



September 15, 2006 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

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Uniform Billing (UB-04) Implementation – UB-92 Replacement



Attention Physicians, Providers, and Suppliers!

Sign up now to the listserv appropriate for you at <http://www.cms.hhs.gov/apps/maillinglists/>.

Get your Medicare news as it happens!

Related Change Request (CR) #: 5072
Related CR Release Date: July 28, 2006
Related CR Transmittal #: R1018CP
Effective Date: March 1, 2007
Implementation Date: March 1, 2007

MLN Matters Number: MM5072

Provider Types Affected

All providers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), using the UB-92

Provider Action Needed

Impact to You

The UB-04 is replacing the UB-92. You may begin using it on March 1, 2007, during an initial transitional period. Starting May 23, 2007, all of your paper claims must use the UB-04 since the UB-92 will no longer be acceptable.

What You Need to Know

CR5072 announces the replacement of the UB-92 by the UB-04, effective March 1, 2007. The UB-04, which is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements, incorporates the National Provider Identifier (NPI), taxonomy, and additional codes.

What You Need to Do

Make sure that your billing staffs are aware of this new uniform institutional provider bill form for paper claims.

Background

At its February 2005 meeting, the National Uniform Billing Committee (NUBC) approved the UB-04 (CMS-1450) as the replacement for the UB-92. Effective March 1, 2007, institutional claim filers such as hospitals, skilled nursing facilities, hospices, and others can begin using the UB-04, with a transitional period between March 1, 2007, and May 22, 2007, during which time either the UB-92 or the UB-04 may be used.

Starting May 23, 2007, all institutional paper claims must be submitted on the UB-04. The UB-92 will no longer be acceptable, even as an adjustment claim, after May 22, 2007.

UB-04

The UB-04 is the basic form that CMS prescribes for the Medicare program. It is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32.

It incorporates the National Provider Identifier (NPI), taxonomy, and additional codes. (Please refer to the crosswalk file attached to CR5072 to show how data elements crosswalk from the UB-92 to the UB-04.) Note that while most of the data usage descriptions and allowable data values have not changed on the UB-04, many UB-92 data locations have changed and, in addition, bill type processing will change.

There are a few details that you should be aware of:

- The UB-04 (Form CMS-1450) is a uniform institutional provider bill suitable for billing multiple third party payers. A particular payer, therefore, may not need some of the data elements.
- When filing, you should retain the copy designated “Institution Copy” and submit the remaining copies to your FI, managed care plan, or other insurer.
- Instructions for completing inpatient and outpatient claims are the same unless otherwise noted.
- If you omit any required data, your FI will either ask you for them or obtain them from other sources and will maintain them on its history record. It will not obtain data that are not needed to process the claim.
- Data elements in the CMS uniform electronic billing specifications are consistent with the Form CMS-1450 (another name for the UB-04) data set to the extent that one processing system can handle both. The definitions are identical, although in some situations, the electronic record contains more characters than the corresponding item on the form because of constraints on the form size not applicable to the electronic record. Further, the revenue coding system is the same for both the Form CMS-1450 and the electronic specifications.
- Also note that CMS is accepting valid NPIs on the UB-04 between March 1, 2007, and May 22, 2007, and the NPI is required as of May 23, 2007.

Additional Information

You can find more information about the UB-04 (Form CMS-1450) by going to CR5072, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1018CP.pdf> on the CMS web site.

Included with CR 5072 are the following:

- A copy of the UB-04 form (front and back) in PDF format (Attachment E)
- The UB-92-to-UB-04 crosswalk (Attachment B)
- UB-04 mapping to the HIPAA institutional 837 (Attachment C)
- The revised portion of the *Medicare Claims Processing Manual*, Chapter 25 (Completing and Processing the CMS 1450 Data Set), Sections 70 (Uniform Bill - Form CMS-1450 (UB-04)) and 71 (General Instructions for Completion of Form

CMS-1450 (UB-04)) (Attachment A). These sections contain very detailed instructions for completing the form.

If you have any questions, please contact your FI/RHHI at their toll-free number, which may be found at

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

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update



Attention Physicians and Providers!

Effective October 1, 2006, Medicare will only generate Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice—transaction 835 version 004010A1—to all electronic remittance advice receivers. For more details, see MLN Matters article SE0656 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0656>.

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Related Change Request (CR) #: 5212

MLN Matters Number: MM5212

Related CR Release Date: August 18, 2006

Related CR Transmittal #: R1031CP

Effective Date: October 1, 2006

Implementation Date: October 2, 2006

Provider Types Affected

Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), Medicare carriers, including durable medical equipment regional carriers (DMERCs) and Durable Medical Equipment Medicare Administrative Contracts (DME MACs).

Provider Action Needed

Impact to You

The November 2005 through February 2006 updates have been posted for the X12N 835 Health Care Remittance Advice Remark Codes (RARCs) and the X12N 835 Health Care Claim Adjustment Reason codes (CARCs).

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has developed a new web site located at <http://www.cmsremarkcodes.info/> on the CMS website, to provide information and help navigate the RARC database more easily. A helpful search tool is provided at this site if you need to find a specific category of code. This new website does not replace the Washington Publishing Company (WPC) web site, <http://www.wpc-edi.com/codes>, as the official site where the most current RARC list resides. Use the list posted at the **WPC web site** if there are any discrepancies between code text listed either on the new web site or in this article, and the code text provided on the WPC web site.

What You Need to Do

Please refer to the *Background* section of this article for a summary of the RARC and CARC code text changes.

Background

Among the codes sets mentioned in the Implementation Guide for transaction 835 (Health Care Claim Payment/Advice), the following two code sets must be used to report payment adjustments and related information for transaction 835 and the standard paper remittance advice for Medicare:

- Claim Adjustment Reason Code (CARC); and
- Remittance Advice Remark Code (RARC).

Additionally, for the coordination of benefits (COB) transaction (837), the CARC must be used.

Both of these code sets are updated three times a year, and Medicare issues recurring Change Requests (CRs) that capture the changes in these code sets that have been approved in the previous four months.

Summary of Current Updates (November 1, 2005 – February 28, 2006 Changes)

Remark Code (RARC) Changes

New: The following code table reflects new remark codes:

New Code	Current Narrative
N365	This procedure code is not payable. It is for reporting/information purposes only.
N366	Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.
N367	The claim information has been forwarded to a Health Savings Account processor for review.
N368	You must appeal the determination of the previously adjudicated claim.
N369	Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

Modified: Remark Code **MA02** was modified effective December 29, 2005. Its modified narrative is:

“If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive

this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days.”

This modification is effective January 1, 2006, and was implemented on or before May 17, 2006.

Deactivated: Code **MA03** was deactivated effective October 1, 2006. Remark code MA02 may be used instead.

Reason Code (CARC) Changes

New: The following table reflects new reason codes:

New Code	Current Narrative	New as of:
193	Original payment decision is being maintained. This claim was processed properly the first time.	February 2006
194	Payment adjusted when anesthesia is performed by the operating physician, the assistant surgeon or the attending physician.	February 2006
195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/service	February 2006

Implementation Date

These code changes will be applied by your Medicare carrier/DMERC/FI/RHHI by October 2, 2006.

Additional Information

CR5212 is the official instruction issued to your Medicare carrier/DMERC/FI/RHHI regarding changes mentioned in this article. CR5212 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1031CP.pdf> on the CMS web site.

For more information on the process used to update these two codes sets, see the *MLN Matters* article, MM44314, available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4314.pdf> on the CMS web site.

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

Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims

Attention Physicians and Providers!



Medicare will delay claims payments during the last 9 days of fiscal year 2006 (September 22 through September 30).

For complete details, see MLN Matters article MM4349 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4349.pdf>

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Related Change Request (CR) #: 5243

MLN Matters Number: MM5243

Related CR Release Date: August 4, 2006

Related CR Transmittal #: R1024CP

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Provider Types Affected

Institutional providers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) for their services

Provider Action Needed

Impact to You

Effective January 1, 2007, institutional Medicare providers who submit claims for their primary facility and its subparts (such as psychiatric unit, rehabilitation unit, etc.) must report a **taxonomy code** on all claims submitted to their FI or RHHI.

What You Need to Know

Please use the attachment to CR5243 (supplied in the **Background** section of this article) to crosswalk the OSCAR (Online Survey Certification and Reporting System) number to the appropriate taxonomy code for your type of facility. The taxonomy code will assist Medicare in crosswalking from the national provider identifier (NPI) of the provider to each of its subparts in the event that the provider chooses not to apply for a unique NPI for each of its subparts individually.

What You Need to Do

Refer to the **Background** section of this article for additional crosswalk information.

Background

Regulations implementing the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 require the use of National Provider Identifiers (NPIs) by covered health care providers and health plans (other than small plans) effective May 23, 2007. (45 CFR Part 162, Subpart D (162.402-162.414))

The Centers for Medicare & Medicaid Services (CMS) will utilize a Medicare Provider Identifier Crosswalk between NPIs and legacy identifiers (such as OSCAR numbers) to validate NPIs received in transactions, assist with the population of NPIs in Medicare data center provider files, and to report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions. (See MM4023 at the link provided below for more information on CMS' implementation of the NPI.) The crosswalk detailed in CR5243

between the provider's OSCAR number and the appropriate taxonomy code will assist in this process.

Attachment to CR5243: Reporting of Taxonomy Codes (Institutional Providers)

The following chart supplies the crosswalk from the OSCAR number to the appropriate taxonomy code based on the provider's facility type.

OSCAR Provider Type	OSCAR Coding	Taxonomy Code
Short-term (General and Specialty) Hospitals	0001-0879 *Positions 3-6 of the OSCAR number	282N00000X
Critical Access Hospitals	1300-1399 *	282NC0060X
Long-Term Care Hospitals (LTCH Swing Beds submitting with type of bill 18X must use the LTCH taxonomy code)	2000-2299 *	282E00000X
Hospital Based Renal Dialysis	2300-2499*	261QE0700X

OSCAR Provider Type	OSCAR Coding	Taxonomy Code
Facilities		
Independent Renal Dialysis Facilities	2500-2899*	261QE0700X
Rehabilitation Hospitals	3025-3099 *	283X00000X
Children's Hospitals	3300-3399 *	282NC2000X
Hospital Based Satellite Renal Dialysis Facilities	3500-3699	Type of Bill 72X and taxonomy code of 261QE0700X and a zip code different than any renal dialysis facility issued an OSCAR number that is located on that hospital's campus
Psychiatric Hospitals	4000-4499 *	283Q00000X
Organ Procurement Organization (OPO)	P in third Position of the OSCAR number	335U00000X
Psychiatric Unit	M or S in third Position	273R00000X
Rehabilitation Unit	R or T in third Position	273Y00000X
Swing-Bed	U, W, Y, or Z in third Position	Type of bill X8X with one of the following to show type of facility in which the swing bed is located: 275N00000X-short term hospital (U); 282E00000X-long term care hospital (W); 283X00000X-rehabilitation facility (Y); or 282NC0060X-critical access hospital (Z)

Be sure to follow the following billing instructions contained in CR5243:

- Report the service facility locator loop (2310E) in an 837-I claim whenever the service was furnished at an address other than the address reported on the claim for the billing or pay-to provider.
- Input the taxonomy code in the 837-I provider loop 2000A, but do not report taxonomy in this loop if there is data reported in the service facility locator loop of the claim.
- Submit separate batches of claims for each subpart identified by a different taxonomy code.
- Providers submitting claims for their primary facility and its subparts must submit a 9-digit zip code on their claims.
- CMS recommends submitting both the OSCAR number and the NPI on claims submitted through May 22, 2007. (Note that failure to report an OSCAR number that corresponds to your NPI could result in a payment delay.)

Implementation Date

The implementation date for this instruction is January 2, 2007.

Additional Information

MM4023 “Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms” is located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf> on the CMS web site.

CR5243 is the official instruction issued to your Medicare FI/RHHI regarding changes mentioned in this article. CR5243 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1024CP.pdf> on the CMS web site.

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

Direct Data Entry (DDE) Screen Changes

Effective September 5, 2006, current users of the FISS DDE system will see changes on the HCPC Inquiry screen (menu 01, submenu 14). New PF keys have been set to maneuver around the redesigned screens. MAP1771 shows the rate effective lines, allowable revenue codes (if applicable) etc. MAP1772 shows the rate information for each effective line. Providers will now be able to access Health Care Procedure Coding (HCPC) pricing information for multiple carriers if they currently are set up with access to multiple provider numbers under their DDE logon id. The provider number field is now located at the top of the screen on the second line. Enter a HCPC code and provider number to pull up the pricing information for that specific provider.

PF Keys
PF6 to scroll down (to see older effective lines)
PF5 to scroll up (for more current effective lines)
PF11 to scroll to right (for the rate screen - MAP1772)
PF10 to scroll to left (to go back to previous screen - MAP1771)

Mass Adjustment of 22x & 23x Bill Types Containing Healthcare Common Procedure Coding System (HCPCS) G0008, G0009 & G0010 with Dates of Service July 1, 2006, and Greater

Attention Skilled Nursing Facilities!

Sign up now for the listserv(s) appropriate for you at <http://www.cms.hhs.gov/apps/maillinglists/>.
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MLN Matters Number: SE0661
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: 4240
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

Skilled nursing facilities (SNFs) that bill Medicare fiscal intermediaries (FIs) for influenza and Pneumococcal Pneumonia Virus (PPV) vaccines

What you need to know

CR4240, (implemented on July 3, 2006) entitled Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus (PPV), Influenza Virus, and Hepatitis B Virus), provided guidelines for Medicare fiscal intermediary (FI) payment for these vaccines and for their administration.

In making this change in Medicare's Fiscal Intermediary Standard System (FISS), the appropriate pricing change needed for HCPCS G0008, G0009 & G0010 (when submitted on 22x & 23x bill types) was omitted.

Therefore, your FIs will be performing a mass adjustment to correct the payment of your claims for these vaccines once the FISS correction is implemented on October 2, 2006. Please note again that the mass adjustment will pertain to 22x & 23x bill types that

contain HCPCS G0008, G0009 & G0010 with dates of service between July 1, 2006, and September 30, 2006. You need not take any action to adjust these claims.

Additional Information

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

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

Deficit Reduction Act of 2005 – Nine Day Payment Hold

This message is a reminder for all providers and physicians who bill Medicare contractors for their services.

A brief hold will be placed on Medicare payments for all claims during the last 9 days of the Federal fiscal year (September 22 through September 30, 2006). These payment delays are mandated by section 5203 of the Deficit Reduction Act of 2005. No interest will be accrued and no late penalties will be paid to an entity or individual by reason of this one-time hold on payments. All claims held during this time will be paid on October 2, 2006.

This policy only applies to claims subject to payment. It does not apply to full denials, no-pay claims, and other non-claim payments such as periodic interim payments, home health requests for anticipated payments, and cost report settlements.

Please note that payments will not be staggered and no advance payments will be allowed during this 9-day hold.

For more information, please view the MLN Matters Article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5047.pdf>.

CMS Announces Outreach Conferences for Section 1011 (of the Medicare Modernization Act of 2003): Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens

Attention Physicians and Providers!

Effective October 1, 2006, Medicare will only generate the Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice – transaction 835 version 004010A1 – to all electronic remittance advice receivers. For more details, see MLN Matters article SE0656 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0656.pdf>.

MLN Matters Number: SE0662
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

Physicians, hospitals, including Medicare critical access hospitals, Indian Health Service facilities, and ambulance service providers treating patients eligible for payment of Section 1011 of the Medicare Modernization Act of 2003 (MMA).

Provider Action Needed

Impact to You

You may be eligible for reimbursement for treating certain individuals under Section 1011 of the MMA. This article announces outreach sessions that will help you learn more about this program.

What You Need to Know

As of August 2006, over 15,500 physician and provider enrollment applications have been approved nationwide to participate in the Section 1011 reimbursement process. But, the Centers for Medicare & Medicaid Services (CMS) advises that funds remain available and you may be eligible.

What You Need to Do

CMS has scheduled two national outreach conferences to inform providers of their potential eligibility to participate and to provide more details. See the remainder of this article for details of these sessions and how this program may help you.

Background

Section 1011 of the MMA provides up to \$250 million per year for federal fiscal years 2005-2008 for payments to eligible providers for emergency services furnished to:

- Undocumented aliens;
- Aliens who have been paroled into a United States port of entry for the purpose of receiving eligible services; and
- Mexican citizens permitted to enter the United States on a laser visa, issued in accordance with the requirements of regulations prescribed under the Immigration and Nationality Act.

The covered services are the same as those required by the Emergency Medical Treatment and Labor Act (EMTALA), as well as related hospital inpatient and outpatient services. Providers do not have to be enrolled in the Medicare program to receive Section 1011 eligibility and payments. However, you do have to enroll in the Section 1011 Program by submitting an application to TrailBlazer Health Enterprises, LLC, the national contractor for the Section 1011 Program.

To provide you with more details about this program, Medicare, through TrailBlazer Health Enterprises, is offering two national outreach sessions for the medical community and the general public. Sessions are open to interested registrants in all states. The two sessions scheduled are as follows:

- **September 26, 2006, from 8:30 a.m. - 12:30 p.m.**
Camino Real Hotel El Paso
101 S. El Paso Street
El Paso, Texas 79901
- **September 28, 2006, from 8:30 – 12:30 p.m.**
Sheraton Newark Airport Hotel
128 Frontage Road
Newark, NJ 07114

These sessions will include an overview of Section 1011, as well as updates regarding Provider Enrollment, Medical Review, Payment Request Processing and Provider Education and Customer Service related to Section 1011. You may register for either session by going to <https://www.TrailBlazerhealth.com/Section1011/CalendarOfEvents/> on the TrailBlazer site.

Note: The September 28, 2006, session in Newark, NJ, will also be available via teleconference. In addition, at the above web site, you will find information on a web-based training event scheduled for September 13.

Additional Information

Additional Information regarding the Section 1011 Program may be found at <http://www.cms.hhs.gov/UndocAliens> on the CMS web site.

To learn more details, or to enroll as a provider, visit the TrailBlazer site at <http://www.TrailBlazerhealth.com/Section1011> on the web. You may also reach TrailBlazer by telephone at 1-866-860-1011.

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.

Clarification: Payment for Blood Clotting Factors Administered to Hemophilia Inpatients

Some Medicare providers have been billing units of drugs and biologicals incorrectly for hemophilia blood clotting factors. The erroneous reporting of units of service has resulted in Medicare overpayments. This instruction is being provided to clarify the billing practices for the providers to ensure that the units of service for blood clotting factor are reported accurately.

The provider must determine the actual dosage furnished to the patient and using the long version of the description of the HCPCs code, translate the dosage into units of service.

For discharges prior to July 14, 2006, you are to divide your units by 100 for billing purposes. For discharges on or after July 14, 2006 providers should no longer divide the number of units by 100 when billing for clotting factors.



Please stay tuned for more hot tips!