
Medicare Fair III
October 27, 2006
Questions and Answers

Contractor Comment: Thank you for attending the NHIC, Corp. Medicare Fair, October 27th in Worcester, MA. Below are the questions raised at our breakout sessions 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 find out about when the next Medicare Fair will be in 2007, please join our mailing list or watch for updates to our Seminar page on the NHIC, Corp. website at: http://www.medicarenhic.com/ne_prov/seminars.shtml. For the latest updates, 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.

Claim Denial Resolution

Question 1: Can a physician be paid for both a hospital discharge in the morning and an admission later in the day?

Answer 2: Medicare will not allow both a discharge and admit code to be paid to the same provider on the same day. The physician should bill the admission code. The admission code is “per day” and represents all Evaluation & Management services rendered that day.

Consolidated Billing

Question 1: How do providers bill for services rendered to patients in Assisted Living Facility?

Answer 2: The place of service for an Assisted Living Facility is 13. The definition attached to place of service 13 is “Congregate residential facility with self-contained living units providing assessment of each resident’s needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services”. Physicians and non physician practitioners are to report medically necessary E&M services to residents in place of service 13 using 99324-99328 (new patient visit) or 99334-99337 (established patient visit).

For a listing and definition of the place of service codes, please see the CMS website at the following link: http://www.cms.hhs.gov/MedHCPCSGenInfo/Downloads/Place_of_Service.pdf

Question 2: Where can I find information about Long Term Care Hospitals (LTCHs) and the Prospective Payment System (PPS)?

Answer 2: According to Publication 100-04, Chapter 3, Section 150 of the CMS Internet Only Manual (IOM), LTCHs are certified under Medicare as short term acute care hospitals that have been excluded from the acute care hospital inpatient PPS. For Medicare payment purposes, LTCHs are generally defined as having an average inpatient length of stay of greater than 25 days. For Publication 100-04, Chapter 3, please review the CMS website at the following link: <http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf>

Frequently Asked Questions

Question 1: For the legacy # (provider's current identification number) to NPI crosswalk, how do providers notify Medicare of their NPI?

Answer 1: At this time, providers do not need to notify Medicare of their NPI separately. Medicare is picking up the NPI in a variety of ways. Since June, Medicare has been capturing the NPI from providers who are submitting new enrollment applications or are making changes to their existing enrollment because in June the application was changed to require the NPI number as part of the process. Beginning October 2, 2006, the legacy number and/or an NPI can be used on electronic claims. At this time Medicare is capturing NPIs submitted on electronic claims.

Question 2: When Medicare is listed as secondary and should be listed as primary, how can the records be corrected and who needs to be contacted? If the patient is unable to make the contact, can the provider call?

Answer 2: The Coordination of Benefit Contractor has responsibility of correcting the records. The patient needs to contact the Coordination of Benefits Contractor at 1-800-999-1118 Monday-Friday 8am-8pm EST with their specific retirement, employment, accident, worker's comp information, etc. According to the COB website, providers may call COB. The following information is posted on the COB page on the CMS website:

In order to better serve you, please have the following information available when you call:

Beneficiaries – Your full name, date of birth, Health Insurance Claim Number (HICN)/Medicare Claim Number (located on your Medicare card below your name) and one additional piece of information such as SSN, address, Medicare effective date(s), whether you have Part A and/or Part B coverage.

Providers – Your Medicare provider number (UPIN/OSCAR/NSC). If you cannot furnish a provider number that matches our database, you will be asked to submit your request in writing. Prior to releasing any Private Health Information about a beneficiary, you will need the beneficiary's last name and first initial, date of birth, HIC number, and gender.

For further information, please see the following COB pages on the CMS website:

<http://www.cms.hhs.gov/COBGeneralInformation/>
http://www.cms.hhs.gov/COBGeneralInformation/03_ContactingtheCOBContractor.asp#TopOfPage
http://www.cms.hhs.gov/ProviderServices/01_overview.asp

Question 3: Has the crossover process to Medigaps and/or Medicaid changed? Are only paid claims crossed over?

Answer 3: The crossover process has changed. The Coordination of Benefit Agreement (COBA) Program and Coordination of Benefits Contractor (COBC) now has the responsibility of the claims crossover process. Trading Partners such as Medigap or Medicaid entities share eligibility information with the COBC. Based on the eligibility information reported, a crossover is done on paid claims. The Medicare Remittance Notice uses Remark Codes to indicate if a crossover has been done. Although a claim may crossover to more than one trading partner, only the payer/insurer second in line will consider the crossover. For a listing of the trading partners (excluding Medicaid) currently in production, please see the following listing on the CMS website: <http://www.cms.hhs.gov/COBAgreement/Downloads/Contacts.pdf> Medicaid for Massachusetts, Maine, New Hampshire and Vermont are also listed as trading partners

Question 4: What are the hospice modifiers? There is no information posted on your website and Customer Service is not able to tell us how to code.

Answer 4: The hospice modifiers can be found in the HCPCS Level II book. When the patient is enrolled in hospice, the following modifiers may apply:

GV-Attending physician not employed or paid under arrangement by the patient's hospice provider

GW-Service not related to the hospice patient's terminal condition.

Question 5: If a provider is a mandatory electronic claim submitter and they are not able to submit Medicare Secondary Payer (MSP) claims electronically due to software limitations or cost of new software, what are the options?

Answer 5: MSP claims should be submitted electronically. If the provider is not able to submit their claims electronically and their software has limitations or they cannot afford new software, the provider should contact NHIC, Corp. Electronic Data Interchange (EDI) office at 781-749-7745 and inquire about the free software Medicare has available for Medicare claims only. The software does not support other payors' claims.

Question 6: Why do claims deny for HMO when the Interactive Voice Response (IVR) system indicates that the patient is not enrolled in a HMO?

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Answer 6: The IVR is able to provide the HMO information (if applicable). If the information provided is inconsistent with the claims processing, please note the confirmation number the IVR provides you with and contact Customer Service: MA (877) 527-6594 and ME, NH & VT (877) 258-4442.

Question 7: Is it true that a provider is not eligible for Electronic Funds Transfer (EFT) if their provider legacy number was issued more than 2 years ago?

Answer 7: A provider is always eligible for EFT. However, if you became a provider prior to 2001 when the CMS 855 enrollment applications were implemented, you will have to submit a completed CMS 855 enrollment application with your EFT application. For more information please see the EFT information on our website:

http://www.medicarenhic.com/edi/download/efform_1006.pdf

Question 8: Can an enrollment application be submitted prior to a Medicare patient being seen?

Answer 8: According to the new CMS 855I (06/06 version) Enrollment Application, Section 4 for practice location indicates that “If you are enrolling for the first time, or if you are adding a new practice location, the date you provide should be the date you saw your first Medicare patient”. Therefore an enrollment application cannot be submitted until a Medicare patient is seen.

Question 9: What does a provider do if they need to make changes to their enrollment application but they do not know their Medicare Identification Number?

Answer 9: The Medicare Identification Number (*if issued*) is required on several areas of the enrollment application for new enrollees, enrolling with another fee for service contractor or changing your Medicare information. According to CMS instructions issued in March 2006, we are unable to release provider eligibility information. If the individual provider requests their provider identification number, our Customer Service department can mail a duplicate Remittance Advice to the practice location on file. If the provider does not have claims on file, Customer Service will instruct the provider to put their request in writing to Written Inquiries, P.O. Box 1000, Hingham, MA 02044. The request must include the provider’s name, Social Security Number, practice location, specialty and signature.

Question 10: Does the referral for a consult have to be in writing?

Answer 10: The 3 R’s apply to consults. All consultations must be requested by an appropriate referral source; include a report of findings; and include recommendations. According to

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Publication 100-04, Chapter 12, Section 30.6.10 F of the CMS IOM indicates the following for Consultation Request:

A written request for a consultation from an appropriate source and the need for a consultation must be documented in the patient's medical record. The initial request may be a verbal interaction between the requesting physician and the consulting physician; however, the verbal conversation shall be documented in the patient's medical record, indicating a request for a consultation service was made by the requesting physician or qualified NPP.

The reason for the consultation service shall be documented by the consultant (physician or qualified NPP) in the patient's medical record and included in the requesting physician or qualified NPP's plan of care. The consultation service request may be written on a physician's order form by the requestor in a shared medical record.

For Publication 100-04, Chapter 12, please see the CMS website at the following link:

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

Question 11: Why does Medicare recoup by offset when the provider has already refunded?

Answer 11: When an overpayment is identified, a letter requesting a refund is sent. 30 days is given to refund and information is given in the letter regarding interest and offset. If a refund is not received, interest is applied and a second letter is sent on the 31st day. The second letter informs the provider that the offset will begin on the 41st day. Interest applies every 30 days regardless if provider is on offset. Refunds should be sent as soon as the first letter is received. If a provider waits to refund, has payments forthcoming from Medicare and wants to avoid interest, it is suggested they call Customer Service and request an immediate offset.

Medicare Bingo

Question 1: Does Medicare recognize modifiers 73 and 74?

Answer 1: Yes, if applicable. The definitions attached to these modifiers are as follows:

Modifier 73-Discontinued Outpatient Hospital/Ambulatory Surgical Center (ASC) procedure prior to the administration of anesthesia.

Modifier 74-Discontinued Outpatient Hospital/Ambulatory Surgical Center (ASC) procedure after administration of anesthesia.

For more information and the payment rules attached to these modifiers, please see the Ambulatory Surgery Center Guide on our website at the following link:

http://www.medicarenhic.com/providers/pubs/ascguide_sept06.pdf

Question 2: Will Medicare be doing seminars on DME Coding?

Answer 2: NHIC, Corp. Part B is separate and distinct from NHIC, Corp. DME. NHIC, Corp. Part B generally does not conduct coding seminars and leaves physician service coding to the

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providers. For the seminars that NHIC, Corp. DME may conduct in the future, please visit their Seminar page at the following link: http://www.medicarenhic.com/dme/dmerc_seminars.shtml
For the Part B Seminars or Fairs that we will be conducting in the future, please visit our Seminar page at the following link: http://www.medicarenhic.com/ne_prov/seminars.shtml
For the latest updates, please join our mailing list.

Question 3: If a provider is not enrolling or making changes to their enrollment, how do they notify Medicare of their NPI?

Answer 3: Please see Question and Answer 1 under the Frequently Asked Questions section above.

Question 4: Why are refunds not posted on a timely manner?

Answer 4: For refund guidance, please see Question and Answer 11 under the Frequently Asked Question section above.

Question 5: Can Electronic Funds Transfer (EFT) be waived?

Answer 5: In June, CMS required that any new enrollee or any provider making changes to their enrollment application, submit NPI and EFT with their enrollment application. The only exception to EFT is if an individual provider is reassigned or reassigning their benefits (e.g. linked or linking to a group)

For more information on the requirement changes, please see the MLN Matters article SE0634 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0634.pdf>

11/16/06