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**Medicare Fair VII**  
October 2, 2007 Manchester, NH  
Questions and Answers



**Contractor Comment:** Thank you for attending the NHIC, Corp. Medicare Fairs. Below are the questions raised 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.

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For Massachusetts, call 1-877-527-6594.

For Maine, New Hampshire or Vermont, call 1-877-258-4442

**Question 1:**  
**May I use a generic ABN?**

**Answer 1:**

The CMS-R-131 form is the new ABN approved by Office of Management and Budget (OMB) on June 18, 2002. There are two CMS-R-131 forms, the General Use form (ABN-G) and the Laboratory Tests form (ABN-L). Both CMS-R-131 ABN forms are standard forms **which may not be modified**. Both contain customizable boxes for the individual requirements of users. The forms are available in English and Spanish at

<http://www.cms.hhs.gov/cmsforms/downloads/cmsr-131-g.pdf>

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**Question 2:**

**What are the extraction capabilities for Medicare Remit Easy Print?**

**Answer 2:**

Version 1.8 includes many improvements, including the latest version of the Claim Adjustment Reason Codes and the Remittance Advice Remark Codes, as well as:

New updates:

- A new Coordination of Benefits (COB) report showing claims that were crossed over
- An import functionality for the Claim Adjustment Reason Codes and Remittance Advice Remark Code updates, so a full version does not need to be reinstalled for code updates only;
- Other capabilities currently available
- An enhanced search functionality, including for the date of service;
- An enhanced Deductible/Coinsurance report to show both deductible and coinsurance amounts greater than zero, as well as those claims with only the coinsurance dollar amount greater than zero;
- More claim detail on the reports;
- When a service line is denied, the number of submitted units will display. The paid units will display when a service line is paid;
- Display of check date instead of 835 product
- A late filing charge correction

The EDI Support Team is here to assist you with any questions or concerns you may have about EDI in New England. The dedicated phone line for NE EDI Support is 781-749-7745.

**Question 3:**

**Are NPI numbers now required on the 1500 form for rendering, ordering or referring providers?**

**Answer 3:**

There are no more UPIN numbers being assigned. Please search the NPI registry to find the correct NPI number for the providers involved with your practice.

The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. You may run simple queries to retrieve this read-only data. For example, users may search for a provider by the NPI or Legal Business Name. There is no charge to use the NPI Registry.

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

After May 23, 2008, legacy numbers will NOT be permitted on ANY inbound or outbound transactions.

As part of this plan, Medicare FFS has been assessing health care provider submission of NPIs on claims. Effective January 1, 2008, your Medicare fee-for-service claims received must include an NPI in the primary fields on the claim (i.e., the billing and pay-to fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI. Claims with only a Legacy provider identifier for the primary fields will be returned as unprocessable. You may continue to include legacy only for the secondary fields, if you choose. Failure to submit an NPI in the primary fields will result in your claim being returned as unprocessable, beginning January 2, 2008.

**Question 4:**

**What is the correct way to bill for the TC and Professional components of radiology? Has Cert reviewed these claims?**

**Answer 4:**

NHIC has recently conducted audits that indicate Modifiers "TC" and "26" are not being utilized properly. Like many physician diagnostic or therapeutic services, cardiographs and echocardiography services may include both the technical and professional components. It is the responsibility of the rendering physician to bill only for the component actually rendered or purchased.

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TC – The technical component is the equipment and technician performing the test. This is identified by adding modifier “TC” to the procedure code identified for the technical component charge.

Modifier “TC” should not be used if there is a specific code which describes a procedure that is 100 percent technical. For example, it would be inappropriate to use modifier TC in conjunction with 93005 (electrocardiogram, routine ECG with at least 12 lead tracing only without interpretation and report) because it is 100 percent technical.

PC/26 – The professional component is the interpretation of the results of the test. When the professional component is reported separately the service may be identified by adding modifier 26.

There are some procedure codes that by definition mean professional component only and don’t require modifier 26. For example, it would be inappropriate to use modifier 26 in conjunction with 93010 (electrocardiogram, routine ECG with at least 12 leads interpretation and reporting only) because it is 100 percent professional.

Medicare Part B contractors process claims for the professional component of radiology services furnished by a physician to an individual patient in all settings under the Medicare Physicians’ fee schedule regardless of the specialty of the physician who performs the service.

Global Billing in an office setting - PC and TC services furnished in a physician’s office, a freestanding imaging or radiation oncology center, or leased hospital radiology department, or other setting that is not part of a hospital are paid by the Medicare Part B carriers under the Medicare Physician’s fee schedule. These services may be billed globally, or by the components. **It would be expected that for each TC procedure there would be a Professional reading that CWF (Common Working File) would edit by DOS for correct payments.**

**EXAMPLE: CT Scan Errors**

The CERT error report has identified billing errors due to inaccurate coding of radiologic procedures for CT scans. For example a CT scan without contrast is ordered and completed. The procedure is billed with a CPT code that describes the procedure as being performed with contrast. The radiology report clearly documents the CT scan was completed without contrast.

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**Question 5:**  
**How do we now bill Medigap?**

**Answer 5:**

The change in Medigap involves transferring the crossover to the COB (Coordination of Benefits Contractor). Please refer to the link below to find the correct code to put on the claim. Medigap is a supplemental insurance to traditional Medicare and would be billed as any other insurance company.

Effective October 1, 2007, the mandatory Medigap claim-based crossover process will be transferred from its Medicare contractors to the national Coordination of Benefits Contractor (COBC). As of that date, Medigap claim-based crossovers will only be transmitted to Medigap insurers in the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-837 professional COB 4010-A1 claim format and, if requested, in the National Council for Prescription Drug Program version 5.1 batch standard 1.1 format for Part B drug claims. The questionnaire is designed to assist the COBC in preparing you for the October 1, 2007, transition to these standard formats, which will be transmitted only from the COBC. The first steps in that transition are

(1) to sign a Coordination of Benefits Agreement (COBA) with the COBC, which details the transmission of Medicare Part B claims for supplemental payment; and

(2) to assign a COBA identification number, which initiates the transmission of claims. Upon assignment of a COBA ID by the COBC, providers will be informed of the new Medigap identifier to trigger Medigap claim-based crossovers to your organization. All current identifiers will be terminated.

<http://www.cms.hhs.gov/COBAgreement/>

and go to the link to COBA ID for billing purposes

<http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf>

**Question 6:**

**May a provider contact Coordinator of Benefits Contractor?**

**Answer 6:**

The Coordination of Benefits (COB) Contractor consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The purposes of the COB program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare



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benefits. The COB Contractor does not process claims, nor does it handle any mistaken payment recoveries or claims specific inquiries. The Medicare intermediaries and carriers are responsible for processing claims submitted for primary or secondary payment. To learn more about the COB follow the link below:

<http://www.cms.hhs.gov/COBGeneralInformation/>

10/25/07

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