CLMA Meeting Q & A's

September 30, 2005

Milwaukee, Wisconsin

WPS Questions

1. When a claim is paid in full by Medicare what can we do to stop having cross over claims sent to the co-insurance? Per Dawn in Medicare Customer Service, when secondary insurances are set up they are to select various parameters one of which is whether or not they are sent claims even though they have already been paid 100%. When the cross over claims are sent the claims receive a remarks code of MA18. These cross over claims on paid accounts generate a great deal of additional work and expense for everyone (Medicare, the insurance company, and the provider).

- Medicare expenses would be associated with generating and transferring the claim.
- Insurance company(s) expenses are with processing the claim and generating an explanation of benefits saying they aren't going to pay anything because Medicare has already paid in full.
- The provider's expenses are associated with processing the insurance explanation of benefit.

As the Carrier, can you initiate an improvement project to contact insurance companies that have not selected to have "no cross over claims sent when 100% of the allowable has been paid"? This would be beneficial to all parties and more than pay for itself from an entire health care system perspective. Also, can you provide us with a canned letter that we can send to the insurance companies ourselves when we see this occurring? The letter would need to include the correct contact information and specifics on what set up needs to be updated.

Answer: Your concerns were discussed with our staff in Crossover. As a carrier that contracts with our trading partners, direction is given on the content and chooses provided in the contract. The final decision is made by our partners. The process to move this function from individual carriers to the Coordination of benefit Contractor, GHI of New York has begun. Therefore, an effort to contact our trading partners is not feasible. You may contact the individual insurance companies that you are dealing with and offer the resolution of changing their contract to not include 100% paid claims.

2. Recently heard of a WPS overpayment case with a physician office that was successfully appealed with the findings:
"WPS Medicare Part B exceeded their authority in bundling a CBC, Comprehensive Metabolic Panel, and a TSH test into CPT code 80050 if there was documented medical

necessity to perform the service". Both the CBC and the TSH have National Coverage Determination (NCD) policies. According to this finding will Medicare be changing their policy to bundle 100% of the time when this combination of tests is performed together and to not pay as "non-covered screening" services? What should providers do have claims reconsidered when they have this combination of tests denied and have diagnosis codes that do support the medical necessity of the individual tests?

Answer

CPT code 80050 is considered a non-covered service. The components that are included in this panel may be paid when medically necessary. Our system will not bundle the components of this panel when billed separately. For Medicare purposes, this panel 80050 is not considered a valid panel. CPT has the tests listed as part of this panel, however Medicare guidelines do not always follow CPT. The panel or grouping of laboratory tests for Medicare is found in IOM 100-04 chapter 16 section 90.2. They are as follows 80076, 80048, 80053, 80069, 80061, and 80051. When performing the laboratory tests (comprehensive metabolic panel, CBC, and TSH) submit the claim with the appropriate procedure code for each test.

3. Policy GU-003 was published as an NCD with an effective date of 7/5/05. It appears as though a screening PAP and pelvic exam will be reimbursed once every three years now instead of every two. Have the frequency edits been changed to deny claims for PAP's and pelvic exams when performed within 36 months?

Answer: Text was taken directly from CMS on their NCD version. Our policy staff is aware of the error and is the process of issuing a corrected version of the policy.

4. Regarding the date of service for specimens collected over a period of greater than 24 hours: I have a reference in the Federal Register (Vol. 70, No. 37, pp 9355-9358) that seems to indicate that the date the collection ends is the correct date of service. However, we are not clear that this is the final rule. Is it indeed the final rule? Have WPS and UGS included this change in their communications to providers?

Answer: According to the Medical Directors as WPS, by definition one cannot perform a 24 hour collection of anything until the 24 hours are over. Therefore, the date of service should be at the end of the collection period.