
Medicare Fairs VIII & IX
April 30, 2008 Norwood, MA
June 3, 2008 South Portland, ME
Questions and Answers

Contractor Comment: Thank you for attending the NHIC, Corp. Spring Medicare Fairs in Norwood, MA and South Portland, ME. Below are the questions that needed clarification or further research. Please note that the questions may have been edited to allow for the greatest dissemination of information to the widest audience.

For all the latest updates including future Medicare Fairs, we encourage you to join our mailing list at: <http://visitor.constantcontact.com/email.jsp?m=1101180493704>. By joining our mailing list, you will receive an email once a week with the latest updates.

Question 1: How do I bill for a routine exam and an E/M rendered on the same day?

Answer 1: This question and answer can be found on the FAQ page of our website at http://www.medicarenhic.com/faq_results.asp

This question arises when physicians perform annual physical examinations on their patients at the same time that they perform follow-up examinations of existing medical conditions. Both services may be billed but only a medically necessary E/M will be covered. The routine exam would be denied as non covered. The provider may only charge the amount he/she has established for the routine exam less the amount for the level of E/M.

For example, if the established charge for the routine exam is \$200 and the charge for the E/M is \$53.29, the E/M would be billed at \$53.29, and the routine exam would be billed at \$146.71 (\$200-\$53.29).

Question 2: When a participating provider reassigns their benefits to a non-participating group, can the group balance bill for services provided?

Answer 2: If the group is non-participating, the group may bill up to the limiting charge amount. State billing laws may affect the amount providers can charge Medicare beneficiaries. In some states, the laws apply only to beneficiaries who meet certain means tests. However, in other states, the provision applies to all beneficiaries. These laws may limit providers charging no more than the Medicare approved amount on all claims, or on non-assigned claims, to charging no more than a small percentage above the approved amount. If you practice in a state with balance billing laws, you should obtain more precise information from the state agency administering those laws. Currently Massachusetts and Vermont have balance billing laws.

Question 3: What are the claims instructions regarding Ambulance transports from an inpatient psychiatric facility to an outpatient hospital for medical services?

Answer 3: Facility to facility transports are discussed in our Ambulance Billing Guide at <http://www.medicarenhic.com/providers/pubs/ambguide.pdf>

If the patient retains "inpatient" status from the sending facility, the facility should bill Part A, not Medicare Part B.

Question 4: Is Medicare omitting PQRI-G codes on crossover claims? Secondary carriers are denying the entire claim as they do not recognize the G codes.

Answer 4: If a PQRI-G code is billed to Medicare, we are obligated to cross it over. We can not strip these codes from the crossover claim. CMS is aware of the issue relating to secondary insurances denying the entire claim.

Question 5: Where can we find NPI#'s for a facility that are required on Medicare Part B claim?

Answer 5: Your question appears to relate to items 32 and 32a of the CMS 1500 claim form or electronic equivalent.

If you did not submit facility # in item 32 prior to the implementation of NPI, you would not need to complete item 32a with a NPI.

At the present time, only claims for purchased diagnostic services require the entry of an NPI number. The CMS-1500 Claim Form Instructions can be found on our website at <http://www.medicarenhic.com/providers/pubs/1500formguide.pdf>

Question 6: Can PQRI related claims be billed electronically or by paper? Can you show us a sample CMS 1500 w/ this type of billing? Where do we get forms?

Answer 6: PQRI can be submitted electronically or on the CMS-1500 Claim Form. However, if you are a mandatory electronic claim submitter, you must submit electronic claims

Here is an example from the CMS PQRI website of a CMS-1500 claim with PQRI codes.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)											22. MEDICAID RESUBMISSION CODE				ORIGINAL REF. NO.									
1. 250 00											3.													
2.											23. PRIOR AUTHORIZATION NUMBER													
24. A. DATE(S) OF SERVICE											B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ERDT Payor Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #			
1	07		01		08		07		01		08		11		99213				1	50	00		NPI	AB01234 0123456789
2	07		01		08		07		01		08		11			3048F				1	0		NPI	AB01234 0123456789
3	07		01		08		07		01		08		11			G8485				1	0		NPI	AB01234 0123456789
4																							NPI	
5																							NPI	
6																							NPI	
25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back)			28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE							
XX-01234567						987654321				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			\$ 50 00		\$		\$ 50 00							

The CMS 1500 claim form may be purchased from the U.S. Government Printing Office at (866) 512-1800, local printing form companies, and/or office supply stores

Question 7: Please define what a “true duplicate” would be for telephone reopenings?

Answer 7: A ‘true duplicate’ is an accurate duplicate and a telephone reopening can **not** be requested. Telephone reopenings may be requested for inaccurate duplicate denials (not a true duplicate). For more information, please see the Educational Article titled Reopening Process posted on our website http://www.medicarenhic.com/providers/articles/reopeningprocess_0408.pdf

Question 8: Does an Iron Dextran injection (Q4098) require a hemoglobin/hematocrit level?

Answer 8: Q4098 became a new HCPCS code as of April 1, 2008. Q4098 replaced J1571. According to the MLN Matters article MM5699, a hemoglobin/hematocrit level needs to be reported on all claims for administration of Erythropoiesis Stimulation Agents (ESA) and on all Non-ESRD, Non-ESA claims requesting payment for anti-anemia drugs.

MM5699 can be found on the CMS website at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5699.pdf>

Question 9: Is there an updated statutorily excluded diagnosis list?

Answer 9: There is no statutorily excluded diagnosis list. A list of services that are General Exclusions from Coverage can be found on in Chapter 16 of the Medicare Benefits Policy Manual (Publication 100-02) which is posted on the CMS website at <http://www.cms.hhs.gov/manuals/Downloads/bp102c16.pdf>

The Medicare & You handbook that is sent to Medicare beneficiaries in the Fall also contains generic information about what is not covered under Part A and B. The Medicare & You 2008 handbook can be found at <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>

Question 10: When a SNF patient is seen in our office, Medicare takes back our entire payment (exam & TC/PC off other services). We then re-bill the exam and cannot get it paid. Is it a TOS or POS issue that we should be billing differently? We understand the TC won't pay due to the patient's Medicare Part A SNF status but why is \$\$ from exam & PC of tests also recovered?

Answer 10: Physician services furnished to SNF residents are not subject to Consolidated Billing and thus are billed separately to the Part B carrier. Many physician services include both a professional and a technical component, and the technical component is subject to CB. The technical component of physician services must be billed to and reimbursed by the SNF.

If the TC was billed to us in error, the amount paid would be recouped. We should not be recouping on the entire claim. If this is happening, please contact Customer Service.

For MA (877) 527-6594

For ME, NH & VT (877) 258-4442

Question 11: Why do claims deny when modifier 59 is submitted? Example: removal of 2 skin lesions; one on arm, one on leg. Should we be billing with modifier 76?

Answer 11: Modifier 59 applies to the National Correct Coding Initiative (NCCI). Most likely if the same procedure code was rendered on separate sites, NCCI does not apply and therefore modifier 59 can not be used. If NCCI does not apply and the same procedure code is rendered on separate sites for separate reasons, the same procedure code would be billed on separate lines and modifier 76 would be submitted on the second line item.

To learn more about NCCI and Modifier 59, please visit the CMS website at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

Question 12: Modifier 76 or Units? When billing for 3 biopsies at multiple sites, why is 3rd biopsy denied as a duplicate. Example, 11100-face, 11101-59 chest, 11101-59 back. Should we be adding another modifier? Sometimes the diagnosis (DX) is the same for the different sites.

Answer 12: 11101 is an add on code to 11100. The National Correct Coding Initiative does not apply to this code combination. Therefore, modifier 59 can not be used. If the same diagnosis applies to both units of 11101, 11101 would be billed on one line and 2 units would be billed. If separate diagnoses apply to each unit of 11101, they would be billed on separate lines and modifier 76 would be submitted on the second line of 11101.

Question 13: Do single provider offices need to sign on each form in chart?

Answer 13: Yes, according to our Medical Review department.

Question 14: What is our responsibility as a provider when patients do not provide liability insurance information and/or retain an attorney?

Answer 14: It is the responsibility of a provider to furnish Medicare with a record on other insurance that may be primary to Medicare on any claim. Providers may also provide potential information to the Coordination of Benefits Contractor.

For the Responsibilities of Beneficiaries, Providers, and Attorneys under MSP, please see the information on the CMS website at

http://www.cms.hhs.gov/MedicareSecondPayerandYou/01_overview.asp#TopOfPage

For more information on Contacting the Coordination of Benefits Contractor

http://www.cms.hhs.gov/COBGeneralInformation/03_ContactingtheCOBContractor.asp

Question 15: Why is procedure code 99340 (Assisted Living Facility of Home Care Plan Oversight) for patients in an assisted living facility being denied? According to the June 2006 Medicare B Resource, this is a covered service.

Answer 15: Hospice Care Plan Oversight was discussed on pages 150 & 151 and Domiciliary, Rest Home or Custodial Care Services Code Changes in 2006 was discussed on pages 164 & 165 of the June 2006 Medicare B Resource.

However, according to the Medicare Physician Fee Schedule Data Base, status B is attached to 99340. Status B =Bundled Code. Payment for covered services are always bundled into payment for other services not specified.

Question 16: If a provider is currently listed under his/her social security number and wants to change to a tax ID, what must be completed? The provider is a sole proprietor and the tax ID is listed in their individual name with a PC added.

Answer 16: Individual providers changing from Social Security Number (SSN) to a Sole Proprietor Tax ID number or Individual providers who are incorporating must complete the CMS 855I Enrollment Application.

Question 17: How many days ahead of time can an application for a new provider be sent in? How many days ahead of time can an application be sent in for a change of information?

Answer 17: No more than 30 days according to our Provider Enrollment department.

For more Provider Enrollment FAQs and links to the Applications, please see the Enrollment page on our website at http://www.medicarenhic.com/ne_prov/enroll.shtml

6/26/2008