

WPS Medicare additional CLMA questions

1. Can a POL (Physicians Office Laboratory) submit a claim for laboratory services ordered by a physician not associated with the physician office?

A Physician Office Laboratory may submit a claim for laboratory services ordered by a physician who is not associated with the physician office. The POL must be CLIA certified and participating in the Medicare program. For the POL to file the claim to Medicare, the referring/ordering physician name will need to appear in Item 17 or electronic equivalent and the UPIN of the referring/ordering should be in Item 17a or electronic equivalent. To see the claim filing instructions please see http://www.cms.hhs.gov/manuals/104_claims/clm104c26.pdf

The same would be true for billing an x-ray or mammogram. The referring/ordering physician name and UPIN would be in Item 17 and 17a. When billing for these services, indicate the performing provider/group Medicare number in Item 33 and on the line item detail the individual performing provider number in Item 24k.

2. We have been reviewing transmittal 104 from CMS that was published 2/11/05 and have questions regarding exactly how this will affect lab claims. Our specific questions are:
 - a. What constitutes a 'MR' denial?

Answer:

To understand what a “MR” denial is, you must understand what the mission of Medical Review is. Medical Review works with Medicare providers to identify claims submission trends through data analysis, and to educate them on the issues identified, conduct medical review of claims as needed, and implement the progressive corrective action.

A “MR” denial is a decision to deny a claim based on Medical Review under this program. Services are reviewed with medical documentation submitted to justify services before considering payment and issuing a denial. For more information please visit our website at http://www.wpsmedicare.com/provider/mr_mission.shtml

Presently, there is no code on provider remittance notices to indicate what is denied for MR reasons and what is not. We will provide further clarification on this once CMS has clarified this for us. There has been talk from CMS that this Change Request 3622 (transmittal 104) could be rescinded.

- b. Is there a list of specific denial codes that are affected?

Answer:

There are specific issues that Medical Review looks for to take corrective action on, to educate the provider community on. The goal is to identify, understand, and potentially influence change in abnormal billing practices and ultimately reduce the

Medicare fee-for-service paid claims error rate. We use data analysis to identify areas with significant existing and emerging claim payment error rates.

A list of specific denial codes used by MR is not available at this time.

- c. Is the focus of this policy only claims that have been reviewed, either pre or post pay?

Answer:

The focus of this transmittal is claims that MR reviews prior to payment.

- d. What claim conditions will generate a review?

Answer:

Medicare uses national data to identify issues with specific procedures, specialties or physicians/providers. We then support the national statistics with regional data to confirm our finding before ever making our first contact/request of the provider. This is usually a request for medical documentation.

Through the Medical Review Progressive Corrective Action (PCA) program of the Centers for Medicare & Medicaid Services (CMS), carriers detect potential billing errors and supply providers with feedback and education to correct those errors.

- e. What is the definition of re-review of denied claims?

Answer:

Medicare Program Integrity Manual (Rev. 36 12-27-02), Chapter 11- Fiscal Administration, Section 1.3-Prepay Review for MR Purposes (Rev. 22, 03-05-02): requires that contractors deny as duplicate a newly submitted line that duplicates a line that a contractor has:

- (a) Already denied for MR reasons,
- (b) Medically reviewed, or
- (c) Contractor requested but did not receive documentation.

The policy says that a claim line can be medically reviewed only once. As of July 5, 2005 the MCS system will deny as a duplicate a newly submitted line against a line that the contractor or system has denied for the above reasons. A line should not be re-reviewed. This transmittal requires that MCS develop a module that will not allow this to happen.

- f. What specific edits will be in place to flag previously denied claims?

Answer:

For FY 2005, WPS will continue to use data analysis tools, national, local and Comprehensive Error Rate Testing (CERT) data to identify potentially inappropriate billing patterns across our four-state jurisdiction (WI, IL, MI, MN).

We are waiting for further clarification from CMS on specific edits that should be in place to flag claims previously denied by Medical Review.

g. What constitutes a situation that cannot be appealed?

Answer:

Providers may not resubmit claim lines denied after Medical Review (MR) or that are undergoing MR. If a provider resubmits a line denied as a result of Medical Review, *the provider may not appeal the denial decision on the resubmitted line.*