



November 15, 2006

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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

Pancreas Transplants Alone (PA)



Attention Physicians, Hospitals, ESRD Facilities!

Sign up now for the Physicians-L, Hospitals-Acute-L, or ESRD-L listservs at <http://www.cms.hhs.gov/apps/maillinglists/>.

Get your Medicare news as it happens!

Related Change Request (CR) #: 5093

MLN Matters Number: MM5093

Related CR Release Date: May 19, 2006

Revised

Related CR Transmittal #: R56NCD and R957CP

Effective Date: April 26, 2006

Implementation Date: July 3, 2006 for carriers; October 2, 2006 for FIs

Note: This article was revised on October 5, 2006, to include this statement alerting affected providers to review *MLN Matters* article SE0674 for important information regarding the continued hold of affected claims. This article is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0674.pdf> on the CMS site.

Provider Types Affected

Physicians and providers billing Medicare fiscal intermediaries (FIs) and carriers for PA

Background

Medicare covers whole organ pancreas transplantation when it is performed in conjunction with or after kidney transplantation (*National Coverage Determination (NCD) Manual*, Section 260.3). However, Medicare does not cover PA in diabetes patients without end-stage renal failure because of a lack of sufficient evidence, based in large part on a 1994 Office of Health Technology Assessment report.

Key Points

This article is based on information contained in Change Request (CR) 5093, which informs physicians and providers that, effective for services performed on or after April 26, 2006, Medicare will cover PA for beneficiaries in the following limited circumstances:

- Facilities must be Medicare-approved for kidney transplantation (Approved centers are found at http://www.cms.hhs.gov/ESRDGeneralInformation/02_Data.asp#TopOfPage on the CMS web site).
- Patients must have a diagnosis of Type I diabetes:
 - The patient with diabetes must be beta cell autoantibody positive; or
 - The patient must demonstrate insulinopenia, defined as a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method. Fasting C-peptide levels will be considered valid only with a concurrently obtained fasting glucose ≤ 225 mg/dL.

- Patients must have a history of medically-uncontrollable labile (brittle) insulin-dependent diabetes mellitus with documented recurrent, severe, acutely life-threatening metabolic complications that require hospitalization.
- These complications include frequent hypoglycemia unawareness or recurring severe ketoacidosis, or recurring severe hypoglycemic attacks.
- Patients must have been optimally and intensively managed by an endocrinologist for at least 12 months with the most medically recognized advanced insulin formulations and delivery systems.
- Patients must have the emotional and mental capacity to understand the significant risks associated with surgery and to effectively manage the lifelong need for immunosuppression.
- Patients must otherwise be suitable candidates for transplantation.

Billing and Claims Processing

- The following ICD-9 CM codes will be recognized by FIs and carriers for pancreas transplantation alone for beneficiaries with type I diabetes when billed with **HCPCS 48554**:

25001, 25003, 25011, 25013, 25021, 25023, 25031, 25033, 25041, 25043, 25051, 25053, 25061, 25063, 25071, 25073, 25081, 25083, 25091, and 25093.
- Carriers and FIs who receive claims for PA services that were performed in an **unapproved facility** should use the following messages upon the reject or denial:
 - **Medicare Summary Notice MSN Message** - MSN code 16.2 (*This service cannot be paid when provided in this location/facility*)
 - **Remittance Advice Message** - Claim Adjustment Reason Code 58 (*Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service*)
- Carriers and FIs who receive claims for PA services that are **not billed using the covered diagnosis/procedure codes listed** above should use the following messages upon the reject or denial:
 - **Medicare Summary Notice MSN Message** - MSN code 15.4 (*The information provided does not support the need for this service or item*)
 - **Remittance Advice Message** – Claim Adjustment Reason Code 50 (These are non-covered services because this is not deemed a 'medical necessity' by the payer)
- Modification of the current coverage policy on pancreas transplants can be found in Publication 100-03, Section 260.3 and claims processing information is located in

Publication 100-04, Chapter 3, Section 90.5.1. The location of this information is listed in the *Additional Information* section of this article.

Note: Carriers and FIs will hold any PA claims with dates of service on or after April 26, 2006, until the claims can be processed in their systems. For FIs this date is October 2, 2006, and for carriers the date is July 3, 2006.

Implementation

The implementation date for this instruction is no later than:

- July 3, 2006, for carriers; and
- October 2, 2006, for FIs.

Additional Information

The official instructions issued to your Medicare FI or carrier regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R56NCD.pdf> for the NCD manual revision and

<http://www.cms.hhs.gov/Transmittals/downloads/R957CP.pdf> for changes to the *Medicare Claims Processing Manual*.

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

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

October 2006 Non-Outpatient Prospective Payment System Outpatient Code Editor (Non-OPPS OCE) Specifications Version 22.0

Related Change Request (CR) #: 5256

MLN Matters Number: MM5256

Related CR Release Date: September 18, 2006

Related CR Transmittal #: R1061CP

Effective Date: October 1, 2006

Implementation Date: October 2, 2006

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for outpatient services not subject to the OPPS

Impact on Providers

This article is based on Change Request (CR) 5256, which announces that the October 2006 Non-OPPS OCE has been updated with new additions, changes, and deletions to Healthcare Common Procedure Coding System (HCPCS) codes and procedure codes.

Background

Change Request (CR) 5256 informs your FIs and RHHIs that the Non-OPPS Outpatient Code Editor (OCE) used to process claims from hospitals not paid under the Outpatient Prospective Payment System (OPPS) has been updated with new additions, changes, and deletions to Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes and descriptions.

To view the specific code updates, which are numerous, please see CR5256 at <http://www.cms.hhs.gov/Transmittals/downloads/R1061CP.pdf> on the CMS web site.

Implementation

The implementation date for CR5256 is October 2, 2006.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1061CP.pdf> on the CMS web site.

If you have any questions, please contact your intermediary at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

October 2006 Update Of The Hospital Outpatient Prospective Payment System (OPPS): Summary Of Payment Policy Changes

Related Change Request (CR) #: 5304

MLN Matters Number: MM5304

Related CR Release Date: September 18 2006

Related CR Transmittal #: R1060CP

Effective Date: October 1, 2006

Implementation Date: October 2, 2006

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) and/or regional home health intermediaries (RHHIs) for outpatient services furnished under the OPPS

Impact on Providers

This article is based on Change Request (CR) 5304, which describes changes to the OPPS to be implemented in the October 2006 OPPS update.

Background

Change Request (CR) 5304 describes changes to, and billing instructions for, various payment policies implemented in the October 2006 OPPS update. The October 2006 OPPS Outpatient Code Editor (OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR5304.

In addition, the October 2006 revisions to OPPS OCE data files, instructions and specifications are provided in Change Request (CR) 5244, "October 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 7.3." CR5244 can be found at

<http://www.cms.hhs.gov/Transmittals/downloads/R1045CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) web site.

Key changes in CR5304 include the following:

1. Device Edit Changes and Questions

a. Addition of HCPCS Code C1820, Generator, Neurostimulator (Implantable), with Rechargeable Battery and Charging System as an Allowed Device for CPT Code 64590, Insertion or Replacement of Peripheral Neurostimulator Pulse Generator or Receiver, Direct or Inductive Coupling

The HCPCS code C1820 has been added as an allowed device for CPT code 64590, based on newly received information that the rechargeable neurostimulator can be implanted for the purpose of stimulating peripheral nerves. This change is effective for services furnished on and after January 1, 2006, the effective date of HCPCS Code C1820.

b. Clarification Regarding Reporting Devices for Pacemakers

Claims containing CPT codes 33206, 33207, 33208, 33213 and 33214 for insertion of pacemakers and leads require both:

- A device code for a pacemaker, and
- A device code for pacemaker leads, which includes:
 - C1779, Lead, pacemaker, transvenous VDD single pass, or
 - C1898, Lead, pacemaker, other than transvenous VDD single pass).

In other words, in order to pass the OCE device edit, a claim for these procedure codes must have at least two devices on the claim: 1) a pacemaker from the column A list of allowed pacemakers for the procedure code being billed and 2) either C1779 or C1898 from column B devices.

2. List of Device Category Codes for Present or Previous Pass-Through

Payment and Related Definitions

CMS has posted a document on the OPPS web site

(http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage) that provides a complete list of the device category codes used presently or previously for pass-through payment, along with their expiration dates, and definitions that were published for certain device category C-codes.

CMS posted this list to facilitate the ability to track all present and previous categories for pass-through payment. Once on the CMS website

(http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage) select “Pass Through Payment Device Category Codes [PDF...]” from the Downloads section.

Note: This list does not include all device codes reportable in the OPSS; there are additional HCPCS codes for devices that were not eligible for pass-through payment. The *Medicare Claims Processing Manual* (Publication 100-04, Chapter 4, §61; <http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf>) provides detailed information on requirements for reporting device codes and satisfying device to procedure edits in the OPSS.

3. New Services

The following new service is assigned for payment under the OPSS:

HCPCS Code	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
C9727	10/01/06	S	1510	Insert palate implants	Insertion of implants into the soft palate; minimum of three implants	\$850.00	\$170.00

4. Drugs and Biologicals

a. Drugs and Biologicals with Payment Rates Based on Average Sales Price (ASP) Effective October 1, 2006

In the CY 2006 OPSS final rule published in the Federal Register November 10, 2005 (70 FR 68643; http://www.access.gpo.gov/su_docs/fedreg/a051110c.html), it was stated that payments for drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary, CMS will incorporate changes to the payment rates in the October 2006 release of the OPSS PRICER. The updated payment rates effective October 1, 2006, will be included in the October 2006

update of the OPSS Addendum A and Addendum B, which will be posted at the end of September at <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage> on the CMS web site.

b. Newly-Approved Drug Eligible for Pass-Through Status

The following drug has been designated as eligible for pass-through status under the OPSS effective October 1, 2006. The payment rate for this item can be found in the October 2006 update of OPSS Addendum A and Addendum B, which will be posted on the CMS web site (<http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage>) at the end of September, 2006.

HCPCS Code	APC	SI	Long Description
C9231	9231	G	Injection, decitabine, per 1 mg

c. Updated Payment Rate for HCPCS C9227, Injection, Micafungin Sodium, per 1mg, Effective April 1, 2006 through June 30, 2006

The payment rate for HCPCS Code C9227 was incorrect in the April 2006 OPSS PRICER. The corrected payment rate listed below has been installed in the October 2006 OPSS PRICER, effective for services furnished on April 1, 2006, through implementation of the July 2006 update.

HCPCS Code	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9227	9227	Injection, micafungin sodium	\$1.89	\$0.38

d. Updated Payment Rate for HCPCS C9230, Injection, Abatacept, per 10mg, Effective July 1, 2006 through September 30, 2006

The payment rate for HCPCS Code C9230 was incorrect in the July 2006 OPSS PRICER. The corrected payment rate listed below has been installed in the October 2006 OPSS PRICER, effective for services furnished on July 1, 2006, through implementation of the October 2006 update.

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9230	9230	Injection, abatacept	\$19.08	\$3.82

e. Payment Rate for CPT 90736, Zoster (Shingles) Vaccine, Live, for Subcutaneous Injection, Becomes Effective on its Date of FDA Approval

Currently, CPT Code 90736 is not payable under OPSS and is assigned to status indicator 'E'. The product described by this code was approved by the Food and Drug Administration (FDA) on May 25, 2006. Therefore, in the October 2006 OCE update, the status indicator for CPT 90736 will be changed from 'E' to 'K' to become payable under OPSS effective May 25, 2006.

CPT 90736 will map to APC 0745. The payment rate for APC 0745 can be found in the October 2006 update of OPSS Addendum A and Addendum B, which will be posted on the CMS Web site at the end of September.

f. Correct Reporting of Units for Drugs

Note: Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 50 mg but 200 mg of the drug was administered to the patient, the units billed should be 4.

Note: Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg, and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only 1 vial was administered. HCPCS short descriptors are limited to 28 characters, which includes spaces, so short descriptors do not always capture the complete description of the drug.

Therefore, before submitting Medicare claims for drugs and biologicals, **it is extremely important to review the complete long descriptors for the applicable HCPCS codes.**

The full descriptors for the Level II HCPCS codes can be found in the latest code books or from the latest Level II HCPCS file, which is available for downloading at: <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage> on the CMS web site.

Providers are reminded to check HCPCS descriptors for any changes to the units when HCPCS definitions or codes are changed.

5. Transitional Outpatient Payments

Effective January 1, 2005, CMS transitioned from metropolitan statistical areas (MSAs) to core based statistical areas (CBSAs).

CR3214 (Transmittal 82, issued on May 14, 2004; <http://www.cms.hhs.gov/transmittals/Downloads/R82OTN.pdf>), instructed FIs to refer to the Inpatient Provider Specific File to determine whether a hospital was rural for purposes of TOPs payments. It also instructed FIs to populate both the Geographic/Actual MSA field and Wage Index MSA field in the Outpatient Provider Specific File (OPSF) using data from the inpatient regulations that were effective on and after October 1, 2004. (An MLN Matters article on CR3214 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3214.pdf> on the CMS web site.)

CR3214 instructed that:

- Changes to wage index classifications that apply to the Inpatient PPS, on or after October 1 of any year, do not apply to the OPSS until January 1 of the next year; and
- FIs should use the OPSF to determine whether a provider was eligible for the Transitional Outpatient Payments System (TOPs) payments, beginning January 1, 2005.

CMS received several inquiries related to the transition from MSAs to CBSA and would like to clarify that it was anticipated FIs would automatically transition from MSAs to CBSAs as of January 1, 2005.

Therefore, effective January 1, 2005, a hospital is considered rural for purposes of TOPs payments if either the Geographic/Actual CBSA field or the Wage Index CBSA field is rural.

A hospital that was rural under MSAs but is urban under CBSAs is no longer eligible for TOPs payments as of January 1, 2005.

Note: Interim TOPs Calculation: If mutually agreed upon by both the FI and the provider, the FI can pay less than the monthly interim TOP payment (85% of the full hold harmless amount) to that provider to avoid significant overpayments throughout the year that must be paid back to the FI at cost report settlement. The interim TOPs payments would be reconciled at cost report settlement, as usual.

6. Coverage Determinations

The fact that a drug, device, procedure, or service is assigned 1) a HCPCS code and 2) a payment rate under the OPSS does not imply coverage by the Medicare program. It only indicates how the drug, device, procedure, or service may be paid if covered by the Medicare program.

FIs determine whether a drug, device, procedure, or service meets all Medicare program requirements for coverage, and whether:

- The drug, device, procedure, or service is or is not reasonable and necessary to treat the beneficiary's condition, or

- The drug, device, procedure, or service is included in or excluded from payment.

Implementation

The implementation date for CR5304 is October 2, 2006.

Additional Information

For complete details, please see the official instruction issued to your FI/RHHI regarding this change. That instruction may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1060CP.pdf> on the CMS web site.

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.

Provider Frequently Asked Questions

4th Quarter FY06 Telephone Inquiries FAQs

- Q1.** I submitted an adjustment on a claim with dates of service 07/18/03 through 08/04/03. When I looked in the system the next day it had hit the U6000 edit. A few days later the adjustment was inactivated (IB9997). Why would my adjustment need to be inactivated?
- A1.** This is an internal process that must be done when the claim you are trying to adjust has been purged from Common Working File (CWF). We must first create an exact copy of the claim you are adjusting and get it posted back to CWF. In the next step we set up an adjustment off of the claim we created that is an exact match to your adjustment request and complete the adjustment process. Your remittance advice will reflect the completed adjustment. If you are a DDE provider you can view our internal handling through the DDE system.
- Q2.** We submitted a claim on 4/19/06, which was then returned to us for resolution (TB9997). After 60 days of no resolution, the claim was inactivated from the system (IB9997). Do we have to resubmit a new claim?
- A2.** Yes. Claims that have been in an RTP (TB9997) status for over 60 days or claims that have been suppressed will be moved to an inactivated status on a weekly basis.

Go to www.mutualmedicare.com

Click on "Claims"

Click on "Status Locations"

http://www.mutualmedicare.com/claims/status_locations.html

- Q3.** We submitted an inpatient claim with dates of service 05/09/06 through 05/28/06. The claim edited with reason code 39502 stating that the units of service associated with the accommodation days must equal the covered days. How do we correct this claim?
- A3.** Your covered days must equal your accommodation days (room and board revenue code). Correct the covered days or units as necessary.
- Q4.** We recently submitted a Medicare secondary claim. The claim edited with reason code 77777 indicating that the primary insurance information is different than what is on the Medicare Secondary Payer (MSP) record on Common Working File (CWF). How can we tell what CWF has for the primary insurance?
- A4.** Direct Data Entry (DDE) providers would need to check Common Working File (CWF) through HIQA for current MSP information. Once HIQA has been accessed, go to page the last page of the record for MSP information.

Non-DDE providers can get this information by contacting Customer Service area for assistance.

- Q5.** We are an Inpatient Prospective Payment System (PPS) provider. Do we have to split bill inpatient claims for patients who remain in our facility at our fiscal year end?
- A5.** No. Under IPPS, providers are to bill inpatient hospital claims through discharge regardless of their fiscal year end.

See Internet Online Manual 100-4/chapter 3/section 20.7.2

Go to www.cms.hhs.gov

Click on "Regulations and Guidance"

Click on "Manuals"

Click on "Internet Online Manuals"

Click on "Publication 100-4"

Click on "Chapter 3"

Go to Section 20.7.2

<http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf>

- Q6.** I have a claim that is suspended for reason code 37077. The external narrative on Direct Data Entry (DDE) states "For Fiscal Intermediary use only". Do I have to do anything to get this claim to process?
- A6.** No. Claims that suspend for reason code 37077 will be worked internally to have the wage index updated.
- Q7.** I have an inpatient claim that edited for reason code 12206. The external narrative through Direct Data Entry (DDE) states the days represented on the claim must match the sum of the covered and noncovered days. This patient admitted into our facility on 07/01/06 and discharged on 07/14/06. I am billing 14 covered days and 14 accommodation days. Why would this claim be returned to me for resolution?

- A7.** If the patient was admitted on 07/01/06 and then discharged on 07/14/06, there should only be 13 covered days on the claim since the patient is discharging on 07/14/06. The discharge day is not a utilized day and therefore, cannot be reflected as a covered day or accommodation unit (room and board revenue code).
- Q8.** I recently billed an outpatient 13X type of bill claim that contained revenue code 730 with no units of service but there were covered charges. The claim edited for reason code 32226 stating that no units are present and the covered charges are greater than zero. Why would this claim be returned to me for resolution?
- A8.** Units are required for this line item, but no units are present. You would need to correct your claim by updating the units for this line item service.
- Q9.** We had a claim reject for reason code 34022 because Medicare Secondary Payer (MSP) records on Common Working File (CWF) was showing another insurance as being primary. CWF was recently updated to show Medicare as primary. How do we get our claim to process and pay?
- A9.** You will need to submit an adjustment with a D7 condition code indicating Medicare is Primary. MSP Adjustments can be submitted electronically or hardcopy. For faster processing of your adjustments we encourage you to submit your adjustments electronically.

Go to www.mutualmedicare.com

Go To "Medicare Secondary Payer"

Go to "General Information for providers"

Go to "Adjustments"

<http://www.mutualmedicare.com/msp/adjustmentsproviders.html>

- Q10.** We had a claim reject for reason code 34013 indicating that the patient was covered by Workers' Compensation. The services provided to this patient were not related to the Worker's Compensation. How can I get this claim to process and pay?
- A10.** You will need to submit an adjustment and place in remarks "not related to Worker's Compensation". Please refer to the MSP FAQ identified below for further instructions.

Go to www.mutualofomahamedicare.com

Go to "FAQ"

Go to "Medicare Secondary Payer"

<http://www.mutualmedicare.com/faq/msp.html#faq10>

4th Quarter FY06 Written Correspondence FAQs

- Q1.** We submitted a claim that rejected for overlapping an incarceration period. We contacted the beneficiary and verified that the beneficiary was not incarcerated at the time of the service. Do we appeal this claim?

- A1.** No. If the incarceration information is incorrect and the provider has the correct information, the provider should contact the CMS Regional Office (RO) in their region. Regional Office contact information can be found at <http://www.cms.hhs.gov/RegionalOffices/>.

If the incarceration information is not known or the provider needs the actual dates of incarceration, the provider should contact the State Department of Corrections or the Department of Mental Health to obtain them.

Once the Incarceration period has been updated providers should do the following:

If the entire claim was rejected and currently has a "R B9997" status, the provider should submit an adjustment request via DDE. If the entire claim was rejected and currently has a "R B9997" status and an "X" in the tape to tape field, the provider should submit a new claim for processing. This situation does not require an adjustment.

Go to <http://www.mutualmedicare.com/>

Go to "Newsletter and resources"

Click on "FAQ" http://www.mutualmedicare.com/faq/billing_coverage.html

- Q2.** If a claim has been inactivated, can we appeal it?
- A2.** No. Claims that have been inactivated are not processed claims. Providers should resubmit an adjustment or a new claim if needed.
- Q3.** We submitted an outpatient claim that was rejected because we initially billed it with incidental only services (W7027). We have additional services to bill and need to add them to the claim. Do we appeal this claim?
- A3.** When a claim denies for incidental services only and additional information needs to be added, the claim should be adjusted to add the additional information. Direct Data Entry (DDE) providers can submit an adjustment request via DDE. Non-DDE providers can send in an adjustment request to the following address:
- Mutual of Omaha Insurance Company
Medicare Administration
PO Box 1602
Omaha, NE 68101
- Q4.** We had a claim deny because Common Working File (CWF) indicates that the patient was unlawfully present in the United States (U538Q). Who do we contact to get it updated?
- A4.** Providers and/or Beneficiaries should contact Social Security Administration (SSA) to have the records updated. The toll free number for the Social Security Administration (SSA) is 1-800-772-1213.

- Q5.** Who do I contact to get Medicare Secondary Payer (MSP) information updated in Common Working File (CWF)?
- A5.** The appropriate contact for reporting changes in Group Health Plan (GHP) insurance coverage, or reporting non-GHP (workers' compensation, liability insurance [including self-insurance], or no-fault insurance) is the CMS' Coordination of Benefits Contractor (COBC).

Initial contact for parties wishing to propose a workers compensation Medicare set-aside amount also remains with the COBC. See <http://www.cms.hhs.gov/COBGeneralInformation/> for further information about the COBC, including contact information, attorney information, etc. The COBC's toll-free line is 1-800-999-1118 (TTY/TDD 1-800-318-8782 for the hearing and speech impaired).

Go to <http://www.mutualmedicare.com/>
Go to "Medicare Secondary Payer"
Click on "Frequently Asked Questions"
<http://www.mutualmedicare.com/msp/index.html>

- Q6.** I had a claim deny for reason code 50129 because the diagnosis billed was not a covered diagnosis in the Cardiac Rehabilitation Local Coverage Determination (LCD). I later realized that the claim was coded with the wrong diagnosis. How can I get this claim corrected?
- A6.** You should submit a hardcopy adjustment request with updated diagnosis codes.
- Q7.** We submitted a claim that was rejected, as medical documentation was not received timely. The medical documentation is ready to submit. Do we appeal this claim?
- A7.** No. The provider would have to submit a request for a reopen. Requests for reopening of claims should be submitted to the Medical Review department with a cover letter indicating it is a reopen. Include the requested medical documentation and submit to the following address:

Mutual of Omaha - Medicare
Attn: Medical Review Department
P.O. Box 1602
Omaha, Nebraska 68101

For a list of the necessary documentation for Medical Review, please refer to the initial Additional Development Request (ADR) or visit 'Documentation Guidelines' found on the Medical Review section of our website.

<http://www.mutualmedicare.com/>

Go to <http://www.mutualmedicare.com/>
Go to "Medical Review"
Click on "FAQ"
Click on "Reopens"
http://www.mutualmedicare.com/faq/medical_review.html#092603

carriers (DMERCs) and DME Medicare Administrative Contractors (DME MACs) for payment.

Provider Action Needed

Impact to You

This article, based on Change Request (CR) 4147, notifies you about changes to the *Medicare Claims Processing Manual*, which ensure that claims with **clerical errors (which include minor errors and omissions)** should be processed as “**reopenings**” and not as “**appeals**.”

What You Need to Know

All reopenings are conducted at the discretion of your Medicare contractor and are therefore not appealable. Your Part A Medicare contractor may continue to handle some errors through the claim adjustment process. The Centers for Medicare & Medicaid Services (CMS) has added “Missing data items, such as provider number or missing date of service” to the definition of clerical errors. Note that clerical errors are limited to errors in form and content, and that omissions do not include failure to bill for certain items or services. Please note that third party payor errors DO NOT constitute clerical errors.

What You Need to Do

Please refer to the *Additional Information* section of this article and to the information in the manual attachment to CR4147 (Pub. 100-04, *The Medicare Claims Processing Manual*, Chapter 34, Section 10) for detailed and updated information regarding reopenings. Please note also that this information replaces what was previously found in Chapter 29, Section 90 of *The Medicare Claims Processing Manual*.

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), and by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Section 937 of MMA requires the establishment of a process for the correction of minor errors and omissions that do not necessitate the use of the formal appeals process.

Additional Information

“A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record.” (Pub. 100-04, *The Medicare Claims Processing Manual*, Chapter 34, Section 10) If your reopening request is denied, you may not appeal the contractor’s refusal to reopen but you can appeal the original claim denial as long as the timeframe to request an appeal has not expired. **Requesting a reopening does not toll the timeframe to request an appeal.** If a reopening results in a revised determination, new appeal rights will be afforded on that revised determination. Not all reopenings result in a revised determination. Some important points to note about reopenings as a result of these changes are as follows:

- Medicare contractors will not use reopenings as an appeal when a formal appeal is not available.
- Medicare contractors may conduct a reopening to revise an initial determination or redetermination. Medicare Secondary Payer (MSP) beneficiary or provider/supplier recovery claims are not reopening actions except where the recovery claim is a MSP

provider/supplier recovery claim. All other MSP beneficiary or provider /supplier recovery claims are initial determinations.

- If a claim is suspended for medical review, a request for additional documentation (ADR) may be required to make a determination. If no response is received within the specified timeframes, the medical review department will likely deny the service as not reasonable and necessary based on lack of documentation. In such cases, if appealed with the requested documentation, the Medicare contractor will perform a reopening instead of an appeal. The reopenings will be performed by the medical review department.
- For Part A Medicare, there are a limited number of clerical errors that can be corrected through the reopening process. Many FIs are handling the correction of errors through the submission of an adjustment or corrected claim. FIs who are handling errors through adjustments will continue to do so.
- Medicare contractors will accept reopening requests only if they are made in writing or over the telephone. Please note that the telephone reopenings process is not required for fiscal intermediaries.
- Medicare contractors will ask the providers or suppliers to fax in the proof to support changes and error correction, when necessary.
- In cases where the issue is: (1) too complex to be handled over the phone or (2) there is a need for additional medical documents, the Medicare contractor will inform the party that their request cannot be processed over the phone. In such instances, the contractor will advise the requestor to file their request in writing.
- Medicare contractors will require the following three items from the caller, prior to conducting a telephone reopening: (1) provider/ physician/supplier name & ID # or NSC #; (2) Beneficiary last name & first initial; and (3) Medicare HICN. **NOTE: Items must match exactly.**

CR4147 is the official instruction issued to your FI/RHHI, carrier, DMERC, or DME MAC regarding changes mentioned in this article. CR 4147 may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1069CP.pdf> on the CMS website.

For additional information relating to the Medicare appeals process, you may wish to refer to Chapter 29 of the *Medicare Claims Processing Manual*, which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf>.

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

Flu season is here! Medicare patients give many reasons for not getting their flu shot, including—"It causes the flu; I don't need it; it has side effects; it's not effective; I didn't think about it; I don't like needles!" The fact is that out of the average 36,000 people in the U.S. who die each year from influenza and complications of the virus, greater than 90 percent of deaths occur in persons 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk to your Medicare patients about the importance of getting their annual flu shot—and don't forget to immunize yourself and your staff. **Protect yourself, your patients, and your family and friends. Get Your Flu Shot.** Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS's website: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf>

CR5225 Electronic Data Interchange (EDI) Media Changes

Some contractors permitted providers to submit EDI claims via fax-imaging, diskette, tape or similar storage media.

CMS has determined that use of such media is not cost effective and must be terminated.

Contractors will reject EDI claims received via fax-imaging, diskette, tape or other similar storage media after March 31, 2007.

Ending The Contingency Plan For Remittance Advice (RA) And Charging For PC Print, Medicare Remit Easy Print (MREP), And Duplicate RAs

MLN Matters Number: MM 5308 **Related Change Request (CR) #:** CR 5308
Related CR Release Date: September 22, 2006 **Effective Date:** October 1, 2006
Related CR Transmittal#: R1063CP **Implementation Date:** October 23, 2006

Provider Types Affected

Physicians, providers and suppliers submitting claims to A/B Medicare Administrative Contractors (A/B MACs) carriers, Durable Medical Equipment Regional Carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries.

Impact on Providers

This Change Request (CR) updates the *Medicare Claims Processing Manual* (Publication 100-04) for ending the contingency plan for Electronic Remittance Advice (ERA), and instructs contractors about charging for PC Print, Medicare Remit Easy Print (MREP), and duplicate Remittance Advice (RA).

Background

This article is based on Change Request (CR) 5308 which

- Updates the *Medicare Claims Processing Manual* (Chapters 22 and 24) to include the end of the contingency period for Electronic Remittance Advice (ERA) effective October 1, 2006; and
- Provides instructions to Medicare contractors (A/B MACs, carriers, DMERCs, DME MACs, FIs, and RHHIs) regarding charging for:
 - Generating and mailing provider requested duplicate remittance advices (RAs). There is no current CMS instruction for contractors to charge for generating duplicate remittance advice (when provider has already been sent

a remittance advice – either in electronic or paper format) and mailing in case of paper remittance advice. Therefore, CR 5308 informs Medicare Contractors that they are now allowed to charge to recoup their cost to generate a duplicate RA if the request comes from a provider or any entity working on behalf of the provider.

- Making PC Print or Medicare Remit Easy Print software available to providers by CD/DVD or any other means when the requested software is available for free to download. Contractors may charge up to \$25.00 for each mailing to cover their cost(s).

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, an ERA sent to a provider **on or after October 16, 2003** is required to be a standard HIPAA compliant ERA, and the ERA standard adopted under HIPAA was ANSI ASC X12N transaction 835, Version 004010A1.

CMS implemented a contingency plan (as of October 16, 2003) to continue to accept and send HIPAA-compliant and non HIPAA-compliant transactions from/to trading partners beyond October 16, 2003, for a limited time.

CMS ended the contingency period for claims in October 2005, and in a Joint Signature Memorandum (JSM/TDL-06518) issued on June 28, 2006, CMS instructed Medicare contractors that it **is ending the contingency period for ERAs on September 30, 2006**.

CR 5308 instructs Medicare Contractors that, on or after October 1, 2006, all ERAs must be provided in the standard HIPAA (ANSI ASC X12N 835 version 004010A1) format.

Implementation

The implementation date for CR5308 is October 23, 2006.

Additional Information

For complete details, please see the official instruction issued to your A/B MAC, carrier, intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1063CP.pdf> on the CMS web site. The revised sections of the *Medicare Claims Processing Manual* are attached to CR5308.

If you have any questions, please contact your carrier, intermediary, or A/B MAC at their toll-free number, which may be found on the CMS web site at: <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

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 Medicare EDI Department.

Claim Balancing for Primary/Secondary Payer

The following balancing/validation process will be performed for all payers that have made payment prior to Medicare. Please ensure within the balancing routine that each payer's submitted and paid amount correlate with the appropriate CAS segments.

Record 575 Field 2 = "P" or "S"

Record 585 Field 7 = Corresponding payers submitted charge
(AMT-02-Loop 2320 Qualifier T3)

Minus:

Record 580 and 660 = Sum of all claim and line level CAS Segments
(Loop 2320/Loop 2430; CAS 03, CAS06, CAS09, CAS12, CAS15, and CAS18)

Equal:

Record 585 Field 3 = Total primary payers paid amount
(AMT-02 Loop 2320 Qualifier C4)

Validation of standard adjustment reason codes
Primary/Secondary

Record 575 Field 2 = "P" or "S"

Record 580 and 660 = All claim and line level CAS Segments
(Loop 2320 and Loop 2430)



Please stay tuned for more hot tips!