



## May 1, 2007 Newsletter

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#### **KEY**

- A** All Providers
- H** Hospital Providers
- S** Skilled Nursing Facility (SNF) Providers
- O** Comprehensive Outpatient Rehabilitation Facility (CORF) And Outpatient Physical Therapy (OPT) Providers
- C** Community Mental Health Center (CMHC) Providers
- R** Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Providers
- E** End-Stage Renal Disease (ESRD) Providers
- P** Hospice Providers
- M** Home Health Providers

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

Mutual of Omaha Insurance Company  
Medicare Area

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

## 2<sup>nd</sup> Quarter FY07 Phone Inquiries FAQs

- Q1. I submitted an adjustment on a claim that was still pending for payment (PB9996). How can I get my adjustment to process through the system?
- A1. If you've submitted an adjustment on a claim that has not yet finalized (PB9997), the adjustment will edit with reason code 30906 and will move into status location SB0098. The adjustment will remain in status location SB0098 until the original claim posts to a remittance advice.
- Q2. I have an outpatient claim editing out for reason code 32403 stating that it is an invalid HCPCS/CPT code. According the Medicare Claims Processing Manual, the HCPCS code I am billing is valid. How can I get my claim to process and pay?
- A2. If you have verified that the HCPCS/CPT code is valid, you can contact Customer Service and provide them the resource. They will then refer this to the appropriate area to have the HCPC file update, if deemed appropriate.
- Q3. How do I bill when a patient discharges from our Skilled Nursing Facility (SNF) and readmits within 30 days?
- A3. The SNF must submit the claim with condition code "57" to indicate the patient previously received Medicare covered SNF care within 30 days of the current SNF admission. The claim should contain occurrence span code 78 indicating the from and through dates of the prior covered SNF stay within 30 days of this SNF admission. The original 3-day qualifying hospital stay must be included on the claim in the occurrence span code section.

Please refer to the Internet Online Manual 100-4/chapter 6/Section 40.3.2  
<http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf>

Go to <http://www.cms.hhs.gov/>  
Click on "Regulations and Guidance"  
Under "Guidance" click on "Manuals"  
Under Manuals Overview on the Left side, Click on "Internet-Only Manuals"  
Under Publications click on 100-04  
Under Downloads click on Chapter 6 – SNF Inpatient Part A Billing  
Scroll down or search for Section 40.3.2

- Q4. How do I bill for a conditional payment?
- A4. The following conditions must be present if requesting a conditional payment:
- MSP value code must be present with no amount listed.
  - Occurrence code 01, 02, 03, 04 or 24 must be present
  - First payer ID on page 4 must = C
  - Insurer name must be present and matches CWF
  - Remarks must be present with a valid reason for requesting conditional payment

Please refer to the Internet Online Manual 100-5/chapter 3/Section 40.3.1

<http://www.cms.hhs.gov/manuals/downloads/msp105c03.pdf>

Go to <http://www.cms.hhs.gov/>  
Click on "Regulations and Guidance"  
Under "Guidance" click on "Manuals"  
Under Manuals Overview on the Left side, Click on "Internet-Only Manuals"  
Under Publications click on 100-05  
Under Downloads click on Chapter 3 – MSP Provider Billing Requirements  
Scroll down or search for Section 40.3.1

Q5. I have an inpatient Part A SNF claim that rejected for reason code 11503. This patient was admitted more than 30 days after their 3-day qualifying hospital stay because their condition prevented them from being able to begin treatment. How do I bill this claim?

A5. When a patient's condition prevents them from being admitted to the Skilled Nursing Facility (SNF) within 30 days, providers should bill the claim with Condition Code "56". This indicates that the admission was delayed more than 30 days because the patient's condition made it inappropriate to begin active care within that period. The original 3-day qualifying hospital stay must be included on the claim in the occurrence span code section.

Please refer to the Internet Online Manual 100-4/chapter 6/Section 40.3.2  
<http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf>

Go to <http://www.cms.hhs.gov/>  
Click on "Regulations and Guidance"  
Under "Guidance" click on "Manuals"  
Under Manuals Overview on the Left side, click on "Internet-Only Manuals"  
Under Publications click on 100-04  
Under Downloads click on Chapter 6 – SNF Inpatient Part A Billing  
Scroll down or search for Section 40.3.2

Q6. I accidentally submitted a Medicare Secondary Payer claim with Medicare as being primary. How can I correct this claim?

A6. Providers should submit an adjustment and use a condition code D7 along with the appropriate adjustment reason code.

Q7. I submitted a Part A SNF claim without the 3-day qualifying stay dates under occurrence span code 70. How can I correct this?

A7. If the claim rejected in FISS with an "X" in the tape to tape indicator then you would need to re-submit a new claim to Medicare with the appropriate occurrence span code 70. If the claim rejected in FISS and there is not an "X" in the tape to tape indicator, then you would need to submit an adjustment to add the occurrence code 70. The adjustment would need condition code "D9" with remarks indicating the reason for the adjustment.

Direct Data Entry providers can find the tape to tape field by pressing the F2 key while on page 2 of the claim.

Non-DDE providers can get this information by contacting our customer service area.

- Q8. I submitted a MSP claim. The claim returned to me for reason code 77745 stating that Medicare's primary. How can I correct my claim?
- A8. If Medicare is the primary payer and a primary payment was received from another insurance, refund the payment and then resubmit the claim as Medicare Primary. If a primary payment was not received from another insurance but a denial was received, please remove all other insurance information from the claim and resubmit the claim as Medicare Primary. If Medicare is not the primary payer, please contact the Coordination of Benefits Contractor (COBC) at 1-800-999-1118 to have the primary insurance information added to the patient's MSP record. When the Common Working File (CWF) is updated, resubmit the patient's Medicare Secondary claim.
- Q9. I submitted a claim through the Direct Data Entry (DDE) system and it edited out for a facility zip code. What page does this go on?
- A9. Page 1 – Under the new fields labeled "TAXO.CD & FAC ZIP".
- Please refer to Mutual Medicare Web site  
[http://www.mutualmedicare.com/news/20061219\\_02.html](http://www.mutualmedicare.com/news/20061219_02.html)
- Go to <http://www.mutualmedicare.com/index.html>  
Under Provider Self Service, click on the "Direct Data Entry" link. Scroll down to DDE Updates. Click on link for Direct Data Entry (DDE) Changes Effective Jan 2, 2007
- Q10. How do I bill when a Part A SNF patient is no longer receiving skilled care?
- A10. You need to bill 2 claims. The first claim should be billed through the date active care ended, with an occurrence code 22 and the date of the last day of skilled care, patient status 30 and a Type of Bill (TOB) of 212 or 213. The second claim would be a No Payment (No-Pay) claim (TOB) 210. This claim can be billed either monthly if a denial is needed or when the patient discharges, whether that would be to home or to a non-certified bed.

## 2nd Quarter FY07 Written Correspondence FAQs

- Q1. We have a patient who was receiving Part B (23X) therapy services 5 times a week in our facility. This patient then went to a hospital and had a 3-day qualifying hospital stay. Can we admit this patient under Part A even though we previously treated them as an outpatient?
- A1. Yes, if the patient meets the definition of skilled services described in 100-2/ Chapter 8/ section 30.3 "Direct Skilled Nursing Services to Patients"  
<http://new.cms.hhs.gov/manuals/Downloads/bp102c08.pdf>
- Go to <http://www.cms.hhs.gov/>  
Click on "Regulations and Guidance"

Under "Guidance" click on "Manuals"  
Under Manuals Overview on the Left side, Click on "Internet-Only Manuals"  
Under Publications click on 100-02  
Under Downloads click on Chapter 8  
Scroll down or search for Section 30.3

Q2. Can Skilled Nursing Facilities bill bi-monthly claims (i.e., 01/01/07-01/15/07 and 01/16/07-01/31/07)?

A2. No, Skilled Nursing Facilities should bill claims on a monthly basis.

Please refer to the Internet Online Manual 100-4/chapter 6/Section 40  
<http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf>

Go to <http://www.cms.hhs.gov/>  
Click on "Regulations and Guidance"  
Under "Guidance" click on "Manuals"  
Under Manuals Overview on the Left side, Click on "Internet-Only Manuals"  
Under Publications click on 100-04  
Under Downloads click on Chapter 6 – SNF Inpatient Part A Billing  
Scroll down or search for Section 40

Q3. Are hospitals eligible to receive a separate payment for a patient who comes into the emergency room and is placed into observation with a diagnosis of chest pain, congestive heart failure or asthma?

A3. Yes, hospitals could receive a separate APC payment for observation services for patients with a diagnosis of chest pain, congestive heart failure or asthma.

Please refer to the Internet Online Manual 100-4/chapter 4/Section 290.4.3  
<http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf>

Go to <http://www.cms.hhs.gov/>  
Click on "Regulations and Guidance"  
Under "Guidance" click on "Manuals"  
Under Manuals Overview on the Left side, click on "Internet-Only Manuals"  
Under Publications click on 100-04  
Under Downloads click on Chapter 4  
Scroll down or search for Section 290.4.3

Q4. What is the difference between National Provider Identifiers (NPI) and Taxonomy codes?

A4. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number) required by all health care providers. A Taxonomy code is used in addition to the NPI, for providers that receive one NPI number but have multiple sub-parts within their facility. The taxonomy code identifies the type of facility that is billing.

Q5. We are a Skilled Nursing Facility being billed by a Podiatrist for his physician services. Aren't physician services excluded from consolidated billing?

- A5. Yes, for Medicare beneficiaries in a covered Part A stay, physician services (professional component) are excluded from consolidated billing.

Please refer to CMS' Overview on SNF Consolidated Billing (CB)  
[http://www.cms.hhs.gov/SNFConsolidatedBilling/01\\_Overview.asp#TopOfPage](http://www.cms.hhs.gov/SNFConsolidatedBilling/01_Overview.asp#TopOfPage)

Go to <http://www.cms.hhs.gov/>  
Click on "Medicare"  
Under "Billing" click on "SNF Consolidated Billing"

- Q6. We have a SNF Part A patient receiving Epoetin Alpha injections. Can we bill this on a SNF 21X Part A claim?

- A6. No, SNFs will not be paid for Epoetin services (dialysis, etc.) when the SNF is the place of service. In order to receive Medicare payment, these services must be provided in a renal dialysis facility.

Please refer to CMS' General Explanation of the Major Categories for Skilled Nursing Facility (SNF) Consolidated Billing  
[http://www.cms.hhs.gov/SNFConsolidatedBilling/70\\_FI\\_File\\_Explanation.asp#TopOfPage](http://www.cms.hhs.gov/SNFConsolidatedBilling/70_FI_File_Explanation.asp#TopOfPage)

Go to <http://www.cms.hhs.gov/>  
Click on "Medicare"  
Under "Billing" click on "SNF Consolidated Billing"  
Under "FI File Explanation" Click on "General Explanation of Major Categories"

- Q7. I have a claim that line rejected for reason code 54NCD. After further review, I determined that the wrong diagnosis was billed. How can I get this line to pay?

- A7. You should submit a hardcopy adjustment request with the updated diagnosis codes.

- Q8. We had a claim reject for reason code U5211 because Common Working File (CWF) had the wrong date of death. CWF has now been updated. How can I get my claim to process?

- A8. If the claim rejected in FISS with an "X" in the tape to tape indicator then you would need to re-submit a new claim to Medicare for processing. If the claim rejected in FISS and there is not an "X" in the tape to tape indicator, then you would need to submit an adjusted claim to Medicare.

Direct Data Entry providers can find the tape to tape field by pressing the F2 key while on page 2 of the claim.

Non-DDE providers can get this information by contacting our customer service area.

- Q9. How do I bill when a patient discharges from our Skilled Nursing Facility (SNF) and readmits within 30 days?

- A9. You should bill a condition code 57 to indicate that the patient previously received Medicare covered SNF care within 30 days of the current SNF admission. The original 3-day qualifying hospital stay must also be included on the claim in the occurrence span code section.

Please refer to the Internet Online Manual 100-4/chapter 6/Section 40.3.2  
<http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf>

Go to <http://www.cms.hhs.gov/>  
Click on "Regulations and Guidance"  
Under "Guidance" click on "Manuals"  
Under Manuals Overview on the Left side, click on "Internet-Only Manuals"  
Under Publications click on 100-04  
Under Downloads click on Chapter 6 – SNF Inpatient Part A Billing  
Scroll down or search for Section 40.3.2

- Q10. We filed a claim with procedure code 0061. The claim rejected because procedure code 0061 has to be billed along with procedure code 0063 according to Change Request (CR) 3811. Can we appeal this denial?
- A10. No an appeal would not be appropriate. According to Change Request 3811 procedure codes 0061 and 0063 must both be present on the claim with the appropriate diagnosis codes.

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## New "K" Codes for Oral/Mask for Use with Continuous Positive Airway Pressure (CPAP) Device



Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting <http://www.cms.hhs.gov/NationalProviderStand/> on the CMS web site.

**Related Change Request (CR) #:** 5525  
**Related CR Release Date:** March 23, 2007  
**Related CR Transmittal #:** R1210CP  
**Effective Date:** July 1, 2007  
**Implementation Date:** July 2, 2007

**MLN Matters Number:** MM5525

### Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Durable Medical Equipment Regional Carrier (DMERCs), DME Medicare Administrative Contractors (DME MAC)), for services to Medicare beneficiaries for CPAP.

### Provider Action Needed

Be sure billing staff are aware that, effective July 1, 2007, three new "K" codes will be established for oral/mask for use with a CPAP device.

## Background

This article is based on Change Request (CR) 5525 and you need to be aware that effective July 1, 2007, the following codes will be added to the system, i.e.:

<b>K0553</b>	Combination oral/nasal mask, used with continuous positive airway pressure device, each
<b>K0554</b>	Oral cushion for combination oral/nasal mask, replacement only, each
<b>K0555</b>	Nasal pillows for combination oral/nasal mask, replacement only, pair

## Additional Information

If you have questions, please contact your Medicare FI, DME MAC, DMERC or A/B MAC at their toll-free number, which may be found at:

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

To see the official instruction (CR5525) issued to your Medicare FI, DME MAC, DMERC or A/B MAC, go to <http://www.cms.hhs.gov/Transmittals/downloads/R1210CP.pdf> on the CMS website.

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## Ambulance Fee Schedule - Ground Ambulance Services - Manualization Revision to the Specialty Care Transport (SCT) Definition



The *Medicare Guide to Rural Health Services: Information for Providers, Suppliers, and Physicians (Second Edition)*, which provides rural information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Deficit Reduction Act of 2005 is now available in downloadable format at <http://www.cms.hhs.gov/MLNProducts/downloads/MedicareRuralHealthGuide.pdf>.

**MLN Matters Number:** MM5533

**Related Change Request (CR) #:** 5533

**Related CR Release Date:** March 30, 2007

**Related CR Transmittal #:** R68BP

**Effective Date:** January 1, 2007

**Implementation Date:** April 30, 2007

### Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs) and carriers), for ambulance services to Medicare beneficiaries

### Provider Action Needed

Providers and suppliers are reminded that the Centers for Medicare & Medicaid Services (CMS) expanded the interpretation of "interfacility" to include both hospitals and Skilled Nursing Facilities (SNFs) in the December 1, 2006 (71 FR 69716) final rule.

## Background

In the February 27, 2002 Federal Register (67 FR 9100) a final rule was published with comment period entitled “*Fee Schedule for Payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Nonemergency Ambulance Services*” that implemented the ambulance fee schedule. In that rule, CMS defined SCT at Section 414.605. In the December 1, 2006 (71 FR 69716) final rule, CMS expanded the definition of “interfacility” to include both hospitals and skilled nursing facilities (SNFs).

In addition, CMS further clarified the kinds of facilities included as origin or destination points for “interfacility” transport for Specialty Care Transport (SCT) purposes. Therefore, for purposes of SCT payment, CMS considers a “facility” to include:

- Only a SNF or a hospital that participates in the Medicare program, or
- A hospital-based facility that meets the requirements for provider-based status.

Medicare hospitals include, but are not limited to, rehabilitation hospitals, cancer hospitals, children’s hospitals, psychiatric hospitals, Critical Access Hospitals (CAHs), inpatient acute-care hospitals, and Sole Community Hospitals (SCHs).

Note: Contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims brought to their attention.

## Additional Information

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

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

For complete details regarding this Change Request (CR) please see the official instruction (CR5533) issued to your Medicare FI, Carrier or A/B MAC. That instruction may be viewed by going to

<http://www.cms.hhs.gov/Transmittals/downloads/R68BP.pdf> on the CMS website.

Providers may review the Federal Regulations for the Ambulance Fee Schedule located at [http://www.cms.hhs.gov/AmbulanceFeeSchedule/04\\_CFRAFS.asp#TopOfPage](http://www.cms.hhs.gov/AmbulanceFeeSchedule/04_CFRAFS.asp#TopOfPage) on the CMS website.

## Update to Medicare Claims Processing Manual, Publication 100-04, Chapter 18, Section 60.1 Regarding Colorectal Screening Services



The *Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet*, which provides information about Inpatient Rehabilitation Facility Prospective Payment System rates and classification criterion, is now available in downloadable format on the Centers for Medicare & Medicaid Services Medicare Learning Network Publications Page located at <http://www.cms.hhs.gov/MLNProducts/downloads/IRFPPSFactSheet0307.pdf>.

**Related Change Request (CR) #:** 5541  
**Related CR Release Date:** March 30, 2007  
**Related CR Transmittal #:** R1217CP  
**Effective Date:** July 1, 2007  
**Implementation Date:** July 2, 2007

**MLN Matters Number:** MM5541

### Provider Types Affected

Physicians, suppliers, and providers who submit claims for screening and diagnostic colorectal services to Medicare contractors (Fiscal intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs)).

### Background

The Centers for Medicare & Medicaid Services (CMS) is aware that Chapter 18, Section 60.1 of the *Medicare Claims Processing Manual* (Publication 100-04) needed clarification regarding application of the annual Part B deductible for **diagnostic** colorectal services. Section 5113 of the Deficit Reduction Act (DRA) of 2005 **waived** the requirement for the annual Part B deductible for **screening** colorectal services, **NOT diagnostic** colorectal services. CR5541 clarifies that portion of the manual.

### Key Points

The following are the key points of the revised portion of Chapter 18, Section 60.1 of the *Medicare Claims Processing Manual*, which is attached to CR5541 (the web address for CR5541 is provided in the *Additional Information* section of this article).

- **Prior to January 1, 2007**, deductible and coinsurance apply to HCPCS codes G0104, G0105, G0106, G0120, and G0121. **On or after January 1, 2007**, the annual Part B deductible is waived for the listed HCPCS coded **screening services**. **Coinsurance still applies.**
- **Coinsurance and deductible applies to the diagnostic colorectal service codes 45330, 45378, and 74280.**

### Additional Information

You may see the official instruction (CR5541) issued to your Medicare carrier, FI, or A/B MAC by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1217CP.pdf> on the CMS website.

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

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### **Incorrect Coinsurance/Deductible: Change Request (CR) 4240**

CR 4240 clarified the payment of vaccine administration in various institutional provider settings. This CR was implemented on July 3, 2006. When this was implemented in the Fiscal Intermediary Shared System (FISS), both coinsurance and deductible were incorrectly assigned on Critical Access Hospital (CAH) type of bill 85X containing Healthcare Common Procedure Coding System (HCPCS) Codes G0008 and G0009 received on or after October 1, 2006.

A correction for this was implemented January 2, 2007. Any bill meeting the criteria stated above that processed between July 3, 2006 and January 2, 2007 will be adjusted by September 28, 2007. **You need not take any action at this time.**

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### **Reporting Your National Provider Identifier (NPI) On Medicare Claims**

As we work toward a smooth transition to the National Provider Identifier, we have found that many providers have obtained NPIs but are not utilizing them when submitting their claims. If you have received your NPI, we **strongly encourage** you to begin including both your legacy number (OSCAR number) and the NPI when submitting claims to Mutual of Omaha-Medicare. Submitting your claims in this manner will help in validating the NPI process during Stage 2 to determine any potential problems or issues that may occur, allow everyone time to make corrections or install fixes prior to May 23, 2007 (Stage 3), and reduce your risk of potential interrupted claim payments.

If you have not obtained your NPI by now you should do so immediately, as once you obtain your NPI it is estimated that it will take 120 days to do the remaining work to use it. This includes working on your internal billing systems, coordinating with billing services, vendors, and clearinghouses, and testing with payers. If you delay applying for your NPI, you risk your cash flow and that of your health care partners as well.

You can apply for an NPI online at: <https://nppes.cms.hhs.gov/> or can call the NPI enumerator to request a paper application at (800) 465-3203.

Information and education on the NPI can be found on the CMS Web site at the CMS NPI page: <http://www.cms.hhs.gov/NationalProvIdentStand>

## Change in the Amount in Controversy Requirement for Federal District Court Appeals

If you have questions regarding the plan of a specific Medicare patient enrolled in a Medicare Advantage (MA) plan, you may wish to contact that plan. A plan directory and MA claims processing contact directory are available at <http://www.cms.hhs.gov/MCRAdvPartDENrolData/> on the Centers for Medicare & Medicaid Services (CMS) website. CMS updates this site on a monthly basis.

**MLN Matters Number:** MM5518

**Related CR Release Date:** March 30, 2007

**Related CR Transmittal #:** R1211CP

**Related Change Request (CR) #:** 5518

**Effective Date:** January 1, 2007

**Implementation Date:** July 2, 2007

### Provider Types Affected

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

### Provider Action Needed

This article is based on Change Request (CR) 5518 which notifies Medicare contractors of an increase in the Amount in Controversy Required to sustain Federal District Court appeal rights beginning January 1, 2007.

### Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for an annual reevaluation, beginning in 2005, of the dollar amount in controversy required for an Administrative Law Judge (ALJ) hearing or Federal District Court review. Therefore, **CR5518 updates the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 29, Sections 330.1 and 345.1) to announce the Amount in Controversy Requirements for ALJ or Federal District Court Appeals during 2007.**

The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2006 was \$100. The amount in controversy requirement increased to \$110 for requests made on or after January 1, 2006. **CR 5518 announces that for ALJ hearing requests made on or after January 1, 2007, the amount that must remain in controversy did not change and remains at \$110.**

The amount remaining in controversy requirement for Federal District Court review prior to January 1, 2006, was \$1,000. That amount increased to \$1,090 on or after January 1, 2006. **CR 5518 announces that for Federal District Court review requests made on or after January 1, 2007, the amount that must remain in controversy is increased to \$1,130.**

### Additional Information

The official instruction, CR 5518, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1211CP.pdf> on the CMS website.

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

## **Comprehensive Error Rate Testing (CERT) Denial of Skilled Nursing Facility Claims Due to Lack of Documentation**

Recent CERT data indicates there have been several Part A Skilled Nursing Facility (SNF) claims paid in error. These claims represent 22% of the total dollars in error for the current CERT reporting period for claims processed from October 1, 2005 to September 30, 2006. These are dollars that have been recouped by Mutual of Omaha- Medicare. The reason for these errors continues to be lack of documentation to support the RUGIII level billed.

The most common errors made by providers are 1) failing to include all look-back documentation and 2) lack of therapy minutes.

The applicable look-back period may be in a previous or subsequent month of the billing period. Examples of these two situations are as follows:

**Example 1** – A patient is admitted to the SNF on February 18, 2006. The Assessment Reference Date (ARD) for the 5-day assessment is February 22, 2006. The dates of service being reviewed are March 01 to March 31, 2006. All documentation for the month of February should be included to support the look-back periods for the 5-day and 14-day assessments since the RUGIII category billed is determined by the skilled services provided during the 7 to 14 days prior to the ARD.

**Example 2** – A patient is admitted to the SNF on March 30, 2006. The ARD is set on the 5<sup>th</sup> day, which is April 03, 2006. The dates billed are the 30<sup>th</sup> and 31<sup>st</sup> of March, but the look-back period is March 30 to April 03, 2006. In this example, the documentation should include the first three days of April, since the look-back dates start with the ARD and the skilled services provided during the last two days of March and the first 3 days of April would determine the RUGIII category billed.

The lack of documentation of therapy minutes also may result in the claim being down-coded, thus reducing payment. In some cases, therapy minutes are recorded on a separate grid, which should be included in the patient's chart. In some facilities, the therapy documentation is kept in the therapy department. It is recommended that the therapy department be consulted to make sure that all applicable documentation for all look-back periods is included.

Finally, it may be to the benefit of the facility to have all outgoing documentation copies checked by clinical personnel in order to avoid documentation errors. Please refer to our website at [mutualmedicare.com](http://mutualmedicare.com), click on "Documentation Guidelines" under the "Medical Review" section for a complete list of documentation needed for medical review.

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.

## **New Connection Option and Updated Forms**

Mutual of Omaha's Medicare Electronic Data Interchange (EDI) Department is pleased to announce the addition of VisionShare, Inc. as a claims processing alternative. VisionShare is an internet-based connection, through Secure Exchange Software, that enables providers to send and receive files without the use of a modem. If you would like more information about VisionShare or to register for their services, please visit their website at [www.visionshareinc.com](http://www.visionshareinc.com) or call them at 1-888-895-2649. Due to this addition we have updated our forms to include the VisionShare option. Effective, April 26, 2007, we will no longer accept the Data Transmission Questionnaires for ERA Only, Vendor Software, and PC-ACE, or the Authorizations for ERA and EMC. The new forms can be accessed from our website via the address below:

[http://www.mutualmedicare.com/news/20070424\\_01.html](http://www.mutualmedicare.com/news/20070424_01.html)

If you have any questions concerning these changes, please contact the EDI Department at 1-866-734-6656.



**Please stay tuned for more hot tips!**