

American Association of Healthcare Administrative Management

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All models, methodologies and guidelines are undergoing continuous improvement and modification by NAS and the Centers for Medicare & Medicaid Services (CMS). The most current edition of the information contained in this release can be found on the NAS web site at <https://www.noridianmedicare.com/> and the CMS web site at <http://www.cms.hhs.gov/>

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Part A Updates

- See handout
 - Article posted to NAS web site 10/2/09
 - Alert: Submitting, Correcting, Adjusting or Canceling MSP Claims Through DDE



Home / Holding of Fiscal Year 2010 IPPS Claims for Special Pay MS-DRGs

Medicare Part A

HOLDING OF FISCAL YEAR 2010 IPPS CLAIMS FOR SPECIAL PAY MS-DRGS

The Centers for Medicare & Medicaid Services (CMS) has identified a claims processing error affecting "special pay" post acute transfer claims with discharges on or after October 1, 2009. (The "special pay" transfer adjustment error only affects claims with the following Medicare Severity Diagnosis Related Groups (MS-DRGs): 28-30, 40-42, 219-221, 477-482, 492-2494, 500-502, 515-517.) Because this error was identified prior to the processing of Fiscal Year 2010 claims, no claims will need reprocessing. Affected claims will only be held, if necessary, and released once the error is corrected on or around October 16, 2009. We regret the inconvenience you have experienced related to this problem.

Posted: 10/16/2009

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Home / Holding of Claims with Reason Code U6803

Medicare Part A

HOLDING OF CLAIMS WITH REASON CODE U6803

The Centers for Medicare & Medicaid Services (CMS) has identified a problem where Medicare Secondary Pay (MSP) claims are suspending in error with Reason Code U6803. We are holding claims that receive Reason Code U6803 until the successful installation of the software fix on October 19, 2009. At that time, we will release and process the claims being held. We apologize for any inconvenience you may have experienced related to this problem.

Posted: 10/9/2009

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- CR 6438 – Effective October 1
 - Describes changes to Common Working File (CWF)
- CR 6520 - Effective October 1
 - The ICD-9-CM codes are updated annually.
 - Reminder – ICD-9 codes are required for all professional claims.

- CR 6445 - RHC and FQHC Coverage and Billing Updates
 - Implement October 5, 2009
 - Professional components of preventive services are part of the overall encounter, and, for types of bill (TOBs) 71x and 73x, have always been billed on lines with the appropriate site of service revenue code in the 052x series.
 - The number of RHC and FQHC services requiring a HCPC and in which additional payment may be made has increased.

- No additional payment will be made for the following vaccines as payment for these is included in the cost report.
 - Influenza virus
 - Pneumococcal pneumonia vaccine
 - Hepatitis vaccine

- Skilled Nursing Facilities
 - CR6523 – Implemented October 5, 2009
 - Medicare systems have been updated and the 74 occurrence span code is no longer needed to bypass 210 no pay bill edits.
 - SNFs must continue to use the occurrence span code 74 to report the leave of absence from and through dates

- Effective October 5, 2009
 - CR 6585 ASP Average Drug Pricing
 - Apply to DOS October 1 through December 31, 2009
 - *CR 6609 Claims Status Category and Claim Status Codes (No MLN posted 8/25/09)*
 - CR 6548 NCD Clinical Lab

- Effective April 2009
 - CR 6387 Medically Unlikely Edits Version 3.1
 - CR 6388 CCI Edits Version 15.1
 - CR 6397 Medicare Physician Fee Schedule Database (MPFSDB)
 - Payment allowance limits for drug pricing updated
 - CR 6383 NCD Clinical Lab

Top Claim Errors

- 38105
 - Outpatient bill type (13x, 14x, 83x, 85x) have overlapping dates and the provider numbers are the same
- 38119
 - Statement covers from date is greater than the admission date
- 31715
 - Units of service are in excess of the medically reasonable daily allowable

- 37544
 - Adjustment is due to change in charges, condition D1 is reported, and all charges equal the original
- 12206
 - Claim from and through dates do not equal covered plus non-covered days
- U6802
 - MSP indicated on claim, but no auxiliary record

- J0885 – Epoetin
- 85610 – Prothrombin Time
- 80061 – Lipid Panel
- J0881 – Darbepoetin
- 93798 – Cardiac Rehab
- C1300 – Hyperbaric Oxygen

- Types of Services Being Appealed
 - Lab
 - Other Therapeutic Services (OTS)
 - Pharmacy
 - Respiratory
 - X-ray Diagnosis

- Outpatient therapy
- Lipid panels
- Ambulance
- SNF
- EPO
- Diagnosis codes
- Procedure codes
- Inpatient admission

Online Tools

Billing Guides

- [Billing Ambulance Claims Electronically](#) [PDF]
- [Billing Chiropractic \(Spinal Manipulation\) Claims Electronically](#) [PDF]
- [Billing Laboratory Claims Electronically](#) [PDF]
- [Billing Mammography Claims Electronically](#) [PDF]
- [Billing Medicare Secondary Payer \(MSP\) Claims Electronically \(Medicare Part B\)](#) [PDF]
 - [Medicare Secondary Payer \(MSP\) ANSI Specifications](#) [PDF]
- [Billing Medicare Secondary Payer \(MSP\) Claims Electronically \(Medicare Part A\)](#) [PDF]
- [Billing Podiatry \(Routine Foot Care\) Claims Electronically](#) [PDF]
- [Billing Purchased Service Claims Electronically](#) [PDF]
- [Billing Roster Claims Electronically](#) [PDF]
- [Billing Therapy \(PT/OT\) Claims Electronically](#) [PDF]

MSP Payment Calculator

MSP Secondary Payment and Savings Calculator

Enter amount billed by provider (BAMT) \$:

Enter Medicare's allowed amount (AAMT) \$:

Enter Primary allowed amount (SA) \$:

Enter Primary paid amount (SP) \$:

Enter amount remaining of Medicare's deductible (DED) \$:

Enter Obligated to Accept Field (OTAF) \$:

Results

Provider billed amount (or the amount the physician/supplier is obligated to accept as payment in full if that is less than the charges) minus Primary insurance payment is

Amount Medicare would pay if services were not covered by Primary insurance is

Higher of the Medicare fee schedule or the Primary insurance's allowable charge minus the amount actually paid by the Primary insurance is

Medicare secondary payment to provider is

Patient responsibility is

- Medicare A > Claims > Claim Submission Timelines

Claims Submission Timelines

Timely Filing Calculator

To calculate the timely filing limit of your service claim enter the date of the service claim below.

Date of Claim: 

(MM/DD/YYYY)

Timely Filing Limit: **12/31/2010**

CMS Pub. 100-4, Chapter 1, Section 70

Redetermination Time Limit Calculator

The redetermination submission deadline is 10/07/2009





Medicare Part A



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Alert-MSP Claims In DDE

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 **Production Alerts** - [view all](#)

- **MN - Mass Adjustments (XXI) claims duplicating**
- **Providers unable to enter ESRD CMS-382 forms via DDE.**

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? **RAC Region B** - [read more](#)

- **MN**

? **RAC Region D** - [read more](#)

- **AK, ID, OR & WA**

Comprehensive Error Rate Testing (CERT)

Top Error Code Descriptions

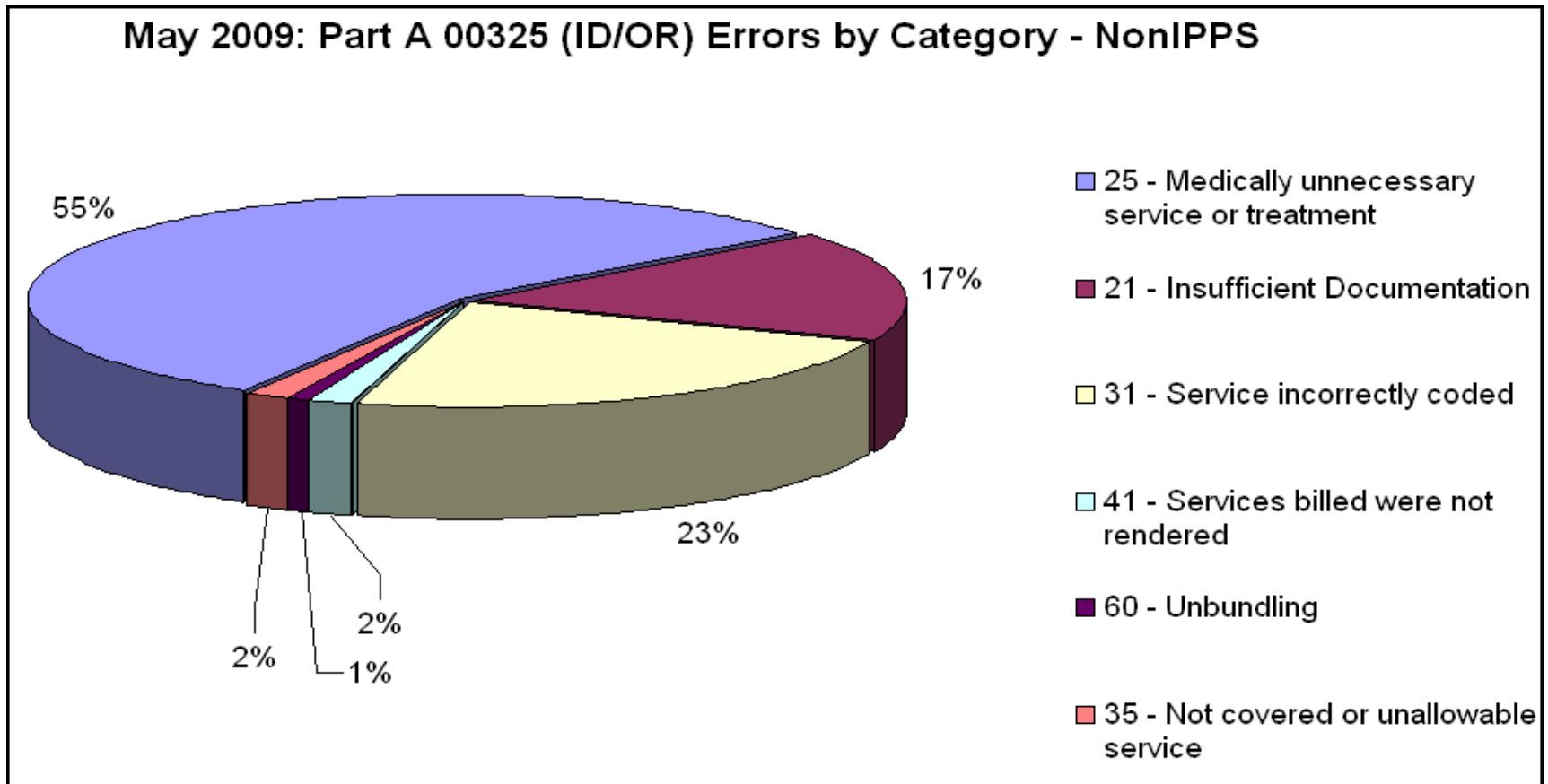
- Important information for Coders, Practitioners and Compliance Officers
 - Why? Common reasons for recoupment
- 21 - Insufficient documentation submitted
- 25 - Medically unnecessary service or procedure rendered
- 31 - Incorrect coding
- 33 - DRG wrong procedure code

CERT Top Errors

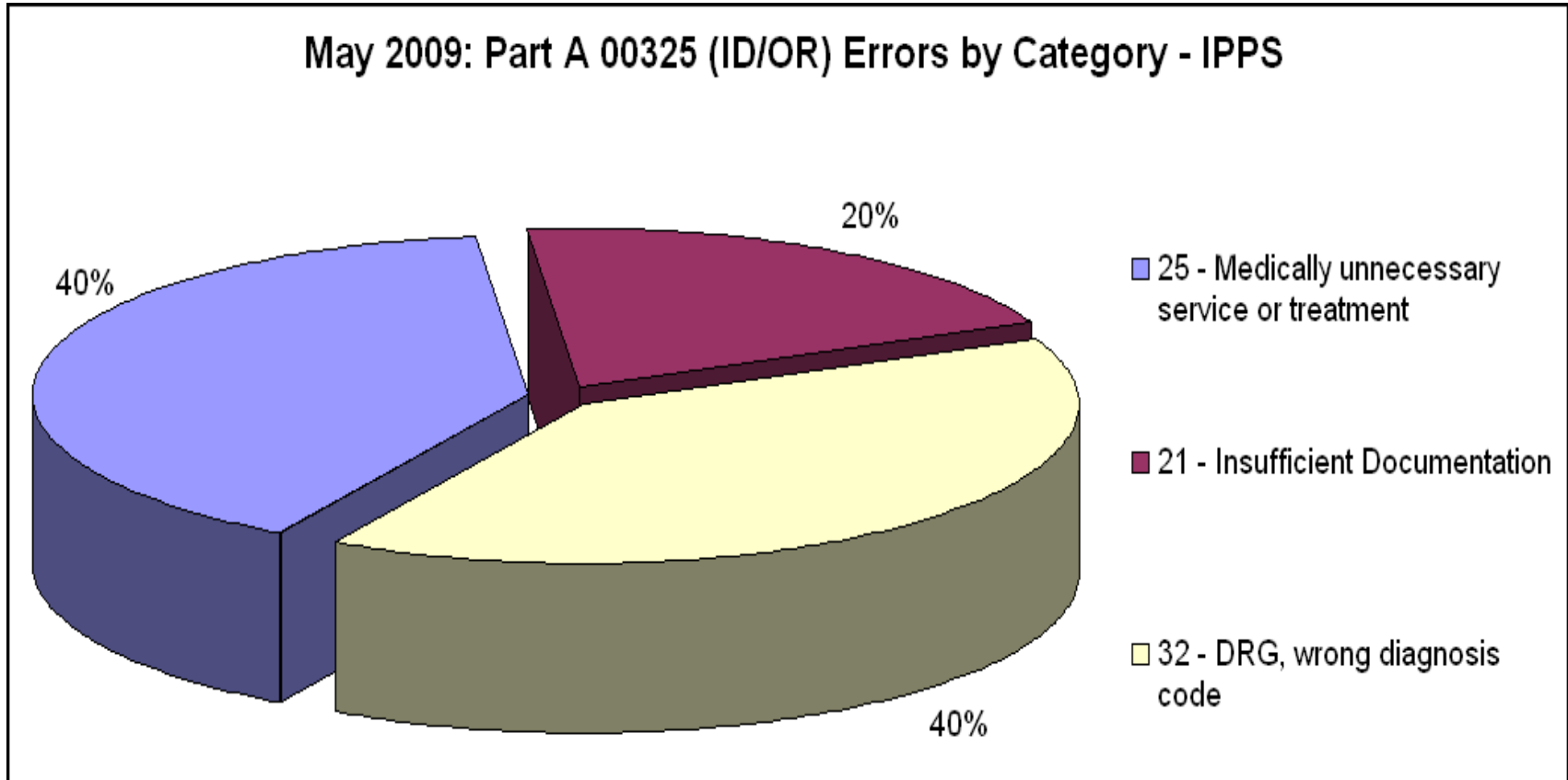
HCPCS /CPT	Description	Error	Correction
J2405	Odansetron HCl, 1 mg	4 units administered – billed 1 unit for the vial	1 unit per 1 mg administered
85027	Complete Blood Count, automated	CBC w/diff performed w/o orders	Bill the service ordered and performed – not protocol
85610	Prothrombin Time	Missing valid MD order	Maintain valid MD order for all services rendered

- Hospital Admissions – not medically necessary
 - Medical documentation must support intensity of services
 - Claim is down-coded when the level of care is not supported
- Physician Orders – not medically necessary
 - Documentation must support physician intent for the specific test ordered and performed
 - Physician signature must be legible
 - Medical records must contain a valid diagnosis

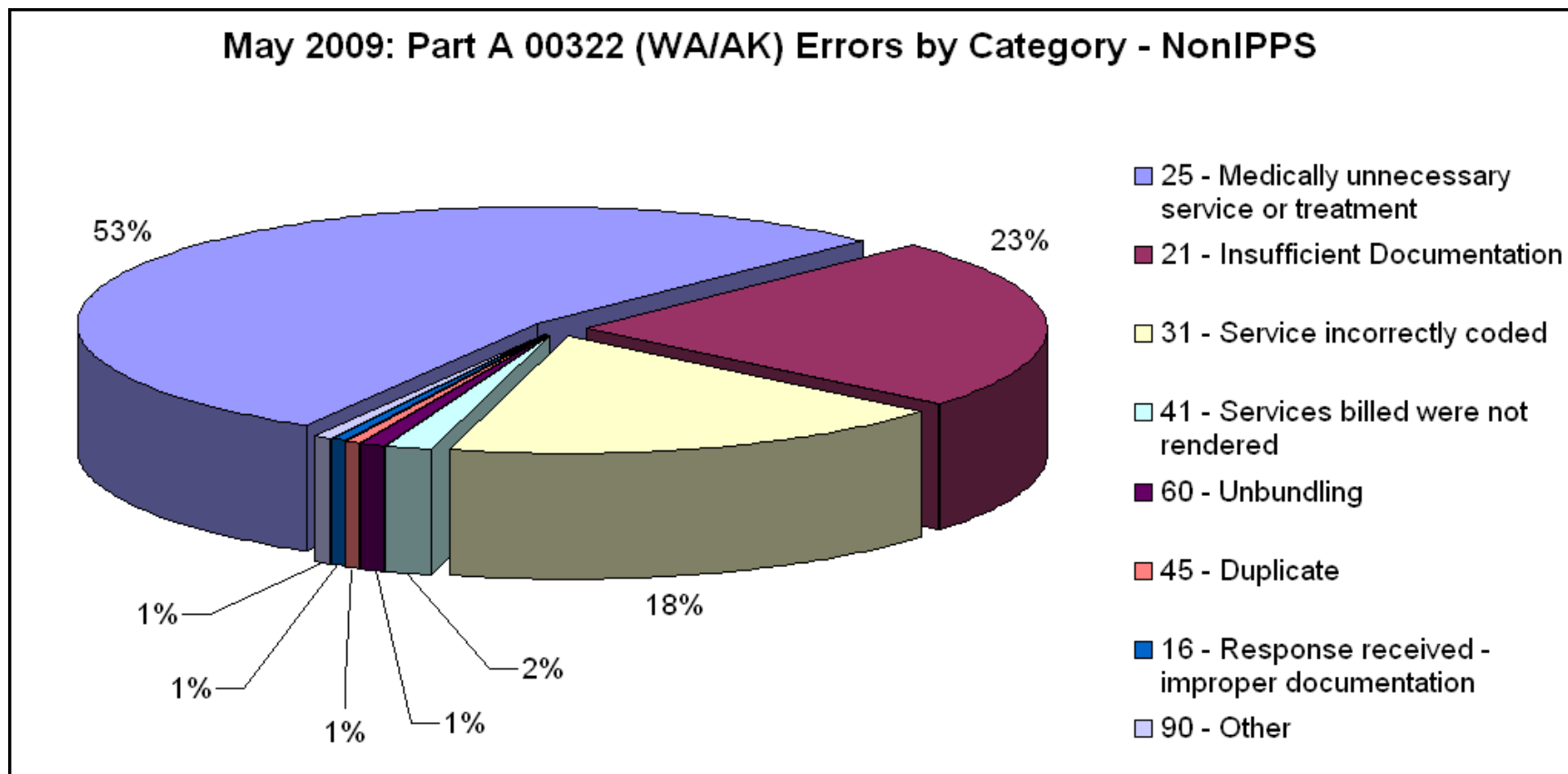
Error codes for Non IPPS claims reviewed



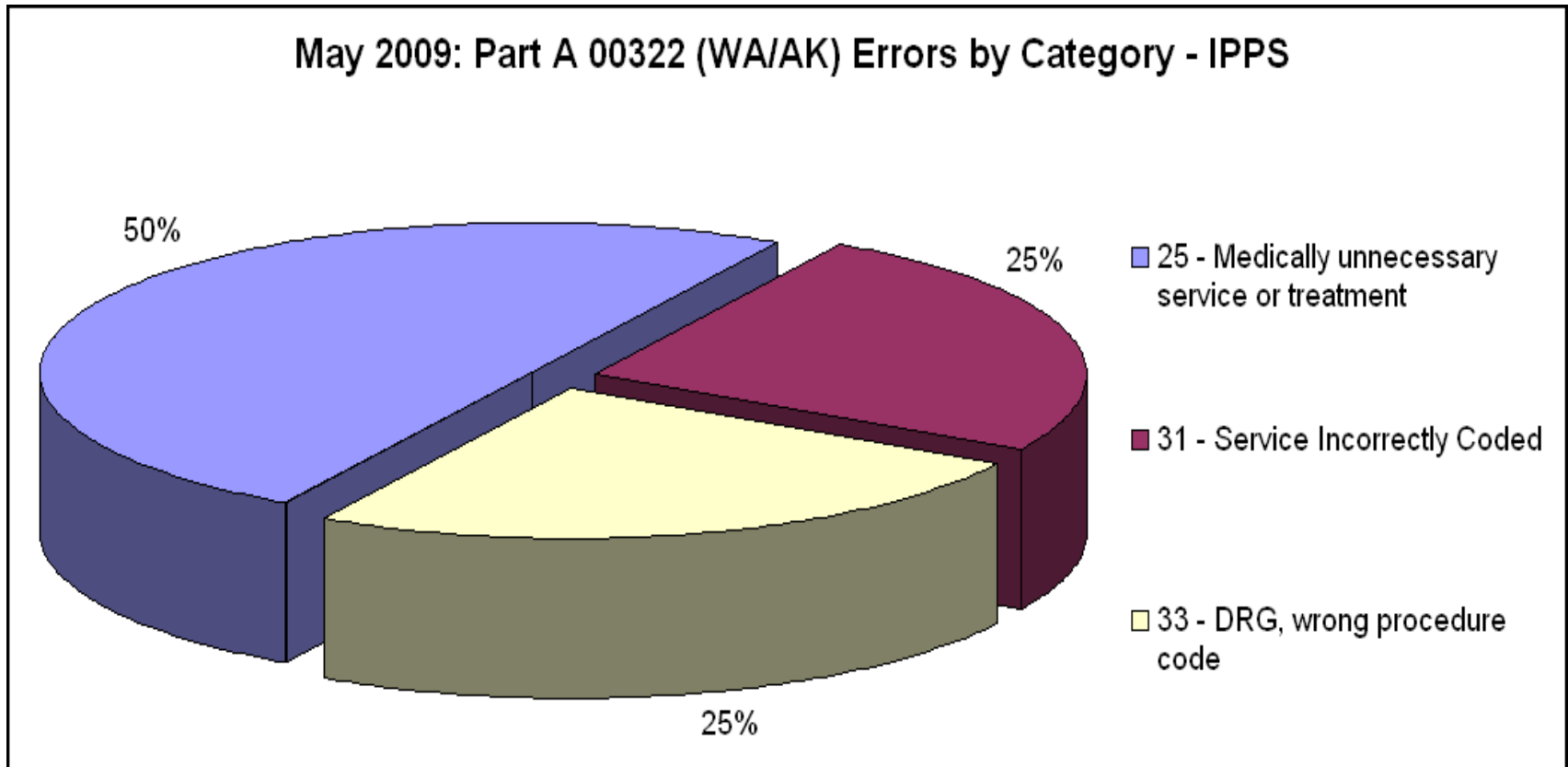
Error codes for IPPS claims reviewed



Error codes for Non IPPS claims reviewed



Error codes for IPPS claims reviewed



Where to Get More Information

- Websites:
 - CMS:
 - www.cms.hhs.gov/cert
 - Noridian:
 - www.noridianmedicare.com

Additional Items

Ask the Contractor Teleconference (ACT)

- Speak directly to Medicare contractor to ask questions on topics of your choice
- NAS staff available to answer questions
- Toll free
- Details found in Medicare A News bulletins
- Reminders sent in weekly e-mails and posted to What's New webpage
- Next ACT Call is November 12, 2009

- 3 assistance levels in PCC
 - 1st level – Interactive Voice Response (IVR)
 - Part B – 1-877-908-8431
 - 2nd level – Customer Service Representatives (CSR) & Customer Service Specialists (CSS)
 - Part B – 1-800-933-0614
 - 3rd level – Provider Relations Research Specialist (PRRS)
- Internet Only Manual (IOM) Publication 100-09, Chapter 6, Sections 30.1, 30.5 and 30.5.1
- CR3376

- As of September 8, 2009, Change Request (CR) 6482 updated Health Insurance Portability and Accountability Act (HIPAA) callback requirements for CSRs
- Must be on hand at time callback is made to authenticate provider:
 - National Provider Identifier (NPI)
 - Provider Transaction Access Number (PTAN)
 - Last five digits of Tax Identification Number (TIN)

- Don't send a Beneficiary on an unexpected trip
- NAS is unable to assist beneficiaries with their questions
 - NAS is mandated by CMS to refer beneficiaries to Beneficiary Contact Center
- Refer it right the first time!
- 1-800-MEDICARE (1-800-633-4227)
 - Hours – 24/7

- Vaccine provided at **no cost** to providers
 - October availability
 - Medicare will not pay providers for vaccine
 - Medicare allows administration code (G9141)
 - Same as influenza vaccine allowable
 - Separate from seasonal influenza vaccine
- Bill diagnosis V04.81
- MLN Article SE0920
 - Medicare Fee-for-Services (MFFS) Billing for the Administration of the Influenza A (H1N1) Virus Vaccine effective 9/1/09

What Questions do you have?

Thank you