
Medicare Fair IV & V
April 24 & May 9, 2007
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. More Fairs have been scheduled for the Fall. Watch for updates to our Seminar page on the NHIC, Corp. website at: http://www.medicarenhic.com/ne_prov/seminars.shtml

Question 1: Does Medicare pay the co-payment amount when there is an insurance primary to Medicare?

Answer 1: The following example from the CMS Internet Only Manual best explains the Medicare Secondary Payment Calculation when co-payments are involved.

Example: Mr. Blue belongs to an employer-sponsored HMO that is primary to Medicare. He had 2 visits with a doctor for which he paid a \$10 co-payment per visit. He has not met his annual Medicare deductible (\$131 in 2007) but is hoping that Medicare will make a secondary payment to reimburse him for these co-payments.

The Medicare allowed amount for each of Mr. Blue's visits was \$32, making a total of \$64 for the 2 visits. To determine whether a Medicare secondary payment can be made, the following calculation is used:

- A. Determine the Medicare payment in the usual manner: $.80 \times \$64$ (\$32 per visit \times 2 visits) = \$51.20
- B. Determine the co-payment amounts: \$20 (2 visits each with a \$10 co-payment)
- C. If the deductible had been met, the lowest of steps 1 or 2 would be payable. Since the deductible has not been met, the amount credited toward the deductible is the Medicare allowed amount plus the total co-payment amount: $\$64 + \$20 = \$84$.

Mr. Blue is credited with \$84 toward his deductible. Since Mr. Blue has not met his deductible, no MSP amount is payable

For additional, please see Publication 100-05, Chapter 5, and Section 40.7.3 of the CMS Internet Only Manual (IOM) at: <http://www.cms.hhs.gov/manuals/downloads/msp105c05.pdf>

Question 2: Is there a standard contingency plan for offices?

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Answer 2: There is no standard contingency plan for offices or small health plans. Please contact your billing company or clearinghouse to determine if they are ready for the May 23, 2007 NPI implementation. If your billing company or clearing house provides you with proprietary software, you will need an upgrade to allow for the NPI. If your office bills electronically directly to NHIC, please contact your vendor about the software’s readiness to send the NPI. You may send a test claim file to NHIC if you wish to test the NPI before you begin sending it in production files. Stratford, the free billing software, supplied by NHIC to providers is NPI ready.

Information pertaining to the CMS NPI contingency plan can be found at:

http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Contingency.pdf

Question 3: How do you bill for a pap smear and pelvic exam conducted on the same day? Can you bill for an Evaluation and Management (E/M) service when the visit was for an annual GYN exam?

Answer 3: You must bill for the service(s) rendered at the time of the exam. G0101 represents cervical or vaginal cancer screening; pelvic and clinical breast examination and screening papanicolaou smear, obtaining, preparing and conveyance of cervical or vaginal smear to laboratory. An E/M or preventive (routine exam) may be billed in addition if rendered. For additional guidance on billing, please see the following information from our Preventive Services Guide:

BILLING FOR COVERED, PREVENTIVE, AND NON-COVERED SERVICES ON THE SAME DAY

NHIC often receives inquiries regarding how to bill for covered, non-covered, and preventive services on the same day. This question arises when physicians perform annual physical examinations on their patients the same time they perform follow-up evaluation of existing medical conditions.

The following examples describe typical situations, and the appropriate billing process:

- A physician furnishes a Medicare beneficiary a covered examination for evaluation of a medical condition at the same place and on the same occasion as a preventive medicine visit (CPT codes 99381-99397). Medicare would normally pay for the covered visit at the level that meets the criteria for coverage as reasonable and necessary if it were billed on a different day (for this example, let’s use 99213). The preventive service would be denied as non-covered screening, and the payment is the responsibility of the patient.
- The physician may charge the beneficiary, as a charge for the non-covered portion of the service, the amount he/she has established as the charge for the preventive medicine service, less the amount that would be owed by Medicare and the patient for the covered visit. In this example, the physician normally bills \$200 for a full preventive service. His/her charge for the 99213 is \$53.29, the Medicare fee schedule amount.

Service	Procedure	DX Code	Fee
Preventive Exam	99397	V70.0	\$146.71

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Answer 4: It is within Medicare benefit categories that a PA, NP, or CNS may provide services without direct supervision and have the service covered. However, a PA, NP, or CNS may opt to provide services incident to an MD or DO.

Physician assistants and Nurse Practitioners are eligible for provider numbers. Therefore they may apply for provider numbers and if applicable, link themselves to groups and bill accordingly. The other option is to bill under the incident to provision of a MD or DO. For additional information regarding PAs and NPs, please see the Non Physician Practitioner Guide at: http://www.medicarenhic.com/providers/pubs/nonphygd_apr07.pdf

Question 5: Are remittance codes MA18 and MA 19 considered secondary?

Answer 5: These remark codes relate to insurances after Medicare. The definition attached to MA 18 is ‘The claims information is also being forwarded to the patient’s supplemental insurer. Send any questions regarding supplemental benefits to them.’ The definition attached to MA 19 is ‘Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claims directly to that insurer.’

Question 6: Is there a way to bill for a Nursing Home visit when patient is not present?

Answer 6: No. Medicare coverage is based on services rendered face to face with the patient. Coverage is not afforded for a Nursing Home visit if the patient is not physically present at the time of the encounter.

Question 7: Is modifier 52 or 53 used by an IDTF doing MRI and the procedure is discontinued? Is modifier 22 used with unlisted procedures such as 76498 (unlisted magnetic resonance procedure)?

Answer 7: Modifier 52 indicated reduced services. Modifier 53 indicates discontinued procedure and applies when a surgical or diagnostic procedure is discontinued. Modifier 22 may be used on unlisted procedures if the narrative field can not accommodate a narrative of the unlisted service rendered.

Question 8: How do we bill for pronouncement of death?

Answer 8: The following is from our Evaluation/Management Guide:

Pronouncement of Death

According to established legal principles, an individual is not considered deceased until there has been official pronouncement of death. An individual is therefore considered to have expired as of the time he/she is pronounced dead by a person who is legally authorized to make such a pronouncement, usually a physician. Reasonable and necessary medical services rendered up to and including pronouncement of death by a physician are covered diagnostic or therapeutic services.

Note: Providers should use a brief evaluation and management service code to bill for the pronouncement of death and indicate “pronouncement of death” in the narrative field.

Question 9: Can I use the old CMS 1500 Claim Form after May 23rd?

Answer 9: The National Uniform Claim Committee revised the CMS-1500 in July 2006 to accommodate the mandated National Provider Identifiers (NPIs). The new version, CMS-1500 (08-05) will replace the CMS-1500 (12-90) version. In September 2006, CMS announced that it would implement the revised CMS-1500 (08-05) form on January 1, 2007, with dual acceptability of both versions until March 31, 2007. Beginning April 1, 2007, the only acceptable version of the form was intended to be the CMS-1500 (08-05) and the prior version, CMS-1500 (12-90), would be unprocessable as of that date. It has recently come to CMS’ attention that there are incorrectly formatted versions of the revised form being sold. Given the circumstances, CMS has decided to extend acceptance the CMS-1500(12-90) version beyond the April 1, 2007 deadline. At present, CMS is targeting June 1, 2007 as the new deadline for use of the CMS 1500 (08-05) version. For updated information, please visit the CMS website at: http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Question 10: How come the Medicare system can not detect duplicates in surgery situations?

Answer 10: The Medicare claims processing system can detect the same date of service, place of service and procedure code is billed. Duplicates should not be submitted.

Question 11: What is the correct procedure for a physician who does subsequent nursing home patients but patient is on hospice?

Answer 11: 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.

The subsequent nursing home visits would be billed and one of the above modifiers would be billed if applicable. If the physician is employed or paid under arrangement by the patient’s hospice provider, the service is billed to the hospice Medicare contractor and not billed to NHIC, Corp.

Question 12: Does it matter which order multiple modifiers go in?

Answer 12: No.

Question 13: On bilateral procedures, do you put the procedure code on one line with modifier 50 and double the fee, or on two lines with the 50 modifier added to the procedure on the second line?

Answer 13: If modifier 50 applies, it is billed on one line with one unit of service. The modifier defines the procedure code as having been done bilaterally.

Question 14: Is there any chance of improving the situation with Evercare?

Evercare and/or Medicare often retract payments. Knowing what insurance is effective for what date of service is nearly impossible for providers.

Answer 14: Evercare is a Medicare Advantage Plan in Massachusetts and is a state specific health plan for Medicaid recipients in Massachusetts. Providers are encouraged to verify eligibility with the patient at the time of service and to make use of the IVR system at NHIC, Corp. by verifying eligibility prior to providing service. The telephone number for the IVR in Massachusetts is (877) 567-3130. Additional contact phone numbers can be found on our website at: http://www.medicarenhic.com/ne_prov/contacts.shtml

Question 15: A new Medicare patient was seen at our office after she became eligible. Medicare did not cross to BCBS Medex. BCBS notified us to resubmit to Medicare so it would “carve out”. How do we get a claim to cross to Medex without it being considered a duplicate claim by Medicare?

Answer 15: If a claim has been submitted to and processed by Medicare, it should not be resubmitted in order to be crossed over to Medex. The Remittance Advice issued on the claim should be addressed with Medex directly.

Question 16: Have you considered a process for correcting all claims in the system rather than thru the appeals process?

Answer 16: CMS sets the standards regarding claim submission and claim resolution. Currently the Reopening and Appeals Process are in place. Minor clerical errors and omissions can be resolved through the Reopening process. To learn more about Telephone and Written Reopenings, please see the Educational Article titled Reopening posted on our website at: http://www.medicarenhic.com/providers/articles/reopenings_0107.htm

Question 17: Does the referral for a consult and report of a consult have to be in writing?

Answer 17: 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 Publication 100-04, Chapter 12, Section 30.6.10 F of the CMS IOM the following information outline the CMS guidelines for Consultation Request and Consultation Report:

Consultation Request

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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.

Consultation Report

A written report shall be furnished to the requesting physician or qualified NPP.

In an emergency department or inpatient or outpatient setting in which the medical record is shared between the referring physician or qualified NPP and the consultant, the request may be documented as part of a plan written in the requesting physician or qualified NPP's progress note, an order in the medical record, or a specific written request for the consultation. In these settings, the report may consist of an appropriate entry in the common medical record.

In an office setting, the documentation requirement may be met by a specific written request for the consultation from the requesting physician or qualified NPP or if the consultant's records show a specific reference to the request. In this setting, the consultation report is a separate document communicated to the requesting physician or qualified NPP.

In a large group practice e/g/ an academic department or a large multi-specialty group, in which there is often a shared medical record, it is acceptable to include the consultant's report in the medical record documentation and not require a separate from the consulting physician or qualified NPP to the requesting physician or qualified NPP. The written request and the consultation evaluation, findings and recommendations shall be available in the consultation report.

For additional information regarding Publication 100-04, Chapter 12, please see the CMS website at: <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

Question 18: Does the Durable Medical Equipment Medicare Administrative Contractor have the same Medicare claims processing payment floors of 14 days for electronic claims and 29 days for paper claims?

Answer 18: Yes. DME claims processing floors are 14 and 29 days. This information can be found in Chapter 4 of the DME MAC A Supplier Manual (Rev. 2007-01, January 2007) at http://www.medicarenhic.com/dme/dmemaca_sm_ch04-rev2007-01.pdf

Question 19: Dr. Haug mentioned in the General session that denied claims can not be resubmitted. Does that include unprocessable claims?

Answer 19: Denied claims are considered separate from claims that have been returned as unprocessable with the remark code of MA130. Remark code MA130 reads "*Your claim*

contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please resubmit the correct information to the appropriate fiscal intermediary or carrier". Unprocessable claims with remark code MA130 are able to be corrected and resubmitted for processing. All other claims that have denied must be resolved through the Reopening or Appeal process.

Question 20: Medical Group Management Association (MGMA) recently indicated that Medicare was going to require a 9 digit ZIP code in October 2007. Is that true?

Answer 20: Medicare payment is based on the locality where the service is rendered. CMS has identified that some ZIP codes fall into more than one payment locality. Therefore, effective for dates of service on or after October 1, 2007, providers performing services paid under the Medicare Physician Fee Service including Purchased Diagnostic Tests and Anesthesia Services in those ZIP codes that cross payment localities shall be required to submit the 9-digit ZIP codes on the claim for where the service was rendered. Claims for services NOT performed in one of the ZIP code areas that cross localities may continue to be submitted with 5-digit ZIP codes. For additional information and the zip codes that fall into more than one payment locality, please see Change Request 5208 issued by CMS at:

<http://www.cms.hhs.gov/transmittals/downloads/R1193CP.pdf>

Question 21: Has the crossover process to Medigaps and/or Medicaid changed? RA indicates that claim was forwarded to Medigap (e.g. United Health Care) but we never hear from Medigap.

Answer 21: The crossover process changed some time ago. The Coordination of Benefit Agreement (COBA) Program and Coordination of Benefits Contractor (COBC) 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 initiated. 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 trading partners

Question 22: 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 22: The Coordination of Benefit Contractor (COBC) has responsibility of correcting the records. The patient (or their advocate) needs to contact the COBC 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 COBC. 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 page on the CMS website:

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

Question 23: If a secondary claim processes incorrectly, does a redetermination need to be requested with the primary insurance's Explanation of Benefits (EOB) attached?

Answer23: Yes. You would request a redetermination and attach any supporting documentation. additional information.

Question 24:

Scenario:

Day 1- A surgeon sees an inpatient for evaluation and management (E&M) of a condition and/or signs/symptoms- inpatient visit billed.

Day 2- The surgeon sees the inpatient again for continued E&M of same condition- inpatient visit billed.

Day 3- The surgeon sees the inpatient again for continued E&M and at that point decides the patient needs surgery-inpatient inpatient visit billed with “-57” modifier and surgery billed.

Day 2 always denies due to global surgery period. Already billed the visit on day 3 with the “-57” modifier. Is there a way to get the visit on day 2 paid?

Answer 24: Based on the scenario given, the surgery must have been major with 90 postoperative days and the decision to perform surgery was the same day as surgery. Therefore Day 2 would deny as included in the 90 day global period for the surgery. To determine the global period for major surgeries, count 1 day immediately before the day of surgery and the 90 days immediately following the day of surgery.

For additional information on services included in the global surgical package, please see the General Surgery Guide at:

http://www.medicarenhic.com/providers/pubs/surgerygd_oct06.pdf

Question 25: What are the requirements for billing Medicare Secondary Payer claims electronically?

Answer 25: If you received an Administrative Simplification Compliance Act (ASCA) and one of the exceptions do not apply, you must send these claims electronically.

For additional information, please see the following MLN Matters articles”

MM3440-ASCA Enforcement of Mandatory Electronic Submission of Medicare Claims at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3440.pdf>

MM4261-Shared Systems MSP Balancing Edit and ASCA Enforcement Update at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4261.pdf>

Question 26: 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 26: 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.

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