

## Medicare Fair X

**Contractor Comment:** Thank you for attending the NHIC, Corp. Medicare Fair in Fitchburg, MA on October 29, 2008. 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.

**Question 1.** Currently I contact the beneficiary and give them full information to call the Coordination of Benefits (COB) contractor when there is a discrepancy as to who should pay primary. The majority will call, yet others do not. What can providers do to aid in this process?

**Answer 1.** Changes in a beneficiary's insurance coverage, changes in employment, and general Medicare Secondary Payer (MSP) questions/concerns are addressed by the COB contractor. If the claim is rejected because the beneficiary no longer has primary coverage under another health insurance plan, the **beneficiary** must contact the COB contractor directly at 1-800-999-1118. It is their responsibility to update their records. We suggest assisting the beneficiary by contacting the COB while they are in your office.

**Question 2.** Medicare originally paid as secondary and it was later determined that Medicare is primary. How does one go about receiving correct payment?

**Answer 2.** You can request a reopening as long as it is within 1 year of the original payment determination. Attach documentation that the primary payer retracted their payment. As long as the beneficiary's Medicare records are updated as primary, additional payment can be issued. You can complete the reopening form located on our Web site and fax your request in. The form is located at [http://www.medicarenhic.com/ne\\_prov/forms.shtml](http://www.medicarenhic.com/ne_prov/forms.shtml)

**Question 3.** Why doesn't Medicare forward claims to Banker's Life as a secondary insurer? We currently have to complete a form and mail them in.

**Answer 3.** Banker's Life and Casualty Company is identified as a Medigap insurer that is participating in the Coordination of Benefits Agreement (COBA) Medigap claim-based process. The COBA ID for billing purposes is 55000. Providers or their billing vendors should include **only** the Medigap COBA IDs on Medicare claims for purposes of triggering crossovers to Medigap insurers. Complete details can be found at <http://www.cms.hhs.gov/MLNMArticles/downloads/SE0743.pdf>

**Question 4.** Do you have a dedicated person to provide just provider enrollment help?

**Answer 4.** All of the Customer Service Representatives (CSRs) have excessive training in all Medicare policies and procedures including provider enrollment issues and are able to respond to all questions. We cannot provide a dedicated CSR for enrollment issues only.

**Question 5.** When calling the IVR on the status of a claim, it does not give the check or non payable check number for us to use to then go to the Medicare Remit Easy Print to locate the remittance advice. Will this feature be added?

**Answer 5.** At this time, there are no plans to add this feature. We thank you for the suggestion and will consider this for future enhancements.

**Question 6.** When will you replace the IVR with online tools to check for eligibility and claim status?

**Answer 6.** We do have a pilot program for such activities, but no funds allotted to expand beyond the pilot program.

**Question 7.** Does the PTAN have to be linked to the NPI for Railroad Medicare?

**Answer 7.** For NHIC, the provider's PTAN must be linked to the provider's NPI for proper claim adjudication. An individual must also complete the reassignment form (855R) so that the individual NPI is linked to the group NPI. You must contact Railroad Medicare directly for their guidelines.

**Question 8.** Please explain the remark code MA27.

**Answer 8.** MA 27 reads: "Missing/incomplete/invalid entitlement number or name shown on the claim." If this message appears, either the patient's Medicare health insurance claim number is incorrect or the name is misspelled. Always ask to see the beneficiary's Medicare card to confirm the name and number.

**Question 9.** We have so much trouble trying to figure out why claims deny and the remark codes for Electronic Remittance Advice (ERA). What can we do?

**Answer 9.** All of the remark codes and explanations can be found at <http://www.wpc-edi.com/>. The ERAs always have 2 messages to explain why the claim denied and what may be missing. If you are still unsure, contact customer service for assistance prior to resubmitting the claim or seeking an appeal.

**Question 10.** What is the point of adding a CLIA modifier QW and the CLIA number on a CLIA waived test?

**Answer 10.** CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare only pays for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level. Certain CPT codes must have the modifier QW to be recognized as a waived test while other CPT codes do not require a QW modifier to be recognized as a waived test. The list is updated quarterly by CMS.

**Question 11.** Debridement of nails (CPT 11721), denied as “information submitted does not support this many services”. Why can’t a beneficiary who is diabetic and has a systemic disease not be seen before 60 days has passed?

**Answer 11.** It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters (60 days), you would need to appeal with documentation to support the medical necessity.

**Question 12.** The psychiatric reduction reduces payment significantly. Is there a copay the beneficiary has to pay?

**Answer 12.** The limitation reduces the established fee schedule amount by 62.5% for each outpatient service received by the beneficiary. The beneficiary is responsible for the difference between the approved amount and the reduced amount in addition to the 20% co-insurance amount. An example of the limitation calculation can be found in the Mental Health Billing Guide on our Web site.

**Question 13.** Can psychiatric providers bill evaluation and management (E/M) codes?

**Answer 13.** Physicians, psychiatrists, nurse practitioners, physician assistants, and clinical nurse specialists can bill E/M services for beneficiaries with psychiatric disorders. Medicare does **not** allow psychologists and clinical social workers to perform E/M services.

**Question 14.** Can providers bill for educating the family about a beneficiary’s mental illness?

**Answer 14.** Family medical psychotherapy (without the patient present) can be considered based on medical documentation submitted with the claim. This service involves family participation in the treatment process of the patient. The service has limited coverage indications which can be found in the Mental Health Billing Guide on our Web site. Family medical psychotherapy is neither a treatment for the relatives, nor treatment for an individual family member’s problem.

**Question 15.** Can psychiatric providers bill for prolonged services?

**Answer 15.** Prolonged services codes can only be billed in conjunction with E/M services (CPT 99201-99350), not with psychiatric services (CPT 90801-90887).

**Question 17.** Are medical telephone consultation codes billable?

**Answer 17.** Telephone services (CPT 99441-99443) are non-covered services. Payment may not be made for these codes.

**Question 18.** Can providers bill for interpreter services?

**Answer 18.** Medicare does not allow payment for interpreter services. This is not billable to the Medicare program.

**Question 19.** Due to “never events”, CMS will no longer pay hospital services related to surgical providers if found negligent. Why punish whole hospitals when one surgeon did a wrong procedure?

**Answer 19.** “Never events” cause serious injury or death to beneficiaries and result in unnecessary costs to Medicare due to the need to treat the consequences of the errors. Any steps taken reflect CMS’s strong conviction that these events, in fact, should be prevented, and their commitment to protecting Medicare beneficiaries from them.