Bone Mass Measurements, Avoiding Denials
Ask-the-Contractor Teleconference (ACT) Transcript

Moderators: Aileen Sigler and Jane Perkins, RN
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The transcript below is from the Bone Mass Measurements Ask-the-Contractor Teleconference (ACT). In some cases, the original questions have been edited for clarity and answers given during the call have been expanded to provide further detail.

Operator: This is Conference #: 61672702.

Good day. My name is Steve and I'll be your conference operator today. At this time, I would like to welcome everyone to the Bone Mass Measurements Avoiding Denials, Ask-the-Contractor Teleconference.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star and then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Aileen Sigler, please go ahead.

Aileen Sigler: Thank you Steve. Good afternoon everybody. Thank you for joining us. I am Aileen Sigler. I'm in the Provider Outreach and Education Department of WPS Medicare. I'm co-presenting today with Jane Perkins who's one of our clinicians on the Provider Outreach and Education (POE) team.

There are no handouts or presentation for today's call. So, don't feel like you've missed it in your email. We are going to have just some brief speaking points and then our question and answer session.

This teleconference is being presented for informational purposes. We all know that Medicare regulations change on a regular basis. We prepared this presentation using the most up to date information possible, but we need to remind you that current Medicare regulations will prevail over anything that we've presented today.

This call is being recorded and the audio as well as the transcript will be posted to the On Demand Training area of our website.

The focus of today's Ask-the-Contractor teleconference is to discuss the bone mass measurement benefit, the importance of correctly billing and documenting the services, a review of those claims, and then some of the results or the common findings that we're finding after doing those reviews - all in an effort to bill and be paid correctly.

According to statistics, over two million broken bones occur every year in the United States due to osteoporosis. Bone mass density studies are
procedures that are used to identify bone mineral density, detect bone loss, or determine bone quality. They’re used to establish a diagnosis of osteoporosis, to assess an individual's risk for fracture, and to assess the response to or the effectiveness of osteoporosis drug therapy.

Medicare will cover bone mass measurement testing for a beneficiary once every 23 months. The regulations actually state at least 23 months since the last bone mass measurement was performed. Testing has to be performed with a device that has been approved by the Food and Drug Administration, and it has to be performed on a qualified individual.

A qualified individual is:

- A woman who has been determined to be estrogen deficient and at a clinical risk for osteoporosis based on her medical history as well as other indicators.

- An individual with vertebral abnormality that may indicate osteoporosis, osteopenia or vertebral fracture, and this is usually indicated by X-rays.

- An individual that’s receiving or expecting to receive an average of 5 milligrams of prednisone or greater per day for more than 3 months could also be considered a qualified individual.

- An individual with primary hyperparathyroidism.

- An individual who’s being monitored to assess their response to or effectiveness of an FDA approved osteoporosis drug therapy.

These individuals are then qualified to receive this test every two years, per the regulations. But there are some exceptions to that two-year rule. Medicare will cover bone mass measurements more frequently than every two years, for certain conditions, if they're medically necessary. These conditions include monitoring of long-term steroid therapy and osteoporosis drug therapy and follow up after discontinuation of drug therapy.

We encourage you to check to see when the patient is eligible before scheduling or performing a bone mass measurement test. We all know the patients or their caregivers may not accurately remember when their last one was done. You can access the Common Working File which is the patient's master record with Social Security or you can use the CMS Secure Net Access Portal or C-SNAP which is our online web-based portal to check eligibility and claim status. We need to use these tools to verify Medicare frequency standards.

Medical review is defined as the collection of information and clinical review of medical records by Medicare contractors to ensure that payments are made only for services that meet all of Medicare coverage, coding and medical necessity requirements. So, in other words, we’re requesting the documentation to see what was ordered, what was performed and comparing
it to what you've billed for. These review activities are directed toward areas where data analysis and information from other Medicare entities may indicate that questionable billing patterns or vulnerabilities may exist that pose a risk to the Medicare trust fund.

The overall goal of the medical review program is to reduce payment errors by identifying and addressing billing errors concerning coverage or coding made by providers. In addition to identifying errors, we want to provide education to hopefully prevent those errors in the future.

All Medicare contractors are required to follow CMS policy instruction. So in addition to the instructions that are found in the internet only manuals, such as the Benefit Policy Manual, and Claims Processing Manual, National Coverage Determinations (NCDs) are also developed by CMS to describe the circumstances in which Medicare covers specific services, procedures or technology on a national basis.

If an NCD does not specifically exclude or limit an indication or circumstance or if the item or service isn't mentioned at all in an NCD or the Internet Only Manuals, then it's up to the Medicare contractors to make the coverage decision by developing a Local Coverage Determination, or LCD.

WPS Medicare has an active published LCD regarding bone mass measurement. It was recently revised, so if you have a printed copy, or have it saved on your desktop, be sure that you're looking at the most recent one. The most recent revision was on July 1st. You can find it on our web site by going to the policy tab which is the first tab in the top navigation. It's numbered L31620. When you bring up the list of the Local Coverage Determinations, you can sort that list by either alphabetical order, (the name of the LCD) or by the policy number. Again, bone mass measurement is policy number L31620. It contains coverage guidelines, coding information such as the type of bill and revenue codes, CPT or HCPCS codes, and the ICD-9 codes. (There's also a policy posted with ICD-10 codes. We will switch over to use this policy on the implementation date of October 1, 2015.)

Finally, there's also a section in the LCD for documentation requirements.

So, I encourage you to become familiar with that Local Coverage Determination and use it as a basis for performing your services, ordering your test, and submitting documentation for medical review.

I'm now going to turn the phone line over to Jane, who's going to give you some more information.

Jane Perkins: Thanks Aileen. My name is Jane Perkins. And I'm a registered nurse with Provider Outreach and Education. We will now talk about the documentation requirements and what we are currently seeing in our medical review department.

Documentation must include a valid physician order for the bone mass testing. The order must be signed and dated. The order may be signed either by hand or electronically. If the order is not signed, there must be medical
documentation in the patient's record by the treating physician that he/she intended that the test be performed.

In the event that the order's signature is illegible, please submit an attestation statement or a signature log. Attestation statements are not acceptable for unsigned orders. Attestation statements are acceptable for unsigned progress notes that support intent.

Other documentation that must be included:
- The bone mass measurement test results with the physician's interpretation
  - The bone mass order, the test performed, and the test bill must all match.
- Covered diagnosis code
  - To support the medical necessity for the services, and that code should be evident within the medical record.

Now, let's discuss the medical review findings regarding documentation. Findings include:
- No physician order
- Unsigned orders
- Illegibly signed orders
  - No signature log or attestation statement submitted
- No progress note to support intent
- No records to support a covered diagnosis
- Missing test results
- And often, the orders, the results, and the code build do not match.

Other issues that we are finding in medical review include providers billing both an axial and a peripheral test on the same date of service.

The new code, 77085, is hitting the edit often. The new code 77085 is a combination code which includes a bone mass measurement and the vertebral fracture assessment. Often, the providers are not submitting the vertebral fracture assessment.

I would encourage providers to revisit the LCD and upon request of medical records, ensure that all documentation is submitted for review to avoid denials.

This concludes the presentation portion of today's teleconference. I'd like to open the lines and give you the opportunity to ask questions.

Steve, will you please remind listeners how to do so?

Operator: Certainly. At this time, I would like to remind everyone in order to ask a question, please press star then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster. Once again, that is star one to ask a question.
Again, if you'd like to ask a question, please press star one on your telephone keypad.

Your first question comes from Amy Lucke. Your line is now open.

Aileen Sigler: Hi, Amy, go ahead.

Amy Lucke: Hi. We have recently had some physicians that are asking us to perform bone densities for body mass index. Does anyone have any information on this and appropriateness?

Aileen Sigler: I don't see any indication in the Local Coverage Determination where bone mass measurement could be used in that indication. So, without further investigation I don't see that that would be something that would be appropriate for billing Medicare.

Next question, please.

Operator: Your next question comes from Cristie Knudsen. Your line is now open.

Aileen Sigler: Hi, Cristie.

Cristie Knudsen: Hi. Hey, Jane said that they have seen that there were issues with billing for both axial, and what was the other type on the same day?

Aileen Sigler: Peripheral.

Cristie Knudsen: Peripheral? OK. Thank you. I just didn't get that down. So, thank you.

Aileen Sigler: OK. Thank you.

Operator: Again, if you'd like to ask a question, please press star one on your telephone keypad. Your next question comes from the line of Cindy Kurber. Your line is now open.

Aileen Sigler: Thank you, Cindy.

Cindy Kurber: We are getting all of our bone densities denied even though we are sending all the documentation that is required and have a covered diagnosis for the Local Coverage Determination. Do you know why that might be?

Aileen Sigler: Have you looked at your individual claim review (ICR) letter? Does it give you any indication as to what the medical review area was finding wrong in your documentation as compared to your bill?

Cindy Kurber: I don't think it specifically says what is wrong. The billers get those letters and they didn't tell us what they're getting denied. But I don't know what it was.

Jane Perkins: Cindy, this is Jane Perkins.
When those claims are medically reviewed, an ICR is filled out and it will give specifically why that particular claim was denied. Whether it was lack of documentation, or whether your orders weren't present. So, what I would encourage you to do is to get a hold of those ICRs and determine, why those claims are denied. In the event that all of the records were there, and the services were medically reasonable and necessary the claims should have been considered for coverage. So, your best bet is to get a hold of those ICRs, find out what was missing and then file a valid appeal and make sure that those missing records are included in the appeal.

Cindy Kurber: So I have to do an appeal on all of them?

Jane Perkins: If it's been medically reviewed, it would have to be appealed.

Cindy Kurber: OK.

Aileen Sigler: And I would go back a little further too, since we don't have a definite reason for your denials or what was missing. Look at those individual claim review letters, like Jane indicated, and then after looking at that and if still doesn't make sense to you or you need someone to give you a little bit more information, call into our customer service area and see if they can look at the claim with you. And then if they need more information, then they can get a hold of someone to do a little bit more digging as well.

Cindy Kurber: Well, I'm just curious because we always send the doctor's order, the report and the doctor's note and we always have a covered diagnosis with it and I just wondered why it would be denied.

Aileen Sigler: Then that's something that needs to be looked into a little further. If you feel that that service should be covered based on everything that you have provided, documented and billed, then you should file an appeal. And we would definitely encourage you to file that appeal if it's a covered and billable service.

Cindy Kurber: OK. Thanks.

Operator: Your next question comes from the line of Elizabeth Yoder. Your line is now open.

Aileen Sigler: Hello, Elizabeth. How are you?

Elizabeth Yoder: Hi, there. We had a mix-up in the department that does these tests for us and they were assigning the new CPT code 77085 to all of our orders when they should have been 77080. They all went under the ADR review and were denied. And I know that we have to appeal them now with the corrected claim and the corrected code on it. But is there some way to do just one mass appeal for all of these claims or do we have to do an individual appeal for each and every claim?

Aileen Sigler: Thank you for your question. The Medicare regulations do indicate that appeals, number one, have to be in writing and two, each appeal has to stand
on its own as an individual claim because it's going to be reviewed by an individual redetermination nurse. So, there is no way to do a mass appeal, unfortunately. Those would have to come in individually.

Elizabeth Yoder: OK. Thank you so much.

Aileen Sigler: Sure. Thank you.

Operator: Your next question comes from the line of Angie McWilliams. Your line is now open.

Angie McWilliams: Hello. We have a question about the bone density. Our physicians say they get information telling them what screening test ought to be done for Medicare patients, and CT Bone Density is one of them. So, when they order them we tell them they can only do it for certain diagnosis and osteoporosis is one that they provide to us a lot but it's not covered.

So, they're coming back to us saying, "Well, Medicare is the one saying we should be doing these screening tests of the patient." Why are they not paying for it? Any thoughts on that?

Kelly: This is Kelly, and I'm a senior in the Medical Review Department. All screenings are performed for osteoporosis, that is correct, however, there needs to be an indication that identifies the need for the screening for osteoporosis. So, it would be as Aileen said, maybe a woman who is post-menopausal so she has an increased concern for bone loss and osteoporosis, screening would then be appropriate for her with the indication of post-menopausal.

So, there is a need for osteoporosis screening but the indication which is separate must be present to support that need.

Angie McWilliams: OK. They're not very happy...

Aileen Sigler: No, and you could refer the physician also to our Local Coverage Determination if that would help. It might take it off of your shoulders for them to actually see it in black and white that Medicare will pay for it under these situations. Do you think that would help, Angie?

Angie McWilliams: Yes, that's what we'll try to do. Thank you.

Aileen Sigler: Sure. Thank you.

Operator: Your next question comes from the line of Robin Malory. Your line is now open.

Aileen Sigler: Hi, Robin.

Robin Malory: Hello. I'm a nurse who is relatively new at looking at the medical necessity for doctor's offices ordering of the DEXA scans, and my question is similar to the
last person regarding the screening. We want to make sure that we have the appropriate diagnosis and medical documentation.

From what I'm reading in the policy, it's stating that the – let's just say the asymptomatic post-menopausal diagnosis is a secondary diagnosis for the bone mass density test. So, my interpretation of the initial screening is we need two diagnoses. So, would we use a V code screening for osteoporosis? I don't know if there is an appropriate V code for that but – so, do we need dual diagnoses for this initial screening?

Aileen Sigler: Well, there's nothing in the policy that indicates is a requirement that there's more than one.

Robin Malory: OK.

Aileen Sigler: And it's a case-by-case basis. You would take the situation for the patient that you have and the indications that they have and diagnosis that they have.

I want to draw your attention to a section that is also in the Local Coverage Determination. If you're familiar with looking at the LCD, at the very end, after the revision history, there's a section that's called, “Associated Documents” and it's a link to a separate PDF document, which contains billing and coding guidelines for bone mass measurement. And I would encourage you to take a look at that section too because there are some more specific hints or tips in there that might help you in those instances.

Robin Malory: OK. I'm going back to the revision history. Could you repeat where we would find those tips? Under the revision explanation, is that correct?

Aileen Sigler: After the revision history.

Robin Malory: OK.

Aileen Sigler: After the revision history, there's a section that has a link and it should say, "Associated Documents Billing and Coding Guideline."

Robin Malory: OK, got it.

Aileen Sigler: Kelly just pointed out, in the ICD-9 Section of the LCD, it says, “When 77078, 77080, 77081, 77085, 76977 or G0130 is done as an initial diagnostic test that determines a diagnosis of 255.0, 733.00, 733.01, 733.02, 733.03, 733.09 or 733.90, code as a secondary diagnosis, the reason for the bone mass density test.” That would be around page five of the LCD depending on which format you're looking at but it's in the ICD-9 Codes that support medical necessity. So, take a look at those, too. I'm not familiar with all of those diagnoses and exactly what each one of them means but take a look at that too to help you identify what exactly is required.

Linda: Aileen, this is Linda. I just want to go back to the question that the provider had regarding sending an appeal. I double checked really quickly with the other supervisor in our department that handles that, and you are allowed to
submit more than one appeal for different beneficiaries at the same time. So, multiple beneficiaries in one appeal. However, the reason for appeal has to be exactly the same for all of them.

So, it's not disallowed but it's not something we encourage because a lot of times there's multiple issues or different issues with each appeal. So, it is something that you can do but we encourage providers to do individual for beneficiaries.

Aileen Sigler: Well, thank you Linda. That's very good information to know.

Linda: You're welcome.

Aileen Sigler: For Elizabeth – in your situation, then if this is something that they would accept, I would consider asking them to see if that's something that you can do. If it's not, then they would tell you but that's certainly encouraging. Thank you, Linda.

Operator: Your next question comes from the line of Melissa Foster. Your line is now open.

Aileen Sigler: Hi, Melissa.

Melissa Foster: Hello. Just a couple things I wanted to ask and couple things I wanted to point out. On our DDE [Direct Data Entry] system, one of our clients denied and they referred us to a retired policy. Of course, when we went out to find out that policy, we saw that it was retired and I guess I just was a little concerned that maybe you all were scrubbing our clients up against an old policy because we've had lots and lots of claims, all denied for medical necessity.

And we're looking at L31620 because I knew this policy was inaccurate when I saw this and we are complying with the LCD and we're still getting lots and lots of denials and we just cannot figure out why. We went over and over the policy multiple times. I've called customer service and they are no help. They tell me to review the policy.

So, what I want to find out about are these ICR letters, what are they and how do we get them because we're not getting any help trying to figure out what the problem is with these denials.

Aileen Sigler: OK. First thing, if the description in the denial that you're given points you to a retired policy, it's probably just because it was just recently updated. It just needs to be redirected to the new policy since it just began.

Melissa Foster: But this policy they're referring to is retired in 2011.

Aileen Sigler: The L31620 is still active. It's been revised but it's still active.

Melissa Foster: Yes, I understand that but the policy on the DDE screen that tells us the denial is referring me to a policy that was retired in 2011.
Aileen Sigler: We will check into that for you. OK?

Melissa Foster: All right.

Aileen Sigler: So, the L31620 is active. It has been revised. We got that part taken care of. The ICR is an individual claim review letter. And those go out once the review is done and I'm going to turn it over to Kelly for just a second to give you a little bit more information about that.

Kelly: Hi, this is Kelly again from the Medical Review Department. When Medical Review is completed an ICR is written up and that gives the individual rational for the denials. For the prepay claim edit reviews that we do, the ICRs do not automatically go out to the facilities. We do thousands of them and to get them out on a timely basis is not possible.

So, what we do ask is that the providers call into the customer service line and they provide the Health Insurance Claim (HIC) number of the claim, the date of service and the type of claim to the customer service representative and she will take that information down and then refer that to the Medical Review Department. At that time we look the ICRs up and we fax it over to the point of contact in the fax number that was provided to the customer service rep. So, it's pretty easy to do and you can request three at one time.

Melissa Foster: OK. That's very helpful. We didn't even know we could get such a thing, as customer service didn't tell us that. OK.

Kelly: And so, once you get that, those will have the rationale for the denials on them. If it's that the order wasn't signed or was illegible that information is on there. So, it's very specific.

Melissa Foster: OK, great.

Kelly: Go ahead with your appeal.

Melissa Foster: OK, great, thank you.

Aileen Sigler: Thank you, Melissa. Thank you, Kelly.

Operator: Your next question comes from the line of Elizabeth Yoder. Your line is now open.

Elizabeth Yoder: Hi.

Aileen Sigler: Hi Elizabeth.

Elizabeth Yoder: Hi, I have a follow up to Linda's response that we are allowed to do that and I thought that we were, because I thought that I remember doing this once many, many years ago but what is the procedure we would follow then to do more than one claim appeal at a time?
Linda: There is no specific procedure, just the appeal request that you submit needs to have all the applicable information for each beneficiary. So, if you can put it on a spreadsheet, a Word document, or however you would like to support all applicable information for each beneficiary. Then, any supporting documentation that you want to submit for each beneficiary would also need to be put into the package.

Elizabeth Yoder: OK.

Linda: As long as the appeal request has the HIC [Health Insurance Claim] number, date of service, it's signed, and it has what you're actually appealing. So long as all the requirements for that are met, then there really is no standard format.

Elizabeth Yoder: OK, great, thank you.

Linda: You're welcome.

Aileen Sigler: Thank you.

Operator: Your next question comes from the line of Sandra Palmer. Your line is now open.

Aileen Sigler: Go ahead.

Sandra Palmer: Hello. I think I heard you say that an axial and a peripheral test should not be billed on the same date but I was wondering if the patient has both primary hyperparathyroidism which would be an indication for a peripheral test and then they also have an indication for an axial test such as osteoporosis established, wouldn't that be an indication to have both the axial and peripheral test?

Aileen Sigler: Although the LCD indicates that under normal circumstances both wouldn't be done on the same date of service, we all know that patients are different. So, on a case by case basis if it would be medically necessary that your patient actually had both on the same day then we would encourage you to appeal that situation and provide the documentation as to why it was medically necessary and then you should be successful that way hopefully. Does that help?

Sandra Palmer: Yes, but if we provide that documentation when the records are initially sent in, isn't anyone looking at that? Why would we have to appeal if it's already in the record that we send?

Aileen Sigler: Well, just one moment. All right, Sandra we're going to do a little bit more investigation while we're on the line here and then we'll come back to that question before we hang up. OK.

Sandra Palmer: OK. Thank you.

Aileen Sigler: Thank you. Next question.
Operator: There are no further questions at this time and I'll turn the call back over to the presenters.

Aileen Sigler: OK, just one moment please. We're going to pause for just about 30 seconds.

All right. Thank you Sandra, thank you for everyone for holding and we know that is listed in the regulation somewhere. We can't find it right at this moment. So, what we're going to do is investigate that and get an answer. We have everybody's e-mail address that registered and we'll send out an e-mail to everybody with the answer to that question.

Steve, have any other questions come in while we were waiting?

Operator: No, there are no more questions.

Aileen Sigler: OK. Well, I want to first of all thank everybody on behalf of all of us here at WPS for your participation today. We hope that you'll take the time to give us your feedback regarding our website. So, when the ForeSee survey pops up when you're on our website, please tell us what you like, and what we should change. We want to make sure that the website is as useful as possible and as efficient as possible, and easy to navigate with not too many clicks. So, give us your feedback, otherwise we're not sure what we can do to make it better. Your feedback is very important to us.

We'd also like to invite you to evaluate our performance as your contractor by completing the Medicare Administrative Contractor (MAC) Satisfaction Indicator, or the MSI survey. Those results are shared with CMS and so this survey is evaluating our performance as your contractor. So, tell us how we're doing. We really do want to know. Again, it's a way for us to improve on the things that we're doing for you.

I also hope that you'll take advantage on the information that is on our website. Sign up for our eNews ListServ, that's the fastest way to get updates from our office.

And we hope that you'll join us at future educational event. Thank you everyone and be looking for that email with the answer to the question about the axial and peripheral on the same day. Thank you.

Operator: So, this concludes today's conference call. You may now disconnect.