We don't believe you are required to bill both runs on the same claim, but we will look into this and put our findings in the minutes.

Since the ZIP code is used for pricing, more than one ambulance service may be reported on the same claim for a beneficiary if all points of pickup have the same ZIP code. Suppliers must prepare a separate claim for each trip if the points of pickup are located in different ZIP codes. This regulation can be found in CMS IOM, Publication 100-04, *Medicare Claims Processing Manual*; Ch. 15; Sec. 30.2 C

Q17: I have a question regarding splints, reachers, etc., used in outpatient Physical Therapy (PT) and Occupation Therapy (OT). Are these separately billable, or is it part of the therapy charge?

A17: In order to appropriately answer this question we need to have the CPT/HCPCS you are questioning.

This concluded the question-and-answer portion of the call.

References included in this presentation are for informational purposes only. Current Medicare regulations will prevail.

There were 74 participants on 41 lines for the teleconference.