

3. Billing Medicare

Contents

3.1	About Medicare Billing.....	3-3
3.1.1	RPMS Third Party Billing and Medicare Claims Creation.....	3-4
3.2	Common Working File (CWF)	3-5
3.3	Medicare Claim Change Condition Codes.....	3-5
3.4	Provider/Supplier Types.....	3-6
3.4.1	Medicare Part A Providers.....	3-7
3.4.2	Medicare Part B Suppliers/Practitioners	3-7
3.5	Procedure for Billing Medicare.....	3-8
3.5.1	Outpatient Medicare Part A	3-8
3.5.2	Outpatient Medicare Part B.....	3-9
3.5.3	Inpatient Medicare Part A	3-9
3.5.4	In/Outpatient Medicare Part A.....	3-9
3.5.5	Inpatient Medicare Part B only	3-9
3.5.6	Billing Medicare Part B	3-10
3.6	Ambulatory Surgery Center Billing - Medicare.....	3-12
3.6.1	Editing a Claim for Facility Billing	3-12
3.6.2	Billing for Professional Component	3-13
3.6.3	Billing for Anesthesia Services.....	3-17
3.6.4	Medicare Ambulatory Surgery Billing Procedure	3-20
3.7	Medicare Secondary Payer (MSP)	3-21
3.7.1	Working Aged.....	3-22
3.7.2	Disability	3-22
3.7.3	End Stage Renal Disease (ESRD).....	3-23
3.7.4	Liability/Automobile Medical or No-Fault/Personal Injury Protection Insurance.....	3-23
3.7.5	Veterans	3-23
3.7.6	Worker's Compensation	3-24
3.7.7	Black Lung.....	3-25
3.7.8	Provider Responsibilities under MSP	3-25
3.7.9	Submitting Medicare Secondary Payer (MSP) Claims.....	3-26
3.8	Medicare Secondary Payer (MSP) Claims Investigation.....	3-27
3.9	Medicare Timely Filing.....	3-28
3.9.1	Part A Timely Filing	3-28
3.9.2	Part B Timely Filing	3-28

3.10	Claims Resubmission Guidelines.....	3-30
3.10.1	Steps for Approving a Secondary/Tertiary Claim in RPMS.....	3-31
3.10.2	Steps for Exporting a Claim:.....	3-32
3.10.3	Steps for Reprinting a Claim for Resubmission.....	3-32
3.11	Reimbursement for Clinical Nurse Specialist or Nurse Practitioner.....	3-32
3.12	Reimbursement for Physician Assistant.....	3-33

3.1 About Medicare Billing

The Centers for Medicare/Medicaid (CMS) is the regulatory agency for Medicare, Medicaid, and Managed Care Organizations. It is mandated that each facility submit electronically, Medicare and Medicaid claims in the HIPAA 837 format.

The IHS fiscal intermediary and carrier for Medicare is Trailblazer Health Enterprises, LLC. Tribes, Federally Qualified Health Center (FQHC), rural health centers, and other non-IHS entities may have other fiscal intermediaries or carriers. Most clinics have arranged with the intermediary/carrier to have claims transmitted electronically.

Reimbursement for covered inpatient ancillary services and outpatient services is based on all-inclusive rates negotiated annually by IHS and by the Center for Medicare/Medicaid (CMS). Services **included in the IHS all-inclusive rates** are:

- devices (other than dental) to replace all or part of an internal body organ, such as colostomy equipment and supplies
- certain ambulance services
- laboratory; radiology; emergency room and outpatient facility services
- other diagnostic services
- physical therapy
- speech pathology
- occupational therapy
- dialysis in the facility or home
- other medical services such as injection of vaccines

For Ambulatory Surgical Centers (ASC), reimbursement is based on rates published in the Federal Register. A deductible and coinsurance applies to the outpatient services.

For the Medicare flat all inclusive rate, it is recommended that the correct E&M code be billed for Part A and Part B, even though some of the Federally Qualified facilities will have their RPMS system default to an agreed upon code by Medicare for billing purposes.

As with all insurers, the correct CPT codes should be coded at the facility, but the billing process should be done according to payer guidelines. All fees should be updated – CPT, HCPCS, Dental, ASC.

Along with these updates your room rates need to be updated. Room rates can be updated by using the CHS claims your facility receives from the private facilities to which you send your patients. Complete a comparison and document as indicated in the following example.

Revenue Code Description	Facility #1	Facility #2	Previous FY	Proposed

RPMS transfer claims data from PCC into the Third Party Billing package. Some facilities are using a Commercial Off-the-Shelf (COTS) product for billing the insurer. If an IHS site is using other software, the data must interface with the RPMS Third Party Billing and Accounts Receivable applications.

3.1.1 RPMS Third Party Billing and Medicare Claims Creation

An option located on the RPMS Third Party Billing Site parameters menu allows a site to customize the claims creation process for Medicare. This option can also be accessed from the Location Edit module.

The prompt is labeled **Medicare Part B?** The user can choose one of the following:

- **YES** – Allows the system to generate Outpatient claims. These claims are generated with a Visit Type of 131 and are usually set up in the Insurer File as All-Inclusive. These are used mainly for FQHC sites that do not have the Part B authority, since the all-inclusive rate includes Part B.
- **NO** – Allows the system to generate two claims, an outpatient claim and a professional component claim:
 - Visit Type 131 – Outpatient
 - Visit Type 999 – Professional Component

131 – Outpatient Facilities that are hospital-based will generally set their prompts up for this.

- **ONLY** – Allows the system to generate professional claims. These claims are generated with a visit type of 000 – Professional Component. These claims are generated with the intention of billing a fee-for-service (itemized) claim for Medicare services. This type of claim is used primarily for Freestanding Health Centers.

3.2 Common Working File (CWF)

The Common Working File (CWF) reorganizes certain claims processing functions to simplify and improve overall Medicare claims processing, by creating localized databases containing total beneficiary histories. CWF was developed by the CMS Bureau of Program Operations and was designed to

- Create a beneficiary data set that contains all entitlement and utilization information in one location.
- Increase program savings by detecting additional duplicate and inappropriate payments.
- Enhance utilization review opportunities because all beneficiary history is in one file.
- Avoid costly adjustment processing and overpayment recovery activities with pre-payment edits, and perform pre-payment A/B data exchange edits within the claims process.

3.3 Medicare Claim Change Condition Codes

Note: These codes are specific to Medicare.

Claim Change Condition Codes

Valid Code	Code Description
D0	Change to Service Dates
D1	Changes to Charges
D2	Changes to Revenue Codes/HCPCS
D3	Second or subsequent interim PPS bill
D4	Change in Grouper input
D5*	Cancel only to correct a HICN or provider identification number
D6*	Cancel only to repay a duplicate payment or overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill)
D7	Change to make Medicare the Secondary Payer
D8	Change to make Medicare the Primary Payer
D9	Any other change
E0	Change in Patient Status
*D5 and D6 are for XX8 Type of Bill only.	

3.4 Provider/Supplier Types

The following list of provider/supplier types is provided as an example for an Indian Health Services facility.

- Ambulance Service Supplier
- Ambulatory Surgical Center
- Audiologist
- Certified Clinical Nurse Specialist
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Clinical/Group Practice
- Clinical Psychologist
- Community Mental health Center
- Comprehensive Outpatient Rehabilitation Facility
- Critical Access Hospital
- Durable medical Equipment, Prosthetics, Orthotics, or Supplies
- End Stage Renal Disease Facility
- Federally Qualified Health Center - for guidelines, go to this website:
<http://www.cms.hhs.gov/center/fqhc.asp>
- Histocompatibility Lab
- Home Health Agency
- Hospice
- Hospital
- Hospital Department Billing for Part B Practitioner Services
- Independent Clinical Laboratory
- Independent Diagnostic Testing Facility
- Indian Health Services Facility (See below instructions)

For information related to these and other Medicare provider/supplier types, go to this website: <http://www.trailblazerhealth.com/>

Descriptions are available for the provider/supplier types, related to the application process for Medicare.

3.4.1 Medicare Part A Providers

Contact the local CMS Regional Office, which will provide guidance and any initial forms required to begin the enrollment process.

3.4.2 Medicare Part B Suppliers/Practitioners

Contact: TrailBlazer Health Enterprises, LLC
Provider Services
P. O. Box 650544
Dallas, TX 75265-0544
Phone: (866) 528-1602

TrailBlazer will provide guidance and any initial forms required to begin the enrollment process.

- Licensed Clinical Social Worker
- Mammography Screening Center
- Managed Care Organization
- Mass Immunization Roster Biller
- Medical Faculty Practice Plan
- Multi-Specialty facility or Group Practice
- Nurse Practitioner
- Occupational Therapist in Private Practice
- Occupational Therapy (Group)
- Organ procurement Organization
- Other Medical Care Group
- Outpatient Physical Therapy-Occupational Therapy/Speech Pathology Services
- Pharmacies
- Physical therapist in Private practice
- Physical Therapy (group)
- Physiotherapy
- Physician Assistant
- Physician
- Portable X-ray Facility
- Psychiatric Unit (of hospital)
- Public Health/Welfare Agency
- Registered Dietitian/Nutrition Professional

- Rehabilitation Agency
- Rehabilitation Unit (of hospital)
- Religious Non-medial
- Rural Health clinic
- Rural Primary Care Hospital
- Skilled Nursing Facility
- Voluntary Health/Charitable Agency

3.5 Procedure for Billing Medicare

TrailBlazers offers the online GPNet software for Medicare billing and follow-up. Other Fiscal Intermediaries (FI) may offer other types of software programs. However, it is strongly recommended that each facility that bills to TrailBlazers, use the GPNet software to do Medicare billing and follow-up.

The TrailBlazers web site has a number of manuals with instructions for Medicare billing.

<http://www.trailblazerhealth.com>

There are multiple bill types. The three-digit alphanumeric code gives three specific pieces of information.

- The first digit identifies the type of facility.
- The second classifies the type of care.
- The third indicates the sequence of the bill in this particular episode of care. This is also known as the “frequency” code.

3.5.1 Outpatient Medicare Part A

First digit	Type of Facility	1 – Hospital 8 – Hospital ASC Surgery
Second Digit	Bill Classification	1 – Inpatient Part A 2 – Inpatient Part B Only 3 – Outpatient
Third Digit	Frequency	0 – Nonpayment/Zero Claim 1 – Admit through Discharge Claim 2 – Interim – First Claim 3 – Interim – Continuing Claim 4 – Interim – Last5 – Late Charge Only Claim 6 – Adjustment of Prior Claim 7 – Replacement of Prior Claim 8 – Void /Cancel of a Prior Claim

3.5.2 Outpatient Medicare Part B

Bill Types for Outpatient Part B Only

13X, 14X - Hospital
23X - Skilled Nursing Facility
34X - Home Health (not PPS)
71X - Rural Health Clinic (RHC)
72X - Renal Dialysis Facility (RDF)
73X - Federally Qualified Health Center (FQHC)
74X - Outpatient Rehabilitation Facility (ORF)
75X - Comprehensive Outpatient Rehabilitation Facility (CORF)
76X - Community Mental Health Center (CMHC)
83X - Hospital Out surgery
85X - Critical Access Hospital (CAH)

Bill Types for Outpatient Part A and B

32X, 33X - Home Health (PPS)

3.5.3 Inpatient Medicare Part A

Bill Types for Inpatient Part A Only

11X - Hospital
18X - Swing Bed
21X - Skilled Nursing Facility
41X - Religious non-medical Healthcare situation

3.5.4 In/Outpatient Medicare Part A

Bill Types for In/Outpatient Part A Only

81X, 82X - Hospice

3.5.5 Inpatient Medicare Part B only

Bill Types for Inpatient Part B Only

12X - Hospital
22X - Skilled Nursing Facility

3.5.6 Billing Medicare Part B

A. Assignment

Under the participating physician program, the physician agrees to accept payment from Medicare (80% of the allowable) plus from the patient, the remaining 20% of reasonable charges after the \$100 deductible has been met.

The payment goes directly to the physician. Effective September 1, 1992, patients are not allowed to submit claims to Medicare (with five exceptions).

Physicians, practitioners, and suppliers who fail to submit claims are subject to civil money penalties of up to \$2,500 for each claim. Situations when a patient may file a claim are:

- Services covered by Medicare for which the patient has other insurance that should pay first;
- Services not covered by Medicare for which the patient wants a formal Part B coverage determination;
- Services provided by a physician who refuses to submit the claim;
- Services provided outside the United States; and
- When durable medical equipment is purchased from a private source.

Reasonable charges is the amount that Medicare lists on the Remittance Advice (RA) – formerly known as Explanation of Benefits (EOB) – which is the allowed (approved) charge for the procedure. This charge may be lower than the fee the physician lists on the claim.

When a physician accepts assignment, he or she may bill the non-beneficiary only 20% of what Medicare considers a reasonable (allowed) charge.

Interest fees cannot be assessed to Medicare patients. Do not collect the Medicare co-payment up front. However, it is permissible to collect the deductible up front for non-beneficiaries only.

B. Nonparticipating (non-par) Physician

A physician who does not participate has an option regarding assignment. The physician may not accept assignment for all services or may have the option of accepting assignment for some services and collecting from the patient for other services performed at the same time and place.

An exception to this policy is mandatory assignment for clinical laboratory tests and services by physician assistants.

Usually, a nonparticipating physician who is not accepting assignment collects the total fee from the patient but may bill no more than the Medicare limiting charge. **Limiting charges** is a percentage limit on fees, specified by legislation, that non-par physicians may bill Medicare beneficiaries above the fee schedule amount.

Medicare sends the payment check to the patient.

C. Patient's Signature Authorization

Signatures are required on all HCFA-1500 claims forms, except Medicare/Medicaid cases.

Sometimes it is not possible to obtain the signature of a Medicare patient because of confinement in a nursing facility or hospital or at home. In such cases, physicians can obtain a lifetime signature authorization from the patient. The lifetime beneficiary claim authorization and information release form is an example that can be used for assigned and non-assigned Medicare claims and kept in the patient's medical records.

The HCFA-1500 form should be submitted with the notation in the patient's signature block: "Patient's payment authorization on file." If the claim will be automatically crossed over and paid by a Medigap carrier, obtain a lifetime signature authorization for the Medigap carrier.

D. Time Limits

The time limit for sending in claims is the end of the year following the year in which services were used.

E. Required Form

The form that physicians use to submit their claims to Medicare is HCFA1500.

- F.** RA documents are received by the physician and the patient, with the Medicare check going to the Physician.
- G.** The following list shows the kinds of physicians' services that Medicare Part B will help pay for.
- Medical and surgical services by a doctor of medicine (MD), doctor of osteopathy (DO or MD), or a doctor of dental medicine or dental surgery (DDS).
 - Certain services by podiatrists (DPM)
 - Limited services by chiropractors (DC), such as subluxation of the spine.

3.6 Ambulatory Surgery Center Billing - Medicare

For the most up-to-date guidance for Ambulatory Surgery Center (ASC) services, go to this website:

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

3.6.1 Editing a Claim for Facility Billing

For instructions for editing a claim for facility billing, see the *RPMS Third Party Billing (ABM) User's Manual*, which is available at this website:

<http://www.ihs.gov/Cio/RPMS/index.cfm?module=home&option=documents>

3.6.2 Billing for Professional Component

The following screen output displays a sample walkthrough of billing for professional component.

Note: The information provided in this example is for demonstration purposes only.

```

Select Add/Edit Claim Menu Option: ED <Enter>
                                         Type ED and press Enter.

EDITING A CLAIM (BILLING CATARACT EXTRACTION)
Select CLAIM or PATIENT: 12346 <Enter>
                                         Enter claim number and Press Enter.

                                         Asterisk (*) marks where Billing Tech needs to review.
Claim Number: 12346
..... (CLAIM SUMMARY) .....

___ Pg-1 (Claim Identifiers) _____ Pg-4 (Providers) _____

Location..: GALLUP MED C           | Attn: COX,JAMES
Clinic....: DAY SURGERY           | Oper: COX,JAMES
Visit Type: PROFESSIONAL COMPONENT|_____ Pg-5A (Diagnosis) _____
Bill From: 11-29-2005 Thru: 11-29-2005 | 1) CATARACT LEFT EYE
                                         |

___ Pg-2 (Billing Entity) _____|_____ Pg-8 (CPT Procedures)

MEDICARE                               ACTIVE | 1) CATARACT SURG W/IOL, 1 STAGE

                                         Press Enter to go to the next page.
    
```

```

~~~~~ PAGE 1 ~~~~~
Patient: 99999          Claim Number: 12346
..... (CLAIM IDENTIFIERS)
.....

    [1] Clinic.....: DAY SURGERY
    * [2] Visit Type.....: PROFESSIONAL COMPONENT
    * [3] Bill Type.....: 999
    [4] Billing From Date..: 10/19/2004
    [5] Billing Thru Date..: 10/19/2004
    [6] Super Bill #.....:
    [7] Mode of Export.....: 837 PROF (HCFA)
    [8] Visit Location.....: GALLUP MED C

-----
Desired ACTION (Edit/View/Next/Jump/Back/Quit): N// <Enter>
                                         Press Enter to go to the next page.

~~~~~ PAGE 2 ~~~~~
Patient: 99999          Claim Number: 12346
..... (INSURERS) .....

To: MEDICARE PART A - TEXAS      * Bill Type...: 999
    12800 INDIAN SCHOOL RD, NE    Proc. Code..: CPT4
    ALBUQUERQUE, NM MEDIA-CARE    Export Mode.: 837 PROF (HCFA)
    (888)763-9836                 Flat Rate...: N/A
.....

          BILLING ENTITY      STATUS      POLICY HOLDER
=====
[1] MEDICARE                  ACTIVE      Patient, Demo
-----
WARNING:072 - EMPLOYMENT STATUS CODE UNSPECIFIED
WARNING:075 - EMPLOYER LOCATION UNSPECIFIED

-----
Desired ACTION (Edit/View/Next/Jump/Back/Quit): N// <Enter>
                                         Press Enter to go to the next page.

~~~~~ PAGE 3 ~~~~~
Patient: 99999          Claim Number: 12346

```

```

..... (QUESTIONS) .....

* [1] Release of Information..: YES   From: 04/04/2005 Thru:
* [2] Assignment of Benefits..: YES   From: 04/04/2005 Thru:
[3] Accident Related.....: NO
[4] Employment Related.....: NO
[5] Emergency Room Required.:
[6] Special Program.....: NO
[7] Outside Lab Charges.....:
[8] Date of First Symptom...:
[9] Date of Similar Symptom.:
[10] Date of 1st Consultation:
[11] Referring Phys. (FL17)  :
[12] Case No. (External ID)..:
[13] Medicaid Resubmission No:
[14] PRO Approval Number.....:
[15] HCFA-1500B Block 19.....:
[16] Supervising Prov.(FL19) :           Date Last Seen:
Enter RETURN to continue or '^' to exit: <Enter>
                               Press Enter to go to the next page.

~~~~~ PAGE 4 ~~~~~
Patient: 99999                Claim Number: 12346
..... (PROVIDER DATA) .....

          PROVIDER          NUMBER          DISCIPLINE
=====
(attending)PROVIDER, DR      8HZ343      OPHTHALMOLOGIST
(rendering)PROVIDER, DR      8HZ343      OPHTHALMOLOGIST

Desired ACTION (Add/Del/View/Next/Jump/Back/Quit): N// <Enter>
                               Press Enter to go to the next page.

~~~~~ PAGE 5A ~~~~~
Patient: 99999                Claim Number: 12346
..... (DIAGNOSIS) .....

BIL  ICD9
SEQ  CODE - Dx DESCRIPTION          PROVIDER'S NARRATIVE
=====
1   366.9 - UNSPECIFIED CATARACT    CATARACT NOS

Desired ACTION (Edit/View/Next/Jump/Back/Quit): N// <Enter>
                               Press Enter to go to the next page.

~~~~~ PAGE 8B ~~~~~
Patient: 99999                Claim Number: 12346
Mode of Export: 837 PROF (HCFA)
..... (SURGICAL PROCEDURES) .....

BIL SERV  REVN  CORR  CPT
    
```

```

SEQ DATE  CODE  DIAG  CODE          PROVIDER'S NARRATIVE  UNITS  CHARGE
=====
1  CHARGE DATE: 10/19/2004
  *** 1      66984 CATARACT SURG W/IOL, 1 STAGE          1  951.00
                                           =====
                                           $951.00

Desired ACTION (Add/Del/Edit/Seq/View/Next/Jump/Back/Quit/Mode):
N//<Enter>
      Keep pressing ENTER until you get to the LAST PAGE (8J).

      Press ENTER, and the system prompts you back to PAGE 1.

KEY ENTER (A) FOR APPROVAL

      ***** 837 PROF (HCFA) CHARGE SUMMARY *****
              Corr
Charge Date   POS TOS  Description   Diag   Charge   Qty
-----
10-19-2004   22  2    66984         1     951.00   1
              -----
TOTAL CHARGE                951.00

Form Locator Override edits exist for POS/TOS

ENTER

              SUMMARY
=====

              Previous          Bill
Form   Charges  Payments  Write-offs  Non-cvd  Amount
-----
837 PROF (HCFA)  951.00  0.00    0.00    0.00    951.00
              =====
              951.00  0.00    0.00    0.00    951.00

Do You Wish to APPROVE this Claim for Billing? Y <Enter>
              Type Y (YES) and press Enter.
    
```



```

~~~~~ PAGE 5A
Patient: 99999          Claim Number:
..... (DIAGNOSIS) .....
BIL ICD9
SEQ CODE - Dx DESCRIPTION          PROVIDER'S NARRATIVE
=====
1 366.9 - UNSPECIFIED CATARACT    CATARACT NOS

Desired ACTION (Add/Del/Edit/Seq/View/Next/Jump/Back/Quit): N//
<Enter>

                                Press Enter to go to next page.

~~~~~ PAGE 8G ~~~~~
Patient: 99999          Claim Number:
Mode of Export: 837 PROF (HCFA)
..... (ANESTHESIA SERVICES) .....

      REVN          BASE   TIME   TOTAL
      CODE          CPT - ANESTHESIA SERVICES      CHARGE  CHARGE  CHARGE
=====

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// A
<Enter>

                                Type A (ADD) and press Enter.

===== ADD MODE - ANESTHESIA SERVICES =====
Select Anesthesia (CPT Code): 00142 <Enter> ANESTH, LENS SURGERY
      ANESTHESIA FOR PROCEDURES ON EYE; LENS SURGERY
      ...OK? Yes// <Enter> (Yes)

      Anesthesia PROVIDER: MELO,FRANCISCO// <Enter> FJM
ANESTHESIOLOGIST

      Anesthesia BASE CHARGE: 183.7// <Enter>
      Anesthesia PLACE OF SERVICE: 22// <Enter> OUTPATIENT HOSPITAL
* Anesthesia UNITS: 1// 60 <Enter>
* Anesthesia MODIFIER: AA <Enter>

Attempting FILEMAN lookup...
      ...OK? Yes// <Enter> (Yes)

                                Press Enter for Yes.

* Anesthesia START DATE/TIME: 101904@0900 <Enter> (OCT 19,
2004@09:00)
* Anesthesia STOP DATE/TIME: 101904@1000 <Enter> (OCT 19, 2004@10:00)
      Anesthesia OBSTETRICAL?:
* Anesthesia TIME CHARGE: 167// 60 <Enter>

      Enter how the anesthesia should look after all required entry.
    
```

```

~~~~~ PAGE 8G ~~~~~
Patient: 99999          Claim Number:
Mode of Export: 837 PROF (HCFA)
..... (ANESTHESIA SERVICES) .....

REVN                      BASE      TIME      TOTAL
CODE    CPT - ANESTHESIA SERVICES  CHARGE  CHARGE  CHARGE
=====
[1] 00142-AA ANESTHESIA FOR PROCEDURES ON EYE; 183.70  60.00  243.70
    LENS SURGERY
    Start Date/Time: 19-OCT-2004 9:00 AM
    Stop Date/Time: 19-OCT-2004 10:00 AM
                                =====
                                $243.70

                Keep pressing ENTER until the system prompts you
                    to return to the Main Menu.

                        Type A to approve the claim.

                ***** 837 PROF (HCFA) CHARGE SUMMARY *****
                          Corr
Charge Date   POS TOS  Description   Diag   Charge   Qty
-----
* 10-19-2004   22  7   00142-AA     1     243.70   60
                                -----
                                TOTAL CHARGE                243.70

Form Locator Override edits exist for POS/TOS

                        Press Enter to go to next page.

                Previous          Bill
                Form   Charges   Payments  Write-offs  Non-cvd   Amount
-----
837 PROF (HCFA)  243.70   0.00     0.00     0.00     243.70
=====
                243.70   0.00     0.00     0.00     243.70

Do You Wish to APPROVE this Claim for Billing? Y <Enter> YES
                        Type YES to approve the claim.
    
```

3.6.4 Medicare Ambulatory Surgery Billing Procedure

The regulatory agency for Medicare program is the Centers for Medicare and Medicaid (CMS). Under the prospective payment system (PPS), Attachment C – for covered ambulatory surgery services, the reimbursable rate is based on the Ambulatory Surgery center (ASC) Group Rates published in the Federal Register. Medicare Part B deductibles and coinsurances apply to eligible covered services.

The coder completes the coding for all ambulatory surgery visits. The coding will be entered in the PCC menu.

The claims generator will convert and create a bill in the Third Party Billing application overnight.

The biller will print out a Flag-As Billable Brief Summary listing and will use this listing as a guide to what visits/claims to bill. The bill type for Ambulatory surgery is 831.

All edits need to be accomplished to complete a “clean” claim. Once all the edits have been made, the biller will determine the approval of the bill and will submit the bill on the appropriate claim form, which will be transmitted electronically.

- Review the Inpatient or Ambulatory Surgery abstracts from UR.
- Verify completeness and accuracy.
- Enter the claims data into the system for processing.
- Review data for completeness and accuracy.

Type of Bills (Locator 4 on the UB92)

– Inpatient Claims 111

The total days in the hospital has been determined to be medically necessary based on the severity of the illness according to the utilization review criteria, or stated another way, the services to the patient have been labeled as “covered services.”

– Ambulatory Surgery 831

This bill type is used to bill for ambulatory surgeries done on an outpatient basis. Ambulatory surgery rates must be used.

– **No Pay Claims** **110**

During the utilization review, the severity of the illness did not warrant hospitalization. The utilization review will indicate “0 Bill”. Remarks should include why the services were not covered.

– **Outpatient Claims** **131**

– **Inpatient Part B Only** **121**

The severity of the illness has been determined not medically necessary based on the utilization review criteria. Room and board for the hospitalization are not covered nor are any provider visits.

– **Other alternate resources** **117**

A claim was processed and paid; however, the patient had other alternate resources that should have been billed. Using “117” will instruct the system to “recoup” reimbursement.

3.7 Medicare Secondary Payer (MSP)

Medicare Secondary Payer (MSP) is used by Medicare when Medicare is not responsible for paying first. It is important to check if Medicare or Medicaid has already been billed and take the appropriate action.

For accounts with two insurance companies, the RPMS Accounts Receivable application requires documentation of the primary billing company.

By Federal law, Medicare is secondary payer to a variety of government and private insurance benefit plans. Medicare should be viewed as the secondary payer when a beneficiary can reasonably be expected to receive medical benefits through one of more of the following means:

- An Employer Group Health plan for **working aged** beneficiaries
- A Large Group Health Plan for **disabled** beneficiaries
- Beneficiaries eligible for **End State Renal Disease**
- **Liability/Automobile medical or no-fault insurance/Personal Injury Protection (PIP)**
- **Veterans Administration (VA)**
- **Workers’ Compensation Plan**
- Federal **Black Lung** Program

Any conditional primary payment(s) made by Medicare for services related to an injury is subject to recovery. Conditional payments can be made on:

- Liability
- Automobile medical or no-fault insurance
- Workers' Compensation

For more information on Medicare Secondary Payer, go to this website:

<http://www.cms.hhs.gov/MedicareSecondPayerandYou/>

3.7.1 Working Aged

Medicare is secondary for the **Working Aged** when the following conditions apply:

- Employer Group Health Plan of 20 or more employees,
- Employer Group Plan covers the same services as Medicare,
- Beneficiary is age 65 or older,
- Beneficiary is entitled to Part A (hospital insurance of Medicare, *and*
- Beneficiary or spouse of beneficiary is actively employed and covered by an employer group plan by reason of his/her employment

3.7.2 Disability

Medicare is secondary for beneficiaries who are under age 65 and are entitled to Medicare due to a **disability** other than End State Renal Disease (ESRD) for the following criteria:

- The beneficiary has coverage under a Large Group Health Plan with 100 or more employees,
- The beneficiary is entitled to Medicare based solely on a disability (other than ESRD), *and*
- The beneficiary is actively employed or covered as a dependent of an actively employed person covered under a Large Group Health Plan with 100 or more employees.

3.7.3 End Stage Renal Disease (ESRD)

The **End Stage Renal Disease (ESRD)** criteria applies to individuals, including dependent children who are entitled to Medicare on the basis of ESRD and who are covered under an Employer Group Plan, regardless of the size of the plan. The criteria are

- If an Employer Group Health Plan (EGHP) is offered through an employer because of his/her employment or employment of spouse or other family member's active employment; then Medicare is secondary to an EGHP for individuals who have Medicare benefits based on ESRD. The beneficiary can be any age; *and*
- The period in which Medicare is secondary is called the coordination of benefit period. Secondary benefits are payable for a period up to 30 months.

3.7.4 Liability/Automobile Medical or No-Fault/Personal Injury Protection Insurance

Section 953 of the Omnibus Budget Reconciliation Act of 1980, amended by the Deficit Reduction Act of 1994, precludes Medicare payment for items or services to the extent that payment has been made or can reasonable be expected to be made under auto medical, Personal Injury Protection (PIP), no-fault, or any **liability** insurance plan or policy, including self-insurance plans.

Services that should be billed to these insurance plans are:

- Services payable under one of the above plans (except third-party liability) – that plan should be billed until all benefits are exhausted.
- Any payments made by Medicare for services payable under one of these policies constitute overpayments and are subject to recovery.
- Liability insurance plan is an exception to the above rule. The physician/supplier has the option to bill Medicare for conditional primary payment.

3.7.5 Veterans

Veterans who are also entitled to Medicare may choose which program will be responsible for payment for services that are covered by both programs. Claims for services for which the veteran elects Medicare coverage should be submitted to Medicare in the usual manner. A denial from the VA is not needed prior to submitting a claim for Medicare.

Medicare will be primary to the VA in the following situations:

- VA denies the services and the services are covered under Medicare.
- Correspondence is received indicating “No VA Coverage.”

Insurers frequently see the following situations with Medicare and VA:

- If the VA is unable to provide treatment for the services at one of its own facilities or by one of its own physicians, they may refer the beneficiary to an outside facility or physician.
- Pre-authorization is obtained from the VA to use an outside facility.
- The beneficiary has been issued a “fee basis” card. This card is an agreement by the VA to pay up to a specified dollar amount for treatment of a specific disability or for any condition specified on the face of the “fee basis” card.

3.7.6 Worker’s Compensation

Federal law precludes payment for services payable under a **Worker’s Compensation** policy. If services are work-related, the Worker’s Compensation policy should be billed until all benefits are exhausted.

Medicare remains primary payer for services not related to Worker’s Compensation.

With Worker’s Compensation:

- Medicare may make payments for Medicare covered services, if not payable under the Worker’s Compensation policy.
- Services payable under a Worker’s Compensation policy that have been paid by Medicare constitute overpayments and are subject to recovery.
- A beneficiary’s statement that an injury or illness is not work-related may be accepted in absence of reasonable doubt.

3.7.7 Black Lung

Medicare will pay secondary to an insurance company paying for **Black Lung** diagnosis with the exception of the United Mine Worker's Association (UMWA). UMWA is their own government entity; therefore, Medicare Part B will deny charges.

However, services rendered to these beneficiaries for conditions not related to black lung diagnoses should be billed directly to Medicare, such as cardiac failure brought on by renal failure. Medicare will pay primary for services not related to black lung disease.

3.7.8 Provider Responsibilities under MSP

Part A provider (hospitals):

- Obtain billing information prior to providing hospital services, using the recommended Centers for Medicare and Medicaid Services' (CMS) questionnaire (or a questionnaire that asks similar types of questions).
- Submit any MSP information to the intermediary, using condition and occurrence codes on the claim

Part B provider (physicians and suppliers):

- Follow the proper claim rules to obtain MSP information, such as group health coverage through employment or non-group health coverage resulting from an injury or illness;
- Inquire at the time of the visit if the beneficiary is taking legal action in conjunction with the services performed.
- Submit an Explanation of Benefits (EOB) form to the designated carrier with all appropriate MSP information. If submitting an electronic claim, provide the necessary fields, loops, and segments to process an MSP claim.

For more information, go to the CMS website:

<http://www.cms.hhs.gov/MedicareSecondPayerandYou/>

3.7.9 Submitting Medicare Secondary Payer (MSP) Claims

To ensure correct reimbursement when Medicare is secondary payer to another insurance company, use the following instructions:

- Screen Medicare beneficiaries for secondary coverage,
 - Send claims to the primary insurance and then to Medicare,
- and*
- If you are filing a Medicare secondary claim on an HCFA-1500 claim form, list all services on the detail lines. Include a copy of the primary insurance company's Explanation of Benefits
 - If you file electronically, you do not need to include a copy of the primary insurance company's Explanation of Benefits. The claim does require the submission of three additional data elements:
 - Medicare secondary type codes;
 - Amount paid by primary payer; and
 - Amount allowed by primary payer

The physician or provider must file a Medicare secondary claim, if he/she receives the primary Explanation of Benefits directly from the beneficiary.

Item 11 of the HCFA-1500 must be completed. By completing this item, the physician or provider acknowledges having made a good faith effort to determine whether Medicare is the primary or secondary payer.

- If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to Items 11a-11c.
- If there is no insurance primary to Medicare, enter the word "NONE" and proceed to Item 12.
- If there has been a change in the insured's insurance status, such as retired, enter the word "NONE" and proceed to 11b.

Item 11a is the insured's birth date and sex; 11b is the employer's name, if applicable; and 11c is the nine-digit payer ID identification number of the primary insurance plan or program.

3.8 Medicare Secondary Payer (MSP) Claims Investigation

Effective January 8, 2001, the **Coordination of Benefit (COB)** contractor assumed responsibility for virtually all initial MSP development activities formerly performed by Medicare intermediaries and carriers. This means the COB contractor is charged with ensuring the accuracy and timely update of data populated on Medicare's eligibility database regarding other health insurance that is primary to Medicare. The COB contractor also handles MSP-related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries.

The COB contractor is primarily an information gathering entity. A variety of methods and programs are used to identify situations in which Medicare beneficiaries have other health insurance this is primary to Medicare:

Process	Description
Secondary Claim Development	When a claim is submitted with an explanation of benefits (EOB) attached from an insurer other than Medicare, a questionnaire is sent to the beneficiary to collect information on the existence of other insurance that may be primary to Medicare.
Self-Report Development	A self-report covers the full spectrum of MSP situations. Any source that contacts the COB contractor initiates this type of development process in order to address these inquiries and to assure that the information provided is accurate.
Trauma Development	When a diagnosis appears on a claim that information is received through correspondence or on a claim that indicates a traumatic accident, injury, or illness, which might form the basis of MSP, a questionnaire is sent to collect information on the existence of other insurance that may be primary to Medicare. This questionnaire may be sent to the beneficiary, provider, attorney, or insurer.
CFR 411.25	This process confirms MSP information received from a third party payer

3.9 Medicare Timely Filing

3.9.1 Part A Timely Filing

Under Medicare law, claims are accepted by the carrier for dates of service in the current year, the previous year, and the last three months (October, November, and December) of the year prior.

For purposes of the time limit, a hospital shall be deemed to have filed a claim for payment for inpatient hospital services on the date it submitted an admission notice for such services, provided the claim is submitted within 60 days after the intermediary or Social Security Administration, as appropriate, replied to the admission notice.

Where the hospital is establishing timely filing of the claim on this basis (i.e., the claim would not otherwise be timely filed), it should so note on the billing or an attachment to the billing, and indicate the date the admission notice was sent and the date the reply was received.

Where there is a Social Security Administration (SSA) error (e.g., misrepresenting, delay, mistake, or other action of SSA or its intermediaries or carriers) that causes the failure of the hospital to file a claim for payment within the time limit, the time limit will be extended through the last day of the sixth calendar month following the month in which the error is rectified by notification to the hospital or beneficiary, but not beyond December 31 of the third calendar year after the year in which the services were furnished. (For services furnished during October -December of a year, the time limit may be extended no later than the end of the fourth year after that year.)

3.9.2 Part B Timely Filing

For Medicare payment to be made for a claim for physician and other Part B services reimbursable on a reasonable charge basis, the claim must be filed no later than the end of the calendar year following the year in which the service was furnished, except for services furnished in the last 3 months of a year, where the time limit is December 31 of the second year following the year in which the services were rendered. This time limit was effective with claims filed after March 1968. (See §§ 266.7 and 266.8 for effect of Federal non-workdays and rules applicable to claims received in the mail.)

For example: A patient received laboratory tests at a clinic in August 2004. The claim for reimbursement for such services must be billed on or before December 31, 2005. If the tests were performed in October 2004, the claim must be filed on or before December 31, 2006.

Where there is an administrative error (that is, misrepresentation, delay, mistake, or other action of SSA or its intermediaries or carriers) that causes the failure of the beneficiary or the hospital, physician, or supplier to file a claim for payment within the time limit specified in § 271, the time limit will be extended through the close of the sixth calendar month following the month in which the error is rectified.

Consideration of possible extension of the time limit on Part B reasonable charge claims will be initiated only if there is a basis for belief that the claimant (the enrollee or his representative or assignee) has been prevented from timely filing by an administrative error. For example, he states that official misinformation caused the late filing, or the social security office calls to the intermediary's attention a situation in which such error has caused late filing.

In some cases, a hospital may have incorrectly billed for a Part B professional component as a hospital expense. For example, a physician's services were erroneously considered entirely administrative in nature and the error was not discovered until the final cost settlement.

Where the claim which included the physician services was filed within the time limit, it establishes protective filing for a subsequent perfection of a Part B claim. Such claims will be considered filed as of the date the incorrect billing was submitted to the intermediary provided the usual claims information (e.g., the SSA-1554 in the case of a hospital-filed claim) is submitted within 6 months after the month in which the notice was sent that payment for the patient care services was disallowed.

The perfected claim may be filed by the physician on the basis of assignment, or by the hospital (where the hospital has a contractual arrangement to bill and receive payment for the physician's services), or may be filed by the patient on the basis of an itemized bill.

A hospital claim filed within the Part B time limit will not establish a filing date for the related professional component where such component was recognized and not included in the provider bill (e.g., no claim was filed for the professional component as a non-provider expense because the physician and hospital could not agree on the exact amount of the component charge or who would bill for it).

Where the hospital bills for physician and hospital services under the combined billing procedure presume that the billing is timely filed as to the physician component if it is timely filed as to the hospital component, and that it is not timely as to the physician component if it is not timely filed as to the hospital component.

Where the time limit has expired on services reimbursable on a reasonable charge basis, there is no requirement that a bill be filed. However, where a person (or organization) accepts assignment within the time limit, but fails to submit a timely claim, he is barred by the terms of the assignment from collecting from the patient or other person amounts in excess of the deductible and coinsurance involved.

For claims submitted electronically to Medicare via GPNNet, the following abbreviations may be returned for denied claims:

R status	Rejected
T status	Return to Provider (RTP)
D status	Medically denied
Type of Bill	XXP (PRO adjustment) or XXI (Intermediary adjustment)

The original bill can be resubmitted on both the status of T or R, if additional or corrected information is supplied. The original type of bill frequency codes should be used. The T status cannot be adjusted (XX7) or voided (XX8), since it is not considered an active bill.

3.10 Claims Resubmission Guidelines

- In some instances, the claim may not be considered unless billing errors are corrected. These Remittance Advices or Explanation of Benefits are routed back to the individual billing clerks for correction and then resubmitted to the respective insurer.
- Claim resubmission may be done via fax, mail, or electronically.
 - The filing limit for Medicaid varies by state, from as low as 120 days to one year. Resubmission of claims is usually within 6 months from the date of the remittance advice.
- Medicare claims are accepted by the carrier for dates of service in:
 - The current year
 - The previous year
 - October, November, December of the year prior to that
 - Resubmission for denied claims must be appealed within 4 months from the remittance date

- Most Private Insurance companies have a one year filing limit. Some private insurers are longer than one year. Resubmissions on denied claims must be completed by December 31 of the next calendar year
- The claim may then be rolled for further billing to secondary/tertiary insurer as applicable.

3.10.1 Steps for Approving a Secondary/Tertiary Claim in RPMS

1. Exit the Accounts Receivable (A/R) menu.
2. Go to the RPMS Third Party Billing application and select the Add/Edit Claim Menu.
3. At the prompt, type **EDCL** (Edit Claim Data) and press Enter..
 - a. Examine claim for accuracy and make corrections if necessary.
 - b. On **Page 1**, check for visit type and mode of export.
 - Visit type is set to Secondary or similar, based on site set up
 - Mode of export allows you to bill the claim on a HCFA 1500 or UB-92 manually. Since Medicare/Medicaid claims are transmitted electronically by utilizing the HIPAA 837P and/or 837I, the mode of export needs to be changed to HCFA-1500 and/or UB-92 so claims can be resubmitted manually.
4. On **Page 2**, select the billing entity and insurer address.
5. On Page 3, review Assignment of Benefits and Release of Information.
6. On **Page 4**, check for provider name and credential.

Note: If corrections are needed on Pages 5A through 9F, claim is routed to Billing technician.

7. JO (Jump Zero) to claim summary.
8. Type **A** to approve the claims.

9. Verify the mode of export and correct dollar amount(s). Then type **Y** (Yes) to approve claim.
10. Exit EDCL.

3.10.2 Steps for Exporting a Claim:

1. Go to the Print Bills Menu, and select **EXPR** to export the approved claim.
2. Select form to be exported (HCFA-1500 or UB-92) and press Enter.
3. Select a print device for the HCFA-1500 or UB-92 form by entering the device for your printer, and press Enter.

3.10.3 Steps for Reprinting a Claim for Resubmission

1. Exit the Accounts Receivable (A/R) Menu.
2. Go to REPR or reprint bill.
3. At the prompt, type **1** for Selective Bill(s) and press Enter.
4. Enter the claim number(s) and press Enter.
5. Enter the print device and enter your printer device for either the HCFA-1500 or UB-92 to reprint ADA.
6. Press Enter to start the print jobs.

For all resubmissions, attach a copy of the Remittance Advice, Explanation of Medicare Benefits, and Commercial insurance EOBs when appropriate

3.11 Reimbursement for Clinical Nurse Specialist or Nurse Practitioner

For the Clinical Nurse Specialist (CNS) or Nurse Practitioner (NP), payments are only under assignment. Direct payments can be made to either the NP or the facility, but only if no facility or other provider charges are paid in connection with the service. Reimbursement would be equal to 80 percent of the lesser of the actual charge or 85 percent of the physician fee.

3.12 Reimbursement for Physician Assistant

For the Physician Assistant (PA), payments are made under an assigned basis. Since the PA services are performed under the direction of the provider, all payments would be made to the provider or facility, but only if no facility or other provider charges are paid in connection with the service.

Reimbursement for eligible services would be equal to 80 percent of the lesser of the actual charge or 85 percent of the physician fee schedule.