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**WPS Medicare
Provider Outreach & Education (POE)
Advisory Group (AG) Meeting
Central Region**

**September 17, 2009
10:00 – 11:30 a.m. CT**

Present:

- Marissa Smith, Southeast Hospital -Acute Hospital, Inpatient Psychiatric Facility (IPF), Inpatient Rehabilitation Facility (IRF)
- Jackie Burczyk, St. Luke's–Kansas City - Acute Hospital, Critical Access Hospital (CAH), IRF, IPF
- Becky Lang, CoxHealth - Acute Hospital, Skilled Nursing Facility (SNF), IRF
- Linda Knox, CoxHealth - Acute Hospital, SNF, IRF
- Keitha Scheib for Janie Elliott, Cass Medical Center - CAH, Rural Health Clinic (RHC)
- Barb Smallwood, St. Anthony's Medical Center - Acute Hospital, IRF, IPF
- Margaret Gregg, Skaggs Community Health Center – Acute Hospital, RHC
- Donna Coates, St. Mary's Health Center – Acute Hospital, IPF
- Betty Council, Missouri HealthNet – Medicaid
- Jennifer Kozinn, North Kansas City Hospital – Acute Hospital
- Paulett Andersen, St. John's Hospital – Acute Hospital, IRF, IPF, SNF
- Irene Flemon, NEA Baptist Memorial – Acute Hospital

Facilitator:

- Elizabeth Uruga, WPS Medicare

The Provider Outreach and Education Advisory Group (POE AG) meeting was held via conference call. The provider members on the call represented multiple provider types.

- **CMS Internet Only Manual (IOM), Publication 100-09, Medicare Contractor Beneficiary and Provider Communications Manual , Chapter 6, Section 20.4**

The primary function of POE Advisory Groups is to assist the FI or A/B MAC in the creation, implementation and review of provider education strategies and efforts. The function of these groups can also be found on the WPS Medicare Website at http://www.wpsmedicare.com/part_a/education/about_pcom.shtml. Please contact Elizabeth Uruga with any suggestions about future topics for seminars, teleconferences, or computer-based training. Elizabeth can be reached at 402-351-3783 or elizabeth.uruga@wpsic.com.

- **Review of National POE AG Minutes from August 13, 2009**

- It was suggested that seminar and Ask-the-Contractor Teleconference (ACT) Web postings contain more detail on why providers need to know the topics discussed in the seminar. Seminar postings are now more detailed.
- It was suggested that a list of acronyms be provided at seminars. A list is being developed. Acronyms used in Web posting for seminars are defined.

- It was suggested that seminars for all Part A providers be differently named to indicate to providers who bill Part B of A that the information is relevant to them. A new name is being developed for these seminars.
- It was suggested that seminars on Medicare Secondary Payer (MSP), Outpatient Prospective Payment System (OPPS), and Skilled Nursing Facility (SNF) be held in the next fiscal year. Seminars on those topics will be held in FY2010.
- Of the suggested topics to include in seminars, the topics are either now included in seminars or will be included in seminars. It was suggested that SNF Ban on Admission be included in seminars, but the group decided this topic would work better as an ACT.
- Of the suggested topics for ACTs, POE will be looking at these topics for ACTs in FY2010.
- It was suggested that more education be provided on basic Medicare topics for people new to Medicare. That education is being developed now.
- Elizabeth Uruga discussed the clarification to Condition Code 44 to ensure that everyone understood.
- Feedback provided on the WPS Medicare Website, the *Communiqué*, and eNews was passed on to the department that handles those publications.
- **New Suggestions**
 - Repetitive Billing ACT
 - Observation ACT
 - 72 hour rule/3 day payment window/outpatient services deemed inpatient ACT with detail on how the rule applies or does not apply to different facility types
 - Modifiers ACT with information on modifier 25 and examples of how it might be appropriate or not appropriate to use for ER visits and procedures
 - Notices of Non-coverage and Preventive Services ACT
 - Hospice patients receiving hospital services ACT
 - Paulett Andersen offered to host an MSP seminar at St. John's Hospital in Springfield, Missouri. Other POE AG members felt this was a good idea and would draw high attendance. Elizabeth Uruga will begin tentatively planning this seminar for January.
 - Barb Smallwood also offered to host seminars at St. Anthony's Hospital in St. Louis. Elizabeth Uruga noted that the upcoming SNF Billing seminar tentatively planned for November in St. Louis will be held at a hotel. St. Anthony's will be considered for future seminars in St. Louis.
- **Open Discussion**
 - **What notices of non-coverage should be provided for preventive services that will not be covered due to frequency limitations?**
 - The only time a revised ABN (CMS-R-131) is required for a preventive service is for Ultrasound Screening for Abdominal Aortic Aneurysm (AAA), Initial Preventive Physical Examination (IPPE), and Diabetes Self-Management Training (DSMT). Please see CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter, 18, Sections 80.8, 120.2.2, and 110.3.3. In other cases, providers have the option of providing the CMS-R-131, but it is not required. In the case of preventive services, the CMS-R-131 may be furnished routinely prior to delivery of the services and should state the frequency limitation as the reason for expecting the denial ("Medicare does not pay for this item or

service more often than the frequency limit”). Please see CMS IOM, Pub. 100-04, Chapter 30, Sec. 40.3.6.4(C).

If a claim denies as provider liable due to frequency limitation for a preventive service other than the three described above, please fax the claim to the attention of Elizabeth Uruga, Provider Outreach and Education at 402-351-8047.

- **Regarding Transmittal R1782CP, Change Request (CR) 6395, 2009, does this CR apply to acute hospitals as well or only to Critical Access Hospitals (CAH)?**
 - CR 6395, Section 148 of the Medicare Improvements for Patients and Providers ACT (MIPPA), announces a change in payment methodology for CAHs submitting claims for certain outpatient clinical diagnostic laboratory tests. The change does not apply to acute hospitals.
- **How should acute hospitals bill for labs for their provider-based RHCs?**
 - If the specimen is collected in the RHC and the patient never enters the hospital, the lab should be billed by the hospital on a 14x type of bill (TOB). If the specimen is collected in the hospital, the lab should be billed by the hospital on a 13x TOB. If one specimen is collected in the RHC and on the same day another specimen for another test is collected in the hospital, both services should be billed by the hospital on a 13x TOB. Please see CMS IOM, Pub. 100-04, Chapter 16, Sec. 40.3.
- **Is routine venipuncture a service that should be included in the provider-based Rural Health Clinic (RHC) visit, or should it be billed as a lab by the base provider?**
 - Laboratory services are not included in the RHC’s all-inclusive rate. Please see CMS IOM, Pub. 100-04, Chp. 9, Sec. 40.4 and 130 and Chapter 16, Sec. 30.3 and 40.5. There is no exception in the Medicare regulations for routine venipuncture.
- **At our acute hospital, we have patients on hospice come to our ER. Per the Emergency Medical Treatment and Active Labor Act (EMTALA), we always provide at least the basic triage and stabilization. When the hospice provider has not approved the ER visit, we are not always able to ascertain that the patient is on hospice (for example, if Common Working File (CWF) has not been updated to show the hospice yet and the patient is unable to speak). How should we bill in these situations? Do we bill the hospice? Do we bill the patient? Should we provide an Advance Beneficiary Notice (ABN)? What if the patient is under duress?**
 - If the services are not related to the terminal illness, the hospital should bill the services to Medicare and report condition code 07. Please see CMS IOM, Pub. 100-04, Chapter 11, Sec. 50. If the services are related to the terminal illness and the hospice did not approve the care, first verify this with the hospice. If the hospice truly did not approve the care, the services should be billed to the patient. No ABN is required by Medicare regulations because the patient should be aware that the right to Medicare payment for the services was waived when hospice was elected. Please see CMS IOM, Pub. 100-02, Ch. 9, Sec. 10. If the services related to the terminal illness are billed to Medicare, the claim will reject as patient liability with U5235.
- **Please explain Transmittal 1778, Change Request (CR) 6405, 2009 and how it relates to Hospital Acquired Conditions (HACs).**

- Transmittal 1778, CR 6405, Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgical or Other Invasive Procedure Performed on the Wrong Body Part; Surgical or Other Invasive Procedure Performed on the Wrong Patient, announces that effective 01/01/09, Medicare will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. Medicare will also not cover hospitalizations and other services related to these non-covered procedures as defined in CMS IOM, Pub. 100-02, Medicare Benefit Policy Manual, Ch. 1, Sec. 10 and 180 and Ch. 16, Sec. 120.

These services are listed in CMS IOM, Pub. 100-03, National Coverage Determinations Manual, Ch. 1, Part 2, Sec. 140.6 – 140.8. The billing requirements for the services are listed in CMS IOM, Pub. 100-04, Ch. 32, Sec. 230.

Hospitals are required to bill two claims when a surgical error is reported and a covered service is also being reported: 1) one claim with covered services/procedures unrelated to the erroneous surgery on a 11x TOB (except TOB 110) and 2) one claim with the non-covered services/procedures related to the erroneous procedures on a 110 TOB. On the non-covered 110 TOB, the Remarks field must indicate one of the applicable erroneous surgery two-digit codes: 1) "MX" for the wrong surgery on a patient, 2) "MY" for surgery on the wrong body part, or 3) "MZ" for surgery on the wrong patient.

For outpatient claims, providers should append the appropriate modifier to all CPT/HCPCS codes related to the erroneous surgery: 1) PA for surgery on the wrong part, 2) PB for surgery on the wrong patient, or 3) PC for the wrong surgery on a patient.

Hospital Acquired Conditions (HACs) are conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. CR 6405 does not change the billing of HACs, which should continue to be identified through the proper use of Present on Admission (POA) Indicators.

- **Upcoming Education**

- **Seminars**

- Medicare Secondary Payer (MSP) seminar on 11/12/09 in Birmingham, AL. Register until 11/4/09 at http://www.wpsmedicare.com/part_a/education/seminars.shtml.
- Skilled Nursing Facility (SNF) Billing seminar on 11/12/09 in St. Louis, MO. Register until 11/4/09 at http://www.wpsmedicare.com/part_a/education/seminars.shtml.

- Other seminars will be posted soon. Please continue to watch WPS Medicare eNews.
- **Ask-the-Contractor Teleconferences (ACTs)**
 - National Correct Coding Initiative (NCCI) Edits ACT on October 28, 2009. Registration is open until 10/26/09.
 - Proper Use of Condition Code 44 ACT on November 9, 2009. Registration is open until 11/4/09.
 - Register for the above ACTs at http://www.wpsmedicare.com/part_a/education/teleconferences.shtml.
 - WPS Medicare Electronic Data Interchange (EDI) ACT on November 12, 2009, at 1:00 p.m. CT. To participate, call 800-305-2862 and reference conference ID 70746399.
- **Future POE Advisory Group Meetings**
 - Via teleconference December 10, 2009, 10:00 a.m. – 11:00 a.m.
 - Via teleconference March 11, 2010, 10:00 a.m. – 11:00 a.m.
 - Via teleconference June 10, 2010, 10:00 a.m. – 11:00 a.m.
 - Via teleconference September 9, 2010, 10:00 a.m. – 11:00 a.m.