Beginner's Guide to Medicare

Published January 2012

Part A

IMPORTANT

The information provided in this manual was current as of December 2011. Any changes or new information superseding the information in this manual, provided in MLN Matters® articles, eBulletins, listserv notices, Local Coverage Determinations (LCDs) or CMS Internet-Only Manuals with publication dates after December 2011, are available at:

http://www.trailblazerhealth.com/Medicare.aspx

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INTRODUCTION TO MEDICARE

Medicare Overview

Medicare is a health insurance program administered by the federal government. It provides health insurance for individuals age 65 and older, disabled individuals younger than 65 and any individual who has chronic kidney disease, otherwise known as End Stage Renal Disease (ESRD).

Medicare legislation was passed in July 1965 and became effective July 1966. Medicare is also known as Title XVIII of the Social Security Act.

The Centers for Medicare & Medicaid Services (CMS), under the Department of Health and Human Services (DHHS), has primary responsibility for the Medicare program. There are several components of CMS at the Regional Office (RO) level: Division of Medicare, Division of Medicaid and Division of Health Standards and Quality. The Division of Health Standards and Quality works with the state licensure and certification Agencies.

The Social Security Administration (SSA) receives funding from CMS to perform services associated with the Medicare program. SSA's responsibilities for the Medicare program include:

- Taking applications.
- Developing proof and determination of an individual's entitlement to benefits.
- Maintenance of eligibility records.
- Initiating action to correct Medicare problems.
- Providing the public with program information.

Four Parts of Medicare

There are four parts to the Medicare program:

- Hospital insurance (Part A) helps pay for inpatient hospital care, inpatient care in a Skilled Nursing Facility (SNF), home health care and hospice care. Medicare Part A has deductibles and coinsurance, but is generally premium-free.
- Medical insurance (Part B) helps pay for doctors' services, outpatient hospital services, Durable Medical Equipment (DME) supplies, ambulance services, and a number of other medical services and supplies that are not covered by the Medicare hospital insurance. Medicare Part B has premiums, deductible and coinsurance amounts for which the beneficiary is responsible. Premiums, deductible and coinsurance amounts are set each year according to formulas established by law. New payment amounts begin each January 1.

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- Medicare Advantage (Part C) is a Medicare program that gives beneficiaries more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have ESRD and were not in a Medicare Advantage plan at the onset of this condition.
- Prescription Drug Coverage (Part D) may be selected by a beneficiary to help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance that private companies provide. Beneficiaries choose the drug plan and pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later. More information regarding prescription drug coverage can be found at http://www.cms.gov/COBPartD/.

Patient Screening

Patient screening is a vital step that is critical to every type of practice. The following should be considered when initiating or updating existing office practices:

- Complete patient profile (name, address, insurance, etc).
- Determination of primary insurance benefits.
- Be aware of those insurance plans that do not have provider/network participation.
- Identify if the patient has a supplemental insurance plan.
- Identify any instances where the patient has an extenuating circumstance that could cause a change in the insurance currently on file (accident/injury)
- Eligibility information, deductible and coverage limitations.
- Special billing requirements based on where the patient resides (consolidated billing).

Health Insurance Card

The accuracy and verification of the Medicare card information is extremely important. The Medicare card contains the beneficiary's name, sex, Health Insurance Claim (HIC) number and the entitlement effective dates. Medicare will not pay for services prior to the entitlement date or after benefits terminate. The termination date will not appear on the Medicare card.

Health Insurance Claim Number Suffixes

All HIC numbers are issued by the Social Security Administration (SSA). HIC numbers are nine-digit numbers with at least one letter suffix (called a beneficiary identification code or BIC) in the 10th position. If there is an 11th position, it may be either a letter or number, e.g., ###-##-A or ###-##-####X#. The HIC number issued by the Railroad Retirement Board (RRB) may contain either six or nine digits with up to a three-position letter prefix, e.g., A###### or MA##-##-####.

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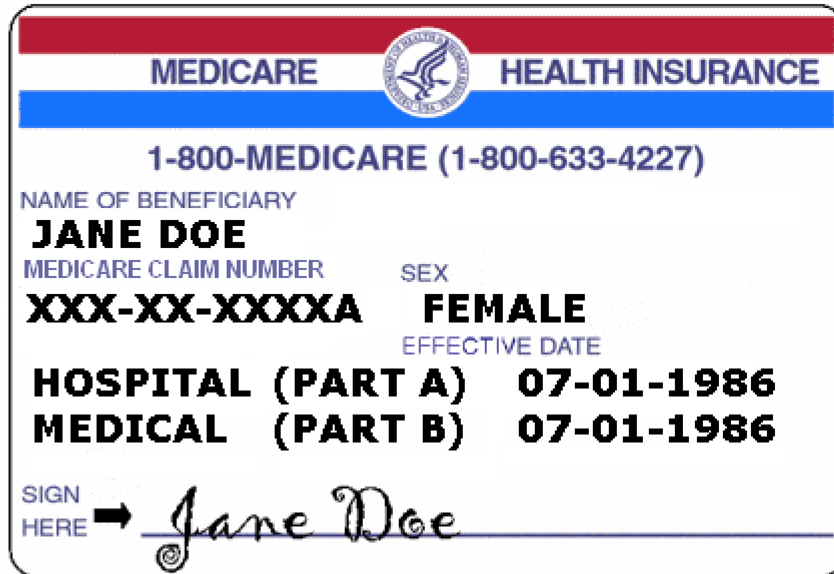
If a beneficiary's entitlement changes, it is possible for the nine-digit number, the prefix, the suffix or all three to change. It is also possible to go from an SSA-issued HIC number to an RRB HIC number or vice versa.

A HIC number suffix is available on the CMS Web site at: http://www.cms.gov/manuals/downloads/ge101c02.pdf.



Name/HIC Number Mismatch

If the beneficiary's name and/or first initial do not match the beneficiary eligibility file exactly as the HIC number entered, the claim will suspend in a Return to Provider (RTP) location. A reason code was programmed in Fiscal Intermediary Standard System (FISS) to prevent claims payment to the wrong beneficiary or to reduce benefits in error. The reason code logic will verify the first six characters of the last name and first initial for the HIC number submitted on claims. When the error is received, the FISS system will update the RTP report and the claim to reflect the beneficiary's name as it appears in the beneficiary eligibility file for the HIC number keyed and not the name submitted by the provider.

Spaces added or omitted in the beneficiary's name (i.e., de la Rosa) and claims filed with Sr., Jr. and Dr. can cause a problem if the name does not appear exactly as indicated on the Medicare card.

Care Outside the United States

Medicare generally does not pay for hospital or medical services outside the United States. Short-term insurance is recommended to beneficiaries who are planning to

travel outside the United States. If the beneficiary has other health insurance in addition to Medicare, the policy should be checked to determine if it covers foreign travel.

Items and services furnished outside the United States are excluded from coverage except for certain services rendered onboard a ship and the following services:

- Emergency inpatient hospital services when the emergency occurred:
  - While the beneficiary was physically present in the United States. Or,
  - In Canada while the beneficiary was traveling without reasonable delay and by the most direct route between Alaska and another state.
- Emergency or non-emergency inpatient hospital services furnished by a hospital located outside the United States, if the hospital was closer to or substantially more accessible from the beneficiary's U.S. residence than the nearest participating U.S. hospital that was adequately equipped to deal with and available to provide treatment of the illness or injury.
- Physician and ambulance services furnished in connection with, and during a period of, covered foreign hospitalization. Program payment may not be made for any other Part B medical or other health services, including outpatient services furnished outside the United States.
- Services rendered on board a ship in a U.S. port or within six hours of when the ship arrived at or departed from a United States port, are considered to have been furnished in U.S. territorial waters. Services not furnished in a U.S. port, or within six hours of when the ship arrived at or departed from a U.S. port, are considered to have been furnished outside U.S. territorial waters, even if the ship is of U.S. registry.

The term "United States" means the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa and, for purposes of services rendered on a ship, includes the territorial waters adjoining the land areas of the United States. A hospital that is not physically situated in one of the above jurisdictions is considered to be outside the United States, even if it is owned or operated by the U.S. government.

Payment may not be made for any item provided or delivered to the beneficiary outside the United States, even though the beneficiary may have contracted to purchase the item while he was within the United States or purchased the item from an American firm. Payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States.

For example, if a radiologist who practices in India analyzes imaging tests that were performed on a beneficiary in the United States, Medicare would not pay the radiologist or the U.S. facility that performed the imaging test for any of the services that were performed by the radiologist in India.

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Coverage of Services Provided to Prisoners

Generally, no payment is made for services rendered to prisoners since the state (or other government component which operates the prison) is responsible for their medical and other needs. (For this purpose, the term "prisoner" means a person who is in the custody of the police, penal authorities, or other agency of a governmental entity.) This may be appealed, but only at the initiative of the government entity. However, the entity must establish that:

- State or local law requires individuals in custody repay the cost of services.
- The state or local government entity enforces requirement to pay by billing and seeking collection from all individuals in custody with the same legal status (e.g., not guilty by reason of insanity), whether insured or uninsured. Also, by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts. This includes collection of any Medicare deductible and coinsurance amounts and the cost of items and services not covered by Medicare.
- The state or local entity documents its case with copies of regulations, manual instructions, directives, etc., spelling out rules and procedures for billing and collecting amounts paid for prisoners' medical expenses.

If one of these circumstances does not exist, the services should not be billed to the Medicare program.

BENEFICIARIES IN STATE OR LOCAL CUSTODY UNDER A PENAL AUTHORITY

Medicare does not cover items and services furnished to beneficiaries in state or local government custody under a penal statute, unless it is determined the state or local government enforces a legal requirement that all prisoners/patients repay the cost of all health care items and services rendered while in such custody and pursues collection efforts against such individuals in the same way, and with the same vigor, as it pursues other debts. CMS presumes a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of health care items and services. Therefore, Medicare denies payment for items and services furnished to beneficiaries in state or local government custody.

For the purpose of Medicare payment, individuals who are in custody include, but are not limited to, individuals who are:

- Under arrest.
- Incarcerated.
- Imprisoned.
- Escaped from confinement.
- Under supervised release.
- On medical furlough.
- Required to reside in mental health facilities.

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- Required to reside in halfway houses.
- Required to live under home detention.
  Or,
- Confined completely or partially in any way under a penal statute or rule.

The Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and no other person or organization has a legal obligation to provide or pay for that service. If the services are paid for directly or indirectly by a governmental entity, Medicare does not pay for the services. These provisions are implemented by regulations 42 CFR 411.4(a) and 411.4(b), respectively. Regulations at 42 CFR 411.4(b) read, "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

- State or local law requires those individuals or groups of individuals repay the cost of medical services they receive while in custody.
- The state or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way, and with the same vigor, that it pursues the collection of other debts."

CMS has established claim level editing to implement this policy using data received from the SSA.

Specifically, the data will contain the names of the Medicare beneficiaries and time periods when the beneficiary is in such state or local custody. This data will be compared to the data on the incoming claims. The Common Working File (CWF) will reject claims where the dates from the SSA file and the dates of service on the claim overlap. Any claims rejected by the CWF will contain a trailer to the Medicare contractor indicating the date span covered. Contractors will in turn deny payment of such claims.

BILLING INSTRUCTIONS

Hospitals that render outpatient services/items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) shall append a HCPCS modifier QJ on all lines with a line item date of service during the incarceration period.

For inpatient claims where the incarceration period spans only a portion of the stay, hospitals should identify the incarceration period by billing as non-covered all days, services and charges that overlap the incarceration period. Providers should use condition code 63 when billing the Medicare Administrative Contractor (MAC).

This condition code indicates that the provider has been instructed by the state or local government agency requesting that the health care items or services be provided to the patient that it is the policy of the state or local government that the prisoner or patient is

responsible for repaying the cost of heath care items and services and that it pursues collection of debts incurred for furnishing such items or services with the same vigor and in the same manner as any other debt. The MAC will deny claims for items and services rendered to beneficiaries under state or local government custody with the following appeal rights when CWF rejects the claim:

- A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that, on the date of service:
  - The conditions of 42 CFR 411.4(b) were met.
  - The beneficiary was not, in fact, in the custody of a state or local government agency under authority of a penal statute.

Part A Hospital Insurance

PART A SERVICES

Part A helps pay for medically necessary care for the following:

- Inpatient hospital care.
- Extended care services in an SNF after a hospital inpatient stay.
- Home health care.
- Hospice care.

The number of covered days used are maintained by CMS to track the beneficiary's eligible days in a benefit period. Part A coverage is renewed every time a beneficiary begins a new benefit period.

INPATIENT HOSPITAL COVERAGE CONDITIONS

Part A will pay for inpatient hospital care if all the following conditions are met:

- The hospital is participating in the Medicare program. (A patient may receive care in a non-participating hospital during emergency situations.)
- A physician prescribes inpatient care for the treatment of an injury or illness.
- The patient requires the kind of care that can only be provided in a hospital.
- The level of care the patient receives is medically necessary according to CMS requirements.

INPATIENT COVERED SERVICES

The following services/supplies are covered when provided to a beneficiary who is an inpatient in the hospital:

- Semiprivate accommodations, except where private accommodations are medically necessary or where semiprivate accommodations are occupied or unavailable; all meals, including special diets; Intensive Care Unit (ICU), if medically necessary.

- Regular nursing services (other than the services of a private-duty nurse or attendant).
- Operating room charges.
- Drugs and biologicals furnished by the hospital.
- Diagnostic laboratory tests.
- Radiological tests and services.
- Medical supplies, such as casts and splints.
- Use of appliances and equipment furnished by the hospital, such as wheelchairs and crutches.
- Physical therapy, occupational therapy and speech pathology.
- Respiratory therapy.
- Inpatient hospital stays for rehabilitation care.
- Inpatient psychiatric hospital services.

EXCLUSIONS FROM COVERAGE

Certain items and services are excluded from coverage under both Medicare Part A and Part B:

- Not reasonable and necessary.
- No legal obligation to pay for or provide.
- Paid for by a governmental entity.
- Not provided within the United States.
- Resulting from war.
- Personal comfort items.
- Routine services and appliances.
- Excluded foot care services and supportive devices for feet.
- Custodial care.
- Cosmetic surgery.
- Charges by immediate relatives or members of the household.
- Dental services.
- Paid or expected to be paid under Workers' Compensation.
- Non-physician services provided to a hospital inpatient that were not provided directly or arranged for by the hospital.

SNF Care

Post-hospital SNF care is covered when furnished by an SNF, or a hospital or CAH with a swing-bed wing.

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Medicare Part A can help pay for certain inpatient care in a Medicare-participating SNF after a hospital stay. The beneficiary must have been an inpatient of a hospital for a medically necessary stay of at least three consecutive calendar days. In addition, the beneficiary must have been transferred to a participating SNF within 30 days after discharge from the hospital.

To be covered, the extended care services must be needed for a condition that was treated during the patient's qualifying hospital stay, or for a condition that arose while in the provider's care for treatment of a condition for which the beneficiary was previously treated in a hospital.

Hospice Medicare Benefit

Hospice care is available for two 90-day periods followed by an unlimited number of 60-day periods during the remainder of the hospice patient's lifetime. Every 60 days, the physician must recertify the patient as terminally ill (life expectancy of six months or less). Benefit periods may be used consecutively or at different times during the beneficiary's life span.

Condition code 07 must be present on the claim when Medicare beneficiaries who are enrolled in hospice are admitted for a condition unrelated to their terminal illness.

Additional information concerning hospice can be found on the Regional Home Health and Hospice Intermediary (RHHI) page on the Palmetto GBA Web site.
http://www.palmettogba.com/palmetto/palmetto.nsf/DocsCat/Home

Home Health Benefit

If a beneficiary requires skilled home health care for the treatment of an illness or injury, Medicare pays for covered home health services furnished by a participating home health agency. The home health benefit is available under Part A and Part B if the following three conditions are met:

- The beneficiary is confined to the home (homebound status).
- There is a need for intermittent skilled nursing, physical therapy, speech-language pathology or continued occupational therapy.
- The beneficiary is under the care of a physician who establishes and approves the plan of care.

Additional information concerning home health care can be found on the RHHI page on the Palmetto GBA Web site.
http://www.palmettogba.com/palmetto/palmetto.nsf/DocsCat/Home

Inpatient Deductible

- *2012 deductible is $1,156.*

- 2011 deductible is $1,132.
- 2010 deductible is $1,100.

A job aid that shows Part A deductible and coinsurance amounts is available at: http://www.trailblazerhealth.com/Publications/Job Aid/MedDedCoIns.pdf.

Benefit Period

A benefit period is a period of time for measuring the use of hospital insurance benefits. It is a period of consecutive days during which covered services furnished to a patient can be paid by the hospital insurance plan.

Example: A patient is eligible for 90 days of hospital care in a benefit period and 100 days of extended care services during the same benefit period. A patient may be eligible for as many as 150 days of hospital care in a benefit period if lifetime reserve days are used. As long as a person continues to be entitled to hospital insurance, there is no limit on the number of benefit periods an individual may have.

A benefit period begins the first day on which a patient is furnished inpatient hospital or an SNF service (by a qualified provider) after entitlement to hospital insurance begins. A transfer from one hospital to another is not considered a discharge even if the transfer is considered a discharge under the Prospective Payment System (PPS). A leave of absence is not considered a discharge from the hospital. Admission to a qualified SNF or to the SNF level of care in a swing-bed hospital begins a benefit period even though payment for the services cannot be made because prior hospitalization or transfer requirement has not been met.

ENDING A BENEFIT PERIOD

A benefit period ends when a beneficiary has not been an inpatient of a hospital or an inpatient of any SNF for 60 consecutive days. The benefits will be renewed for full and coinsurance days only.

To determine the 60-consecutive-day period, begin counting with the day the individual was discharged. A benefit period cannot end while a beneficiary is an inpatient of an SNF where the SNF is defined as a facility which is primarily engaged in providing skilled nursing care and related services to residents who require medical or nursing care, or rehabilitation services for injured, disabled or sick people.

An individual may be discharged from and readmitted to a hospital or an SNF several times during a benefit period and still be in the same benefit period if 60 consecutive days have not elapsed between discharge and readmission. The stays need not be for related physical or mental conditions.

A beneficiary is an inpatient in an SNF only if the beneficiary's care in the SNF meets certain skilled level of care standards. The beneficiary must need and receive a skilled

level of care while in the SNF. This means that in order to be considered an inpatient while in an SNF, the beneficiary must have required skilled services on a daily basis and received daily skilled services that could, as a practical matter, only have been provided in an SNF on an inpatient basis. If these provisions were not met during the prior SNF stay, the beneficiary was not an inpatient of the SNF and, therefore, the prior SNF stay did not prolong a benefit period.

Lifetime Reserve Days

Each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services to draw upon after using 90 days (60 full and 30 coinsurance) of inpatient hospital services in a spell of illness. The utilization of these days is solely optional by the patient. Depending on the situation, the patient may elect not to use the lifetime reserve days. These situations would include:

- The average daily charge for covered services furnished during a lifetime reserve billing period is equal to or less than the coinsurance amount for lifetime reserve days and:
  - The hospital is reimbursed on a cost reimbursement basis.
  - The hospital is reimbursed under the prospective payment system and lifetime reserve days are needed to pay for all or part of the outlier days.
- The beneficiary has no regular days available at the time of admission to a hospital reimbursed under the PPS and the total charges for which the beneficiary would be liable if he does not use lifetime reserve days are equal to or less than the sum of the coinsurance amounts of the lifetime reserve days needed for the stay.

Note: For hospitals reimbursed under the PPS, if a patient has one or more regular benefits (non-lifetime reserve, i.e., coinsurance days) days remaining in the benefit period upon entering the hospital, Medicare will pay the entire PPS amount for non-outlier days. Therefore, it would not benefit the patient to utilize his lifetime reserve days.

Note: A Medicare beneficiary who is eligible for medical assistance (Medicaid) under a state plan should be advised that such assistance would not be available if his lifetime reserve days are not used.

Part B Medical Insurance

Medicare Part B medical insurance helps pay for:

- Physicians' services.
- Outpatient hospital care.
- Diagnostic tests.
- DME.

- Ambulance services.
- Many other health services and supplies not covered by Medicare Part A.

OUTPATIENT (PART B) ANNUAL DEDUCTIBLE

The beneficiary must meet the deductible only once a year. The deductible can be met by any combination of covered expenses. The beneficiary does not have to meet a separate deductible for each different kind of covered service received.

- *2012 deductible is $140.*
- 2011 deductible is $162.
- 2010 deductible is $155.

COINSURANCE AMOUNTS

After a beneficiary meets the annual deductible, the patient will owe a share of the Medicare-approved amount for most services and supplies, which is called the coinsurance. Usually, the coinsurance share is 20 percent of the Medicare-approved amount.

BLOOD DEDUCTIBLE

A beneficiary is responsible for the deductible for the first three pints of blood furnished per calendar year.

- The three-pint blood deductible is considered met if replaced.
- The blood deductible applies only to blood costs and does not apply to blood processing costs.
- The blood deductible applies only to whole blood and packed red cells.
- Some states are free-blood states.

OUTPATIENT HOSPITAL SERVICES

Hospitals provide two types of services to outpatients who are covered under Medicare Part B:

- Services that are diagnostic in nature.
- Other services that aid the physician in treating a patient.

Some covered outpatient services are:

- Emergency Room (ER) and outpatient clinic services.
- Diagnostic services.
- Laboratory services.
- X-ray and other radiology services.
- Physical therapy.
- Occupational therapy.

- Speech-language pathology.
- Medical supplies, such as splints and casts.
- Dialysis in the facility or home.
- Some ambulance services.
- Other medical services (i.e., influenza vaccine, hepatitis B vaccine, etc.).
- Devices (other than dental) to replace all or part of an internal body organ, (i.e., colostomy).
- Equipment and supplies.

Medicare Part B Facilities/Services

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES

Under certain circumstances, Medicare helps pay for outpatient services beneficiaries receive from a Medicare-participating Comprehensive Outpatient Rehabilitation Facility (CORF). Covered services include physicians' services; physical, speech, occupational and respiratory therapies; counseling; mental health treatment; and other related services. The beneficiary must be referred by a physician who certifies that skilled rehabilitation services are needed. For most CORF services, the beneficiary is responsible only for the Medicare Part B annual deductible and 20 percent of the Medicare-approved charges.

PARTIAL HOSPITALIZATION FOR MENTAL HEALTH TREATMENT

Partial hospitalization is an ambulatory program of active care that lasts less than 24 hours a day. Under certain conditions, Medicare Part B helps pay for partial hospitalization for mental health services furnished by hospital outpatient units and by qualified Community Mental Health Centers (CMHCs). If the beneficiary is considering mental health treatment, the individual should check with the program chosen to see if it meets the conditions for Medicare payment.

OUTPATIENT REHABILITATION FACILITY SERVICES

Under certain circumstances, Medicare helps pay for outpatient services beneficiaries receive from a Medicare-participating Outpatient Rehabilitation Facility (ORF). Covered services include physical, speech, and occupational therapy services. The beneficiary must be referred by a physician who certifies that skilled rehabilitation services are needed.

END STAGE RENAL DISEASE

The End Stage Renal Disease (ESRD) program extends Medicare coverage to individuals who have permanent kidney failure, require either dialysis or transplantation, and meet certain other eligibility requirements. Medicare reimbursement for outpatient maintenance dialysis and related physician and laboratory services are based on a prospective method of payment, whether furnished at home or in a hospital-based or

independent dialysis facility. The beneficiary is responsible only for the Medicare Part B annual deductible and 20 percent of the Medicare-approved charges.

View the ESRD manual for additional information.
http://www.trailblazerhealth.com/Publications/Training Manual/esrdmanual.pdf

RURAL HEALTH CLINIC SERVICES

Medicare Part B helps pay for services of physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses (under certain conditions), clinical psychologists and clinical social workers furnished at a Rural Health Clinic (RHC). The beneficiary is responsible only for the Medicare Part B annual deductible plus 20 percent of the billed charge for the clinic.

View the RHC manual for additional information.
http://www.trailblazerhealth.com/Publications/Training Manual/rhcmanual.pdf

FEDERALLY QUALIFIED HEALTH CENTER SERVICES

Federally Qualified Health Centers (FQHCs) are located in both rural and urban areas. Medicare Part B helps pay for services of physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses (under certain conditions), clinical psychologists, clinical social workers and certain preventive health services. The beneficiary does not have to pay the Medicare Part B annual deductible for services provided under the FQHC benefit. The beneficiary is responsible for 20 percent of the Medicare-approved charge for the clinic.

SPECIALIZED SERVICES

Certain specialized services provided at a FQHC are not part of the FQHC benefit. For these services, the beneficiary does have to meet the Medicare Part B annual deductible. As long as the center meets Medicare requirements to provide these specialized services, Medicare Part B can help pay for them. The center will tell the beneficiary if the service needed is a specialized service. For example, the center may provide screening mammograms. If the beneficiary receives a mammogram at the center, the beneficiary is responsible for any unmet part of the Medicare Part B annual deductible plus 20 percent of the Medicare-approved charge for the mammogram.

OUTPATIENT PHYSICAL AND OCCUPATIONAL THERAPY AND SPEECH–LANGUAGE PATHOLOGY SERVICES

Medicare Part B helps pay for medically necessary outpatient physical and occupational therapy or speech-language pathology services if the following conditions are met:

- The physician prescribes the service.
- The physician or therapist sets up the plan of treatment.
- The physician periodically reviews the plan.

The beneficiary can receive physical therapy, occupational therapy or speech-language pathology services as an outpatient of a participating hospital or SNF, or from a participating home health agency, rehabilitation agency, or public health agency. The provider of services may only charge the beneficiary for any part of the annual deductible that is not met, 20 percent of the remaining approved amount and any non-covered services.

The beneficiary can also receive services directly from an independently practicing, Medicare-approved physical or occupational therapist in the office or in the beneficiary's home if a doctor prescribes such treatment.

View the Medicare Part B *Therapy Services* manual for additional information.
http://www.trailblazerhealth.com/Publications/Training Manual/Physical Therapy.pdf

Health Care Provider/Supplier Enrollment Process

NATIONAL PROVIDER IDENTIFIER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the National Provider Identifier (NPI) as this identifier. The NPI is a numeric 10-digit identifier consisting of nine numbers plus a check digit in the 10th position. NPIs replaced health care provider identifiers.

HIPAA-covered entities, such as providers completing electronic transactions, health care clearinghouses and large health plans, must use only the NPI to identify covered health care providers in standard transactions.

SUBPARTS

HIPAA-covered entities are legal entities. Often, a health care provider that is an organization may include components that function as health care providers somewhat independently of the "parent" (the covered organization health care provider of which they are a part). These components are called "subparts." Subparts may conduct their own HIPAA-standard transactions, be certified by the state separately from their "parent," or be located at the same location as, or a different location from, their "parent." The covered organization health care provider needs to determine if it consists of any such subparts and, if so, determine if any of those subparts need to have their own unique NPIs in order to be identified in HIPAA-standard transactions. Many providers enrolled in Medicare are actually subparts. Examples of subparts may include different components of an organization health care provider, such as different departments of a hospital, and separate physical locations of an organization health care provider, such as the different locations of the members of a chain.

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For more information, go to the CMS Web site at:
http://www.cms.gov/NationalProvIdentStand/.

NEW PROVIDER/SUPPLIER ENROLLMENT PROCESS

To improve the enrollment process for new Medicare providers/suppliers, CMS has implemented a provider/supplier enrollment process. The provider/supplier enrollment process is a critical function that assures only qualified and eligible providers/suppliers are enrolled in the Medicare program and receive reimbursement for services rendered to beneficiaries. Any individual, group or organization that provides covered services to beneficiaries must enroll in the Medicare program and remain enrolled as a condition of being reimbursed for those services. The Medicare Health Care Provider Enrollment Application (Form CMS-855) is issued by CMS and approved by the Office of Management and Budget for use in collecting the information and documentation that must be verified to assure the applicant is qualified and eligible to enroll in the Medicare program.

TrailBlazer Provider Enrollment encourages physicians, non-physician practitioners, and provider or supplier organizations to use the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) to enroll in Medicare, view their Medicare enrollment data and update their Medicare enrollment information.

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Visit the Provider Enrollment *Part A Getting Started* Web page for additional information concerning the provider enrollment process.
http://www.trailblazerhealth.com/Provider Enrollment/PartAGettingStarted.aspx

Reporting Taxonomy Codes (Institutional Providers)

Institutional providers submitting claims for their primary facility and its subparts (i.e., psychiatric unit, rehabilitation unit, etc.) will report a taxonomy code on all their claims submitted to the MAC.

The National Uniform Claim Committee (NUCC) maintains the Healthcare Provider Taxonomy Code (HPTC) updates. The NUCC updates the code set twice a year with changes effective April 1 and October 1. *The HPTC list is available from the NUCC.*
http://www.nucc.org/index.php?option=com_wrapper&Itemid=50

Medicare Code Editor (MCE)

Congress enacted the Projected Payment System for Medicare inpatient hospital services as Title VI of the Social Security Amendment. Under Title VI, hospitals are paid a fixed rate by Diagnosis-Related Groups (DRGs) for treating Medicare patients.

To determine the appropriate DRG for a Medicare patient, hospitals must report the age, sex, discharge status, principal diagnosis, any additional diagnoses and

procedures performed to Medicare. The DRG assumes the patient information provided is accurate and no attempt is made by the DRG to edit the data for accuracy. Only for extreme inconsistencies in the patient information will a patient not be assigned a DRG.

MCE EDITS

Listed below are three types of edits that can be performed before a DRG assignment is made:

- Code edits – Examines a record for the correct use of ICD-9-CM codes that describe a patient's diagnoses and procedures. They include basic consistency checks on the interrelationship among a patient's age, sex, diagnoses and procedures.
- Coverage edits – Examines the type of patient and procedures performed to determine if the services are covered.
- Clinical edits – Examines the clinical consistency of the diagnostic and procedural information on the claim to determine if they are clinically reasonable and therefore should be paid.

The MCE detects and reports errors in the coding of claims data. While the MCE identifies and indicates the nature of the error, it does not correct the error. A particular error condition is associated with each type of coding error identified by the MCE. The following billing data are subject to edit:

- Invalid Diagnosis or Procedure Codes – The MCE checks the validity of each diagnosis and procedure, including the admitting diagnosis, against the ICD-9-CM code table. If the code is not in this table, the code will reject. Verification of the code will be required before the claim will process. Valid ICD-9-CM codes are listed in the latest clinical modification (ICD-9-CM) Volume 1 (Disease) and Volume 3 (Procedures).
- Invalid Fourth or Fifth Digit for Diagnosis Codes – The MCE identifies and will reject any code, diagnosis or procedure billed that requires a fourth or fifth digit. When coding, ensure the code is carried out to the full ICD-9-CM code requirement.
- "E" Code as Principal Diagnosis – "E" codes describe the circumstances that caused an injury, not the nature of the injury and, therefore, are not allowable as the principal diagnosis.
- Duplicate Coding – Any secondary diagnosis that is the same code as the principal diagnosis is considered a duplicate code and, therefore, may cause a conflict when assigning a DRG. The claim will be rejected.
- Age Conflict – The MCE detects inconsistencies between the patient's age and any diagnosis billed. Examples are:
    - A 5-year-old with benign prostatic hypertrophy.
    - A 78-year-old obstetric delivery.

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MEDICARE CODING ERROR

In the above cases, the diagnosis is clinically impossible in a patient of the indicated age. Therefore, either the diagnosis or the age is presumed to be incorrect.

The four age code categories listed in the following chart are also monitored by the MCE:

Diagnoses	Description
Newborn	A subset of diagnoses is intended only for newborns and neonates. These are "newborn" diagnoses. For "newborn" diagnoses, the patient's age must be 0 years.
Pediatric	Certain diagnoses are only considered reasonable for children between the ages of 0 and 17. These are "pediatric" diagnoses.
Maternity	Diagnoses identified as "maternity" are only coded for patients between the ages of 12 and 55 years.
Adult	A subset of diagnoses is considered valid only for patients 14 years and older. These are "adult" diagnoses. For "adult" diagnoses, the age range is 15 through 124.

- Sex Conflict – The MCE also detects inconsistencies between a patient's sex and diagnosis or procedure codes being billed.

  Examples:
  - A male patient with cervical cancer (diagnosis).
  - A male patient with a hysterectomy (procedure).
- Manifestation Code as Principal Diagnosis – These codes describe the manifestation of an underlying disease, not the actual disease itself. Therefore, it cannot be billed as a principal diagnosis.
- Non-Specific Principal Diagnosis – A set of diagnosis codes, particularly those described as "not otherwise specified," are identified by the MCE as non-specific diagnoses. Although these codes are valid according to the ICD-9-CM coding scheme, more precise coding is required.
- Unacceptable Principal Diagnosis – There are selected codes that describe a circumstance that influences an individual's health status but is not a current illness or injury; therefore, they are unacceptable as the principal diagnosis.

  Note: In a few cases there are codes that are acceptable if a secondary diagnosis is coded.
- Medicare as Secondary Payer Alert – The MCE identifies situations that may involve automobile medical, no-fault, or liability insurance.
- Non-Specific Operating Room Procedures – A set of operating room procedure codes, particularly those described as "not otherwise specified," are identified by

the MCE as non-specific. Although these codes are valid according to the ICD-9-CM coding scheme, more precise coding is required.

- Non-Covered Operating Room Procedures – There are some operating room procedures not covered by the Medicare program.
- Open Biopsy Check – Biopsies can be performed as open (i.e., a body cavity is entered surgically), percutaneously (by punch) or endoscopically (through a scope). The DRG definitions assign a patient to different DRGs depending on whether or not the biopsy was open. The MCE monitors all open biopsies.
- Bilateral Procedure – There are certain codes that do not accurately reflect performed procedures in one admission on two or more different bilateral joints of the lower extremities. A combination of these codes shows a bilateral procedure when, in fact, they could be a single joint procedure (i.e., duplicate procedures). If two or more of these procedures are coded, the claim will be flagged for postpay development and records will be requested.
- Invalid Age – Claims will edit for development if an age older than 124 is reported. If the beneficiary's age is established as older than 124, enter 123.
- Invalid Sex – It is important that the correct sex is billed to determine the appropriate DRG. Usually, the Medicare contractor can make the necessary corrections without contacting the provider.
- Invalid Discharge Status – In determining the appropriate DRG assignment, it is necessary to code the discharge status correctly.
- Invalid Discharge Date – An invalid discharge date is one that does not fall into the acceptable range of numbers used to represent the month, day, or year (e.g., 13/03/90, 12/32/90, etc.). If no discharge date is entered, it is also considered invalid.

Services With a Gender/Procedure Conflict

Institutional providers should report condition code 45 on any inpatient or outpatient claim related to transgender, ambiguous genitalia or hermaphrodite issues. This claim-level condition code should be used by institutional providers to identify these unique claims and alerts the MAC that the gender/procedure or gender/diagnosis conflict is not an error allowing the sex-related edits to be bypassed.

Billing Using the UB-04

The UB-04 is a uniform institutional provider bill suitable for use in billing multiple third-party payers. The UB-04 includes requirements for the National Provider Identifier (NPI).

The UB-04 (Form CMS-1450) can be located on page 18 of Change Request (CR) 5072:
http://www.cms.gov/Transmittals/Downloads/R1104CP.pdf.

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Institutional billing codes are available from the National Uniform Billing Committee (NUBC) Web site via the NUBC's *Official UB-04 Data Specifications Manual*. http://www.nubc.org/

UB-04 Type of Bill (TOB) Codes

- **011X** Hospital Inpatient.
- **012X** Hospital Inpatient (Part B).
- **013X** Hospital Outpatient.
- **014X** Hospital Other (referred diagnostic services).
- **018X** Swing Bed (Hospital or Rural Primary Care Hospital).
- **021X** SNF Inpatient.
- **022X** SNF Inpatient (Part B).
- **023X** SNF Outpatient.
- **024X** SNF Other (referred diagnostic services).
- **033X** Home Health (includes visits or use of HHA DME under Part A plan of treatment).
- **041X** Religious Non-Medical Health Care Institution.
- **071X** RHC.
- **072X** ESRD.
- **073X** FQHC (dates of service prior to April 1, 2010).
- **077X** FQHC (dates of service on or after to April 1, 2010).
- **074X** ORF.
- **075X** CORF.
- **076X** CMHC.
- **083X** Hospital Outpatient Ambulatory Surgical Center (ASC).
- **085X** CAH.

Note: Effective for dates of service on or after January 1, 2008, the MAC no longer processes claims for TOB 83X for Ambulatory Surgery Centers (ASCs).

FISS Claims Processing

REASON CODE FILE

- The reason code file is the heart of claims processing within FISS.
- The reason code is a five-digit alpha-numeric code.
- It is used to communicate errors, actions or conditions associated with a particular claim as it processes through FISS.

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- Several reason codes can be listed to describe one error.
- Reason codes appear on the online screens; the Automated Date Review and the Return to Provider report.
- Changes/updates are made to the reason code file daily.
- Providers can view the reason code file online or on the TrailBlazer Web site under the Self-Service Tools link.
- Reason codes are used for both informational and instructional purposes:

Examples:

Reason Code	Standard Message
37192	This Medicare claim has been approved for payment.
T5052	CMS records indicate the beneficiary is not on file.

Reason Code Positions 12345

Position 1		Position 2345
0	– Common Working File (CWF)	Current CWF Codes
1	– Consistency edits	0125–9999
2	– Reserved	
3	– FISS	0000–9799
4	– File maintenance	Alpha 001 – Alpha 899
5	– Medical review	0001–9999
7	– State specific	0001–9999
A–Z	– CWF (except W)	Current CWF Codes
W	– Outpatient Code Editor/Medicare Code Editor and Grouper	0001–29999

STATUS/LOCATION INFORMATION SHEET

Status/Location

FISS processing is driven by the Type of Bill (TOB). The claim path or processing path is defined for each TOB. A claim is routed through the system based on a predefined path of locations. The location of a claim indicates the processing step in which the claim has completed or currently resides. FISS has automated and manual locations defined. Manual processing locations are unique to the functional needs to internal processing.

The status of a claim reflects the condition of the claim as it is residing in the claim path location. The following are valid pending and finalized FISS statuses:

PENDING LOCATION

- S (Suspense) – The claim is placed in this location in order to research and to make any updates/corrections before processing can continue.
- M (Manual) – Clerical intervention required. Claims moved manually to another department, employee desk, etc. as reflected by the location.
- B (Batch processing) – A series of systematic batch cycles must be run to continue claims processing.

FINALIZED LOCATIONS

- D (Medical denial) – Final disposition of a claim due to a medically reviewed denial with no reimbursement.
- P (Processed) – Final disposition of a claim that has been approved for processing.
- R (Non-medical reject) – Final disposition of a claim that has been rejected due to a duplicate claim, benefits exhausted.
- T (Return to Provider (RTP)) – Final disposition of a claim that requires further billing information from the provider in order to complete claims processing. If the correction is not received regarding the RTP, the claims will be inactivated in the system.
- I (Inactive) – Final disposition of a claim once it has been in the RTP status for *180* days.

CLAIM LOCATION

The claim location has a five-position code specifying where the claim is located:

- The first position identifies the type of processing occurring on the claim. FISS has three possible types of processing:
  - Manual (M).
  - Online (O).

  - Batch (B).
- The **second and third** positions of the location code identify the functional driver of the program application processing the claim. These two positions indicate the system automated locations (see following chart).
- The **fourth and fifth** positions represent locations requiring manual intervention to continue processing of the claim. They identify a specific department or desk responsible for continued processing of the claim. These are internal codes set up by the MAC.

Online providers should focus only on the second and third positions of the location to identify where their claim is located in the system using the following chart.

Status	Batch (Position 1)	Location (Position 2–3)	Location (Position 4–5)
A Good D Deny F Forced I Inactive M Manual move P Processed R Reject S Suspend T RTP U Return to QIO	B Batch process M Manual process O Offline process	01 Initial 02 Control driver 04 UB-04 Data element edit driver 05 Consistency driver (I) 06 Consistency driver (II) 15 Administrative driver 25 Duplicate driver 30 Entitlement driver 35 Lab/HCPCS driver 40 ESRD driver 50 Medical policy driver 55 Benefits/Utilization driver 60 ADR driver 65 PPS/Pricer driver 70 Payment driver 75 Postpay driver 80 MSP primary driver 85 MSP secondary driver 90 CWF driver 95 Denial driver 99 Session termination	00 System location 01 Common 10 Inpatient 11 Outpatient 12 Special 13 Medical review 16 MSP CP CWF problem FP FISS problem Session Termination 96 Scheduled payment 97 Final online 98 Final off-line 99 Final purge

Reason Code Ranges for Drivers and Locations

The following table shows the reason code ranges for the various drivers and locations:

Driver	Location	Reason Code Ranges
Consistency II	06	31300–31329 – Payer ID 31330–31399 – Occurrence code/span 31400–31499 – Future edits 31500–31649 – Bill type
Administrative (Accesses additional files)	15	31650–32999 W0001–W2999 – MCE/OCE and Grouper
Duplicate	25	38000–38599
Entitlement	30	39000–39499 (MCO editing)
Lab/HCPCS	35	36200–36999
ESRD edit	40	36000–36199
Medical policy	50	50001–59999
Benefit utilization	55	39500–39699
ADR	60	39700–39799
PPS Pricer	65	37000–37150
Payment module	70	37500–37999
Postpayment	75	38600–38999
MSP primary	80	34000–34499
MSP secondary	85	33000–33999 34500–34900
CWF	90	09900–09999 – Transmission error A0001–X0999 – Disposition (alpha)
Denial	95	39800–39899
Session termination	99	37159–37199

ELECTRONIC MEDIA CLAIM (EMC) OVERVIEW

Electronic Claims

ELECTRONIC DATA INTERCHANGE

Electronic Data Interchange (EDI) is the process of transacting business electronically. It includes submitting claims electronically (paperless claims processing), as well as Electronic Funds Transfer (EFT) and electronic inquiry for claim status and patient eligibility.

TrailBlazer encourages physicians, suppliers, billing services and clearinghouses to submit claims electronically and to take advantage of other electronic services offered.

BENEFITS OF EMC FILING

Medicare providers can easily take advantage of the many benefits of submitting claims electronically. Medicare claims turn around faster and are reimbursed sooner, thus improving cash flow. Payment for electronic claims may be released after 14 days; payment for paper claims can be issued on the 29th day following receipt of the clean claim.

When submitting claims electronically, an immediate notification is sent, indicating TrailBlazer has received the Medicare claims. The front-end editing system provides notification of critical claim-filing errors, allowing a provider to correct a claim before it enters the Medicare processing system. There is no waiting for a denial if the claim was submitted incorrectly. The provider is able to correct claims immediately.

There are several alternatives to submitting claims data electronically:

- Work through a software vendor who can provide the level of practice management system support needed for practice.
- Submit Medicare claims directly to the MAC or through a clearinghouse.
- Choose to have a billing agent handle all or part of the Medicare billing.
- Choose to use Medicare's free billing software.

CLAIM STATUS AND ELIGIBILITY INQUIRY

Direct Data Entry (DDE), formerly known as GPNet Online Services, is a computer inquiry system that provides easy and immediate access to claims processing and beneficiary eligibility information for Medicare providers. The information can be obtained through dial-up capabilities using software that is provided at no cost.

DDE Online Services saves time and money by allowing access to the following information:

- Detailed claims information on pending and paid claims.
- Electronic claims batch inquiry.
- Beneficiary eligibility information – for Medicare participating providers only.
- Reference files for valid diagnosis/procedure codes, modifiers, Healthcare Common Procedure Coding System (HCPCS) and payer codes.
- Direct data entry for Medicare Part A providers.

For more information on DDE Online Services, call the EDI helpline at (866) 749-4302.

The enrollment packet for DDE Online Services is available at:
http://www.trailblazerhealth.com/Publications/PDF Form/EDIEnrollmentPacket.pdf.

The J4901 EDI enrollment packet can be accessed at:
http://www.trailblazerhealth.com/Publications/PDF Form/J4901EDIEnrollmentPacket.pdf.

RETURN TO PROVIDER (RTP)

Billing transaction processing in FISS can fail edits that require a provider to correct information on the bill. When this occurs, FISS will automatically move the billing transactions to the RTP file, status/location T B9997. The provider must access the RTP file and correct the error(s) before the billing transaction will continue to process.

If an initial Part A bill has been returned to the provider or rejected, the provider must have information that will allow completion of the bill. The RTP process is a mechanism to eliminate rekeying of the bill by both the provider and the MAC.

All RTP bills are considered inactive in the system; therefore, only a correction of an error will reactivate the claim for processing. Because of this, an RTP bill cannot be adjusted or voided. RTP bills are maintained in a file and are available for correction for *180* days. The RTP claims will remain in the "T" status for *180* days. An update to the system will occur every Saturday and move RTP claims over *180* days to Inactive (I) status. RTP claims are no longer accessible after *180* days and must be re-entered entirely to be processed for payment.

An RTP does not cause a duplicate reject if a new corrected claim is submitted.

Top RTP Reason Codes

REASON CODE 32402

This reason code indicates the claim has a HCPCS billing error that occurred due to one of the following conditions:

- A revenue code is present, requiring a HCPCS code that is missing.
- The HCPCS code is not on the HCPCS file.
- The HCPCS code for that line item is invalid for the dates of service on the claim.
- The revenue code on the line item being edited does not match any of the allowable revenue codes for that HCPCS code.

Resolution:

- Verify the dates of service on the claim.
- Verify the revenue code billed is correct.
- Review CPT/HCPCS code(s) for keying errors.

REASON CODE T5052

This reason code indicates:

- The beneficiary identification submitted on the claim is incorrect.
- Medicare records do not exist for this beneficiary.

Resolution:

- Ensure the Health Insurance Claim (HIC) number submitted on the claim matches the HIC number on the beneficiary's Medicare card.

REASON CODE N5052

This reason code indicates that the beneficiary's name and HIC number do not match in the CWF.

Resolution:

- Compare the information submitted on the claim to the beneficiary's Medicare card.
- Ensure the beneficiary's name and HIC number are reported exactly as they appear on the beneficiary's Medicare card.

Visit the Top Billing Errors Web page to view the quarterly top RTP and reject errors:
http://www.trailblazerhealth.com/Claims/Reports.

For a listing of reason codes, refer to the Reason Code Search tool on the TrailBlazer web site at:
http://www.trailblazerhealth.com/Tools/ReasonCodeSearch.aspx.

MEDICARE SECONDARY PAYER (MSP)

MSP Laws

The following are laws that make Medicare payments secondary to those of another insurance:

- Title XVIII of the Social Security Act.
- Federal Coal Mine Act.
- Omnibus Reconciliation Act (ORA) of 1980.
- Omnibus Budget Reconciliation Act (OBRA) of 1981.
- Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982.
- Deficit Reduction Act (DEFRA) of 1984.
- Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.
- OBRA of 1986.
- OBRA of 1987.
- OBRA of 1990.
- OBRA of 1993.
- Balanced Budget Act (BBA) of 1997.

Group Coverage

There are three plans that fall under group coverage. Group coverage is awarded on the basis of active employment of the patient or the patient's spouse. The three plans are:

- Working-aged coverage.
- Coverage due to disability.
- ESRD coverage.

These three groups fall into the same categories as entitlements to the Medicare program.

Working Aged

The Age Discrimination in Employment Act, administered by the Equal Employment Opportunity Commission, requires employers to offer to their employees age 65 and older, and to the age 65 and older spouses of employees of any age, the same coverage as they offer to employees and employees' spouses younger than 65. Medicare beneficiaries have the right to reject the employers' plan coverage and to have Medicare as their primary coverage. However, when Medicare is the primary insurer, the employers cannot offer such employees or their spouses secondary coverage on items or services covered by Medicare.

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The following conditions must be met for Medicare to be the secondary insurance:

- Medicare beneficiary must be age 65 or older.
- Entitled to group health coverage by virtue of active employment or that of a spouse. If the coverage is through the spouse, the spouse can be of any age.
- Employer must have 20 or more employees or be part of a multi-employer group insurance plan (at least one employer in the group must have more than 20 employees).
- Beneficiary must be entitled to Part A benefits (does not apply to disability or ESRD rules).
- Medicare becomes the primary payer upon retirement.

Payments made by an Employer Group Health Plan (EGHP) satisfy Medicare deductible and coinsurance amounts.

Disability

Entitlement to Medicare through disability requires the beneficiary to be younger than 65 and to have a disability other than ESRD. At age 65, the disability rules no longer apply and the patient's insurance status would be evaluated under the rules of working-aged provision.

The following conditions must be met for Medicare to be the secondary insurance:

- Medicare beneficiary must be younger than 65.
- Entitled to group health coverage by virtue of active employment or that of a spouse or family member.
- If group health coverage is through spouse's employment, the spouse may be any age.
- Employer must have 100 or more employees, or be part of a multi-employer group insurance plan (at least one employer in the group must have 100 or more employees).
- Medicare becomes the primary payer upon retirement.

Payments made by an EGHP satisfy Medicare deductible and coinsurance amounts.

ESRD

Medicare benefits are secondary to benefits payable under an EGHP for individuals entitled to Medicare on the basis of ESRD. The age and previous entitlements to Medicare do not come into play as long as ESRD is part of the entitlement picture. ESRD can affect individuals of any age.

The following conditions must be met for Medicare to be the secondary insurance:

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- Medicare beneficiary must be entitled due to ESRD.
- Entitled to group health coverage by virtue of current or past employment or current employment of the spouse or family member.
- There is no size limitation on the employer.
- Medicare beneficiary may be any age.
- A 30-month coordination period for any individual.

Payments made by an EGHP satisfy Medicare deductible and coinsurance amounts.

ESRD Coordination Period

A	B	C
Dialysis Begins	**Medicare Begins**	**Medicare Becomes Primary**
0 to 3 months	**1 to 30 months**	**30 to 36 months**
There is a waiting period of three months for an ESRD patient to become entitled to Medicare. This period may be cut short if the patient receives a kidney transplant or begins training for self-dialysis.	Medicare is secondary to an EGHP for a period up to 30 months.	Medicare is primary to any other coverage as long as the patient is covered under original entitlement period. A full and simultaneous lapse in both Part A and Part B coverage must occur before a second coordination period may begin. (Medicare coverage will terminate 36 months after a successful kidney transplant.)

Non-Group Coverage

There are four plans that fall into this category: workers' compensation, Veterans Affairs, Federal Black Lung Program and liability plans. Non-group plans are awarded on the basis of prior service or incident. These plans never offer spousal coverage. Active employment is not a requirement for any of these plans to be in place and the plans can affect all beneficiaries, regardless of the type of Medicare entitlement the beneficiary has.

Liability

Section 953 of Public Law 96-449 provides that payment may not be made under Medicare for any item or service to the extent that payment has been made or can reasonably be expected to be made for any item or service under an automobile medical or no-fault insurance policy or plan, or under any liability policy or plan.

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Medicare is secondary payer to all automobile, medical and no-fault insurance. When the patient is being treated for an injury or illness that resulted from an automobile accident or other accident for which a no-fault automobile medical insurance plan provides coverage, that insurer should be billed first. If 120 days have elapsed and the liability insurer has made no payment, the facility may file an assigned claim for conditional primary payment. However, if the clinic does file with Medicare, it must drop its claim against the liability insurer, except for applicable Medicare deductible and coinsurance amounts.

When payment or denial is received from the liability insurance, a claim can be submitted to Medicare that indicates a payment or denial from the liability insurer.

Veterans Affairs

Veterans Affairs (VA) provides payment to other facilities for treatment related to a military service disability only when it is unable to provide treatment for those services at one of its own facilities. Always obtain pre-authorization for services to be covered by the VA. The VA also provides a monthly fee basis ID card that contains the information needed to bill the VA.

The veteran criterion applies to Medicare beneficiaries who are also entitled to VA benefits. Medicare cannot make a payment if the VA furnishes services directly, except in the cases of emergency inpatient or outpatient hospitalization.

Medicare may pay secondary benefits for VA-authorized services furnished by a non-VA physician or supplier in the following cases:

- The VA charges the veteran/beneficiary a copayment for authorized services.
- Payment made by the VA for authorized services are credited to Medicare deductibles.

It is advantageous for the beneficiary to have the VA pay when the VA does not charge a deductible or coinsurance.

Workers' Compensation

The Workers' Compensation program is a government-supervised and employer-supported system for compensating employees for injury or disease suffered in connection with their employment, whether or not the injury was fault of the employer.

Payment made under Medicare may not be made for any item or service to the extent that payment has been made or can reasonably be expected to be made for such items or services under a state or federal Workers' Compensation law or plan.

All Workers' Compensation acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing

care and other necessary restorative items and services. However, in some states there are limits on the amounts of medical and hospital care provided.

The Federal Black Lung Program

Some Medicare beneficiaries are entitled to receive medical benefits under the Federal Black Lung Program for services rendered for a condition attributable to lung disease or conditions caused by mining.

Medicare will not pay for benefits covered under the Federal Black Lung Program. However, services rendered to these beneficiaries for conditions not related to a black lung diagnosis should be billed directly to Medicare (such as cardiac heart failure brought on by renal failure).

The address for black lung bills is:

Federal Black Lung Program
P.O. Box 8302
London, KY 40742-8302

When Primary Carrier Does Not Make a Payment

There are instances when the primary carrier processes a claim without making a payment. The most common of these is when payment was applied to the patient's deductible. When this occurs, it is necessary to submit a claim to Medicare reporting occurrence code 24 in FLs 31–34.

Medicare may make a conditional payment if the provider files a proper claim under the group health plan and the plan denies the claim in whole or in part (i.e., payment was applied to the patient's deductible, primary benefits exhausted). When this occurs, providers follow the normal procedures when billing Medicare Secondary Payer (MSP), with the following exceptions:

- Enter occurrence code 24 and the date of the denial from the primary carrier in FLs 31–34.
- Enter the appropriate value code and "0000" (zeroes) in the dollar amount in FLs 39–41.
- Enter "C" (for conditional payment) and the primary carrier's name in FL 50a. Enter "Z" and Medicare in FL 50b.
- Enter the reason the primary payer did not make payment in FL 80 (Remarks).

  Note: The claim will be returned if the reason the primary carrier declined payment does not appear in FL 80.

Medicare will not make a conditional payment when the provider receives a reduced or no payment because of failure to file a proper claim. The term "proper claim" means one that is filed in a timely manner and meets all other filing requirements specified by the

primary carrier (e.g., mandatory second opinion, prior notification before seeking treatment).

When this occurs, the provider must report that a reduced or no payment was made and the amount the primary carrier would have paid if the primary carrier had paid on the basis that a proper claim had been filed. The Medicare secondary payment is the amount Medicare would have paid if the primary carrier had paid on the basis that a proper claim had been filed.

Providers will follow the normal procedures when billing MSP with the following:

- Enter occurrence code 24 and date of the denial from the primary carrier in FLs 31–34.
- Enter the appropriate value code and dollar amount the primary carrier would have paid if the primary carrier had paid on the basis that a proper claim had been filed.
- Enter the appropriate payer code and name of the primary carrier in FL 50a. Enter "Z" and "Medicare" in FL 50b.
- Enter the reason primary did not make payment in FL 80 (Remarks).

When the primary carrier pays less than the actual charges (e.g., under the terms of a preferred provider agreement) and less than the amount the provider is obligated to accept as payment in full (e.g., because of imposition of a primary payer deductible and/or copayment, but not because of failure to file a proper claim), Medicare uses the amount the provider is obligated to accept as payment in full in its payment calculation.

When this occurs, providers follow the normal procedures when billing MSP with the following:

- Enter value code 44 and the amount the provider agreed to accept from the primary payer in FLs 39–41.
- Enter the appropriate value code and amount primary payer paid in the dollar amount in FLs 39–41.

Note: Value code 44 should be reported when the provider receives a reduced or no payment because of failure to file a proper claim and the amount that would have been received (if a proper claim had been filed) is less than the actual charges and less than the amount the provider agreed to accept as payment in full.

POINTS TO REMEMBER

- All MSP claims can be submitted electronically.
- In instances when the primary carrier applies only a portion of its payment to the deductible, providers will submit a routine MSP filing reporting the amount allowed by the primary payer in FLs 39–41.

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- Occurrence code 24 is not required on claims to Medicare where the VA is also an insurer. In these situations, the patient decides whether to bill VA or Medicare.
- Denials due to services provided prior to the start of coverage or services after the termination date of coverage should not be submitted with occurrence code 24. The beneficiary's MSP record must be updated to allow the claim to process as Medicare primary.

Medicare Secondary Quick Reference Sheet

This tool will assist in proper coding of MSP claims. The FL list is to be used in addition to the FLs required for a specific TOB. Always verify the correct value code is being used to represent the money paid by the primary carrier.

Payment Indicator	Value Code	Description
A	12	Working Aged
B	13	ESRD
C	ALL	Conditional Payment Request
D	14	Auto Liability
E	15	Workers' Compensation
G	43	Disability
H	41	Federal Black Lung Program
I	42	VA
L	47	Liability Other (i.e., slip and fall, or malpractice)

Note: Use value code 44 when the amount the provider agreed to accept from the primary payer is less than the charges but higher than the payment received when an MSP payment is due. Enter value code 44 to indicate the amount you were obligated or required to accept from a primary payer. When a lesser amount is received and is less than the charges, an MSP payment is due. Value code 44 is used in conjunction with value codes 12, 13 and 43.

Required MSP Fields in the UB-04

Value Codes	12	13	14	15	41	42	43	47
Form Locator 31–34 Occurrence Code			X	X				X
Form Locator 38 Primary Insurer's Address	X	X	X	X	X	X	X	X
Form Locator 39–41(a–d) Value Code and Amount	X	X	X	X	X	X	X	X
Form Locator 50 Payer Identification	X	X	X	X	X	X	X	X
Form Locator 58 Insurers' Name	X	X	X	X	X	X	X	X
Form Locator 59 Patient's Relationship	X	X	X	X	X	X	X	X
Form Locator 60 Identification Number	X	X	X	X	X	X	X	X
Form Locator 61 Group Name	X	X	X	X	X	X	X	X
Form Locator 62 Group Number	X	X		X			X	
Form Locator 65 Employer Name	X	X		X			X	

COB CONTRACTOR

All MSP records that require updates have to go through the Coordination of Benefits (COB) contractor. The toll-free number is (**800) 999-1118.**

MEDICAL NECESSITY

"Medical necessity" is defined as services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member and are not excluded under another provision of the Medicare program.

Medicare notifies the providers of limited coverage and medical necessity on the TrailBlazer Web site. The information is posted as notices, which can be found on the Local Coverage Determinations (LCDs) Web page.

Definition of Limited Coverage

Coverage of certain procedures is limited by the diagnosis. If the diagnosis listed on the claim is not the same as one of those listed as covered for the procedure, the procedure is denied.

NATIONAL COVERAGE DETERMINATIONS

National Coverage Determinations (NCDs) are developed by CMS to describe the circumstances for Medicare coverage nationwide for a specific medical service procedure or device. NCDs generally outline the conditions for which a service is considered to be covered (or not covered) under Section 1862(a)(1) or other applicable provisions of the Social Security Act.

NCDs are CMS' medical policy relating to outpatient services. A listing of all NCDs is available on the CMS Web site.
http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

LOCAL COVERAGE DETERMINATIONS

CMS indicated that in the absence of statute regulations or national coverage policy, intermediaries are to develop Local Coverage Determinations (LCDs) to describe when and under what circumstances an item or service will be covered. The MAC must also develop LCDs to clarify or provide specific details on national coverage guidelines. Medical policy is the basis for Medical Review (MR) decisions made by the MR staff. LCDs are only applicable to determinations made under the authority of 1862 (a)(1)(A) of the Social Security Act (medically reasonable and necessary services).

LCDs may be developed for the following providers:

- Community mental health centers.
- Comprehensive outpatient rehabilitation facilities.
- End-stage renal disease facilities.
- Federally qualified health centers.
- Hospital outpatient services.
- Outpatient rehabilitation facilities.
- Rural health clinics.
- Skilled nursing facilities.

Visit the LCDs Web page to view TrailBlazer's LCDs.
http://www.trailblazerhealth.com/Tools/LCDs.aspx

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE

Covered and Non-Covered Services

Providers must submit services on separate claims when a service not pertaining to an Advance Beneficiary Notice of Noncoverage (ABN) was rendered during the same period as a service requiring an ABN. Statement dates of the claims cannot overlap. If the time periods cannot be separated (i.e., service requiring an ABN given on same day as a service not requiring an ABN), a single claim must be submitted. Providers must report the overlapping period, occurrence code 32, show all services as covered and include modifier GA with the Healthcare Common Procedure Coding System (HCPCS) code to identify the revenue code line for which the ABN was given.

Note: This is an exception and should only be used when it is impossible to separate the billing periods.

Providers should inform the patient if it is not certain Medicare will cover the services; however, this does not mean a CMS-R-131 form must be issued. If the patient makes the decision to receive the services but requests Medicare to make a medical coverage determination, the claim is submitted as a demand bill. Services in question are submitted on a separate claim with condition code 20 and all charges are shown as non-covered.

If the patient decides to receive the services but requests the charges be submitted to Medicare for a denial, possibly for another insurer, the claim is submitted as a request for denial. Services in question are submitted on a separate claim with condition code 21 and all charges are shown as non-covered.

Charges are submitted on one claim when additional services are rendered on the same day as a non-covered service for which an ABN was given. At a later date, the provider determines that an ABN should have been given for another non-covered service as follows:

- The covered services and the non-covered services for which the ABN was given are submitted as covered along with modifier GA on the line item for which the ABN was given.
- The non-covered service for which an ABN was not given should be submitted as non-covered. This service will be denied as "provider liable."

Effective April 1, 2010, two HCPCS Level 2 modifiers have been updated to distinguish between voluntary and required uses of liability notices used in association with ABNs:

- Redefined GA modifier (waiver of liability statement issued as required by payer policy). Modifier GA should be reported when a **required** ABN was issued for a service. It should only be used to report when a required ABN was issued for a

service. It should not be reported in association with any other liability-related modifier and should continue to be submitted with covered charges.

- GX modifier (notice of liability issued, voluntary under payer policy). Modifier GX should be reported when a **voluntary** ABN was issued for a service. Providers may use the GX modifier to provide beneficiaries with voluntary notice of liability regarding services excluded from Medicare coverage by statute. The GX modifier must be submitted with non-covered charges only and will be denied as a beneficiary liability.
- GZ modifier (item or service expected to be denied as not reasonable or necessary). The GZ modifier indicates that an ABN was not issued to the beneficiary and signifies that the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy. In addition, Medicare contractors will not perform complex medical review on any claim line items submitted with the GZ modifier. Line items denied due to the presence of the GZ modifier will reflect the following codes:
  - Claim Adjustment Reason Code (CARC) 50, "These services are non-covered services because this is not deemed a 'medical necessity' by the payer." Group code CO (Contractual Obligation) is used to show provider/supplier liability.

  Note: Medicare contractors will automatically deny claim line items submitted with a GZ modifier, effective for dates of service on or after July 1, 2011.

Hospital-Issued Notice of Noncoverage (HINN)

The Hospital-Issued Notices of Noncoverage (HINN) informs the patient of impending liability at the time of admission or if they remain in the hospital beyond their discharge date, and what appeal rights they have.

Examples of HINNs and instructions may be downloaded from the CMS Web site at http://www.cms.gov/BNI/05_HINNs.asp.

Important Message From Medicare

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights.

The Important Message From Medicare (IM) must be delivered no later than two calendar days after admission. The initial copy may be given as part of the preadmission process, but no earlier than seven days prior to admission. If the notice is given more than two calendar days prior to admission, a follow-up copy must be delivered.

The IM must be delivered to the beneficiary in person and must be both signed and dated by the beneficiary. However, if the beneficiary is unable to understand the notice,

it may be delivered to and signed by the beneficiary's legal representative or another person whom the beneficiary has indicated may act for him.

The original signed copy of the notice must be given to the patient and a copy must be retained by the hospital. The hospital determines the best method of storage of the notices. Hospitals must document timely delivery of all IM notices.

If a beneficiary or his representative refuses to sign the notice, an annotation should be placed in the patient signature line or the "Additional Information" section, or another sheet of paper may be attached to the notice.

A second copy of the signed IM must be delivered to the beneficiary as soon as possible prior to discharge, but not more than two days before the planned date of discharge. This second copy can be either a copy of the previously signed notice, or a new IM can be given. If a new IM is given, the beneficiary's or representative's signature must be obtained on the new IM.

If discharge cannot be predicted in advance, the second copy may be delivered on the day of discharge; however, it must be delivered at least four hours prior to the time of discharge.

"An Important Message From Medicare" (Form CMS-R-193) can be found at http://www.cms.gov/BNI/Downloads/CMSR193.pdf.

MEDICAL REVIEW

Medical Review Overview

Medicare law stipulates all services covered by the Medicare program must be medically necessary for the diagnosis or treatment of acute illness or injury or replacement of malformed or malfunctioning body parts. The Medical Review (MR) team determines if services rendered were medically reasonable and necessary. The MR team includes the medical director, registered nurses and licensed practical nurses. MR examines the medical records for claims submitted, and determines which claims to review for the following reasons:

- Exclusions – CMS requires review of claims for procedures that might be exclusions, such as dental services or foot procedures.
- Beneficiary request – Any claim that a beneficiary requests be reviewed will prompt medical review of the claim.

Focused Medical Review

Focused Medical Review (FMR) is the targeting and directing of Medicare Part A and Part B resources on claims for services where there is the greatest risk of inappropriate payment by the beneficiary or the Medicare Trust Fund. FMR involves an analysis of national and local utilization and billing databases, prepayment MR and postpayment MR to identify those services and, ultimately, those providers who are ordering and delivering medically unnecessary services. The objectives of FMR are to:

- Maximize program protection against inappropriate payments.
- Decrease denials of claims by educating providers to bill only for services that are medically necessary and covered by the Medicare Trust Fund.
- Educate providers on appropriate practices to help improve quality of care for the beneficiaries.
- Avoid inconvenience to providers who adhere to program requirements.

Medically necessary services, as defined by Medicare law, are those that are reasonable and necessary for the diagnosis or treatment of an illness or an injury or for the improvement of a malformed body member. Generally accepted standards of medical practice in the state are used as the basis for these determinations.

MEDICAL REVIEW PROGRESSIVE CORRECTIVE ACTION

This section provides further guidance, underlying principles and approaches to be used in deciding how to deploy resources and tools for Medical Review (MR). These concepts are already part of existing manual instructions (e.g., how to conduct MR) but are amplified here for easy understanding of expectations and basic requirements.

Medical Review Based on Data Analysis

Data analysis is an essential first step in determining whether patterns of claims submission and payment indicate potential problems. Such data analysis may include simple identification of aberrancies in billing patterns within a homogeneous group or much more sophisticated detection of patterns within claims or groups of claims that might suggest improper billing or payment.

Data analysis itself may be undertaken as part of general surveillance and review of submitted claims, or may be conducted in response to information about specific problems stemming from complaints, provider or beneficiary input, fraud alerts, reports from the Centers for Medicare & Medicaid Services, other contractors or independent government and non-government agencies.

Probe Review

Before deploying significant MR resources to examine claims identified as potential problems from data analysis, MR will select a small “probe” sample of potential problem claims (prepayment or postpayment) to validate the hypothesis that such claims are being billed in error. This ensures MR activities are targeted at identified problem areas. Such a sample should be large enough to provide confidence in the result, but small enough to limit administrative burden. A general rule of thumb for the decision about how many claims should be included in the probe sample is that it should not exceed more than 20–40 claims for any individual provider (in the case of a hypothesized provider-specific problem), or 100 claims distributed among a wider universe of providers (in the case of a hypothesized systematic problem). For provider-specific problems, MR will notify providers (in writing or by telephone) that a probe sample is being done and of the results of the probe review.

After validating that claims are being billed in error, MR will target reviews of providers or services that place the Medicare Trust Funds at the greatest risk.

Additional Development Request

If the documentation needed to make an MR determination is not received within 30 days from the date of the documentation request, the claim will be denied as not medically necessary, based on insufficient documentation. The routine Return to Provider (RTP) second request letters for medical records will no longer be sent.

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Provider Notification

Written notification will be sent to all providers when they are placed on MR and removed from MR. It is recognized that some providers may remain on MR for long periods of time, despite educational interventions and use of the Progressive Corrective Action (PCA) concepts. For extended MRs, written notification will be provided at least every six months on the MR status.

NOTIFICATION LETTERS

Notification letters will be clear and concise and will include at least the following information:

- The reasons for MR.
- Previous review findings (if applicable).
- Planned MR (level of review and duration), potential for continuation of or increase in MR levels (if identified problems continue, additional problems are identified, etc.).
- Description of the specific actions the provider must take to resolve the problems identified in the MR process.
- When appropriate, an offer to provide individualized education and the name and telephone number of a contact person who is familiar with the contents of the notification letter will be made.

Provider Feedback and Education

When a widespread problem affecting a large number of providers is identified, focused provider education will be provided. The overall goal of providing feedback and education is to ensure proper billing practices so claims will be submitted and paid correctly.

Visit the Part A Medical Review Web page for specific information concerning TrailBlazer Medical Review (MR) efforts and documentation tips.
http://www.trailblazerhealth.com/AMR.aspx

MEDICARE PART A REDETERMINATION (APPEALS) PROCESS

Appeals of Claims Decisions

Medicare offers five levels in the Part A appeals process. The levels, listed in order, are:

- Redetermination.
- Reconsideration.
- Administrative Law Judge (ALJ) hearing.
- Departmental appeal board review.
- Judicial review in U.S. District Court.

The appellant must begin at the first level after receiving a medical denial. Each level of appeal has procedural steps the appellant must take before appealing to the next level. If the appellant meets the procedural steps at a specific level, the appellant is then afforded the right to appeal any determination or decision to the next level in the process. The appellant may exercise the right to appeal any determination of decision to the next higher level, until appeal rights are exhausted. Although there are five distinct levels in the appeals process, the redetermination (Level 1) is the only level in the appeals process that the contractor performs.

Providers are encouraged to use the Provider Assistance Request Form when submitting a request. This form is available on the TrailBlazer Web site at http://www.trailblazerhealth.com/Publications/PDF Form/assist.pdf.

WHAT IS NOT A REDETERMINATION

Not all claims can be appealed. Some examples of claims that are not considered a redetermination are:

- Claims still in process.
- Adjusted/voided claims.
- Claims where Medicare is the secondary payer.

Redetermination – The First Level of Appeal

The redetermination process is available to providers who are dissatisfied with the initial determination on their finalized claims and wish to appeal the decision. The request must be submitted within 120 days of the Remittance Advice (RA) date or notice of the initial determination. The redetermination review is performed by TrailBlazer and is based on the documentation submitted. The following information is needed to process a redetermination request:

- The beneficiary's name.
- The Medicare Health Insurance Claim (HIC) number of the beneficiary.

- The specific service(s) and/or item(s) for which the redetermination is being requested.
- The specific date(s) of service.
- The name and signature of the person filing the redetermination request (requests received without the appropriate signature are returned).
- Complete medical and billing records for the services for which the redetermination is being requested. This includes:
  - Itemized statements (detailed listing of all charges) and matching CMS-1450 (UB-04) claim forms.
  - Physician's orders.
  - X-ray reports.
  - All test results.
  - Medical history.
  - Minimum Data Set.
  - Documentation of severity or acute onset.
  - Consultation reports.
  - Billing forms.
  - Referrals.
  - Initial evaluation/plan of treatment.
  - Nurses' notes.
  - Copies of communications between physician and/or beneficiary, hospital, laboratory, etc.
  - All progress notes.
  - Medication records.
  - Ambulance run sheets.
  - Visual fields and photos.
  - Therapy records.
  - Mammogram reports.
  - Operative report.
  - Pathology report.
  - Denial letter or RA indicating the denial notice.
  - All other information that validates rendering of service(s) (for dates of service billed).

If all the above information is not included, the request may be denied as invalid. If the provider is notified the redetermination request is invalid, the provider may resubmit a valid request to TrailBlazer. The redetermination request will be completed within 60 days.

Reconsideration – The Second Level of Appeal

An individual who is dissatisfied with the contractor's redetermination may request a reconsideration within 180 days of receipt of the redetermination. Reconsiderations are processed within 60 days by entities called Qualified Independent Contractors (QICs). The reconsideration must be filed with the QIC specified in the redetermination notice.

The redetermination notice will include the QIC contact information and a reconsideration request form, which must accompany the request for reconsideration.

ALJ Hearing – The Third Level of Appeal

An individual who is dissatisfied with the QIC's reconsideration or dismissal decision may request an ALJ hearing. The ALJ hearing request must be in writing and be submitted within 60 days of receipt of notice of the QIC's reconsideration. The amount in controversy requirement must also be met. The amount remaining in controversy requirement for requests made on or after January 1, 2012, is $130.

Departmental Appeals Board – The Fourth Level of Appeal

The level of administrative review available to parties after the ALJ hearing decision or dismissal order has been issued, but before judicial review is available, is the Departmental Appeals Board (DAB) review. The part of the DAB that reviews Medicare cases is called the Medicare Appeals Council. The DAB evaluates requests for review and makes final decisions whether to review or to decline review decisions of ALJs as well as orders for dismissals by ALJs. This request for review should be submitted within 60 days from the receipt of the ALJ hearing decision.

Judicial Review in U.S. District Court – The Fifth Level of Appeal

The circumstances allowing for an appeal or escalation to the U.S. District Court level of review are limited and articulated in 42 CFR 405.1136. The time limit for filing a judicial review is 60 days from the receipt of the DAB's decision. The appellant must file the complaint with the U.S. District Court and the amount in controversy requirement must be met. The amount remaining in controversy requirement for requests made on or after January 1, 2010, was $1,260. For requests made on or after January 1, 2011, the required amount in controversy must be at least $1,300. *For requests made on or after January 1, 2012, the required amount in controversy must be at least $1,350.*

The following charts provide additional assistance with the appeals process.

Medicare Fee-for-Service Appeals Process		
Appeal Level	**Time Limit for Filing Request**	**Monetary Threshold to Be Met**
Redetermination	120 days from date of receipt of the notice of initial determination	None
Reconsideration	180 days from date of receipt of the redetermination	None
ALJ	60 days from date of receipt of reconsideration	For requests filed on or after January 1, *2012*, at least $130 remains in controversy. *This amount remains unchanged from the previous calendar year.*
DAB Review/Appeals Council	60 days from date of receipt of ALJ hearing decision	None
Federal Court Review	60 days from date of receipt of the Appeals Council decision or declination of review by DAB	For requests filed on or after *January 1, 2012, at least $1,350* remains in controversy.

Where to File a Medicare Part A Appeal	
Level	**Where to File**
Redetermination	Medicare Administrative Contractor (MAC)
Reconsideration	QIC
ALJ	MAC or DHHS Office of Medicare Hearings and appeals field office if heard by a QIC
DAB Review	DAB or ALJ hearing office
Federal Court Review	U.S. District Court

MEDICALLY DENIED CLAIMS

Effective July 1, 2009, providers are no longer able to submit electronic adjustments on claims that contain medically denied charges. Changes to medically denied claims are handled either through the redeterminations or claims reopening process.

All services submitted to Medicare for payment are subject to medical review. There are three possible outcomes when a claim is medically reviewed:

- All services on the claim are paid.
- Some of the services are paid and others are denied.
- All services on the claim are denied.
- Services that fail to meet medical necessity requirements are denied as non-covered with a line item reason code that begins with the number five.

Providers with Direct Data Entry (DDE) capability can determine if a non-covered claim line was denied due to medical necessity. To access this information via DDE (MAP 171D):

- Select option **01** (Claims Inquiry) and press **Enter.**
- Select option **12** (Claims) and press **Enter.**
- Enter the National Provider Identifier (NPI), HIC number and dates of service.
- Select the claim.
- Press **F8** to go to page 2 (MAP 1712).
- Place the cursor anywhere on the line that has non-covered charges.
- Press **F2** to view MAP 171D.

A redetermination request should be submitted when the provider is disputing any service that has been medically denied on the claim. This includes any modifications to the ICD-9-CM coding on the claim.

The complete medical record should be submitted with the redetermination request. Information on how to request a redetermination is available on the Part A Redeterminations Web page.
http://www.trailblazerhealth.com/Appeals/Redeterminations/RedeterminationsPartA.aspx

Reopenings

CLAIMS WITH MEDICALLY DENIED CHARGES

There are two reasons for requesting a reopening on claims that contain medically denied services:

- Adding or removing charges but not adding an additional diagnosis to a claim with medically denied charges, when the provider is not disputing the denied charges.
- Adding occurrence code 32 and/or modifier GA to indicate an ABN was given for services previously denied as provider liable. The ABN must be submitted with the adjustment request.

CANCELLATION OF CLAIMS WITH MEDICALLY DENIED CHARGES

Valid reasons to request a cancel would be:

- Claim processed under an incorrect NPI or Provider Transaction Access Number (PTAN).
- Claim processed under an incorrect HIC number.
- Outpatient claim that should be combined with an inpatient claim.

BENEFICIARY RIGHTS TO ITEMIZED STATEMENT

Misleading Statements Sent to Beneficiaries

Providers who send monthly bills/account statements must include language that clearly explains, in a prominent area of the bill, that Medicare beneficiaries with current entitlements are responsible only for deductibles, coinsurance or non-covered services.

Section 1866(a) of the Social Security Act and 42 CFR 489.20–42 indicate that, as part of the provider's participation agreement, providers agree not to charge any individual for items and services covered by the Medicare program, other than applicable deductibles and coinsurance amounts.

Many hospitals send bills/account statements to patients before, or at the same time, a bill is submitted to Medicare and monthly statements follow until Medicare pays the bill. Although there may be a small disclaimer indicating that Medicare is being billed or the balance is zero, there is usually a strong reminder that the beneficiary is ultimately responsible for paying the bill if Medicare does not.

Adequate notification on the statement prevents patients from inadvertently paying the amount shown and then attempting to obtain refunds later.

The BBA of 1997 gives beneficiaries the right to submit a written request for an itemized statement from their providers/suppliers for any Medicare item or service. The law requires providers/suppliers to furnish the itemized statement within 30 days of the request or subject to a civil monetary penalty of $100 for each unfulfilled request. If an itemized statement is received, the beneficiary may request the Medicare contractor to review specific issues (i.e., services not provided, billing irregularities and appropriate measures to recover any amount inappropriately paid).

Guide Concerning the Format and Substance of the Itemized Statement

The information on the itemized statement should enable the beneficiary to reconcile the itemized statement with the Medicare Summary Notice (MSN). Providers/suppliers should not charge beneficiaries for the itemized statement. Below are some suggestions regarding the types of information that might be helpful for the beneficiary to receive on an itemized statement:

- Name of beneficiary.
- Date(s) of service.
- Description of item or service furnished.
- Number of services furnished.
- Provider/supplier charges.

- An internal reference or tracking number.

If Medicare has adjudicated the claim, additional information can be included on the itemized statement, such as:

- Amounts paid by Medicare.
- Beneficiary responsibility for coinsurance.
- Medicare claim number.

The statement should also include the name and a telephone number for the beneficiary to call if there are further questions.

An example of the Medicare Summary Notice can be viewed at: http://www.medicare.gov/publications/pubs/pdf/SummaryNoticeA.pdf.

BENEFICIARY CHANGE OF ADDRESS

The following instructions from CMS specify the circumstances under which beneficiary addresses may be changed on MAC files.

The beneficiary address will be updated when the MAC receives a change of address from the CWF. When there is no CWF address available, the MAC will use the address currently on file with the submission of a claim. CWF will process the claim and as long as it does not reject the claim for any other reason, it will approve the claim to pay, but will also create a request from the Entitlement Database (EDB) for an update to get the current address (this could be either a beneficiary address or a representative payee address). The MAC will receive the EDB update within 48 hours and will apply it to any claim processed after the update.

The files also will be changed if:

- The MAC receives notice from the U.S. Postal Service Address Change Service (ACS) or the National Change of Address (NCOA) service.
- The MAC receives written, dated and signed notification from a beneficiary requesting a permanent or temporary address change. The request must contain the beneficiary's name, date of birth and HIC number. If the request appears to be a form letter (e.g., the required information appears in preprinted spaces or is a photocopy), the request will be verified with a phone call to the beneficiary within two business days. If the MAC cannot reach the beneficiary on the initial call, a written notice will be sent to the beneficiary to verify the change of address request.
- The MAC receives a verifiable request for a permanent or temporary address change over the telephone. A verifiable phone request is one in which the caller can provide the beneficiary's name, HIC number, date of birth, and information about the most recent service such as a date, type of service and name of the provider. If the caller is requesting a permanent change of address, the MAC will inquire as to whether the address change has been reported to the SSA. If not, the MAC will request the caller telephone the SSA at (800) 772-1213. If the caller is requesting a temporary change of address, the MAC will inquire as to whether the caller has reported the change of address to the U.S. Postal Service. If not, the MAC will instruct the caller to do so. The MAC will inform the caller that the temporary change of address will be terminated within CMS' files (based on the period of time the caller requested, but no longer than nine months). CMS will then use the address (from the CWF) provided by SSA.
- The MAC receives written, dated and signed notification from a court of law naming a personal representative of an estate. The notification must contain the beneficiary's name and HIC number.

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- The MAC receives written, dated and signed notification from a court of law naming a power of attorney. The notification must contain the beneficiary's name and HIC number.

Under no circumstances can a beneficiary's address be changed on the MAC file as a result of a change noted on any claim form.

COMMON WORKING FILE

The Common Working File (CWF) reorganizes certain claims processing functions to simplify and improve overall Medicare claims processing by creating localized databases containing total beneficiary histories. CWF was developed under the leadership of the CMS Bureau of Program Operations and was designed with certain advantages in mind:

- Create a beneficiary data set that contains all entitlement and utilization information in one location.
- Increase program savings by detecting additional duplicate and inappropriate payments.
- Enhance utilization review opportunities because all beneficiary history is in one file.
- Avoid costly adjustment processing and overpayment recovery activities with prepayment edits and perform prepayment A/B data exchange edits within the claims process.

TIME LIMITS FOR FILING BILLS

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which amended the time period for filing Medicare Fee-for-Service (FFS) claims as one of many provisions aimed at curbing fraud, waste and abuse in the Medicare program.

Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service.

Written Statements of Intent to Claim Medicare Benefits

POLICY CLARIFICATION

Medicare will no longer accept Statements of Intent (SOIs) to extend the timely filing limit. The policy for SOI procedures has been eliminated from Medicare regulations; therefore, Medicare will no longer accept SOIs to extend the timely filing period of claims.

CHARGES FOR MISSED APPOINTMENTS

CMS's policy allows physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments. The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly.

The amount the physician or supplier charges for the missed appointment must apply equally to all patients (Medicare and non-Medicare), in other words, the amount the physician/supplier charges Medicare beneficiaries for missed appointments must be the same as the amount that they charge non-Medicare patients (whatever amount that may be).

With respect to Part A providers, in most instances a hospital outpatient department can charge a beneficiary for a missed appointment without violating its provider agreement and 42 CFR 489.22. Because 42 CFR 489.22 applies only to inpatient services, it does not restrict a hospital outpatient department from imposing charges for missed appointments by outpatients. In the event, however, that a hospital inpatient misses an appointment in the hospital outpatient department, it would violate 42 CFR 489.22 for the outpatient department to charge the beneficiary a missed appointment fee.

Medicare does not make any payments for missed appointment fees/charges that are imposed by providers, physicians, or other suppliers. Charges to beneficiaries for missed appointments should not be billed to Medicare.

CLAIMS PAYMENT FLOORS

Claim Payment Dates

PAPER CLAIMS

Payment for paper claims can be issued on the 29th day following receipt of the clean claim.

ELECTRONIC CLAIMS

Claims filed electronically can be paid as early as 14 days from receipt of the claim. An electronic claim is one that is submitted via the Central Processing Unit (CPU) to CPU transmission, tape, diskette, direct data entry, direct wire, dial-in telephone or personal computer upload or download.

Claims Processing Timeliness

The Omnibus Budget Reconciliation Act (OBRA) of 1986 established claims processing timeliness requirements for all Medicare claims:

- 100 percent of all electronic "clean" claims must be processed in 30 days.
- 95 percent of all hard copy claims must be processed in 30 days.
- 98 percent of all claims must be processed in 60 days.

A "clean" claim is defined as any claim that does not require outside development.

Electronic Claims Submission

The change in the payment floor is further incentive for providers to consider use of electronic claims submittal to improve cash flow, recordkeeping and claims status tracking ability. Assistance is provided to help providers convert to electronic billing.

Receipt Date

Paper claims received by 5 p.m. on a business day, or by closing time if the MAC routinely closes between 4 p.m. and 5 p.m., must be treated as received on that business day. Paper claims received after 5 p.m. may be considered as received the next business day.

Paper claims are considered received if delivered to the MAC by the U.S. Postal Service, picked up from a post office box or otherwise delivered to the MAC by close of business. The paper claim receipt date rule also applies to electronic claim tapes and diskettes submitted by providers.

Interest Payments

Provider interest payments will begin on clean claims not processed timely on the 31st day after date of receipt of a clean electronic claim or on the 31st day after date of receipt of a clean paper claim.

MEDICARE RA

The CMS standardized the electronic format used by intermediaries for sending Medicare payment information to supplemental payers. CMS mandated contractor usage of this format for any trading partner agreements signed after July 1, 1994. However, companies using local formats were not required to change to the standardized format. When a new MAC is selected or assigned, the Medicaid agencies are not always ready to accept the mandated standardized format.

Providers can identify crossover information on the standard paper RA by the claim status codes in the CLM STATUS field. Claim status codes indicate if the claim was crossed over to another entity or is a reversal of a previous payment.

An example of a standard paper RA can be viewed at:
http://www.trailblazerhealth.com/Publications/Job Aid/rahandout.pdf.

Paid or Rejected Claims

Claims that are paid or rejected will appear on the RA with the reason codes and remark codes. As a reminder, claims that are awaiting RTP responses will not be shown on the RA because they are not finalized claims.

ANSI Reason Codes

The ANSI adjustment reason and remark codes listed on the RA are available to providers on the Washington Publishing Company Web site listed below. These files are updated frequently; therefore, it is recommended that providers check these sites often:

Health Care Claim Adjustment Reason Codes
http://www.wpc-edi.com/codes/claimadjustment

RA Remark Codes
http://www.wpc-edi.com/codes/remittanceadvice

Providers with DDE capability may inquire and review ANSI reason codes from the DDE system. The steps below should be followed:

- Select **01** (Inquiries) from the Medicare Part A menu (MAP 1701) and press **Enter.**
- Select **68** (ANSI Reason Codes) from the submenu (MAP 1702).
- From the ANSI Standard Codes Inquiry Selection Screen (MAP 1581), key a **C** in the Record Type field and press **Enter** to bring up a summary of all Adjusted Claim (ADJ) Reasons. Use **Tab** to move the cursor beside the desired code. Key an **S** to select the reason code and press **Enter.** The particular code will be displayed. The specific code also may be keyed in the Standard Code field and press **Enter.**

The steps listed above should be followed to inquire and review the groups, remarks and appeals codes.

Electronic Remittance Advice

The Electronic Remittance Advice (ERA) conforms to the requirements of the American National Standards Institute (ANSI) and is in the ANSI-835 format. ANSI-835 is a variable-length record designed for wire transmission. To be eligible to receive the ERA, a provider must bill electronically and be able to receive ANSI-835 telecommunications. Also, providers must have an ANSI-835 translator to reformat the ERAs from the ANSI-835 format to their format. There are several vendors who offer translators.

Medicare Part A will support the following ERA transmissions:

- **Advantis:** Providers will need an Advantis account. In order to obtain this account, please contact Advantis at (800) 588-5808. Indicate communications will be with BlueCross BlueShield of South Carolina (dba TrailBlazer Health Enterprises®). Providers are responsible for the cost of all EDI transactions for the ERAs through Advantis.
- **rEDI•link:** The rEDI·link will support numerous asynchronous telecommunication protocols, including Kermit, Xmodem (Check Sum), Ymodem (Batch), and Zmodem. Most off-the-shelf communication software will support one or all these protocols. Providers may select any of the protocols indicated; however, Zmodem is recommended based on its speed and reliability.
- **PC-Print:** At this time, Medicare Part A offers free software that allows a provider to print an ERA from a personal computer. This software is not flexible and will only print the RA in a set format. The PC-Print application can be used on three Windows platforms: Windows 3.1, Windows 95 and Windows NT.
- **ERA Specifications:** At this time, Medicare Part A supports the following ERA versions: 3030.2A, 3051.3A and 3051.4A and the Health Insurance Portability and Accountability Act (HIPAA)-compliant 4010.A1. *Beginning January 1, 2012, Version 5010 will be required.*

Providers can obtain a copy of the 835 Version *5010* specifications from the Washington Publishing Company (WPC) Web site at http://www.wpc-edi.com/.

Standard Paper RA

The standard paper Remittance Advice (RA) is mandated for use by all providers who are still receiving hard copy RAs and is used by all MACs.

Providers will not receive the FISS five-digit reason code on their RAs. This five-digit reason code can be viewed online when processing Return to Provider (RTP) claims corrections and inquiries or entering claims in FISS. American National Standards Institute (ANSI) reason codes and remark codes are included on the standard paper

RA. The ANSI reason and remark codes are included on the Medicare Part B and Medicare Part A RAs. Therefore, the MAC will not utilize some of the codes defined.

Electronic Funds Transfer (EFT)

All Medicare Part A and Part B providers have the option of having their Medicare payments sent directly to their bank accounts via EFT. EFT eliminates manual handling of checks and mail time to receive payments. Contact TrailBlazer for more information on EFT.

To ensure the Medicare Part A EFT process occurs correctly, the following documents must be completed and signed by the appropriate person for each separate Claim Control Number (CCN). Complete instructions are provided.

- Authorization agreement for EFT.
- IRS Form W-9.
- Bank certification.
- Contact for EFT.

For further information or assistance, please contact:

ERA Help Desk – Part A
(469) 372-1010
(469) 372-1441
(469) 372-0446

EFT Help Desk – Part A
(469) 372-0353
(469) 372-1441
(469) 372-0446

ADJUSTMENTS, VOIDS AND CREDIT BALANCES

Adjustment Procedures

Adjustment bills are the most common mechanism for changing a previously accepted bill. They are required to reflect the results of the Quality Improvement Organization (QIO). Adjustments may also be requested by CMS via the Common Working File (CWF) if it discovers that bills have been accepted and posted in error to a particular record.

When an error has been discovered after a claim has been submitted to Medicare and the claim is finalized on a Remittance Advice (RA), an adjustment can be submitted to correct the claim.

Providers must submit all adjustment requests as Type of Bill (TOB) XX7 debit or XX8 cancel. Since several different sources can initiate an MSP adjustment (e.g., provider, CWF or MAC), the MSP designation, XXM, takes priority over any other source of an adjustment except OIG adjustments, XXK. When the provider submits a Medicare Secondary Payer (MSP) adjustment request to the MAC, it will change the TOB to XXM.

Providers cannot submit MSP claims using DDE since the DDE process does not support the CAS segment adjustments as found in the 837.

Providers who normally submit claims via DDE may use the free PC-Ace Pro32 billing software, which has MSP billing capabilities, including the required CAS segment to identify CAS segment adjustments. Providers may use any 837 billing software deemed warranted to submit MSP claims.

If the provider has more than one reason to adjust a claim, the claim change condition code that best describes the main reason for the adjustment should be used. Do not submit more than one claim change reason code.

Note: If the original claim has a "T" (Return to Provider (RTP)) status, the provider can resubmit a new bill, indicating the additional/corrected information on the new bill. Use the original TOB frequency. Some "R" (Reject) status claims can be resubmitted as a new claim, depending on the processing of the claim.

Electronic adjustments cannot be made on the following:

- "T" status – RTP.
- TOB XXP – QIO adjustment (must send an appeal to QIO).

ADJUSTMENT IDENTIFICATION

Medicare will identify the following bill types that relate to the entity generating the adjustment request:

TOBs	Adjustment Type
XX7	Provider (debit)
XX8	Provider (cancel)
XXF	Beneficiary
XXG	CWF
XXH	CMS
XXI	MAC
XXM	MSP
XXP	QIO
XXJ	Other
XXK	OIG

HARD COPY BILLERS

Hard copy billers must report:

- TOB 0XX7 – FL 4.
- Document Control Number (DCN) (14-digit number indicated on the RA) – FL 64 of the claim being adjusted.
- Claim change reason code, condition code – FLs 18–28 (A and B).
- Alpha adjustment reason code – FL 80 (remarks).
- A brief narrative explaining the reason for the adjustment request – FL 80.

Note: It is important that the 14-digit DCN on the RA is indicated on the adjustment claim copy. Omitting this number could prevent the adjustment from being processed.

ADJUSTMENT CONDITION CODES

Listed below are the adjustment condition codes that must be present to indicate why the claim is being adjusted:

- D0 – Changes to service dates.
- D1 – Changes to charges.
- D2 – Changes to revenue codes/Healthcare Common Procedure Coding System (HCPCS) codes. Effective for dates of service January 1, 2009, and after, use condition code D2 to report changes to revenue codes/HCPCS codes/Health Insurance Prospective Payment System (HIPPS) rate codes.

- D3 – Second or subsequent interim Prospective Payment System (PPS) bill.
- D4 – Change in clinical codes (ICD-9-CM) for diagnosis and/or procedure codes.
- D7 – Change to make Medicare the secondary payer.
- D8 – Change to make Medicare the primary payer.
- D9 – Any other change.
- E0 – Change in patient status.

ADJUSTMENT REASON CODES

Listed below are the adjustment reason codes that must be present to indicate why a claim is being adjusted.

- DS – Discharge status change.
- IB – PPS interim bill.
- IC – Invalid/incorrect revenue code.
- OC – Procedure code change.
- DC – Diagnosis code change.
- CC – Charge change.
- UT – Affects beneficiary utilization.
- HC – HCPCS (invalid HCPCS code).
- DT – Changes in dates of service.
- AS – Ambulatory surgical center.
- WC – Workers' Compensation.
- VA – Veterans Affairs.
- BL – Black lung.
- ES – End stage renal disease.
- AU – Automobile.
- OT – Other (must provide a narrative description in COND/DES or Remarks field).
- WE – Working aged.
- DB – Disabled.

If an adjustment reason code is missing, the claim will reject with reason code 32901 (the TOB frequency code is equal to seven, but the adjustment reason code is not valid or missing).

Void (Cancel) Procedures

CONDITION CODES

Condition codes for submitting cancel requests are:

- D5 – Incorrect provider identification number, incorrect Health Insurance Claim Number.
- D6 – Duplicate payment, OIG recoveries.

HARD COPY BILLERS

Hard copy billers must report:

- TOB 0XX8 – FL 4.
- DCN (14-digit number indicated on the RA) – FL 64.
- Claim change reason code, condition code – FLs 18–28 (A and B).
- Alpha adjustment reason code – FL 80 (Remarks).
- A brief narrative explaining the reason for the void – FL 80.

Credit Balance

A credit balance is an improper or excess payment made to a provider as a result of patient billing or claims processing errors.

REPORTING REQUIREMENTS

When to Report

A credit balance report should be submitted to Medicare within 30 days after the close of each calendar quarter. Quarter endings are the following dates:

- March 31.
- June 30.
- September 30.
- December 31.

Only one report per facility should be filed at the end of the quarter.

What to Report

The report should include all claims reflecting a Medicare credit balance as of the last day of the reporting quarter.

Who Reports

All providers of health care services participating in the Medicare program are required to submit a quarterly report. If there are multiple provider numbers for specific units within the facility, a report is to be submitted for each provider number.

How to Report

Only outstanding credit balance claims filed on the UB-04 should be reported on the CMS-838 form. Part A and Part B credit balance claims should be reported on separate

forms. A Credit Balance Certification page must be filed even if there are no credit balances to report.

The CMS-838 form and instructions may be accessed at:
http://www.cms.gov/cmsforms/downloads/CMS838.pdf.

REPAYMENT OF CREDIT BALANCES RESULTING FROM MSP PAYMENTS

Providers must repay credit balances resulting from Medicare Secondary Payer (MSP) payments within the 60-day period. Federal regulations at 42 CFR 489.20(h) require providers to pay Medicare within 60 days from the date payment was received from another payer (primary to Medicare) for the same service.

PROGRAM COMPLIANCE

Fraud and Abuse

Providers and suppliers have an obligation, under law, to conform to the requirements of the Medicare program. Fraud and abuse committed against the program may be prosecuted under various provisions of the U.S. Code and could result in the imposition of restitution, fines and, in some instances, imprisonment.

Following are the three standards CMS uses when judging whether abusive acts in billing were committed against the Medicare program:

- The services must be medically necessary.
- The services must conform to professionally recognized standards.
- The services must be provided at a fair price.

EXAMPLES OF FRAUD

- Billing for services that were not furnished and/or supplies not provided. This includes billing Medicare for appointments the patient failed to keep.
- Altering claim forms and/or receipts in order to receive a higher payment amount.
- Duplicate billings, including billing the Medicare program and the beneficiary, Medicaid, or some other insurer in an effort to receive payment greater than what is allowed.
- Offering, paying, soliciting or receiving bribes, kickbacks or rebates, directly or indirectly, in cash or any other type of payment, in order to induce referrals of patients or the purchase of goods or services that may be paid for by the Medicare program.
- Although these types of practices may initially be categorized as abusive in nature, under certain circumstances they may develop into fraud if there is evidence the subject knowingly and willfully committed the abusive practice.

EXAMPLES OF ABUSE

- Providing medically unnecessary services or services that do not meet professionally recognized standards.
- Billing Medicare significantly more than for non-Medicare patients.
- Submitting bills to Medicare that are the responsibility of other insurers under the Medicare Secondary Payer (MSP) regulation.
- Violating the participating physician/supplier agreement.
- Breaches in the assignment agreement.
- Violating the limitation amount.

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DISCOUNTS AND COUPONS

Discounts, rebates or other reductions in price may violate the anti-kickback statute. A discount is a reduction in the amount a seller charges a buyer for a good or service.

Example: A coupon offering a free initial visit or half-price services would be considered a discount by Medicare. The only way such services may be billed to the Medicare program is if the same discount is passed on to Medicare. In other words, providers may not bill the Medicare program for services offered to beneficiaries free of charge.

Discounts offered to beneficiaries must be clearly and accurately reported on Medicare claim forms.

PREVENTIVE SERVICES

CMS is committed to promoting the appropriate use of Medicare preventive benefits. Medicare covers a broad range of services to:

- Prevent disease.
- Detect disease early when it is most treatable and curable.
- Manage disease so that complications can be avoided.

The Patient Protection and Affordable Care Act (PPACA) allows for the waiver of coinsurance and deductible for some preventive services with dates of service on or after January 1, 2011. More information can be found in MLN Matters® article MM7012 at:
http://www.cms.gov/MLNMattersArticles/downloads/MM7012.pdf.

TrailBlazer and CMS have Web pages dedicated to preventive services:

- http://www.trailblazerhealth.com/Specialty Services/Preventive Services/default.aspx.
- http://www.cms.gov/PrevntionGenInfo/.
- http://www.trailblazerhealth.com/Publications/Job Aid/WaiverofDedandCoinsforPrevSvcs.pdf.

Additional Preventive Services Resources

To increase awareness of preventive services covered by Medicare, CMS has developed a variety of educational products.
http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf

COMPREHENSIVE ERROR RATE TESTING (CERT)

Medicare contractors receive more than 2 billion claims per year. To protect the Medicare Trust Fund and keep the Medicare program viable, CMS implemented the Comprehensive Error Rate Testing (CERT) program to measure the accuracy of Medicare FFS payments.

Through CERT, CMS calculates specific error rates including:

- Provider compliance error rate (which measures how well providers prepared claims for submission).
- Paid claims error rate (which measures how accurately carriers, Fiscal Intermediaries (FIs), and MACs made coverage, coding and other claims payment decisions) for specific contractors, service types and provider types.

CERT Methodology

CMS uses the CERT program to measure and improve the quality and accuracy of Medicare claims submission, processing and payment. Under this program, numerous randomly selected claims are reviewed each year. The results of these reviews are used to characterize and quantify local, regional and national error rate patterns. CMS uses this information to address the error rate through appropriate educational programs.

CERT Request

The request for records, with the official CMS logo, will contain several documents the provider must read and use. They identify the specific service for which records must be submitted, a list of the medical documentation requested and explicit instructions on how to mail or fax the information.

Steps to follow when submitting medical records to the CERT contractor are:

- Photocopy each record (verify records are for the correct date of service).
- Make sure all copies are complete, legible and contain both sides of each page, including page edges.

- Complete copies should include specific records to support the services on the claim(s) identified on the pull list and include all documentation that supports medical necessity of the service as billed on the claim.
- Complete the CERT Operations barcoded cover sheet for each record (if the barcoded sheet is not available, write the CERT Claim ID (CID) number on each page of the documentation).
- Attach the completed CERT Operations barcoded cover sheet to the corresponding photocopied chart and mail or fax to the CERT contractor.

The request for medical records/documentation is sent under a federally mandated program to monitor and improve the accuracy of Medicare payments to physicians and other providers. **It is imperative to respond to requests in a timely manner.**

The CERT Documentation Contractor (CDC) contacts providers for medical record documentation according to the following schedule:

- Day 0 – Call 1 and send letter 1 or fax 1.
- Day 30 – Call 2 and send letter 2 or fax 2.
- Day 45 – Call 3 and send letter 3 or fax 3.
- Day 60 – Send letter 4.
- Day 76 – Score claim as an error on the Claims Status Web site.

WHAT HAPPENS NEXT?

After a claims payment determination has been made, all error findings are provided to TrailBlazer. Any overpayment or underpayment will be processed for all claims where TrailBlazer agrees with the CERT claims payment determination. CMS convenes a panel to resolve payment determination disputes between CERT and Medicare contractors. CMS' determination on disputed claims is final and binding for CERT and all other Medicare contractors.

Should a claim be denied by CERT, the billing provider or the beneficiary can appeal. **Appeals should be sent to the MAC (TrailBlazer)**. Do not send appeal requests to the CERT contractor.

Appeals for CERT-denied claims follow the same course of appeals as all other claims TrailBlazer denies.

Additional Resources

The following CERT resources are available:

- To contact the CERT contractor, call (301) 957-2380.
- The CERT Web site may be accessed at: https://www.certprovider.com/certproviderportal/pages/default.aspx.

ZONE PROGRAM INTEGRITY CONTRACTOR (ZPIC)

CMS continues its efforts to ensure the highest integrity of its programs and health care security for all its beneficiaries. To help achieve these goals, CMS created new entities entitled Zone Program Integrity Contractors (ZPICs). The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) changed CMS' contracting structure by phasing out the fiscal intermediaries and carriers while phasing in the Medicare Administrative Contractors (MACs) for Medicare claims processing. As a result, seven zones were created based on the newly established MAC jurisdictions.

CMS awarded the ZPIC contract for Zone 4 (which includes Colorado, New Mexico, Oklahoma and Texas) to Health Integrity, LLC. Health Integrity performs the integrity functions for Medicare Parts A, B, Durable Medical Equipment (DME), home health and hospice, as well as the Medicare-Medicaid Data Match project. These efforts include the following six tasks:

- Performing data analysis and data mining.
- Conducting medical reviews in support of benefit integrity.
- Supporting law enforcement and answering complaints.
- Investigating fraud and abuse.
- Recommending recovery of federal funds through administrative action.
- Referring cases to law enforcement.

Through these efforts, Health Integrity:

- Develops innovative data analysis methodologies for detecting and preventing abusive use of services early.
- Develops high-quality fraud case referrals for law enforcement.
- Identifies appropriate corrective actions.

The Health Integrity staff includes data analysts, nurse reviewers and fraud investigators.

Case Referrals

Any suspected fraud, waste or abuse in Medicare Parts A, B, DME, home health or hospice for Colorado, New Mexico, Oklahoma and Texas should be referred to the ZPIC. Fraud cases may involve beneficiaries, physicians or other providers, or other organizations. CMS requires referrals for fraud cases to be made within 30 days of detection. Timely referrals are necessary to take full advantage of leads in an investigation. As time progresses, important information in a case may become more difficult to track down.

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QUALIFIED CASES

Cases meeting any of the following criteria should be referred to the ZPIC:

- Potential criminal, civil or administrative law violations.
- Allegations extend beyond one provider, involving multiple providers, multiple states or widespread schemes.
- Allegations involving known patterns of fraud.
- Pattern of fraud or abuse threatening the life or well-being of beneficiaries.
- Scheme with large financial risk to the Medicare program or beneficiaries.

RECOMMENDED INFORMATION IN A REFERRAL

Every referral to the ZPIC should contain specifics that will allow an investigator to follow up on a case, including basic identifying information and contacts as well as a description of the allegations.

Referrals should include:

- Name of person submitting the referral, organization and contact information for follow-up.
- Summary of the issue:
  - Include the basic who, what, when, where, how and why.
  - Any potential legal violations.
- Specific statutes and allegations:
  - List civil, criminal and administrative code or rule violations, both state and federal.
  - Detailed description of the allegations or pattern of fraud, waste or abuse.
- Incidents and issues:
  - List incidents and issues related to the allegations.
- Background information:
  - Contact information for the complainant, perpetrator or subject of the investigation, and beneficiaries, providers or other entities involved.
  - Additional background information that may assist investigators, such as names and contact information of informants, witnesses, Web sites, geographic locations, corporate relationships and networks.
- Perspectives of interested parties:
  - Includes provider, CMS and beneficiary.
- Data:
  - Existing and potential data sources.
  - Graphs and trending.
  - Maps.
  - Financial impact estimates.

- Recommendations in pursuing the case:
  - Next steps, special considerations and cautions.

TRANSMITTING REFERRALS

Because specific information may include data protected by HIPAA or the Privacy Act, referrals should be transmitted by either of the following methods:

- Call the ZPIC at (972) 383-0000 and provide the information to the complaint specialists, who will key the information into a database, acknowledge and follow-up on the complaint.

  Or,
- Complete and fax a Fraud Referral Form to the ZPIC at (972) 383-0010 or mail it to:

Health Integrity, LLC
Attn: ZPIC
Heritage Square 1
4835 LBJ Freeway, Suite 750
Dallas, TX 75244-6017

FOLLOW-UPS

When referring a case, providers must keep in mind that ZPIC investigators may be contacting them later to discuss details or obtain written documents or other information. Any information related to a potential fraud case should be retained for 10 years.

As an investigation ensues, new leads and data may suggest additional questions or actors involved in a case. Often an initial allegation may be the tip of an iceberg. Providers should be ready to respond as a case develops.

All cases referred to the ZPIC should receive an acknowledgment letter within five days and a resolution letter once the case has reached a conclusion. Some cases may take years to be fully resolved and prosecuted.

REQUEST FOR INFORMATION

Federal law enforcement agencies may submit a Request for Information (RFI) to obtain Medicare claims data. Upon receipt of an RFI from a federal agency, Health Integrity will provide the requested claims information and data analysis in graphs and tables.

Additional Resources

The following ZPIC resources are available:

- To contact Health Integrity, call (972) 383-0000.

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- The Health Integrity Web site can be accessed at: http://www.healthintegrity.org/index.html.
- A listing of ZPIC contacts is available at: http://www.healthintegrity.org/html/contracts/zpic/contacts.html.

RECOVERY AUDIT CONTRACTOR (RAC)

The goal of the recovery audit program is to identify improper payments made on claims for health care services provided to Medicare beneficiaries. This is done as a postpayment review. The claims processing contractors are the entities responsible for adjusting the claim, handling collections (offsets and checks) and reporting the debt on the financial statements.

Improper payments may be overpayments or underpayments. Overpayments can occur when health care providers submit claims that do not meet Medicare's coding or medical necessity policies. Underpayments can occur when health care providers submit claims for a simple procedure but the medical record reveals that a more complicated procedure was actually performed.

The RAC is paid on a contingency-fee basis on both the overpayments and underpayments it finds. Health care providers that might be reviewed include hospitals, physician practices, nursing homes, home health agencies, DME suppliers and any other provider or supplier that bills Medicare Parts A and B.

Region C RAC Contractor

CMS awarded Connolly Healthcare the contract to provide recovery audit services for Region C, which includes the states of Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, North Carolina, New Mexico, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia, as well as the territories of Puerto Rico and the U.S. Virgin Islands.

The RAC employs a staff consisting of nurses, therapists, certified coders and a Contractor Medical Director (CMD).

Review Process Overview

The RAC will review claims on a postpayment basis and will use the same Medicare policies as carriers, FIs and MACs. NCDs, LCDs and CMS manuals will be utilized in determining whether the claim was paid correctly. The medical records are due 45 days from the date of the medical request letter.

Issues identified by the RAC will be approved by CMS prior to a widespread review. Once an issue receives CMS' approval, the RAC will use its own proprietary software and systems as well as its knowledge of Medicare rules and regulations to determine what areas to review. Connolly Healthcare uses data analysis techniques to identify those claims most likely to contain underpayments or overpayments. This process is called "targeted review." The RAC will target a claim if the claim contains information that leads it to believe the claim is likely to contain an underpayment or overpayment.

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To prevent interference with potential fraud reviews being performed by other entities (such as CMS, the ZPIC, law enforcement, the OIG, etc.), suppressed/excluded claims are uploaded to a RAC Data Warehouse (a Web-based application that houses all RAC identifications and collections). Connolly Healthcare will input claims into the RAC Data Warehouse before attempting to identify or recover underpayments or overpayments.

Types of Reviews

AUTOMATED REVIEW

An automated review occurs when a RAC makes a claim determination at the system level without a human review of the medical record.

Connolly Healthcare will communicate to the provider the results of each automated review that results in an overpayment determination as well as which coverage/coding/payment policy or article was violated. If the review does not result in an overpayment, the RAC may elect to not communicate the results to the provider.

COMPLEX REVIEW

A complex review occurs when a RAC makes a claim determination utilizing human review of the medical record. The RAC may use complex review in situations where the requirements for automated review are not met or the RAC is unsure whether the requirements for automated review are met.

Connolly Healthcare will complete its complex reviews within 60 days from receipt of the medical record documentation. There may be some instances where the RAC may request a waiver from CMS if an extended time frame is needed due to extenuating circumstances.

The results of the complex reviews will be communicated to the provider (i.e., every review where a medical record was obtained) in a detailed review (a results letter), including cases where no improper payment was identified. In cases where an improper payment was identified, the RAC will inform the provider of which coverage/coding/payment policy or article was violated.

Providers submitting medical records to the RAC should follow the published guidelines found on the Connolly Healthcare Web site at: http://www.connollyhealthcare.com/RAC/pages/record_submission.aspx.

Note: Whenever performing complex coverage or coding reviews (i.e., reviews involving the medical record), Connolly Healthcare will ensure that coverage/medical necessity determinations are made by registered nurses or therapists and that coding determinations are made by certified coders.

RAC Appeals

The appeal process for RAC denials is the same as the appeal process for the MAC. When the RAC completes a medical record review (in the case of a complex review) or issues a demand letter (in the case of an automated review), providers then have two options:

- Initiate a discussion (a "discussion period") with the RAC.
  Or,
- File an appeal with the MAC (TrailBlazer).

THE CONNOLLY HEALTHCARE ENVELOPE

Providers' office staff, mailroom personnel and medical record departments should be familiar with the appearance and design of the RAC envelope.

Recommendations for Providers

- Check the RAC Web site weekly for new issues and what improper payments were found.
- Conduct an internal assessment to identify if your office is in compliance with Medicare rules.
- Identify and implement corrective actions to promote compliance (e.g., initiate awareness in the mailroom, medical records and Medicare billing departments about RAC requests for medical records and be familiar with Connolly Healthcare's envelope logo).
- Appeal RAC decisions when necessary.
- Learn from past experiences (i.e., conduct meetings on post-audit findings).
- Complete a Provider Contact Form so the RAC knows the precise address and the contact person it should use when sending medical record request letters. The form is found under the "Provider Contact Information" tab on Connolly Healthcare's Web site at: http://www.connolly.com/healthcare/Pages/CMSRACProgram.aspx.

Additional Resources

The following RAC resources are available:

- To contact Connolly Healthcare, call (866) 360-2507.

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- The Connolly Healthcare Web site can be accessed at: http://www.connollyhealthcare.com/RAC/Pages/cms_RAC_Program.aspx.
- RAC contractor award information, contingency fee percentages and the implementation schedule can be found on the CMS Web site at: http://www.cms.gov/RAC/01_Overview.asp.
- Providers are encouraged to sign up for the RAC listserv at: https://subscriptions.cms.hhs.gov/service/subscribe.html?code=USCMS_542.

REVISION HISTORY

Date	Section	Description of Revision
September 2009	Manual Title	Changed manual title from *Medicare Basics* to *Beginner's Guide to Medicare*.
	All	Deleted references.
	Medicare Policy for Beneficiaries in State or Local Custody Under a Penal Authority	Per CR 6544, dated September 4, 2009, CMS clarified its regulations at 42 CFR 411.4(b).
	H1N1	Added H1N1 billing and policy per CMS MLN Matters SE 0920.
November 2009	Services With a Gender/Procedure Conflict	Added section per CR 6563, dated October 28, 2009.
	Advance Beneficiary Notice of Noncoverage	Per CR 6563, dated October 29, 2009, CMS revised and added a modifier.
	Adjustment Procedures	Per CR 6426, dated June 26, 2009, instructions given on using 837 Institutional CAS for MSP.
January 2010	Other Billing Procedures	Added H1N1.
	Coverage and Billing for H1N1 Vaccine and Administration	Added condition code A6.
February 2010	Chronic Kidney Disease	Added sections on chronic kidney disease and billing requirements for coverage of kidney disease patient education services per CR 6557, dated December 18, 2009.
	Claim Payment Dates	Updated the year under time limits for filing bills.
	Comprehensive Error Rate Testing (CERT), Zone Program Integrity Contractor (ZPIC) and Recovery Audit Contractor (RAC)	Added new sections for CMS programs.
March 2010	All sections	Reorganized manual.
	Patient Screening	Added overview.
	Health Insurance Claim	Removed HIC number suffix definitions.

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Date	Section	Description of Revision
	Number Suffixes	Added link to CMS HIC Number Suffix List, IOM Pub. 100-01, Chapter 2.
	RTP	Added overview and top RTP reason codes.
	Medical Necessity	Added new section.
	National Coverage Determinations	Added new section.
	ALJ Hearing	Updated amount in controversy for 2010.
	Judicial Review	Updated amount in controversy for 2010.
	Medically Denied Claims	Added new section.
	Reopenings	Added new section.
	Preventive Services	Removed service descriptions. Added overview.
April 2010	Coverage of Services Provided to Prisoners	Updated per CR 6880.
	Time Limits for Filing Bills	Updated the timely filing information based on JSM 10214, dated March 31, 2010.
December 2010	Inpatient Deductible	Updated deductible information for CY 2011 per CR 7224.
	Part B Medical Insurance	Updated deductible information for CY 2011 per CR 7224.
	Electronic Claims	Added link to J4901 EDI enrollment packet.
February 2011	Judicial Review in U.S. District Court – The Fifth Level of Appeal	Updated required amount in controversy for 2011.
	Preventive Services	Updated preventive services offered by Medicare.
March 2011	Billing Using the UB-04	Deleted reference and added NUBC information per JSM 11166
	Electronic Funds Transfer (EFT)	Updated ERA and EFT numbers.
	Preventive Services	Removed H1N1 administration from the preventive services listing.
October 2011	Advance Beneficiary Notice of Noncoverage	Added information concerning the GZ modifier.
	Time Limits for Filing Bills	Removed old information and added new information per PPACA.

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Date	Section	Description of Revision
	Preventive Services	Added information per MM7012.
December 2011	*Inpatient Deductible; Part B Medical Services*	*Added deductible amounts for CY 2012.*
	Health Care Provider/ Supplier Enrollment Process	*Added information about Internet-PECOS application and link to the Part A Getting Started Web page.*
	Reporting Taxonomy Codes (Institutional Providers)	*Updated link from WPC to the NUCC.*
	Status/Location; Return to Provider (RTP)	*Updated the number of days a claim can remain in RTP status. Added links to Top Billing Errors page and Reason Code Search tool.*
	Medical Review Progressive Corrective Action	*Added link to the Part A Medical Review Web page.*
	Appeals	*Updated amount in controversy for judicial review for 2012.*
	Electronic Remittance Advice	*Updated Version 4010 to 5010.*
	Preventive Services	*Deleted list of available tests. Linked to comprehensive manuals located on the TrailBlazer and CMS Web sites.*