

WPS/ UGS  
CLMA Meeting  
January 13, 2006  
Madison, WI

UGS, LLC Questions and Answers

1. A patient of ours was traveling through Canada and became ill. She went into Atrial Fib. She was taken to a Canadian hospital. UGS will not cover services in Canada. This was a real emergency. Why would there not be any coverage?

**Answer: Reference IOM 100-4, Chapter 3 Section 110-110.8: The Medicare payment in the situation above is limited in that items and services furnished outside the United States are excluded from coverage except for the following Canadian and Mexican services:**

- **Emergency inpatient hospital services where the emergency occurred:**
  - i. **While the beneficiary was physically present in the U.S. ( See 110.1A)**
  - ii. **In Canada while the beneficiary was traveling, without unreasonable delay, by the most direct route between Alaska and another state. (See 110.1B)**
  - iii. **Emergency or non-emergency inpatient hospital services furnished in a Canadian or Mexican hospital closer to, or substantially more accessible from the beneficiary's U.S. residence than the nearest participating U.S. hospital which was adequately equipped to deal with and available to provide treatment of the illness or injury. Physician and ambulance services in connection with, and during the period of covered foreign hospitalization will be considered for payment.**
  - iv. **There are guidelines to establishing an emergency see section 110.2.**
  - v. **The patient cannot be on vacation in Canada or Mexico.**
  - vi. **Coverage requirements for payment to be made by Medicare are in section 110.5.**

2. Are the guidelines for a 48 hour Holter™ monitor different from the 24 hour guidelines? If so, what are the guidelines for allowing a 48 hour Holter™? (The CPT code used is the same for 24 and 48 hour use; Hook up 93225 and Analysis & Report without MD 93226).

**Answer: Reference IOM 100-3 Chap. 1 Section 20.15. (Electrocardiography services) Holter™ monitors typically record over a 24 hour period. A 24 hour recording is generally adequate to detect most transient arrhythmias. Documentation of medical necessity is required for monitoring longer than 24 hours.**

3. Is there a limit to how many Holters™ a patient can be billed for in a month, three months, or a year. If so what is the limit and what are the exceptions?

**Answer: There are currently no frequency guidelines documented for the Holter™ monitor.**

**4.**

**Scenario:**

A large healthcare organization owns several clinics each with their own laboratories and applicable individual CLIA licenses as well as a hospital with a hospital based laboratory. Many times a patient will be at a clinic and a request will be made for laboratory tests. Some of the tests from the same collection will be performed by the Physician Office Laboratory (POL); some will be referred on to the Hospital based laboratory. How should these tests be billed?

- a. POL bills for its tests and Hospital based laboratory bills for their own tests? (Result is patient has two accounts one at the POL & one at the Hospital and the patient may receive two bills in the end).
- b. Hospital based laboratory bills with split claims based upon CLIA number and location of testing? (Result patient has two billing accounts; one for the non-lab clinic services and one hospital account for all of the hospital and clinic lab services)
- c. POL bills with split claims based upon CLIA number and location of testing? (Result patient has only one clinic billing account with all services rendered at clinic and from Hospital lab.)

**Answer: In the example, it appears that the hospital lab and the clinic labs are owned by the same healthcare organization. In that case, it seems appropriate for the referring lab to bill for all the tests performed. The referring lab must identify the referred service with modifier 90 and identify the reference lab by including the CLIA number and address on the claim.**

Policy References:

- 1. CMS Manual System - Pub. 100-04 Medicare Claims Processing CR3090 Trans 85. According to CMS Transmittal 85 - Change Request 3090 – Publication 100-4 Section I.

**General Information Policy:**

Although Medicare payment may generally be made to an independent clinical laboratory only for those tests that it performs, **payment may also be made** to a laboratory for a test that is on the **clinical laboratory fee schedule** that it has referred to another laboratory, provided the referring laboratory meets one of the following three conditions.

- \* It is located in, or is part of, a rural hospital
- \* It is wholly-owned by the reference laboratory: or both it and the reference laboratory are wholly-owned subsidiaries of the same entity; or
- \* It refers no more than 30 percent of the clinical laboratory tests annually to other laboratories, (not including referrals made under the wholly-owned proviso, above).

The billing laboratory, whether it is the referring laboratory or the reference laboratory, must submit its claim to the carrier in which it is enrolled by reason of having a physical presence.

When the billing laboratory is the referring laboratory it must:

- \* Identify the referred service as such by use of the modifier 90, and
- \* Identify the reference laboratory by specifying its CLIA number and address (i.e., the address where the test was actually performed).

5. Please define specialty code 69, independently billing clinical laboratories as referenced in CR 3090. How do physician office laboratories, hospital based laboratories, and independent reference labs fit into or out of this specialty code?

**Answer: First note that independent labs would not bill Part A on a CMS 1450 form. With that said, specialty code 69 describes a clinical laboratory that is defined as clinical medical lab under CMS. Specialty codes are codes developed by CMS that correspond to the Health Care Provider Taxonomy Codes (HPTC). Taxonomy codes are a standard administrative code set that identifies the provider type or specialty at the claim level. These codes are defined in the following table:**

<http://new.cms.hhs.gov/MedicareProviderSupEnroll/downloads/taxonomy.pdf>

6. When a hospital based laboratory sends phlebotomists to draw a specimen from a non-patient in a nursing home, assisted living facility, or at home should they be collecting an MSP questionnaire?

**Answer: Reference CMS IOM 100-5 Section 20.1 under Policy. In situations where there is a face to face encounter with the beneficiary, intermediaries and carriers shall instruct hospitals and independent labs that they are required to collect MSP information from the beneficiary when billing for lab services.**

7. What is the Medicare reimbursement for CPT code 88380 (micro dissection)? I cannot find it on either the lab or physician fee schedule. Are there billing restrictions on this code?

**Answer: Micro dissection (CPT 88380) has a status indicator of N under OPPS, which means it is paid as part of the procedure. If a hospital is not paid under OPPS, the code is not subject to the lab fee schedule. Provider reimbursement will be calculated on provider submitted charges.**

8. The AMA has created a new CPT code for occult blood detection 82272. Since Medicare pays for an annual occult blood screening, how should providers submit this service when it's performed for a screening reason? At this time, there isn't a matching HCPCS G code for CPT code 82272. Will Medicare pay annually for CPT 82272 with a screening ICD-9 code?

**Answer: The HCPCS codes for fecal occult blood in 100-4, Chapter 18 are still valid and must be followed when a screening is submitted to Medicare for payment. CPT**

**code 82272 should be used when diagnostic services are performed. For example, a patient goes to the doctor and states that they are feeling run down, and upon inquiry, admits to dark stool; the doctor does a digital rectal exam and guaiac test.**

9. The genetic modifier appendix of the 2006 CPT book was greatly expanded. Are there any initiatives for Medicare to begin requiring their use on claims?

**Answer: At this time, we are not aware of any plans for Medicare to require the genetic modifier on claims.**

10. What instructions should we as indirect providers of services, give to beneficiaries who are inappropriately classified as deceased in the Medicare files? Are there specific contact numbers we can provide? We have had the beneficiaries correct the social security file only to have the next claim submitted be denied as patient is deceased.

**Answer:** If the file at the SSA has been verified as updated by the beneficiary, ask the beneficiary to contact 1-800-633-4227 the general Medicare number and ask for assistance.

### **Additional Questions from Meeting January 13, 2006**

11. If a claim is missing a diagnosis code can the provider submit it as a re-opening and not an appeal?

**Answer:** The provider can only correct a diagnosis code that has been submitted on the claim before it was denied, for example the numbers were transposed in error. If you are adding a diagnosis code that was not on the claim originally, you must go through the Appeal process.

12. Is there a website for the providers to utilize so they can get the format for the new NPI field?

**Answer:** Yes, go to <http://www.cms.hhs.gov/NationalProvidentStand/> . You may also download information such as the background on NPI, definition of NPI and Legacy Identifiers, primary and secondary providers, crosswalk process, the NPI transition schedule, claim rejection, Effect on the X12 837 incoming claims, COB, paper claims forms transition schedule, Standard Paper Remits (SPRs), Medicare Remit Print software (PC-Print- Part A and easy Print B), and Medicare Free Billing Software (PC-ACE). Please see MedLearnMatters number MM4023 for details at:

[www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4023.pdf](http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4023.pdf)