



April 1, 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
- 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 - Full Replacement of CR 3572, New Case-Mix Adjusted End Stage Renal Disease (ESRD) Composite Payment Rates and New Composite Rate Exceptions Window for Pediatric ESRD Facilities CR 3572 is Rescinded

Related Change Request (CR) #: 3720

Medlearn Matters Number: MM3720

Related CR Release Date: February 18, 2005 **Revised**

Related CR Transmittal #: 477

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

This article discusses a full replacement of CR 3572 (Transmittal 370), which was issued by CMS on November 19, 2004 (refer to our February 1, 2005 Medicare Newsletter).

Provider Types Affected

Providers of ESRD services

Provider Action Needed

This article contains information provided in Change Request (CR) 3720, which explains that the Centers for Medicare & Medicaid Services (CMS) is using a limited number of characteristics that explain variation in reported costs for composite rate services consistent with the legislative requirement. The current composite payment rates will be adjusted for individual patient characteristics and budget neutrality for services furnished on or after April 1, 2005.

Background

In accordance with the Social Security Act (Section 1881(b)(12)(A)), as added by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Section 623(d)(1)),

“The Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished (by providers of services and renal dialysis facilities in a year) to individuals in a facility and to individuals at home. The case-mix under the system would be for a limited number of patient characteristics.”

The use of a case-mix measure permits the targeting of greater payments to facilities that treat more costly and resource-intensive patients. The methodology for applying patient characteristic adjusters (applicable to each treatment) will determine the case-mix adjustment (which will vary for each patient). Thus, an ESRD facility's average composite payment rate per treatment will depend on its unique (patients) case-mix.

The patient characteristic variables that are utilized in determining an individual patient's case-mix adjusted composite payment rate include the following:

- Five age groups,
- Low Body Mass Index (BMI),
- Body surface area (BSA), and
- Patients under age 18.

Note: Pediatric ESRD patients (defined as under the age of 18) receive a specific case-mix adjustment factor. As a result, none of the other case-mix adjustors (i.e., the five age groups, low BMI and BSA) are applicable to pediatric ESRD patients.

The ESRD Pricer Program uses each patient's height and weight (as reported on billing Form CMS-UB 92) to automatically calculate the low BMI and BSA case-mix adjustments to an ESRD facility's composite payment rate.

Budget neutrality is designed to ensure that the total aggregate payments each year from the Medicare Trust Fund do not increase or decrease as a result of changes in the payment methodology. Therefore, the case-mix adjusted composite rate payments for 2004 must result in the same aggregate expenditures for 2005 (as if the adjustments are not made).

While the magnitude of some of the patient specific case-mix adjustment factors appears to be significant, facility variation in the case-mix is limited. Regardless of the type of provider, the average case-mix adjustments for patient characteristics do not vary significantly. This is because of the overall similarity of the distribution of patients among the eight case-mix classification categories across facility classification groups.

Because ESRD facilities can maintain their current exception rates, they should compare their exception rate to the basic case-mix adjusted composite rate to determine the best payment rate for their facility.

Each dialysis facility has the option of being paid at:

- Its current exception rate, or
- The basic case-mix adjusted composite rate (including all of the MMA 623 payment adjustments).

If the facility retains its exception rate, it is not subject to any of the adjustments specified in Section 623 of the MMA

Also, determinations as to whether an ESRD facility's exception rate per treatment will exceed its average case-mix adjusted composite rate per treatment are best left to the entities affected.

Each ESRD facility is required to notify its FI in writing at any time if it wishes to:

- Give up or withdraw its exception rate, and
- Be subject to the basic case-mix adjusted composite payment rate methodology.

The case-mix adjusted composite payment rates will begin 30 days after the FI's receipt of the facility's notification letter. ESRD facilities that elect to retain their exceptions do not need to notify their FIs.

Note: CMS is opening a new pediatric facility exception request window for pediatric facilities that **did not** have an approved exception rate as of October 1, 2002 (MMA, Section 623(b)(1)(D)).

The statute defines the term "pediatric facility" as a renal facility with at least 50 percent of whose patients are individuals under 18 years of age. If a pediatric ESRD facility projects (on

the basis of prior years' cost and utilization trends) that it will have an allowable cost per treatment higher than its prospective rate, the facility may request that CMS:

- Approve an exception to that rate, and
- Set a higher prospective payment rate.

CMS will adjudicate these exception requests in accordance with the exception criteria contained in:

- The Code of Federal Regulation (CFR), Title 42, Chapter IV, Part 413, Section 180. See 42 CFR 413.180, which can be found at the following Government Printing Office (GPO) web site:

http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr413_04.html

- Publication 15, Medicare Provider Reimbursement Manual (PRM), Part I, Chapter 27, which can be found at the following CMS web site:

http://www.cms.hhs.gov/pub151/PUB_15_1.asp

If the facility fails to adequately justify its pediatric exception request (in accordance with regulations or program instructions), its exception request will be denied.

Implementation

The implementation date for this instruction is April 4, 2005.

Additional Information

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

http://www.cms.hhs.gov/manuals/transmittals/pm_trans/R477CP.pdf

If you have any questions, please contact your assigned supervisor at their toll-free number, which may be found at:

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

Addition of CLIA Edits to Certain Health Care Procedure Coding System (HCPCS) Codes for Mohs Surgery

Related Change Request (CR) #: 3458

Medlearn Matters Number: MM3458

Related CR Release Date: January 14, 2005

Related CR Transmittal #: 434

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Provider Types Affected

Physicians and clinical diagnostic laboratories billing Medicare carriers for Mohs Surgery

Provider Action Needed

Impact to You

The Mohs micrographic surgical treatment for skin cancer requires the trained physician to serve as pathologist and surgeon. The applicable HCPCS codes (17304, 17305, 17306, 17307, and 17310) include the physician microscopic exam and interpretation, which are characterized

as high complexity tests under the Clinical Laboratory Improvement Amendments (CLIA). Thus, these HCPCS codes will be subject to CLIA edits.

What You Need to Know

The Clinical Laboratory Improvement Amendments of 1998 (CLIA) require a facility to be appropriately certified for each test performed.

The following types of facilities will not be permitted to bill for the above noted tests: those without a valid current CLIA certificate; those with a current CLIA certificate of waiver (certificate type code 2); OR those with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4)

What You Need to Do

Please stay current with requirements for the Mohs Micrographic Surgical procedure to ensure accurate claims processing. The Mohs micrographic surgery HCPCS codes (17304, 17305, 17306, 17307, and 17310) will require either: a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), OR a CLIA certificate of accreditation (certificate type code 3).

Background

The Clinical Laboratory Improvement Amendments of 1998 (CLIA) require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid pay only laboratory tests performed by certified facilities, each HCPCS code that includes a laboratory test is currently edited at the CLIA certificate level.

The Mohs surgery procedure usually includes the following steps:

- A physician generally removes the visible cancer, along with a thin layer of additional tissue;
- The removed tissue specimen is cut into sections, stained, and marked on a detailed diagram;
- The tissue is frozen on a cryostat, very thin slices are removed from the entire edge and undersurface and these slices are then placed on slides and stained for examination under the microscope;
- The physician examines the entire undersurface and complete edge of the tissue specimen, and all microscopic “roots” of the cancer are precisely identified and pinpointed on the Mohs map; and
- Upon microscopic examination, if residual cancer is found, the physician utilizes the Mohs map to direct the removal of additional tissue.

The process is repeated as many times as necessary to locate any remaining cancerous areas within the tissue specimen. When the microscopic examination reveals that there is no remaining tumor, the surgical defect is repaired.

The HCPCS codes for Mohs micrographic surgery [i.e., 17304, 17305, 17306, 17307, and 17310] require a physician to act as both a surgeon and a pathologist. These codes include the

physician's microscopic examination and interpretation of tissue specimens. Both the microscopic examination and interpretation of tissue specimens are categorized as high complexity tests under CLIA in the specialty of histopathology.

At this time, all laboratory tests covered under CLIA are edited at the CLIA certificate level. The previously mentioned Mohs micrographic surgery HCPCS codes would require either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid current CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2), or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) will not be permitted to bill for these tests.

Medicare carriers will deny payment if a CLIA # is not submitted on claims by facilities for the HCPCS codes of 17304, 17305, 17306, 17307, and 17310.

Additional Information

The official instruction issued to your carrier regarding this change can be found online, referenced via CR 3458, at:

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

On the above online page, scroll down while referring to the CR NUM column on the right to find the link for CR 3458. Click on the link to open and view the file for the CR.

If you have questions regarding this issue, you may also contact your carrier at their toll free number, which may be found at:

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

Correction to Healthcare Common Procedure Coding System (HCPCS) Code A4217

Related Change Request (CR) #: 3714
Related CR Release Date: March 4, 2005
Related CR Transmittal #: 489
Effective Date: January 1, 2005
Implementation Date: July 5, 2005

Medlearn Matters Number: MM3714

Provider Types Affected

Providers billing Medicare Fiscal Intermediaries (FIs) for HCPCS code A4217

Provider Action Needed

This article is based on information contained in Change Request (CR) 3714, which revises prior instructions included in CR 3300 (Transmittal 236, July 23, 2004) that required using modifier AU (Item Furnished in Conjunction with a Urological, Ostomy, or Tracheostomy Supply) with HCPCS Code A4217 (Medical, Surgical, and Self-administered Injection Supplies).

Background

Change Request (CR) 3300 (Business Requirement 3300.6) instructed that modifier AU (Item Furnished in Conjunction with a Urological, Ostomy, or Tracheostomy Supply) must be present on claims containing HCPCS Code A4217 (Medical, Surgical, and Self-administered Injection Supplies).

However, it has come to the attention of the Centers for Medicare & Medicaid Services (CMS) that HCPCS code A4217, **without the presence of modifier AU**, can be used in conjunction with Durable Medical Equipment (DME).

Therefore, **this article removes the requirement that modifier AU always be present with HCPCS code A4217. Claims received on or after January 1, 2005 with HCPCS Code A4217 (and no modifier) may be considered a DME supply and processed accordingly.**

All other policies as outlined in the Medicare Claims Processing Manual (Pub. 100-04), Chapter 20, Section 30.9 regarding the presence of modifier AU with HCPCS code A4217 remain the same.

Implementation

The implementation date for this instruction is July 5, 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 CR 3714 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>

Claims Status Code/Claims Status Category Code Update

Related Change Request (CR) #: 3715

Medlearn Matters Number: MM3715

Related CR Release Date: March 4, 2005

Related CR Transmittal #: 490

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Provider Types Affected

All providers submitting Health Care Claim Status Transactions to Medicare carriers, including Durable Medical Equipment Carriers (DMERCs), and Fiscal Intermediaries (FIs)

Provider Action Needed

This is a reminder item regarding the periodic update of certain code sets used as a result of the Health Insurance Portability and Accountability Act (HIPAA). Effective July 1, 2005, the

Medicare Claims processing system will update its lists of Health Care Claims Status Codes and Health Care Claims Status Category Codes with all applicable code changes posted online with the “new as of 10/04” and prior date designations.

Background

Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as non-clinical or non-medical code sets.

Claim Status Category Codes and Claim Status Codes are used in the Health Care Claim Status Response (277) transaction:

- Claim Status Category Codes indicate the general payment status of the claim.
- Claim Status Codes provide more detail about the status communicated in the general Claim Status Category Codes.

These codes are available online at:

<http://www.wpc-edi.com/codes/Codes.asp>

Additional Information

The official instruction issued regarding this change can be found at:

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

On the above page, scroll down the CR NUM column on the right to find the link for CR 3715. Click on the link to open and view the file for the CR.

If you have questions regarding this issue, you may also contact your carrier or intermediary at their toll free number, which may be found at:

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

April 2005 Outpatient Prospective Payment System (OPPS) Outpatient Code Editor (OCE) Specifications Version 6.1

Related Change Request (CR) #: 3743

Medlearn Matters Number: MM3743

Related CR Release Date: March 4, 2005

Related CR Transmittal #: 494

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Provider Types Affected

All providers billing outpatient services to Medicare Fiscal Intermediaries (FIs) that are paid under the Outpatient Prospective Payment System (OPPS)

Provider Action Needed

This instruction is based on information contained in Change Request (CR) 3743 which is to 1) inform FIs that the April 2005 OPPS OCE specifications have been updated with new additions,

changes, and deletions, and 2) insure that FIs install the updated April 2005 OPSS OCE (Version 6.1) into their systems.

Background

Full details of Version 6.1 of the OPSS OCE are contained in CR3743 and will not be repeated in this article; especially since many of the details are not changing, and providers paid under the OPSS are likely familiar with these details. The modifications of the Outpatient Code Editor/Ambulatory Patient Classification (OCE/APC) for the April 2005 release (V6.1) are summarized in the following table:

	Mod. Type	Effective Date	Edit	Description
4.	Logic	4/1/05	71	New edit 71 "Claim lacks required device code" – RTP When a claim is submitted with a specified procedure without a code for the required device for that procedure, the claim will be returned to the provider. Exceptions are made for procedures that are discontinued as reflected by the presence of a modifier 52, 73 or 74 on the claim.
5.	Logic		38	Modify criteria for edit 38 to require an implantation procedure on the same claim (instead of the same day), when a code with status indicator H is submitted
6.	Logic	1/1/05		Add new Status Indicator M – Service not billable to the F I – Payment Indicator 3
7.	Logic	1/1/05	72	New edit 72 "Service not billable to the Fiscal Intermediary" - RTP. Apply to codes with Status Indicator = M
8.	Data		69	Apply to specified G-codes if date of service is after 1/29/05
9.				Make HCPCS/APC/SI and modifier changes, as specified by CMS.
10.	Content		19,20, 39,40	Implement version 11.0 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)
11.	Content		41	Add new rev code 0024, SI = B if submitted without HCPCS
12.	Content	4/1/03	41	Add new rev code 0658; SI = B if submitted without HCPCS
13.	Content	7/1/01	41	Change SI for rev code 0273; SI = N if submitted without HCPCS
14.	Content		41	Remove erroneous codes 0091 and 3100 from list of valid revenue codes
15.	Content	4/1/04	41	Delete rev code 0184
16.	Content	10/1/03	41	Delete rev code 0909
17.	Content	1/1/05	22	Re-activate modifier 27
18.	Content	1/1/05	22	Re-activate modifier GX
19.	Content	4/1/05	71	Added new procedure/device code pairs for edit 71.

Note: You should also read through the specifications in the official instruction (CR 3743) issued to your intermediary, and note the highlighted sections which also indicate changes from the prior release of the software. Some OCE/ APC modifications in the release may also be retroactively added to prior releases. If so, the retroactive date appears in the "Effective Date" column in the above table.

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to the following Centers for Medicare & Medicaid Services web site:

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

From that web page, look for CR 3743 in the CR NUM column on the right, and click on the file for that CR.

Implementation

The implementation date for this instruction is April 4, 2005.

Additional Information

If you have any questions, please contact your intermediary at their toll-free number found at:

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

Standardization of Fiscal Intermediary Use of Group and Claim Adjustment Reason Codes and Calculation and Balancing of TS2 and TS3 Segment Data Elements

Related Change Request (CR) #: 3685

Medlearn Matters Number: MM3685

Related CR Release Date: February 4, 2005

Related CR Transmittal #: 470

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

Provider Types Affected

Providers who bill Medicare fiscal intermediaries (FIs)

Provider Action Needed

Impact to You

Effective July 1, 2005, The Center for Medicare & Medicaid Services (CMS) will require FIs to report a specific group code in combination with specific reason codes in electronic remittance advice (ERA) and in standard paper remittance advice (SPR) transactions. In addition, CMS has put forth additional requirements for the FI regarding correct calculation for TS2 and TS3 Segment Data Elements in remittance advice transactions.

What You Need to Know

FIs will not use a PR group code unless a claim indicates that a provider obtained an Advanced Beneficiary Notice (ABN) for a service not generally considered as reasonable and necessary for treatment of a patient.

What You Need to Do

To ensure accurate understanding of remittance advice transactions, please review the information included here and remain current with guidelines pertaining to ERA and SPR transactions.

Background

Effective July 1, 2005, The Center for Medicare & Medicaid Services (CMS) will require FIs to report a specific group code in combination with specific reason codes. In addition, CMS has put forth additional requirements for the FI regarding correct calculation for TS2 and TS3 Segment Data Elements.

The X12 835 remittance advice and 837 coordination of benefits (COB) implementation guides (IG) require that a group code that assigns financial responsibility for a non-paid amount is reported in conjunction with applicable claim adjustment reason codes that explain full or partial denials of services.

As part of the continuing effort to foster standardized reporting among fiscal intermediaries, CMS will require FIs to report a specific group code in combination with specific reason codes.

Medicare FIs are permitted to use the following group codes in combination with specific reason codes:

- CO (Contractual Obligation) => provider is financially liable,
- CR (Correction and Reversal) => no financial liability,
- OA (Other Adjustment) => no financial liability, and
- PR (Patient Responsibility) => patient is financially liable.

Please note that although X12 permits use of group code PI (payer initiated), with an adjustment reason code, CMS has never permitted Medicare FIs to use this group code as it fails to identify financial liability for the unpaid amount.

FIs will not use alternate group and reason code combinations unless a claim indicates that a provider obtained an Advanced Beneficiary Notice (ABN) or other notice of non-coverage for a service Medicare may not pay because it is generally not considered reasonable and necessary for treatment of a patient or if the item and/or service is one for which the financial liability protections in Section 1879 of the Social Security Act (SSA) could apply.

Example:

Case One: A patient signed an ABN indicating that:

- The provider advised the patient before rendering and billing for a service that the service is not usually covered by Medicare because it is deemed to be not necessary and reasonable , AND
- The patient still requested the service and agreed to pay for the service if denied by Medicare:

Group code PR (patient responsibility) applies with reason code 50 (used to deny a service not considered reasonable and necessary).

Case Two: The provider did not obtain an ABN from a patient for a service not considered reasonable and necessary. In this case, group code CO (contractual obligation) applies with reason code 50.

A provider is prohibited from billing a Medicare beneficiary for any adjustment amount identified with a CO group code, but may bill a beneficiary for an adjustment amount identified with a PR group code.

In addition, CMS has also put forth additional requirements for the FI regarding TS2 and TS3 Segment Data Elements. Most of these data elements report totals for categories of data elements reported elsewhere in an 835. Although the X12 835 IG does not specifically require that these totals balance against the applicable individual data elements, CMS will require that these totals balance. In most cases, the amounts to be included in a TS2 or TS3 data element totals are evident from the applicable semantic note.

The following two tables list the semantic notes from the X12 workbook that apply to these segments and data elements. When reported, these data elements must comply with these semantic notes.

TS3 Segment – Transaction Statistics

Number	Code/Description of Code
01	TS301 is the provider number.
02	TS302 is the facility type code
03	TS303 is the last day of the provider's fiscal year.
04	TS304 is the total number of claims.
05	TS305 is the total of reported charges.
06	TS306 is the total of covered charges.
07	TS307 is the total of noncovered charges.
08	TS308 is the total of denied charges.
09	TS309 is the total provider payment.
10	TS310 is the total amount of interest paid.
11	TS311 is the total contractual adjustment.
12	TS312 is the total Gramm-Rudman Reduction.
13	TS313 is the total Medicare Secondary Payer (MSP) primary payer amount.
14	TS314 is the total blood deductible amount in dollars.
15	TS315 is the summary of non-lab charges.
16	TS316 is the total coinsurance amount.
17	TS317 is the Health Care Financing Administration Common Procedural Coding System (HCPCS) reported charges.
18	TS318 is the total Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.
19	TS319 is the total deductible amount.
20	TS320 is the total professional component amount.
21	TS321 is the total Medicare Secondary Payer (MSP) patient liability met.
22	TS322 is the total patient reimbursement.
23	TS323 is the total periodic interim payment (PIP) number of claims.
24	TS324 is total periodic interim payment (PIP) adjustment.

TS2 Transaction Supplemental Statistics

Number	Code/Description of Code
01	TS201 is the total diagnosis related group (DRG) amount.
02	TS202 is the total federal specific amount.
03	TS203 is the total hospital specific amount.
04	TS204 is the total disproportionate share amount.
05	TS205 is the total capital amount.
06	TS206 is the total indirect medical education amount.
07	TS207 is the total number of outlier days.
08	TS208 is the total day outlier amount.
09	TS209 is the total cost outlier amount.
10	TS210 is the diagnosis related group (DRG) average length of stay.
11	TS211 is the total number of discharges.
12	TS212 is the total number of cost report days.
13	TS213 is the total number of covered days.
14	TS214 is total number of non-covered days.
15	TS215 is the total Medicare Secondary Payer (MSP) pass-through amount calculated for a non-Medicare payer.
16	TS216 is the average diagnosis-related group (DRG) weight.
17	TS217 is the total prospective payment system (PPS) capital, federal-specific portion, diagnosis-related group (DRG) amount.
18	TS218 is the total prospective payment system (PPS) capital, hospital-specific portion, diagnosis-related group (DRG) amount.
19	TS219 is the total prospective payment system (PPS) disproportionate share, hospital diagnosis-related group (DRG) amount.

Additional Information

The official instruction issued to your FI regarding this change can be found at:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3685. Click on the link to open and view the file for the CR.

If you have questions regarding this issue, you may also contact your fiscal intermediary at their toll free number, which may be found at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>

Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process

Related Change Request (CR) #: 3709 **Medlearn Matters Number:** MM3709
Related CR Release Date: February 11, 2005
Related CR Transmittal #: 474
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

Provider Types Affected

All physicians, providers, and suppliers billing Medicare Fiscal Intermediaries (FIs) and carriers

Provider Action Needed

This instruction includes information contained in Change Request (CR) 3709 which directs Medicare Contractors (carriers, intermediaries, and Durable Medical Equipment Regional Carriers [DMERCs]) to issue special automated correspondence from their internal systems to physicians, providers, and suppliers informing them that claims that were expected to be crossed over to supplemental payers/insurers (as indicated on a previous Remittance Advice) were not crossed.

Background

Through the national COBA process, Medicare will automatically cross claims over to a supplemental payer/insurer that may pay after Medicare has made its payment decision on the claim. There may be situations (such as claim errors related to HIPPA) that prevent Medicare from crossing a claim over to the supplemental payer/insurer.

In those situations where Medicare is unable to cross the claim, CR 3709 directs Medicare Contractors to issue special automated correspondence to notify physicians, suppliers, and providers when claims previously selected for crossover by Medicare were subsequently unable to be crossed to the supplemental payer/insurer.

The correspondence sent to the physician, supplier, or provider will contain specific claim information, including the Internal Control Number (ICN)/Document Control Number (DCN), Health Insurance Claim (HIC) number, Medical Record Number (if the letter is from an intermediary and the claim was for Part A services), Patient Control Number (if present on the claim), beneficiary name, date of service, and the date the claim was processed. In addition, the letter will include the following message:

“The above claim(s) was/were not crossed over to the patient’s supplemental insurer due to claim data errors.”

Upon receipt of such correspondence, the physician, supplier, or provider is advised that the claim is not being crossed automatically and the provider may take appropriate action to obtain payment from the supplemental payer/insurer.

Implementation

The implementation date for CR 3709 is July 5, 2005.

Additional Information

Complete details of the COBA Error Notification process are included in the official instruction issued to your carrier/DMERC/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 3709 in the CR NUM column on the right, and click on the file for that CR.

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

ATTENTION SMALL PROVIDERS

**“Small Provider” Education and Training Survey
Mutual of Omaha-Medicare**

Education and training activities look for ways to inform providers of Medicare programs and policies, new Medicare initiatives, significant changes to the Medicare program, and to address issues that are of concern to providers.

In order to better serve and expand communications with our small providers, we would like to gain an understanding of your educational needs. Small providers are defined by law as providers with fewer than 25 full time equivalents.

We would be interested in receiving input from our small providers as to what topics or areas of concern your would like to have addressed. Additionally, we would like your views on what methods of providing this information are more effective and efficient in your day-to-day operations.

Please take a moment to answer the following questions, and mail or fax the completed form to:

Mutual of Omaha-Medicare
Mutual of Omaha Plaza
Lower Level 2-Attention Sheryl Torres
Omaha, NE 68175
Fax: 402-351-8047, Attn. Sheryl Torres

1. What topics or areas of concern would you like to see included in future educational activities or newsletters?

2. What training method(s) do you find most effective and efficient?

Circle applicable method(s):

- Seminars
- Telephone
- Web Site/Webinars
- Computer Based Training
- Publications and Bulletins
- Other, please explain _____

Comments _____

3. Do you have access to the Mutual of Omaha-Medicare web site? Yes ___ No ___

If yes: How many hours per week do you spend utilizing this resource? _____

Do you have a good understanding of our web site? Yes ___ No ___

4. Location of provider/facility: (Please mark appropriate region)

Northeast _____ Southeast _____ Central _____ West _____

Thank you for taking the time to complete this survey.
Mutual of Omaha-Medicare

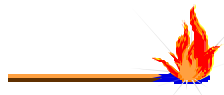
To our providers....keep informed of Medicare Integrity Program issues as they arise by reading the MIP Tip in every issue.

"MIP Tip"

This tip is brought to you from our Claims Department.

Billing For Diagnostic And Screening Mammographies

Reminder - diagnostic and screening mammographies furnished by hospitals were required to be billed under type of bill (TOB) 14X. This requirement changed effective April 1, 2005 to require billing for diagnostic and screening mammography claims under the TOB 13X. Please see our December 15, 2004 newsletter for more information.



Please stay tuned for more hot tips!