Medicare Newsletter

Medicare Area
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mutualmedicare.com
A CMS Contracted Intermediary

January 15, 2005 Newsletter

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KEY

A All Providers
H Hospital Providers
S Skilled Nursing Facility (SNF) Providers
O Comprehensive Outpatient Rehabilitation Facility (CORF) And Outpatient Physical Therapy (OPT) Providers
C Community Mental Health Center (CMHC) Providers

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R Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Providers
E End-Stage Renal Disease (ESRD) Providers
P Hospice Providers
M Home Health Providers

If you have any questions regarding this newsletter, please contact your Customer Service Representative. However, some articles may contain a specific telephone number to contact for assistance.

Mutual of Omaha Insurance Company
Medicare Area

To stay informed of Medicare issues as they arise, please register for our Electronic Mail List at: www.mutualmedicare.com/signup

MMA-Addition of Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists as Emergency On-Call Providers for Critical Access Hospitals

Related Change Request (CR) #: 3228
Medlearn Matters Number: MM3228
Related CR Release Date: August 27, 2004
Related CR Transmittal #: 285
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Provider Types Affected
Critical Access Hospitals (CAHs)

Provider Action Needed
Be aware of the changes, introduced by Section 405 of the Medicare Modernization Act (MMA), that allow CAHs to include physician assistants, nurse practitioners, and clinical nurse specialists as CAH emergency room on-call providers, effective with dates of service on or after January 1, 2005.

Background
Section 405 of the MMA introduces the following changes for CAHs beginning with cost reporting periods that start on or after January 1, 2005:

- CAHs may include physician assistants, nurse practitioners and clinical nurse specialists as CAH emergency room on-call providers.
- CAHs may include amounts for reasonable compensation and related costs of these non-physician practitioners who are on call, and payment will be made via the cost report settlement process.
- Non-physician practitioners who are on call do not have to be present on the premises of the CAH involved.
- Non-physicians practitioners who are on call cannot be furnishing physician services at another site while on call.
- Non-physician practitioners who are on call cannot be on call at any other provider or facility while on call.

The Medicare Claims Processing Manual is being revised as a result of the Change Request (CR3228), on which this article is based. Section 30.1.3 of Chapter 3 of that manual is revised and CAHs should note that the revision requires that, for the costs associated with these non-physician practitioners to be allowable, the costs must be incurred under a written contract that requires the on-call provider to come to the CAH when the provider's presence is medically required.

Additional Information
To view the entire instruction issued to your intermediary, go to:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp
Once at that site, look for CR3228 in the CR NUM column on the right and click on the file for that CR. If you have any questions, please contact your Medicare fiscal intermediary at their toll free number, which may be found at:
http://www.cms.hhs.gov/medlearn/tollnums.asp .

The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2003 for Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

On December 10, 2004, the Centers for Medicare & Medicaid Services (CMS) published Change Request 3567, which provides the latest available IRF-specific data (SSI data files) to compute an IRF's SSI ratio for the specified fiscal year (FY). An IRF may use this ratio as part of the formula to estimate their adjustment for low-income patients (LIP) for a cost reporting period that begins subsequent to that specified FY. The file will be updated annually (usually each October/November). More specifically, this instruction provides updated data for determining additional payment amounts for Inpatient Rehabilitation Facilities (IRF) with a disproportionate share of low-income patients. The SSI/Medicare beneficiary data for IRF PPS is available to fiscal intermediaries (FIs) electronically and contains the name of the facility, provider number, SSI days, covered Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients. FIs will use this information to update their provider specific file. The file is located at the following CMS Web site address:

http://www.cms.hhs.gov/providers/irfpps/ssidata_ratios.asp

The tables at this CMS Web site address contain the files for calculating the SSI ratio for each fiscal year. Please make note that the last 3 years share the same data files until the cost reporting period is settled for the most recent fiscal year.

FIs use this data to determine an initial PPS payment amount, and if applicable, to determine a final payment amount for IRFs with cost reporting periods beginning on or after the first day of the cost reporting period, and before the first day of the next cost reporting period. Since the disproportionate share percentage is based on a facility's cost reporting period, FIs make a final determination of the amount of this percentage to compute the final low-income patient (LIP) adjustment at the year-end settlement of the facility's cost report. The final LIP adjustment is used to retrospectively adjust the initial PPS payment amount.

If you have any questions regarding this topic, please contact the Audit Supervisor assigned to your facility.

Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2005 for 9 Metropolitan Statistical Areas (MSAs) with New Wage Index Values Effective January 1, 2005

Background: Annual updates to the PPS rates are required by §1888(e) of the Social Security Act, as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA), and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), relating to Medicare payments and consolidated billing for SNFs.

Policy: The Centers for Medicare & Medicaid Services (CMS) published the SNF payment rates for FY 2005 (that is, beginning October 1, 2004 through September 30, 2005), in the Federal Register on July 30, 2004 (69 FR 45775). CMS published a Correction Notice to the SNF payment rates for FY 2005 on October 7, 2004 (69 FR 60158). CMS will publish changes to the following 9 MSAs in a Correction Notice.

The instruction in Change Request 3651 provides information on updates to the wage index for the 9 MSAs listed below:

MSA	Old Value	New Value
3960 – Lake Charles, LA	0.7959	0.7972
4280 – Lexington, KY	0.8053	0.9219
5000 – Miami, FL	1.0225	0.9870
5380 – Nassau-Suffolk, NY	1.2921	1.2907
5600 – New York, NY	1.3587	1.3586
6780 – Riverside-San Bernardino, CA	1.0975	1.0970
8780 – Visalia-Tulare-Porterville, CA	0.9964	0.9975
8960 – West Palm Beach-Boca Raton, FL	1.0059	1.0362
9040 - Wichita, KS	0.9472	0.9486

Fiscal Intermediaries (FIs) in the 9 effected MSAs will apply the new wage index effective January 1, 2005. Providers in these MSAs will need to split their billing so that the new wage index is used starting January 1, 2005. All other providers should continue their usual billing process.

If you have any questions concerning this matter, please contact the Audit Supervisor assigned to your facility.

January 2005 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 6.0

Related Change Request (CR) #: 3583 **Medlearn Matters Number:** MM3583
Related CR Release Date: December 3, 2004
Related CR Transmittal #: 387
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Provider Types Affected

All outpatient providers with the exception of hospitals not subject to the OPPS.

Provider Action Needed

Affected hospitals and providers should note that the related CR provides intermediaries with the January 2005 updates of the Outpatient Prospective Payment System (OPPS) Outpatient Code Editor (OCE).

Background

This article reflects specifications that were issued for the October 2004 revision of the OCE (Version 5.3), and all shaded material in the attachment to CR 2583 reflects changes incorporated into the January version of the revised OPPS OCE (Version 6.0). It contains detailed OCE instructions and specifications to be utilized under the OPPS for those providers paid under the OPPS.

Note: Discontinued HCPCS codes were retained in prior year's January OCE updates in order to facilitate the 90-day grace period that was allowed for such HCPCS codes. As mentioned in Medlearn Matters article MM3093, this 90-day grace period is being eliminated effective January 1, 2005. The MM3093 article may be viewed at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3093.pdf.

Summary of Modifications

The modifications of the OPPS OCE for the January 2005 release (V6.0) are summarized in the table below. Readers should also read through the specifications attached to CR 3583 and note the highlighted sections, which also indicate changes from the prior release of the OPPS OCE software.

Instructions for accessing the complete specifications are provided in the *Additional Information* section of this article. Note also that some of these modifications have an effective date earlier than January 1, 2005 and such dates are reflected in the "Effective Date" column.

Some OCE/APC modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective Date' column.

OPPS OCE Modifications

Mod. Type	Effective Date	Edit	
Logic	8/1/2000	27	Change disposition for edit 27 from claim rejection to **Claim Denial**
Logic	1/1/05		New packaging flag 4: "Packaged as part of drug administration APC payment." For all bill types where APCs are assigned, apply to excess drug administration APC units or occurrences when multiple occurrences are submitted without modifier – 59; or when more than the maximum allowed number of occurrences are submitted with modifier – 59. (See Appendix I.)
Logic	7/1/04	68	New edit 68 "Service submitted prior to date of National Coverage Determination (NCD) approval."
Logic	1/1/05	52	Replace procedure code Q0081 with 90780 in T procedure exemption for payable observation.
Logic	1/1/05	56&57	Remove requirement for Ancillary testing from payable observation logic.
Logic	10/1/03	23	For all bill types where edit 23 is applied, extend edit 23 to require line item date on all line items, not just on lines with HCPCS codes (HIPAA requirement).
Logic	10/1/04	69	New edit 69 "Service provided outside approval period" - **Line item rejection.** Make HCPCS/APC/SI and modifier changes, as specified by CMS.
Content		19,20, 39,40	Implement version 10.3 of the NCCI file, removing all code pairs which include Anesthesia (00100-01999), E&M (92002-92014, 99201-99499), MH (90804-90911), CAD (76082, 76083) or Drug Admin (96400-96450; 96542-96549; 90780,90781).
Content	1/1/05		Remove all HCPCS codes deleted 12/31/04 from the valid code list effective 1/1/05 (No grace period).
Content	8/1/00	16, 17	Remove all 'Add-on' codes from the Exclusive bilateral list that is used for the bilateral edits (16, 17).
Content		22	Add new modifiers to the valid modifiers list as indicated by CMS.
Doc		67	Change description for edit 67 to read "Service provided prior to FDA approval."
Doc		56, 57	Revise description for edits 56 and 57 to delete reference to ancillary procedures; descriptions to read "E/M condition not met and line item date ..."

Implementation

The implementation date for this instruction is January 3, 2005.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR3583 in the CR NUM column on the right, and click on the file for that CR.
If you have any questions, please contact your intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

January 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of OPPS Outpatient Code Editor (OCE) Data Changes and OPPS PRICER Logic; Changes to Payment for Diagnostic Mammography

Related Change Request (CR) #: 3586 **Medlearn Matters Number:** MM3586
Related CR Release Date: December 3, 2004
Related CR Transmittal #: 385
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Provider Types Affected
Hospitals and other providers paid by Medicare under the OPPS

Provider Action Needed
Affected providers should note that this article and related CR3586 provide information changes to the OPPS OCE data files and OPPS PRICER logic being implemented in the January 2005 update. The article also describes payment policy changes for diagnostic mammography.

Background
The policies implemented in this CR 3586 were provided in the 2005 OPPS final rule (Federal Register, November 15, 2004), and the attachment to the official instruction (issued to your intermediary) contains a detailed summary of data changes to the OPPS OCE, effective January 1, 2005, including the following:

- Ambulatory Payment Classification (APC) Changes
- Diagnosis Code Changes
- Healthcare Common Procedure Coding System (HCPCS)/Common Procedure Terminology (CPT) Code Changes
- HCPCS Description Changes
- APC Assignment Changes
- Status Indicator or Edit Changes
- Modifier Changes, and
- Revenue Code Changes

PRICER Changes
The OPPS PRICER logic as described in CR 3586 will be effective beginning January 1, 2005, unless otherwise noted in CR 3586. These are summarized as follows:

- The Centers for Medicare & Medicaid Services (CMS) is in the process of reviewing the wage indexes for the Inpatient Prospective Payment System (IPPS). This review may impact the wage index values. CMS emphasizes that the methodology for adjusting OPPS payment and co-payment rates for geographic wage differences using the IPPS wage index has not changed. The policy of CMS has consistently been to adopt the IPPS wage index for purposes of payment under the OPPS, and finalized tables will be published in a future Federal Register document. The final wage index values will be in the January 2005 OPPS PRICER.
- New OPPS payment rates and coinsurance amounts will be effective January 1, 2005. APCs have coinsurance amounts limited to 45 percent of the payment rate, effective January 1, 2005.

Some APCs have coinsurance limits equal to the inpatient deductible of $912, which is also effective as of January 1, 2005.

• For outliers for hospitals, CMS will change the factor multiplied by the total line item payments from 2.6 to 1.75. In addition, the cost for the line item must exceed the APC payment plus a fixed dollar threshold of $1,175. The factor used to multiply the difference between line item payments and costs remains at 50 percent.

• For outliers for Community Mental Health Centers (CMHCs; bill type 76x), CMS will change the factor multiplied by the total line item payments from 3.65 to 3.5. The factor used to multiply the difference between line item payments and costs remains at 50 percent.

• There are no device offsets for 2005.

Payment for Diagnostic Mammography

In addition, affected providers should note that section 614 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides for a change in payments for diagnostic mammography (HCPCS 76090, 76091, G0204, and G0206), including diagnostic computer-aided detection (CAD) services (code 76082), furnished by hospitals subject to the OPPS. Effective for services provided on or after January 1, 2005, Medicare will pay for diagnostic mammography, including the CAD services, based on the Medicare Physician Fee Schedule, and such payments will not be based on the OPPS.

Implementation

The implementation date for this instruction is January 3, 2005.

Additional Information

The list of diagnosis, HCPCS/CPT, APC, and other code changes, additions, and deletions is extensive. The changes and the respective effective dates of each change are detailed in an extensive attachment to the official instruction, CR 3586, which has been issued to your intermediary. That instruction may be viewed at:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3586 in the CR NUM column on the right, and click on the file for that CR. If you wish to view the November 15, 2004, final rule, you may find it at: http://www.cms.hhs.gov/providers/hopps/2005fc/1427fc.asp

If you have any questions, please contact your intermediary at their toll-free number found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

January 2005 Update of the Hospital Outpatient Prospective Payment System (OPPS): Billing for Devices that Do Not Have Transitional Pass-Through Status and that Are Not Classified as New Technology Ambulatory Payment Classification (APCs) Groups

Related Change Request (CR) #: 3606 **Medlearn Matters Number:** MM3606
Related CR Release Date: December 17, 2004
Related CR Transmittal #: 403
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Provider Types Affected
Hospitals and other providers subject to the OPPS

Provider Action Needed
Affected providers should note that this article and the related CR3606 describe changes to billing for devices that do not have transitional pass-through status and are not classified as new technology APCs.

Background
Under the OPPS, the Centers for Medicare & Medicaid Services (CMS) packages payment for an implantable device into the APC for the procedure performed for that implantation. Because the passthrough status of so many devices expired at the end of CY2002, CMS discontinued the codes that were established to report pass-through devices in CY2003.

However, CMS found that, in order to improve the specificity of data used for developing payment bases for device-dependent APCs, the device codes and related charges were needed. Therefore, in CY2004, CMS reestablished the device codes and encouraged hospitals to report the data on a voluntary basis.

In CY2005, such reporting will be required in order to process the claims.

The goal is to base payment for device-dependent APCs under the OPPS on single bill claims data, without adjustment for erratic data, and unless otherwise noted, all changes addressed in this article and CR3606 are effective for services furnished on or after January 1, 2005.

Effective January 1, 2005, hospitals paid under the OPPS submitting claims on bill types 12X and 13X that report procedure codes requiring the use of devices must also report the applicable Healthcare Common Procedure Coding System (HCPCS) codes and charges for all devices that are used to perform the procedures where such codes exist. This is necessary so that the OPPS payment for these procedures will be correct in future years in which the claims are used to create the APC payment amounts.

Effective for services furnished on or after April 1, 2005, Medicare will return to the provider any claim that reports an applicable "device-required" procedure code that does not report at least one device HCPCS code required for that procedure. Chapter 4 of the *Medicare Claims Processing Manual* has been amended to include tables that show the specific codes and edits that Medicare will use to implement these requirements, specifically:

• Table 1 in Section 61.1 of Chapter 4 lists the HCPCS codes for devices to be reported, as applicable, on the same claim as procedures in which devices are used; and

• Table 2 of Section 61.2 of Chapter 4 shows the list of procedure-to-device code edits.

To assist providers, these tables are available in Excel® format on the CMS' OPPS Web page at: http://www.cms.hhs.gov/providers/hopps/2005fc/1427fc.asp

The January 2005 OPPS OCE and OPPS PRICER will reflect the changes identified in this notification, and their installation instructions were provided in the following Change Requests (CRs):

• January 2005 OPPS PRICER installation instructions were provided in *CR3586: January 2005 Update of the Hospital Outpatient Prospective Payment System: Summary of OPPS Outpatient Code Editor Data Changes and OPPS PRICER Logic*. A Medlearn Matters article, MM3586, is available on this CR at: http://www.cms.hhs.gov/medlearn/matters

• January 2005 OPPS OCE installation instructions were provided in *CR3583: January 2005 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 6.0.* A Medlearn Matters article, MM3583, is also available on CR3583.

Implementation

The implementation date for this instruction is January 3, 2005.

Additional Information

The *Medicare Claims Processing Manual (Pub. 100-04), Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)* has been revised to include the new Section 61 and that section contains the two tables mentioned earlier in this article.

The new manual section is attached to the official instruction released to your intermediary. You may view that instruction by going to:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR3606 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Provider Frequently Asked Questions

Q. How do I enter a Medicare number into the Voice Response Unit (VRU) if it has a letter and a number at the end of it?

A. If the HIC number for the patient is nine numbers followed by a letter and a number, you would enter it as indicated in the following example:

Example: HIC #-123456789C1
Enter into the VRU as: 11 22 33 44 55 66 77 88 99 2# 11
These instructions are on our web site at:
www.mutualmedicare.com/pdf/VRU_instructions.pdf

Q. Can I bill for more than one bilateral procedure per day?

A. Yes, you can bill more than one bilateral procedure on a claim. Refer to the Medicare Claims Processing Manual, Pub 100-4, Chapter 4, Section 20.6 on how to bill bilateral procedures.

Q. How many units of group psychiatric therapy can be billed per day?

A. Per the Medicare Claims Processing Manual, Pub 100-4, Chapter 4, Section 260.1, service units for psychiatry are to be billed as:

- Hospitals- Report the number of times the service or procedure, as defined by the HCPCS code, was performed.
- CAH-Report the number of times the revenue code visit was performed.
- CMHC- Report the service units as the number of times the service or procedure, as defined by the HCPCS code, was performed. When reporting units for HCPCS with no reference to time (either as minutes, hours, or days) then the CMHC should not bill for sessions of less than 45 minutes (i.e. 45 minutes equal 1 unit).

Q. What is a "benefit period" and how is it calculated?

A. Per the Medicare Benefit Policy Manual, Pub 100-2, Chapter 3, Section 10, it states that a benefit period is a period of consecutive days during which medical benefits for covered services are available to the beneficiary.

- Under Part A Hospital the patient has 60 full days, 30 coinsurance days and 60 lifetime reserve days.
- Under SNF Part A the beneficiary has 20 full days and 80 coinsurance days available when they have had a 3 day qualifying stay in a hospital.

The benefit period is renewed when a beneficiary **has not been** in the hospital or a SNF Part A stay receiving a skilled level of care for 60 consecutive days.

- If you are a DDE provider, when a beneficiary admits into your facility you should sign onto HIQA to obtain the current benefit period and prior benefit period information, and you should also look at the DOLBA (Date of Last Billing) date. If their date of admission has been more then 60 days from this date the benefit period would be renewed. If you

are not sure how to access HIQA, go to www.mutualmedicare.com and click on DDE Manual. The manual will provide you with the proper steps on accessing HIQA.
**Please note that HIQA is only as accurate as the day you view it, benefits will change as claims are processed.

- Non-DDE providers can check eligibility through the VRU (Voice Response Unit) at 1-866-580-5983. The VRU will provide the current benefit period information. Instructions for using the VRU are available on our web site at www.mutualmedicare.com; click on VRU.
  **Please note that the VRU is only as accurate as the day you call, benefits will change as claims are processed.

Q. Claims that are editing for reason code M5052 or F5052 appear to take an extended amount of time to process. Is there anything that can be done to expedite the processing of the claims?

A. Claims in location M5052 or F5052 are searching for the beneficiary information on Common Working File (CWF). There are several CWF host sites where beneficiary information is stored; therefore, multiple host sites may need to be checked until the record is located. This process can take several days as the claim will automatically re-cable by the system to the next host site until the beneficiary record is located and the claim is processed. If the beneficiary record it is not located at any of the host sites, CWF will return a message to us indicating there is a problem with the beneficiary's name and/or Medicare number. If CWF provides a corrected Medicare number we will update the claim, otherwise, the claim will be denied with reason code 30715.

Q. A patient exhausted their SNF benefits while in our facility but remained at a skilled level of care. The patient was then discharged to the hospital and is now returning to our facility with a qualifying three-day inpatient hospital stay. Is the patient now eligible for a new benefit period?

A. In this situation the patient exhausted their SNF benefits but remained at a skilled level of care, therefore, the benefit period is not renewed. Per the Medicare General Information, Eligibility, and Entitlement Manual, Pub 100-1, Chapter 3, Section 10.4.2 -Ending a Benefit Period-The benefit period ends with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor a SNF receiving a skilled level of care. To determine the 60 consecutive day period, begin counting with the day the individual was discharged.

Q. What is the proper way to submit a hardcopy adjustment?

A. Submit a UB92 with bill type 117 and use the proper 'D' condition code. You can find a list of the 'D' condition codes in the "Quick Reference Guide Flipchart" located on our web site at www.mutualmedicare.com under the Direct Data Entry (Remote) section. The DDE section also includes some helpful tips such as:

- Only one condition code may be reported on the adjustment/cancel claim request.?
- If more than one condition code could apply, choose the single reason that best describes the adjustment being requested.
- Use condition code 'D1" only when the charges are the only change on the claim.

- If condition code ‘D9’ is reported, indicate the reason for the adjustment in the ‘REMARKS’ field on ‘Claim Page 04.’

Q. How are internal resolution reason codes handled?

A. These claims are in internal files to be worked by Medicare personnel. If there is something on the claim that needs to be corrected by the provider, the claim will be sent back to you in a TB9997 location where you can access it. If you have information to correct the claim that is pending “No provider action needed”, please call the correction line and request the information be corrected. The correction line numbers are:

NE Team	1-866-580-5985
SE Team	1-866-580-5979
Central Team	1-866-580-5982
West Team	1-866-580-5980

The correction line hours are 7:00 a.m. to 4:30 p.m. central time, Monday through Thursday.

Q. How do I correct an outpatient claim that is editing for reason code 17710?

A. Claims editing with reason code 17710 are in a Return to Provider (RTP) location. To correct the claim you must remove the ICD-9-CM procedure code(s) and date(s). If you are unable to access the claim, you may call the claims correction line and an examiner will assist you.

Additional information can be found in our July 1, 2004 Newsletter, page 21.

Q. I have a claim that denied with a “54NCD” reason code. Can I adjust the claim or do I have to appeal it?

A. If you receive a 54NCD denial and it was submitted it with the wrong diagnosis codes you can submit it as a hardcopy adjustment. Hardcopy adjustments are sent to PO Box 1602, Omaha, NE 68101

If the diagnosis code is correct you can appeal the denial.

Update of Healthcare Common Procedure Coding System (HCPCS) Codes and File Names, Descriptions, and Instruction for Retrieving the 2005 Ambulatory Surgical/Surgery Center (ASC) HCPCS Deletions and Master Listing

Related Change Request (CR) #: N/A **Medlearn Matters Number:** SE0463
Related CR Release Date: N/A
Effective Date: January 1, 2005
Implementation Date: January 5, 2005

Provider Types Affected
Ambulatory Surgical Centers

Provider Action Needed
Be aware that HCPCS codes 50559, 50959, and 50978 are being deleted from the ASC list effective for services performed on or after January 1, 2005.

Background
The Centers for Medicare & Medicaid Services (CMS) is updating the ASC HCPCS codes list as a result of changes in the American Medical Association (AMA) Physician's Current Procedural Terminology (CPT). The deletions of the HCPCS codes described in this notification are the results of changes in the CPT for
2005. There are no additions or replacement codes.

Additional Information
The link to your Carrier's website may be found at:

http://www.cms.hhs.gov/medlearn/tollnums.asp

Should you have any additional questions, please feel free to call your carrier/intermediary at their toll free number, which may also be found at that same Web Site.

Guidance Regarding Elimination of Standard Paper Remittance (SPR) Advice Notices in the Old Format

Related Change Request (CR) #: N/A **Medlearn Matters Number:** SE0451
Effective Date: N/A **Revised**
Implementation Date: January 1, 2005 for providers billing carriers, April 4, 2005 for providers billing fiscal intermediaries

Note: This article was revised on December 7, 2004 to revise the implementation date for providers billing fiscal intermediaries (FIs) and clarifies expectations for carrier changes.

Provider Types Affected
All Medicare physicians, providers, and suppliers

Provider Action Needed

The Centers for Medicare & Medicaid Assistance (CMS) has issued a memorandum to all Medicare carriers and FIs, including Durable Medical Equipment Regional Carriers (DMERCs) and Regional Home Health Intermediaries (RHHIs) stating that, effective January 1, 2005, only the 835 version 4010A1 flat file is to be used to produce the Standard Paper Remittance (SPR) advice notices; no other format for SPRs will be used.

Background

CMS prohibits the inclusion of data in paper remittance advice notices that is not included in the Electronic Remittance Advice (ERA) transactions. The most recent version of the SPR advice and the ERA contain the same information in the comparable fields and data elements, including the same codes. The same flat file should be used to produce both the SPR and 835 version 4010A1 ERA.

Note: The effective date has been revised to April 4, 2005 for FIs.

Providers billing intermediaries are also advised that they may see new data elements in their SPRs, i.e.:

- An additional field for the new technology add-on payment;
- A "PRE PAY ADJ" (presumptive payment adjustment) field in the claim detail section; and
- A new field to report a provider-level adjustment used to balance an "out of balance" remittance on the SPR summary page.

Providers billing carriers should note that not all carriers and DMERCs will be able to create SPRs directly from an 835 flat file. In such cases, carriers and DMERCs may continue to follow current practices for SPR preparation, but they must ensure that each SPR issued contains the same data elements that would be reported in the equivalent segments and data elements of an 835 version 4010A1 if produced for the same claims and provider. This applies to SPRs produced both for providers that have already transitioned to the 835 version 4010A1, and to those that received earlier versions of the 835 or the National Standard Format ERA pending transition.

Also, providers billing carriers and DMERCs should know that carriers and DMERCs have been told that SPRs may not contain data, other than the contractor's name and address and some calculated totals (as permitted in the SPR format in Chapter 22 of the Medicare Claims Processing Manual), that is not reported in the ERA.

Additional Information

Refer to Chapter 22 of the Medicare Claims Processing Manual, Publication 100-4, which can be found online at:
http://www.cms.hhs.gov/manuals/104_claims/clm104c22.pdf

Additional information regarding the Fiscal Intermediary Part A 835 flat file, including a sample of the most recent SPR format, is available in CR 3344. You may view that CR at: http://www.cms.hhs.gov/manuals/pm_trans/R252CP.pdf

If you have any questions regarding receipt of or conversion to ERAs, please contact your carrier/intermediary. If you bill an intermediary, their number may be found at:
http://www.cms.hhs.gov/providers/edi/anum.asp

If you bill a carrier, their number may be found at:
http://www.cms.hhs.gov/providers/edi/bnum.asp

MMA – Implementation of Section 921 of the Medicare Modernization Act (MMA) – Provider Customer Service Program

Related Change Request (CR) #: 3376 **Medlearn Matters Number:** MM3376
Related CR Release Date: September 10, 2004
Related CR Transmittal #: 113
Effective Date: January 1, 2005
Implementation Date: January 5, 2005, unless otherwise indicated

Provider Types Affected
Physicians, providers, and suppliers

Provider Action Needed
This instruction implements Section 921 of the Medicare Modernization Act (MMA). It creates the Provider Customer Service Program (PCSP) at most Medicare contractors. Collectively, carriers and fiscal intermediaries (FIs) are referred to as contractors or Medicare contractors. Because of funding limitations, the Centers for Medicare & Medicaid Services (CMS) is implementing this instruction in phases. Currently, only carriers and some FIs will be implementing this program in January 2005. Check with your carrier/FI to see if they are participating in the first phase. Note: Mutual of Omaha-Medicare will be implementing all phases within this CR.

Background
Medicare contractors are required to implement a PCSP designed to meet provider informational and educational needs.

The PCSP flows from provisions in Section 921 of the MMA that strengthen and enhance Medicare's ongoing efforts associated with provider inquiries and education. The PCSP is designed to improve accuracy, completeness, consistency, and timeliness by ensuring that providers' issues are addressed by staff with the appropriate levels of expertise.

The PCSP includes the following three principal components:
- Provider self-service technology
- Provider contact center (PCC)
- Provider outreach and education

Provider Self-Service Technology
- Self-service technology will enable the contact centers to handle the increasing volume of provider calls by allowing providers access to certain information without direct personal assistance from Medicare contractor staff. Contractors will require providers to use the interactive voice response (IVR) systems to access information about claims status, beneficiary eligibility, and remittance advice code definitions.

Provider Contact Center
The PCC will respond to inquiries from the following:
- Telephone calls
- Letters

• Faxes
• E-mails

Contractors will use an inquiry triage process for telephone inquiries to ensure that inquiries are answered by the staff with the appropriate expertise. Each contractor will organize its customer service representatives (CSRs) into at least two levels.

Inquiries that require even more specialized expertise or research or that just require significant additional time to resolve will be referred to a new group, the Provider Relations Research Specialists (PRRSs).The PRRS will provide clear and accurate written answers within 10 business days for at least 75 percent of cases referred by telephone CSRs, 20 business days for 90 percent of the cases referred by telephone CSRs, and 45 business days for 100 percent of all cases (referred by CSRs or from the general inquiries area). All general inquiries (letter, fax, and e-mail) will be answered within 45 business days.

Provider Outreach and Education

This component of the PCSP includes all provider outreach, education, and training activities that your carrier/FI currently performs, plus some additional requirements and activities. These new areas include:

• Training tailored for small providers and tailored to reduce the claims error rate
• Enhanced use of the Internet
• Local “Ask-the-Contractor” teleconferences and other new methods of communication

Small providers are defined by law as providers with fewer than 25 full-time equivalents or suppliers with fewer than 10 full-time equivalent staff. Contractors are required to identify providers meeting the definition of small providers and, beginning April 1, 2005, offer to all providers at least two educational programs tailored to the needs of the small providers/suppliers within their jurisdiction. Thereafter, contractors shall offer at least one additional event tailored to small providers per quarter with a minimum of six such events per state per federal fiscal year. (Thus, there may be more than one event in certain quarters of the year.)

Additional Information

For complete details, please see the official instruction issued to your contractor regarding this change. That instruction may be viewed by going to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3376 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions or want to take advantage of any opportunities under this expanded PCSP, visit the web site of your carrier/intermediary or call them at their toll-free number, which may be found at:

http://www.cms.hhs.gov/medlearn/tollnums.asp

Medicare Newsletter

Medicare Area
P.O. Box 1602 • Omaha, NE 68101
mutualmedicare.com
A CMS Contracted Intermediary

Dear Provider,

Mutual of Omaha is committed to the highest level of service to health care providers and the Medicare beneficiaries they serve.

We need your assistance with completing this year's provider survey. This survey will allow us to gain insights about the services we provide to you. Once the survey results are compiled, we will share them with you. We plan to use the outcomes from this survey to identify opportunities for process improvements. Please feel free to gather input from the appropriate individuals throughout your organization. This year, we are utilizing an electronic automated process we hope you will find to be convenient and user friendly. We would like you to complete the survey no later than February 28, 2005.

Please utilize the following address to access the Provider Survey. http://www.mutualmedicare.com/provider_survey.html.

Notification of the Provider Survey will also be communicated via our electronic mail list, and posted within the "What's New" section of our web site located at www.mutualmedicare.com.

We appreciate your time and efforts in completing this survey.

Sincerely,

Richard W. Reeves
Vice President & Director Medicare
Mutual of Omaha

To our providers….keep informed of Medicare Integrity Program issues as they arise by reading the MIP Tip in every issue.

"MIP Tip"

This tip is brought to you from our Provider Education and Training Department.

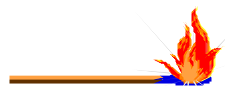
Provider Education

This year our Provider Education and Training (PET) Department will be introducing training via computer-based training and teleconferences.

The first of a series of computer based training modules, Skilled Nursing Facility Prospective Payment System Consolidated Billing, is available on our web site at www.mutualmedicare.com. Visit our web site frequently; as additional computer based training modules will be released throughout the upcoming year.

We will also present "Ask-the-Contractor Teleconferences" where information will be shared and discussed with our providers. These one and one-half hour teleconferences will be based on provider type. The initial "Ask-the-Contractor Teleconference" will focus on Skilled Nursing Facility Prospective Payment System Consolidated Billing and will consist of an overview and a question and answer session. Notification of these teleconferences will be posted on our web site and via our electronic mail list (EML).

Our EML provides updates on education, newsletters, LCD's, special announcements and more. If you are not already a registered subscriber, sign up for our EML on our web site today!



Please stay tuned for more hot tips!