



July 15, 2006 Newsletter

In This Issue....

	<u>Audit & Reimbursement</u>	
H	Medicare Bad Debts Referred to a Collection Agency	2
	<u>Claims</u>	
A	National Provider Identifier (NPI)...Reminder to Enumerate; Countdown has Begun!	2
	<u>General Information</u>	
A	Keeping in Touch with Medicare Fee-for-Service Providers	3
	<u>Medical Review</u>	
A	Lumbar Artificial Disc Replacement (LADR)	3
A	Therapy Caps Exception Process	6
A	Non-Autologous Blood Derived Products for Chronic Non-Healing Wounds	11
	<u>MSP</u>	
A	Modification to Online Medicare Secondary Payer Questionnaire	12
	<u>MIP Tip</u> - Receive your Remittance Advice Electronically	25
	<u>KEY</u>	
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

Medicare Bad Debts Referred to a Collection Agency

The Centers for Medicare and Medicaid Services' (CMS) long-standing position is Medicare bad debts, as defined in 42 CFR 413.80(d) and (e) (unpaid beneficiary deductible and coinsurance) referred to a collection agency are not uncollectible and may not be reimbursed as Medicare bad debts. In accordance with this position, we are informing you that Mutual of Omaha will not reimburse uncollected deductible and coinsurance amounts until all collection efforts cease, including collection efforts made by an outside agency. A hospital that refers debts to a collection agency shall not claim those as bad debts for Medicare reimbursement until the agency ceases all collection activity and returns the debt to the hospital.

One of the regulatory criteria for an allowable bad debt is that sound business judgment established there was no likelihood of recovery of the debt at any time in the future (42 CFR §413.89(e)(4)). However, the fact a provider has referred a debt to a collection agency implies at least some likelihood that a recovery may take place. For this reason, CMS adopted the position that debts referred to a collection agency are not uncollectible and may not be reimbursed.

A hospital that, as of August 1, 1987, was reimbursed by its fiscal intermediary for debts at a collection agency may qualify for continued reimbursement of current year debts at a collection agency under the bad debt "moratorium" created by Congress. See section 4008(c) of the Omnibus Budget Reconciliation Act (OBRA) of 1987 for the text of the law.

If you have any questions, please contact the audit supervisor assigned to your facility.

National Provider Identifier (NPI)...Reminder to Enumerate; Countdown has Begun!

Countdown has begun; do you have your NPI? Don't risk disruption to your cash flow – Get your NPI now! National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. **Every** healthcare provider needs to get an NPI! Learn more about NPI and how to apply by visiting www.cms.hhs.gov/NationalProvIdentStand/ on the CMS website. This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation. A Countdown Clock is now available on this page to remind health care providers of the number of days left before the compliance date; bookmark this page as new information and resources will continue to be posted.

For more information on private industry NPI outreach, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative website at <http://www.wedi.org/npoi/index.shtml> on the web.

Keeping in Touch with Medicare Fee-for-Service Providers

Let CMS keep you up-to-date!

In the fast-paced, ever-changing world in which we live, it's all too easy to find yourself inundated with information. The Centers for Medicare & Medicaid Services (CMS) offers a way for you to receive consistent and accurate information regarding recent news, policy changes, and updates: **CMS Mailing Lists**. Also referred to as listservs, these electronic mailing lists enable you to receive e-mails about the latest CMS Fee-for-Service (FFS) initiatives. All that is required to subscribe is your name and a valid e-mail address, and you can start receiving electronic updates automatically!

So many choices...

There is a CMS Mailing List for everyone! To subscribe, visit the CMS Mailing Lists web page at www.cms.hhs.gov/apps/maillinglists/ on the CMS website to see all available listservs, specifically the following that are targeted to Medicare FFS providers:

- Medicare Learning Network
- MLN Matters Articles
- Medicare Providers
- Open Door Forums
- Partnerships
- Prescription Drug Benefit (PDB)

Lumbar Artificial Disc Replacement (LADR)

MLN Matters Number: MM5057

Related Change Request (CR) #: 5057

Related CR Release Date: June 23, 2006

Effective Date: May 16, 2006

Related CR Transmittal #: R60NCD and R992CP

Implementation Date: July 17, 2006 (carriers); October 1, 2006 (FIs)

Provider Types Affected

All physicians and providers who bill Medicare carriers and fiscal intermediaries (FIs) for LADR.

Providers Action Needed

This article and Change Request (CR) 5057 provide specific information regarding the new national coverage determination (NCD) for LADR. The message is three pronged: 1) Effective May 16, 2006, the LADR with the Charite lumbar artificial disc is not covered by Medicare for beneficiaries over 60 years of age, i.e., on or after the beneficiary's 61st birthday; 2) Medicare coverage under the investigational device exemption (IDE) and/or clinical trial policy for other lumbar artificial discs is not impacted by this decision and such coverage continues if the billing requirements are met and the appropriate codes are submitted; and 3) For patients 60 years of age and younger, there is no NCD, leaving such determinations to continue to be made by the local contractors.

Background

The Centers for Medicare & Medicaid Services (CMS), upon completion of a national coverage analysis (NCA) for LADR, determined that LADR with the Charite lumbar artificial disc is not reasonable and necessary for Medicare patients over 60 years of age and is, therefore, non-covered for this patient population. For Medicare beneficiaries 60 years of age and younger, there is no NCD, leaving such determinations to be made by the local Medicare carrier or FI.

This NCD focuses on the LADR with the Charite lumbar artificial disc because it is the only United States Food and Drug Administration (FDA) approved lumbar artificial disc at this time. The FDA has approved the use of the Charite artificial disc for spine arthroplasty in skeletally mature patients with degenerative or discogenic disc disease (DDD) at one level for L4 to S1.

The addition of section 150.10 of Pub.100-03 is an NCD. NCDs are binding on all carriers, FIs, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4), effective May 1, 2005). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

Billing Requirements

The following are the billing requirements for LADR according to the revised *Medicare Claims Processing Manual*, Chapter 32, Section 170, which is effective May 16, 2006.

- Assuming the providers bill separately, physicians and hospitals need to **issue the appropriate liability notice**, (Advance Beneficiary Notice (**ABN**) or Hospital Issued Notice of Non-coverage (**HINN**), to beneficiaries over 60 years of age who choose to have this procedure using the Charite lumbar artificial disc.
- The following language should be included in the ABN:
 - Under the "Items or Service" Section: Lumbar Artificial Disc Replacement (LADR) with the Charite Lumbar Artificial Disc.
 - Under the "Because" Section: After a national coverage analysis (NCA), Medicare issued a national coverage determination (NCD) (Section 150.10 of *Medicare NCD Manual*) that stated that LADR with the Charite Lumbar Artificial Disc is not reasonable and necessary for Medicare beneficiaries over 60 years of age. Therefore, LADR with the Charite lumbar artificial disc is non-covered for beneficiaries over 60 years of age. Medicare never pays for this service for this Medicare population.
 - Hospitals need to have a **beneficiary who is over 60 years of age sign a HINN** if he/she wishes to have the procedure done when a Charite lumbar artificial disc is used in the procedure. If the beneficiary is not informed prior to admission that he or she is financially liable for the admission, the provider is liable.

Information for Providers Billing Carriers

- For patients over 60 years of age. claims submitted with Category III Codes 0091T (Single interspace, lumbar) and/or 0092T (Each additional interspace) will be denied unless performed under an approved IDE/clinical trial. (**Note:**

The Charite lumbar artificial disc is the only artificial disc approved by the Food and Drug Administration, therefore the procedure (0091T or 0092T) would be using the Charite unless under an IDE/clinical trial.)

- For patients over 60 years of age for procedures performed under the IDE/clinical trial and approved by the contractor, claims submitted with 0091T or 0092T and the modifier QA will be allowed and normal claims processing criteria for IDEs/clinical trials will be followed.

Information for Providers Billing FIs

For patients over 60 years of age, claims submitted with ICD-9 CM procedure code 84.65 (Insertion of total spinal disc prosthesis, lumbosacral) is never payable and will be denied unless performed under an approved IDE/clinical trial. For patients over 60 years of age for procedures performed under the IDE/clinical trial and approved by the contractor, the FI will pay for LADR only when submitted with ICD-9 procedure code 84.65 with condition code 30 and diagnosis code V70.7 when submitted on type of bill (TOB) 11X.

- For services submitted on TOB 11X in critical access hospitals (CAH), the payment will be 101% of reasonable cost.
- For services submitted on TOB 11X from inpatient hospitals, including Indian Health Services (IHS) inpatient hospitals, will be paid under IPPS based on the DRG.
- For services submitted/performed on TOB 11X, IHS CAHs will be paid under 101% facility specific per diem rate.

Medicare Summary Notice (MSN) and Claim Adjustment Reason Code Messages for Denied Claims

- The following MSN: 21.24 will be issued: "This service is not covered for patients over age 60." along with a Claim Adjustment Reason Code such as: 96 "Non covered charge(s)."

Implementation

The implementation date for this instruction is July 17, 2006, for claims submitted to carriers and October 1, 2006, for claims submitted to Medicare FIs. But, in both instances, the change applies to services provided on or after May 16, 2006.

Additional Information

The official instructions issued to your Medicare carrier and intermediary regarding this change are in two transmittals for CR5057. Transmittal R60NCD contains the NCD instructions and can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R60NCD.pdf> on the CMS web site. The claims processing instructions are in Transmittal R992CP, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R992CP.pdf>.

If you have questions, please contact your Medicare intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/apps/contacts/> on the CMS web site.

Therapy Caps Exception Process

MLN Matters Number: MM4364

Revised Related Change Request (CR) #: 4364

Related CR Release Date: February 15, 2006

Effective Date: January 1, 2006

Related CR Transmittal #: R52BP, R140PI, R855CP

Implementation Date: No later than March 13, 2006

Note: This article was revised on July 3, 2006, to modify the transmittal number and Web address for the change made to the *Medicare Benefit Policy Manual*. All other information remains the same.

Provider Types Affected

Providers, physicians, and non-physician practitioners (NPPs) who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers) under the Part B benefit for therapy services.

Key Points

- Effective January 1, 2006, a financial limitation (therapy cap) was placed on outpatient rehabilitation services received by Medicare beneficiaries. These limits apply to outpatient Part B therapy services from all settings except the outpatient hospital (place of service code 22 on carrier claims) and the hospital emergency room (place of service code 23 on carrier claims). Outpatient rehabilitation services include:
 - **Physical therapy** - including outpatient speech-language pathology: Combined annual limit for 2006 is \$1,740; and
 - **Occupational therapy** - annual limit for 2006 is \$1,740.
- In 2006 Congress passed the Deficit Reduction Act (DRA), which allows the Centers for Medicare & Medicaid Services (CMS) to grant, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, **exceptions to therapy caps for services provided during calendar year 2006**, if these services meet certain qualifications as medically necessary services (Section 1833(g) (5) of the Social Security Act).
- The exception process may be accomplished automatically for certain services, and by request for exception, with the accompanied submission of supporting documentation, for certain other services.
- Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if those beneficiaries:
 - Meet specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR4364) for exception from the therapy cap; or
 - Meet specific criteria for exception, in addition to those listed in the *Medicare Claims Processing Manual*, Pub. 100-4, Chapter 5, where the Medicare contractor has published additional exceptions, when the

contractor believes, based on the strongest evidence available, that the beneficiary will require additional therapy visits beyond those payable under the therapy cap.

- Medicare beneficiaries may be manually excepted from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the above bulleted criteria for automatic exceptions. You may submit a request, with supporting documentation, for a specific number (not to exceed 15 future treatment days for each discipline of occupational therapy, physical therapy, and speech language pathology services) of additional therapy visits.
- Please refer to the *Additional Information* section of this article for more detailed information about the therapy caps exception process.

Background

Financial limitations on Medicare-covered therapy services (therapy caps) were initiated by the Balanced Budget Act of 1997. These caps were implemented in 1999 and for a short time in 2003. Congress placed moratoria on the limits for 2004 and 2005.

The moratoria are no longer in place, and caps were implemented on January 1, 2006. Congress has provided that exceptions to these dollar limitations of \$1,740 for each cap in 2006 may be made when provision of additional therapy services is determined to be medically necessary.

Additional Information

Billing Guidelines

- **KX Modifier:** You must include a KX modifier on the claim identified as a therapy service with a GN, GO, GP modifier when a therapy cap exception has been approved, or it meets all the guidelines for an automatic exception. This allows the approved therapy services to be paid, even though they are above the therapy cap financial limits.
- **Separate requests:** You must submit separate requests for exception from the combined physical therapy and speech language pathology cap and from the occupational therapy cap. In general, requests for exception from the therapy cap should be received **before** the cap is exceeded because the patient is liable for denied services based on caps.
- **Subsequent requests during the same episode of care:** To request therapy services in addition to those previously approved, you must submit a request for approval along with supporting documentation for a specific number of additional therapy treatment days, not to exceed 15, **each time** the beneficiary is expected to require more therapy days than previously approved. It is appropriate to send documentation for the entire planned episode of care if the episode exceeds the 15 treatment days allowed.
- When those additional visits are approved as reasonable and necessary based on the documentation you submit, an exception to the therapy cap will be approved and bills may be submitted using the KX modifier. If the contractors have reason to believe that fraud, misrepresentation, or abusive billing has occurred, they have the authority to review claims and may deny claims even though prior approval was granted.

ICD-9 Codes That Qualify for the Automatic Therapy Cap Exception Process Based Upon Clinical Condition or Complexity

The CR4364 transmittal that contains these codes is the one that revises the *Medicare Claims Processing Manual*, available at <http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf> on the CMS web site. You may wish to bookmark that link so you may easily reference these codes.

Documentation

Providers who believe that it is medically necessary for their patient to receive therapy services in excess of the therapy cap limitations (and the patient does not fall into the automatically excepted categories mentioned above) must submit documentation, sufficient to support medical necessity, in accordance with the revised *Medicare Benefit Policy Manual*, Pub.100-02, Chapter 15, Section 220.3; and the revised *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, Sections 10.2 and 20, with the request for treatment days in excess of those payable under the therapy cap. These manual sections contain important definitions, as well as examples of acceptable documentation, and are attached to CR4364. CR4364 is in three parts, one each for the revised manuals, i.e.:

- The *Medicare Benefit Policy Manual*, located at <http://www.cms.hhs.gov/Transmittals/downloads/R52BP.pdf> on the CMS web site;
- The *Medicare Claims Processing Manual*, located at <http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf>; and
- The *Medicare Program Integrity Manual*, located at <http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf> on the CMS web site.

The following types of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise:

1. **Evaluation and Certified Plan of Care** - 1-2 documents.
2. **Certification** - Physician/NPP approval of the plan required 30 days after initial treatment-or delayed certification.
3. **Clinician-signed Interval Progress Reports** (when treatment exceeds 10 treatment days or 30 days) – These must be sufficient to explain the beneficiary’s current functional status and need for continued therapy with the request for therapy visits in excess of those payable under the therapy cap. This is not required to be provided daily in treatment encounter notes or for an incomplete interval when unexpected discontinuation of treatment occurs.
4. **Treatment Encounter Notes** – The Treatment Encounter Note is acceptable if it records the name of the treatment; intervention, or activity provided; the time spent in services represented by timed codes; the total treatment time; and the identity of the individual providing the intervention. These may substitute for Progress Reports if they contain the requirements of interval progress reports at least once every 10 treatment days or once in the interval.
5. For therapy caps exceptions purposes, **records justifying services over the cap**, either included in the above or as a separate document. Please see the revised Section 220.3 of the

Medicare Claims Processing Manual located at <http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf> for more details about the types of documentation required and explanations of what that documentation should contain.

When reviewing documentation, Medicare contractors will:

- Consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary;
- Consider a dictated document to be completed on the day it is dictated if the identity of the qualified professional is included in the dictation;
- Consider a document an evaluation or re-evaluation (for documentation purposes, but not necessarily for billing purposes) if it includes a diagnosis, subjective and/or objective condition, and prognosis. This information may be included in or attached to a plan. The inclusion of this information in the documentation does not necessarily constitute a billable evaluation or reevaluation unless it represents a service; and
- Accept a referral/order and evaluation as complete documentation (certification and plan of care) when an evaluation is the only service provided by a provider/supplier in an episode of treatment.

Medicare Contractor Decisions

If determined to be medically necessary, your Medicare contractor will grant additional treatment days for occupational therapy, physical therapy, and speech language pathology.

It is preferable that the request for exception be received before the therapy cap is actually exceeded. However, your Medicare contractor will approve additional therapy treatment days retroactively if they are deemed medically necessary, in the exceptional circumstance where a timely request for exception from the therapy cap is not received before the therapy cap is surpassed. Your Medicare contractor may also approve additional therapy visits already provided when the request is accompanied by documentation supporting medical necessity of the services.

Please note that outpatient therapy services appropriately provided by assistants or qualified personnel will be considered covered services only when the supervising clinician personally performs or participates actively in at least one treatment session during an interval of treatment. Claims for services above the cap that are not deemed medically necessary will be denied as a benefit category denial.

If your Medicare contractor does **not** make a decision within 10 business days of receipt of the request and documentation, then the decision for therapy cap exception is considered to be deemed **approved** as medically necessary for the number of future visits requested (not to exceed 15).

Notification

You will be notified as to whether or not an exception to the cap has been made (and if so, for how many additional future visits) as soon as practicable once the contractor has made its decision.

This notification is not an initial determination and, therefore, does not carry with it administrative appeal rights. For examples of the standard letters from the *Medicare Program Integrity Manual*, 100-8, Section 3.3.1.2, please refer to the Attachments to CR4364. The examples include:

- Letter #1 - Approved
- Letter #2 - Negative Decision-Medical Necessity
- Letter #3 - Denied-Insufficient Documentation

Revised Medicare Summary Notice (MSN) Messages

The MSN messages (17.13; 38.18) are revised to inform beneficiaries about the therapy caps and approved medically necessary exceptions. These notices are also part of CR4364.

Once again, there are three transmittals that comprise CR4364. They are:

- The *Medicare Benefit Policy Manual* revision at <http://www.cms.hhs.gov/Transmittals/downloads/R52BP.pdf> on the CMS web site;
- The *Medicare Claims Processing Manual* revision, located at <http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf> on the CMS web site;
- The *Medicare Program Integrity Manual* revision, located at <http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf> on the CMS web site.

If you have any questions, contact your Medicare contractor at their toll free number, which is available at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf> on the CMS web site.

Non-Autologous Blood Derived Products for Chronic Non-Healing Wounds

MLN Matters Number: MM5123

Related Change Request (CR) #: 5123

Related CR Release Date: June 9, 2006

Related CR Transmittal #: R977CP and R59NCD

Effective Date: April 27, 2006

Implementation Date: July 10, 2006

Provider Types Affected

Physicians, providers and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs) and/or regional home health intermediaries (RHHIs) for chronic non-healing wound related services furnished to Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 5123 which instructs Medicare contractors (carriers, FIs, and RHHIs) that claims submitted for **becaplermin**, a self-administered, non-autologous growth factor for chronic, non-healing, subcutaneous wounds **will remain non-covered**.

Becaplermin, Healthcare Common Procedure Coding System (HCPCS) **S0157**, is nationally non-covered because it is usually self-administered by the patient.

Background

After releasing a national non-coverage determination (NCD) on Autologous Blood-Derived Products for Chronic Non-Healing Wounds in December of 2003, an error was printed in the NCD Manual.

To correct that error, the Centers for Medicare & Medicaid Services (CMS) is revising section 270.3 of the *National Coverage Determinations (NCD) Manual* (Publication 100-03, Chapter 1, Part 3, "Blood-Derived Products for Chronic Non-Healing Wounds") to accurately reflect the payment policy for non-autologous blood derived products for chronic non-healing wounds, effective April 27, 2006.

In this revision, the following sentence is being deleted:

"Coverage for treatments utilizing becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous non-healing wounds, will remain at local carrier discretion. Becaplermin is approved by the Food and Drug Administration." The correct statement should read:

"Coverage for treatments utilizing becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous wounds, **will remain nationally non-covered** under Part B based on §1861(s)(2)(A) and §1861(s)(2)(B) because this product is usually self-administered by the patient."

While CMS makes every effort to provide accurate and complete information, the erroneous coverage statement printed in the NCD Manual regarding nonautologous blood-derived products was not intended, and is not part of the Decision Memorandum (DM) posted on December 15, 2003. Non-autologous blood-derived products are not in the same class as the products referred to in the December 15, 2003, DM.

NCDs are binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR 405.1060)(a)(4), effective May 1, 2005). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD (see section 1869(f)(1)(A)(i) of the Social Security Act).

Additional Information

CR5123 is the official instruction issued to your Medicare carrier or FI/RHHI regarding changes mentioned in this article. There are two transmittals for CR5123. Transmittal 59, containing the NCD revision, is available at <http://www.cms.hhs.gov/Transmittals/downloads/R59NCD.pdf> on the CMS web site. Transmittal 977, containing the Medicare claims processing instructions, is at <http://www.cms.hhs.gov/Transmittals/downloads/R977CP.pdf> on the CMS web site.

If you have questions please contact your Medicare FI at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf> on the CMS web site.

Modification to Online Medicare Secondary Payer Questionnaire

CMS has issued CR 5087. This CR rescinds and replaces CR 4098 effective September 11, 2006. Providers are to replace any previous versions of the model questionnaire with this new version. The model version can be found in the Medicare Secondary Payer (MSP) Manual, Chapter 3 – MSP Provider, Physician, and Other Supplier Billing Requirements, Section 20.2.1 – Admission Questions to Ask Medicare Beneficiaries. CMS has also issued a Medlearn Matters article number MM5087 - Modifications to Online Medicare Secondary Payer Questionnaire. The link to this article is provided below. The new version of the model questionnaire with instructions is provided below. This version is currently available on Mutual's Medicare web site www.mutualmedicare.com in the MSP section. If you have any questions regarding the usage of the questionnaire please contact the MSP Department at 1-866-734-1521.

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5087.pdf>

The following *questionnaire contains questions that can be used to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers may use this as a guide to help identify other payers that may be primary to Medicare. This questionnaire is a model of the type of questions that may be asked to help identify Medicare Secondary Payer (MSP) situations. If you choose to use this questionnaire, please note that it was developed to be used in sequence. Instructions are listed after the questions to facilitate transition between questions. The instructions will direct the patient to the next appropriate question to determine MSP situations.*

PART I

1. Are you receiving Black Lung (BL) Benefits?

___ Yes; Date benefits began: *MM/DD/CCYY*

BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL.

___ No.

2. Are the services to be paid by a government *research* program?

___ Yes.

GOVERNMENT RESEARCH PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.

___ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for *your* care at this facility?

___ Yes.

DVA IS PRIMARY FOR THESE SERVICES.

___ No.

4. Was the illness/injury due to a work-related accident/condition?

___ Yes; Date of injury/illness: *MM/DD/CCYY*

Name and address of workers' compensation plan (WC) plan:

Policy or identification number: _____

Name and address of your employer:

WC IS PRIMARY PAYER ONLY FOR CLAIMS FOR WORK-RELATED INJURIES OR ILLNESS, GO TO PART III.

No. **GO TO PART II.**

PART II

1. Was illness/injury due to a non-work-related accident?

Yes; Date of accident: *MM/DD/CCYY*

No. **GO TO PART III**

2. *Is no-fault insurance available? (No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.)*

Yes.

Name and address of no-fault insurer(s) and no-fault insurance policy owner:

Insurance claim number(s): _____

No.

3. *Is liability insurance available? (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.)*

Yes.

Name and address of liability insurer(s) and responsible party:

Insurance claim number(s): _____

___ No.

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE ACCIDENT. LIABILITY INSURANCE IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE LIABILITY SETTLEMENT, JUDGMENT, OR AWARD. GO TO PART III.

PART III

1. Are you entitled to Medicare based on:

___ Age. **Go to PART IV.**

___ Disability. **Go to PART V.**

___ End-Stage Renal Disease (ESRD). **Go to PART VI.**

Please note that both “Age” and “ESRD” OR “Disability” and “ESRD” may be selected simultaneously. An individual cannot be entitled to Medicare based on “Age” and “Disability” simultaneously. Please complete ALL “PARTS” associated with the patient’s selections.

PART IV – AGE

1. Are you currently employed?

___ Yes.

Name and address of your employer:

___ No. *If applicable, date of retirement: MM/DD/CCYY*

___ *No. Never Employed.*

2. *Do you have a spouse who is currently employed?*

___ Yes.

Name and address of your *spouse's* employer:

___ No. *If applicable, date of retirement: MM/DD/CCYY*

___ *No. Never Employed.*

IF THE PATIENT ANSWERED “NO” TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED “YES” TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. *Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?*

___ Yes, *both.*

___ Yes, *self.*

___ Yes, *spouse.*

___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**

4. *If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees?*

___ Yes. **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number (*this number is sometimes referred to as the health insurance benefit package number*): _____

Group identification number: _____

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

___ No.

5. *If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 20 or more employees?*

___ **Yes. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number (*this number is sometimes referred to as the health insurance benefit package number*): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

___ No.

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 4 AND 5, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

PART V – DISABILITY

1. Are you currently employed?

___ Yes.

Name and address of your employer:

___ No. *If applicable, date of retirement: MM/DD/CCYY*

___ *No. Never Employed.*

2. Do you have a spouse who is currently employed?

___ Yes.

Name and address of your *spouse's* employer:

___ *No. If applicable, date of retirement: MM/DD/CCYY*

___ *No. Never Employed.*

3. Do you have group health plan (GHP) coverage based on your own or a *spouse's* current employment?

___ Yes, *both.*

___ Yes, *self.*

___ Yes, *spouse.*

___ No.

4. Are you covered under the GHP of a family member other than your spouse?

___ Yes.

Name and address of your family member's employer:

___ No.

IF THE PATIENT ANSWERED "NO" TO QUESTIONS 1, 2, 3, AND 4, STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

5. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 100 or more employees?

___ Yes. ***GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.***

Name and address of GHP:

Policy identification number (*this number is sometimes referred to as the health insurance benefit package number*): _____

Group identification number: _____

Membership number (*prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient*): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

___ No.

6. *If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 100 or more employees?*

___ **Yes. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number (*this number is sometimes referred to as the health insurance benefit package number*): _____

Group identification number: _____

Membership number (*prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient*): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

___ No.

7. *If you have GHP coverage based on a family member's current employment, does your family member's employer, that sponsors or contributes to the GHP, employ 100 or more employees?*

___ **Yes. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

___ No.

IF THE PATIENT ANSWERED "NO" TO QUESTIONS 5, 6, and 7, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

PART VI – ESRD

1. Do you have group health plan (GHP) coverage?

___ Yes.

IF APPLICABLE, YOUR GHP INFORMATION:

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder /named insured: _____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

IF APPLICABLE, YOUR SPOUSE'S GHP INFORMATION:

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder /named insured: _____

Relationship to patient: _____

Name and address of employer, if any, from which your spouse receives GHP coverage:

IF APPLICABLE, YOUR FAMILY MEMBER'S GHP INFORMATION:

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder /named insured: _____

Relationship to patient: _____

Name and address of employer, if any, from which your family member receives GHP coverage:

No. **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

Yes. Date of transplant: *MM/DD/CCYY*

No.

3. Have you received maintenance dialysis treatments?

Yes. Date dialysis began: *MM/DD/CCYY*

If you participated in a self-dialysis training program, provide date training started:
MM/DD/CCYY

No.

4. Are you within the 30-month coordination period *that starts MM/DD/CCYY?* (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis). If the individual is participating in a self-dialysis training program or has a kidney transplant

during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)

Yes.

No. **STOP. MEDICARE IS PRIMARY.**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

Yes.

No.

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP *already primary* based on age or disability entitlement)?

Yes. ***GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.***

No. **MEDICARE CONTINUES TO PAY PRIMARY.**

If no MSP data are found in *the Common Working File (CWF)* for the beneficiary, the provider still asks the *types of questions above* and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process.

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 Systems Department.

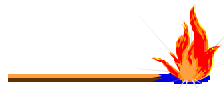
Receive your Remittance Advice Electronically

The Centers for Medicare & Medicaid Services (CMS) is encouraging providers to change from the hardcopy Remittance Advice (RA) to the Electronic Remittance Advice (ERA). The ERA enables you to view claims information the day it is available rather than waiting for your RA to be delivered via paper. The ERA also allows you to download and store it in an electronic format for future use. No more requests for duplicate RAs need to be submitted as you can print a copy yourself and will not have to wait for the RA to be mailed.

Along with faster receipt, storage, and download capability, many software vendors have developed the technology to post the ERA notices automatically. The automatic posting process is reliable and efficient. Check with your software vendor to see if you have this capability.

To obtain the ERA authorization form, visit our Web site at: www.mutualmedicare.com/edi/era, and select the link titled Authorization for Electronic Remittance Advice (ERA). Fax the completed form to us at 402-351-6188, to begin this process.

If you have any questions regarding the receipt of the ERA, please do not hesitate to contact us at 866-734-6656.



Please stay tuned for more hot tips!