

# MEDICARE 2010 UPDATES

NATIONAL GOVERNMENT  
SERVICES

For the

CENTRAL OHIO PATIENT  
ACCOUNT MANAGERS

# New Claim Filing Time Limits

- Regulations changed by Patient Protection and Affordable Care Act (PPACA)
  - New one-year timely filing rule, based on date of service
  - Medicare Part A & Part B Fee-For-Service claims
  - Permission in law to allow exceptions to one-year filing deadline
    - No exceptions established at this time

# New Claim Filing Time Limits

<b>Services Rendered:</b>	<b>Claim Filing Date</b>
10/01/07 – 09/30/08	12/31/09
10/01/08 – 09/30/09	12/31/10
<b>10/01/09 – 12/31/09</b>	<b>12/31/10</b>
<b>01/01/10 and after</b>	<b>1 calendar year from date of service</b>

# Claim Filing Rules

- Claims not submitted by time limit are provider-liable
- Beneficiary cannot be charged for provider-liable charges

# Bundling Rules

## 72 Hour Rule:

- Applies to diagnostic services
- Not necessarily related to the inpatient admission
- Rule changed in 2008
  - Originally looked at from and through dates
  - Changed to look at line item dates of service
    - Change Request 5880, issued February 1, 2008

# Bundling Rules

## 24 Hour Rule:

- Applies to therapeutic services (non-diagnostic) services
  - Final Rule, 1998
  - Principle diagnosis on both inpatient and outpatient claims must be exact 5 digit match
- May separately bill for outpatient therapeutic services not meeting diagnosis requirements
  - Billing of outpatient services not required
  - Do the math

# Bundling Rules

From CMS IOM 100-04, Chapter 3, Section 40.3, paragraph B:

For this provision, diagnostic services are defined by the presence on the bill of the following revenue and/or CPT codes:

0254 - Drugs incident to other diagnostic services

0255 - Drugs incident to radiology

030X - Laboratory

031X - Laboratory pathological

032X - Radiology diagnostic

0341, 0343 - Nuclear medicine, diagnostic/Diagnostic

Radiopharmaceuticals

035X - CT scan

0371 - Anesthesia incident to Radiology

# Bundling Rules

0372 - Anesthesia incident to other diagnostic services

040X - Other imaging services

046X - Pulmonary function

0471 - Audiology diagnostic

0481, 0489- Cardiology, Cardiac Catheter Lab/Other

Cardiology with CPT codes 93501, 93503, 93505, 93508,

93510, 93526, 93541, 93542, 93543, 93544, 93556,

93561, or 93562 diagnostic

0482- Cardiology, Stress Test

0483- Cardiology, Echocardiology

053X - Osteopathic services

061X - MRT

062X - Medical/surgical supplies, incident to radiology or  
other diagnostic services

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# RAC UPDATES

## Recent Updates

- **04/06/10: CMS Announces Series of Nationwide RAC 101 Calls.** The subject matter of the RAC conference calls will be RAC 101. They will be presented by CMS staff. The content on each call will not change drastically. The RAC operational process will be discussed and there will be a question and answer session held at the end. The information presented will not be drastically different from other RAC 101 sessions that were held in the past in conjunction with the hospital and/or medical associations. These calls offer another opportunity for providers who missed the earlier presentations to hear the RAC 101 session and to ask any questions they may have regarding the RAC process. Registration is not required for the calls.

# RAC 101 CALL

- April 28, 2010 1:00pm - 2:30pm EST:  
Nationwide RAC 101 Call, 1-877-251-0301,  
meeting ID: 66532244
- May 4, 2010 1:00pm - 2:30pm EST: Nationwide  
RAC 101 Call for Home Health and Hospice  
Providers, 1-877-251-0301, meeting ID:  
66524952
- May 5, 2010 1:00pm - 2:30pm EST: Nationwide  
RAC 101 Call for DMEPOS, 1-877-251-0301,  
meeting ID: 66527260
- May 12, 2010 1:00pm - 2:30pm EST:  
Nationwide RAC 101 Call for Physicians, 1-877-  
251-0301, meeting ID: 66529242

# Contacting the RAC

- Phone number: 877-316-RACB (7222)
- E-mail Address: [racb@cgi.com](mailto:racb@cgi.com)
- CGI Medicare RAC Region B Website: <http://racb.cgi.com>

# RAC 935 Recoupment Process

- May appear on remit that RAC is initiating a take-back on an initial adjustment
- A negative amount is shown on the line for the adjustment
- Check summary page, the amount is added back in
- Money not recouped until 41<sup>st</sup> day unless an appeal is filed or a check is received

# Patient Protection and Affordable Care Act

PPAC signed into law on March 23, 2010:

- New provisions continue to be communicated
  - Extension of outpatient hold harmless provision
    - Rural hospitals with fewer than 100 beds
    - All sole community hospitals
    - Effective with dates of service 1-1-10 through 12-31-10
    - Reasonable cost payment for clinical lab tests in hospitals with fewer than 100 beds

# Patient Protection and Affordable Care Act

## Payment policy for laboratory technical component:

- Independent labs were allowed to bill for technical component through 2009
- Provision expired in December, 2009
- Section 3104 of the PPACA extends the provision retroactive to January 1, 2010
- Independent laboratories may now submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed.
- Effective for dates of service January 1, 2010 through December 31, 2010

# Patient Protection and Affordable Care Act

## Extension of therapy cap exceptions:

- Section 3103 of the act extends the therapy cap exception
  - Therapy providers may continue to submit claims with KX modifier when appropriate
  - January 1, 2010 through December 31, 2010

# Provider Outreach and Education Advisory Group

## What is it?

- Advisory group made up of representatives from hospitals, SNFs, therapy providers, ESRD providers and associations (OHA, OHCA, AOPHA, etc.)

## What is the purpose?

- To assist National Government Services in producing and providing relevant and targeted education to the provider community

## How is this done?

- Suggestions
- Review of educational materials (slide presentations, articles, etc.)

# Provider Outreach and Education Advisory Group

## March 4, 2010 Meeting

- Discussed topics for 2010 Convention
- Discussed new CBT for preadmission services
- Provider Enrollment updates

Minutes for all meetings are posted on the NGS web site

- [www.ngsmedicare.com](http://www.ngsmedicare.com)
- Click on Education and Support, select POE Advisory Group
- Click on POE Advisory Group Meeting Minutes

# Provider Outreach and Education Advisory Group

## Becoming a member

- Limited number of slots available
- Contact Michael Davis, Manager of Provider Outreach and Education at [Michael.D.Davis@anthem.com](mailto:Michael.D.Davis@anthem.com) or [Jennifer.Tirotta@anthem.com](mailto:Jennifer.Tirotta@anthem.com) to request membership
- Needed
  - ESRD
  - Skilled Nursing
  - Small and rural hospitals

# Medicare University

## NGS Education Initiative

- Education at your fingertips
  - Computer Based Training (CBT)
  - Part A, Part B, DME
  - New CBTs being developed
- No travel required
  - Medicare University can be entered from any computer with internet access
- Earn Medicare University Credits
  - Register on NGS web site, [www.ngsmedicare.com](http://www.ngsmedicare.com)
  - Click on the Medicare University icon
  
- Impress your boss

# NGS Convention

## 2009 Virtual Convention

- Well received
  - Convenient
  - Cost saving for both NGS and providers
- Feedback
  - Sessions were informative
  - Convenience of no travel was appreciated
  - Still like face to face and the opportunity to network

# NGS Convention

## 2010 Convention

- Face to face event
  - August 18, 2010—pre-registration
  - August 19-20, 2010—full day of sessions
- Location
  - Louisville Marriott Downtown, Louisville, Kentucky
  - Watch for list serve announcing registration
- Part A and Part B sessions
  - Some sessions will be combined

# MAC Updates

# MAC Contractor Status

The table below gives the current status of all MAC  
Jurisdiction Contractor Status

A National Heritage Insurance Corp.	Fully Implemented
B National Government Services	Fully Implemented
C CIGNA Government Services	Fully Implemented
D Noridian Administrative Services	Fully Implemented
1 Palmetto Government Benefits Administrators	Fully Implemented
2 PROTEST OF CONTRACT AWARD	Bid Corrective Action
3 Noridian Administrative Services	Fully Implemented
4 TrailBlazer Health Enterprises	Fully Implemented
5 Wisconsin Physicians Services	Fully Implemented
6 PROTEST OF CONTRACT AWARD	Bid Corrective Action

# MAC Contractor Status, Con'd

7 PROTEST OF CONTRACT AWARD	Solicitation Cancelled
8 PROTEST OF CONTRACT AWARD	Bid Corrective Action
9 First Coast Service Options, Inc	Fully Implemented
10 Cahaba Gov't Benefit Administrators	Fully Implemented
11 PROTEST OF CONTRACT AWARD	Bid Corrective Action
12 Highmark Medicare Services	Fully Implemented
13 National Government Services	Fully Implemented
14 National Heritage Insurance Corp.	Fully Implemented
15 PROTEST OF CONTRACT AWARD	Bid Corrective Action

# MAC Updates

CMS will not transition providers from legacy fiscal intermediaries and carriers to the following MACs until procurement corrective action on the respective contract awards has concluded.

A/B MAC Jurisdiction 2  
A/B MAC Jurisdiction 6  
A/B MAC Jurisdiction 7  
A/B MAC Jurisdiction 8  
A/B MAC Jurisdiction 11  
A/B MAC Jurisdiction 15

In taking corrective action on the Jurisdiction 7 A/B MAC contract award, CMS plans to issue a new solicitation during calendar year 2010. The legacy fiscal intermediaries and carriers will continue to service the providers in those workloads until further notice.

# Medicare Secondary Payer

# MSP Updates

Providers need to be aware that due to new information issued by the Centers for Medicare & Medicaid Services (CMS) in CR6426, providers may no longer submit Medicare Secondary Payer (MSP) claims via FISS DDE. This change is not date of service or receipt date driven. Therefore, as of Monday, October 5, 2009, all DDE MSP claims (when PF9d) will be assigned reason code 31265 which states the following:

*Effective October 5, 2009 with the implementation of Change Request (CR) 6426, providers will no longer be able to submit Medicare Secondary payer (MSP) claims via FISS/DDE. This includes all MSP claim submissions, corrections and/or adjustments and cancels including claims being billed conditionally. MSP and conditional claims must be submitted electronically (837I) following the instructions in CR 6426 or, if applicable, via hardcopy submission of UB-04 (CMS-1450) claim forms.*

# Electronically Billing MSP Claims

Articles on our Web site:

[www.NGS Medicare.com](http://www.NGS Medicare.com)

- Electronic Medicare Secondary Payer Specifications for Inbound Claims
- What Does This Reject or Return to Provider Reason Code Really Mean?
- PC-ACE Pro32 Quick Reference Guide: Medicare Secondary Payer Guide

# MSP Updates

## Timely Filing

- Watch your dates, especially if you are waiting for payment from a primary payer such as workers' comp or any accident involving med-pay or liability

# MSP and the COBC

- COBC did a presentation at the Virtual Convention
- Responded to 62 questions

# MSP and the COBC

- Is there any time the COBC won't take a call from the provider and the beneficiary must call?
- Once a provider is verified by the COBC by providing their NPI or provider number, the provider may give any MSP information to the COBC. The COBC reviews the source of the information on file. There may be some situations where COBC may need to go back to the employer or beneficiary to verify the information. So in some cases, if the beneficiary calls, the record may be updated without development.

# MSP and the COBC

- We have called in the past and been told that the patient has to call. Has that changed?
- Once a provider is verified by the COBC by providing their NPI or provider number, the provider may give any MSP information to the COBC. The COBC may develop for authenticity. Employer and insurance companies may provide info to the COBC as long as they are listed on the beneficiary's record. If not (e.g., new employer/insurer), the COBC may develop for authenticity.

# MSP and the COBC

- What exactly are providers allowed to update on a Medicare patients file?
- Once a provider is verified by the COBC by providing their NPI or provider number, the provider may give any MSP information to the COBC. However, the COBC may need to develop for validity prior to adding the changes/updates to the beneficiary's CWF record.

# MSP and the COBC

- Is there a number for a beneficiary to call to close an old MSP file that is still showing as current?
- The beneficiary can call 1 - 800 - MEDICARE or the COBC at (800) 999 - 1118. If the case is a liability case, the beneficiary should call the MSPRC at (866) 677 - 7220. 8 a.m.-8 p.m. ET

# MSP and the COBC

- How long does it take to update a COB file from the time new information is given to Medicare?
- Timeframes differ based on the source of the information and whether COBC has to conduct additional development. If no additional development is required, updates can be completed within 48 hours.

# MSP and the COBC

- If we ask that a family contact the COBC to establish a record, should we wait to file a claim?
- You should not file a claim with Medicare until the CWF record is updated. The provider may also give the COBC the information. However, the COBC may need to develop for authenticity.

# MSP Questions from the VC

- MSP Part A - 2 presentations
  - 53 questions submitted
- MSP Part B - 1 presentation
  - 64 questions submitted

# MSP Questions from the VC

- How long do we have to file MSP claims after the primary has paid/processed the claim?
- The same timely filing limitations that apply to Medicare primary claims also apply to MSP claims. There is no extension of the Medicare timely filing limitations for MSP purposes. It is important that once a provider bills a primary payer, that it follow - up with that payer as often as possible so that MSP claims can be filed timely with Medicare.

# MSP Questions from the VC

- If we don't submit electronic billing to primary payers and we don't receive an 835 electronic remittance advice (ERA) file from primary payers with CAS adjustment codes, how will we submit an MSP claim?
- We believe that if you have an explanation of benefit (EOB) statement or some type of remittance from the primary payer, you should be able to determine the CAS segments needed for the electronic MSP claim. Please check with your Medicare billing vendor.

# MSP Questions from the VC

- If we have not been sending Medicare our MSP no-payment (full-payment) claims, how do we go about starting to do so? Do we need to disclose to Medicare that we have
- 10 Medicare University 2009 Virtual Convention Q&A MSP Billing: How to Bill Medicare When the Primary Payer Has Not Paid the Claim in Full (200)
- not been sending these and do we go back as far as we can based on Medicare timely filing limits?
- You can begin to submit the MSP no - payment (full - payment) claims to Medicare immediately. Please go back as far as the Medicare timely filing limits will allow.

# MSP Questions from the VC

- I was told that providers should bill Medicare as secondary for a beneficiary even when there would be no beneficiary balance after the primary payer pays. This should be done so the beneficiary's Medicare deductible amounts can be credited in Medicare's system. Is this still correct?
- Yes, this is still correct. Providers should submit MSP full - payment (no payment) claims to Medicare for all inpatient services, and for all outpatient services when there is still a Part B deductible that hasn't been met.
- Reference the CMS IOM Publication 100 - 05, *Medicare Secondary Payer Manual, Chapter 3, Section 40 entitled "Completing the Form CMS - 1450 in MSP Situations by Providers"* and its subsections for information on coding the MSP claims and Chapter 5, Section 40.8 entitled *"Intermediary Processing Procedures for Medicare Secondary Claims"* and subsections for information on how Medicare processes the MSP claims.

# MSP Questions from the VC

- We have tried sending our MSP claims electronically with no luck. Can we send a hardcopy CMS-1450 (UB-04) instead?
- Providers can only submit hardcopy claims if they have an Administrative Simplification Compliance Act (ASCA) waiver on file. Therefore, MSP claims can be submitted in hardcopy format only if the provider has an ASCA waiver on file. Otherwise, the claims must be submitted electronically. Please contact your billing vendor to determine how to electronically submit MSP claims to Medicare. In addition, see National Government Services Web site to review information on the new edits related to MSP in the article "What Does This Reject or Return to Provider Really Mean?" at <http://www.ngsmedicare.com/Content.aspx?CatID=1&DOCID=20940>. We are also working on additional educational materials to address this. These will be posted on the Web site, once available.

# Medicare or MSP Open Discussion