

# Indian Health Service

## Medicare Part A Provider Outreach and Education

# Important

- The information contained in this presentation was current as of March 2009 and can be found in the *Indian Health Service Manual*. All manuals can be downloaded from:
  - <http://www.trailblazerhealth.com/Publications/Manuals/Default.aspx?DomainID=1>

# Change Request (CR) 6300

- Payments on the Medicare Physician Fee Schedule (MPFS) for providers with multiple service locations:
  - Dated February 13, 2009.
  - CMS Internet-Only Manual (IOM), Pub. 100-04.
  - Transmittal 1681.
  - Different locations may be in a different payment locality than the parent provider.
  - The nine-digit ZIP code of the satellite facility is used to determine the locality.

# Change Request (CR) 6300 (Cont.)

Services that are paid subject to the MPFS are adjusted based on the applicable payment locality. Medicare systems determine which locality applies using ZIP codes. In cases where the provider has only one service location, the payment locality used to calculate the fee amount is determined using the ZIP code of the master address contained in the Medicare contractors' provider file.

# Roster Billing

# Roster Billing

- Roster billing:
  - At least five beneficiaries on the same date are required.
  - The simplified (roster) claims filing procedure applies to providers other than Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) that conduct mass immunizations.
  - Mass immunizers attach a standard roster to a single preprinted UB-04 that contains the variable claims information regarding the service provider and individual beneficiaries.

# Roster Billing (Cont.)

- The roster must contain, at a minimum, the following information:
  - Provider name and number
  - Date of service
  - Patient name and address
  - Patient date of birth
  - Patient sex
  - Patient Health Insurance Claim Number (HICN)
  - Beneficiary signature or stamped “signature on file”

# Roster Billing (Cont.)

- For inpatient Part B services (12X and 22X), the following data elements are also
- needed:
  - Admission date
  - Admission type
  - Admission diagnosis
  - Admission source code
  - Patient status code



# Roster Billing (Cont.)

- UB-04 shows the following preprinted information in the specific Form Locators (FLs):
  - The words “See Attached Roster” in FL 8a (Patient Name).
  - Patient status code 01 in FL 17 (Patient Status).
  - Condition code M1 in FLs 18–28 (Condition Code) (See note below).
  - Condition code A6 in FLs 18–28 (Condition Code).
  - Revenue code 0636 in FL 42 (Revenue Code), along with the appropriate HCPCS code in FL 44 (HCPCS Code).
  - Revenue code 0771 in FL 42 (Revenue Code), along with the appropriate HCPCS “G” code in FL 44 (HCPCS Code).

# Roster Billing (Cont.)

- “Medicare” on line A of FL 50 (Payer).
- The words “See Attached Roster” on line A of FL 51.
- Diagnosis code V03.82 for PPV or V04.8 for influenza virus vaccine in FL 67 (Principal Diagnosis Code).
- The provider’s own National Provider Identifier (NPI) reported in the NPI field for the attending physician on claims submitted.
- The submission of an NPI for an ordering/referring provider is mandatory.
- After several attempts to obtain the NPI from the ordering/referring/attending/operating/other/service facility provider/purchased service provider, the provider or supplier who is furnishing the services or items shall report his own name and NPI in the Ordering/Referring/Attending/Operating/Other/Service Facility Provider/Purchased Service Provider fields on the claim.

# Roster Billing (Cont.)

Provider Name		Pay-to Name		3a PAT. CNTL #	4 TYPE OF BILL		
Street Address		Street Address or Post Office Box		3b MED. REC. #	XXX		
City, State, ZIP Code		City, State, ZIP Code		5 FED. TAX NO	SubID	6 STATEMENT COVERS PERIOD	
Telephone; Fax; Country Code				XX-XXXXXXX	MMDDYY	THROUGH	
8 PATIENT NAME		9 PATIENT ADDRESS		7			
a See Attached Roster				For 12X and 22X TOB, admission date, admission type, admission diagnosis and patient status codes are required.			
10 BIRTHDATE	11 SEX	ADMISSION		CONDITION CODES			
		12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	
				X		01	
						A6	
						M1	
31 OCCURRENCE		32 OCCURRENCE		33 OCCURRENCE		34 OCCURRENCE	
CODE DATE		CODE DATE		CODE DATE		CODE DATE	
Shown on roster.		Shown on roster.		Patient status 01 used on outpatient claims only. Use appropriate coding for inpatient claims.		Condition code A6 allows Medicare to process claim without patient liability.	
35 OCCURRENCE SPAN		36 OCCURRENCE SPAN		37		38	
CODE FROM THROUGH		CODE FROM THROUGH					
39		40 VALUE CODES		41 VALUE CODES		42	
CODE AMOUNT		CODE AMOUNT		CODE AMOUNT		CODE AMOUNT	
a		b		c		d	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
0636		Influenza Vaccine		XXXXX		MMDDYY	
0771		Administration		G0008		MMDDYY	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1		\$\$\$		\$\$\$		\$\$\$	
1		\$\$\$		\$\$\$		\$\$\$	
3							
5							
6							
7							
				CPT codes 90655, 90657, 90658 or 90660, as appropriate.			

# Roster Billing (Cont.)

0001	PAGE X	OF X	CREATION DATE				MMDDYY	TOTALS →	\$\$\$:	\$\$	\$\$\$:	\$\$	23
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		XXXXXXXXXX			
Medicare		XXXXXX		X	X			57 OTHER PRV ID					
58 INSURED'S NAME			59 P.REL	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.					
See Attached Roster				See Attached Roster									
63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME					
66 DX	V0481	X	A	B	C	D	E	F	G	H	68		
9	I	J	K	L	M	N	O	P	Q				
69 ADMIT DX		70 PATIENT REASON DX		XXXXX	b	c	71 PPS CODE	72 ECI	a	b	c	73	
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE DATE		75		76 ATTENDING NPI		XXXXXXXXXX	QUAL	xx	XXXXXX
								LAST		Last Name		FIRST	First Name
c. OTHER PROCEDURE CODE		d. OTHER PROCEDURE DATE		e. OTHER PROCEDURE DATE				77 OPERATING NPI				QUAL	
								LAST				FIRST	
80 REMARKS				81 CC				78 OTHER NPI				QUAL	
				a				LAST				FIRST	
Influenza Vaccine Roster Bill Example				b				79 OTHER NPI				QUAL	
				c				LAST				FIRST	
				d									

# Roster Billing (Cont.)

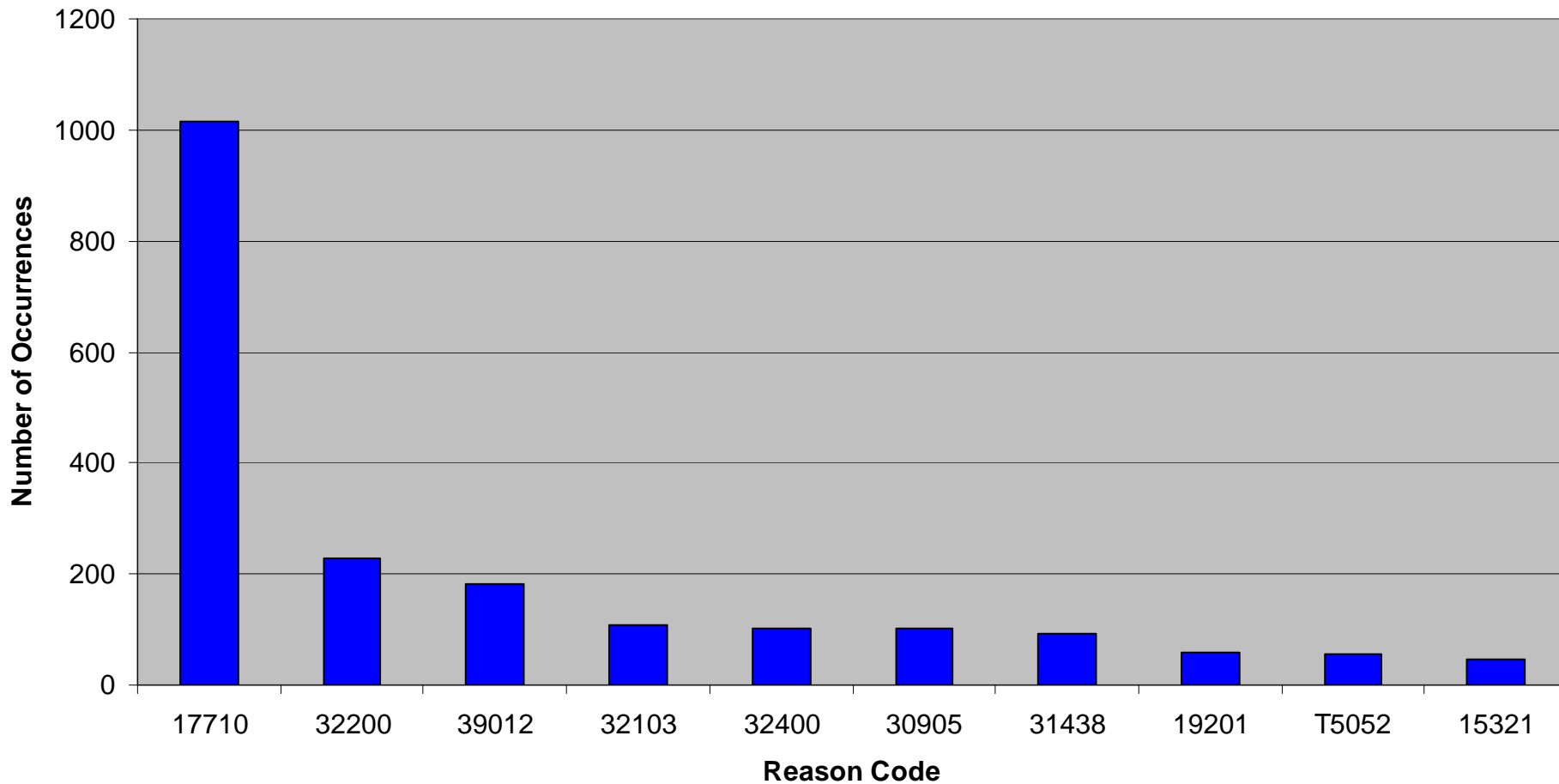
## PATIENT INFORMATION

	HIC Number	Last Name	First Name	Initial	Date of Birth	Gender
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

# Top Billing Errors

# January 2009

## JANUARY TOP TEN RTPs



# January 2009 (Cont.)

- Top Return to Provider (RTP) errors:
  - 17710 – Outpatient claims may not contain ICD-9-CM procedure codes:
    - Resolution: Remove ICD-9-CM procedure codes from claim.
  - 32200 – Principal diagnosis codes V048 and/or V0382 are present without condition code A6:
    - Resolution: Add condition code A6 (FLs 18–28) on all influenza or pneumococcal vaccines.



# January 2009 (Cont.)

39012 – Claim submitted past timeliness filing; justification is required:

- Resolution: Add remarks explaining the reason the claim is being filed outside the timely filing guidelines.

32103 – The NPI submitted on the claim is not on the NPI crosswalk:

- Resolution: If correct, the National Plan and Provider Enumeration System (NPPES) should be contacted to verify that the Online Survey Certification and Reporting (OSCAR)/Provider Identification Number (PIN) corresponds with the NPI in its files.

# January 2009 (Cont.)

32400 – A HCPCS code is required for the line item being edited:

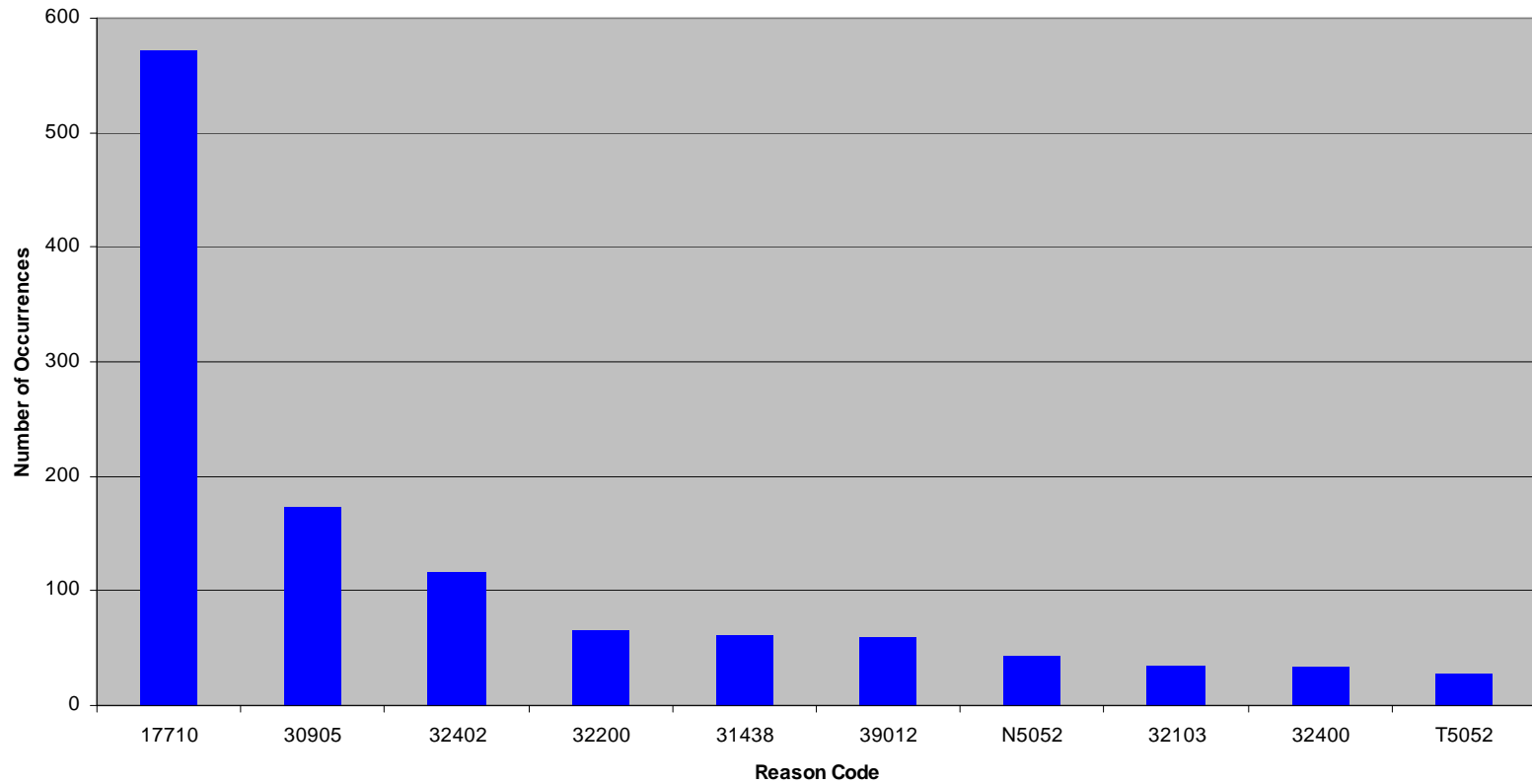
- Resolution: Add the appropriate HCPCS code to the line item in FL 44.

30905 – No record of processing an original claim for this adjustment:

- Resolution: Submit the claim as an original bill.

# February 2009

FEBRUARY TOP TEN RTPs



# February 2009 (Cont.)

- Top Return to Provider (RTP) errors:
  - 17710 – Outpatient claims may not contain ICD-9-CM procedure codes:
    - Resolution: Remove ICD-9-CM procedure codes from claim.
  - 30905 – No record of processing an original claim for this adjustment:
    - Resolution: Submit the claim as an original bill.

# February 2009 (Cont.)

32402 – The HCPCS code is either missing or is invalid for the revenue code:

- Resolution: Verify that the HCPCS code submitted is valid; correct or add the HCPCS code in FL 44.

32200 – Principal diagnosis codes V048 and/or V0382 are present without condition code A6:

- Resolution: Add condition code A6 (FLs 18–28) on all influenza or pneumococcal vaccines.

# February 2009 (Cont.)

31438 – A HCPCS code is required when condition code A6 is present on the claim:

- Resolution: Add the appropriate HCPCS code for influenza or pneumococcal vaccines.

39012 – Claim submitted past timeliness filing; justification is required:

- Resolution: Add remarks explaining the reason the claim is being filed outside the timely filing guidelines.

# Billing Guidelines for Vaccines

- Vaccines:
  - If a physician sees a beneficiary for the sole purpose of administering the influenza virus vaccine, the pneumococcal vaccine, and/or the hepatitis B vaccine, they may not routinely bill for an office visit.
  - However, if the beneficiary actually receives other services constituting an “office visit” level of service, the physician may bill for a visit in addition to the vaccines and their administration, and Medicare will pay for the visit in addition to the vaccines and their administration if it is reasonable and medically necessary.

# Billing Guidelines for Vaccines (Cont.)

- Billing guidelines for pneumococcal pneumonia:
  - Revenue codes:
    - 0636 Pharmacy, drugs requiring detailed coding
    - 0771 Preventive care services, vaccine administration
  - CPT/HCPCS codes:
    - 90732© Pneumococcal vaccine
    - G0009 Administration of pneumococcal vaccine



# Billing Guidelines for Vaccines (Cont.)

– Diagnosis codes:

- V0382            Pneumococcal vaccine
- V063.6        Both pneumococcal vaccine and  
                  influenza vaccine

– Condition code:

- A6

# Billing Guidelines for Vaccines (Cont.)

- Billing guidelines for influenza virus:

- Revenue codes:

- 0636 Pharmacy, drugs requiring detailed coding.
    - 0771 Preventive care services, vaccine administration.

- CPT/HCPCS codes:

- 90655<sup>©</sup> Flu vaccine no preservative 6-35 months of age.
    - 90656<sup>©</sup> Flu vaccine no preservative 3 & older.
    - 90657<sup>©</sup> Flu vaccine, 6-35 months, im.
    - 90658<sup>©</sup> Flu vaccine age 3 & over, im.
    - 90660<sup>©</sup> Flu vaccine, nasal.
    - G0008 Administration of influenza virus vaccine.

# Billing Guidelines for Vaccines (Cont.)

– Diagnosis codes:

- V0481      Influenza virus vaccine.
- V063.6      Both pneumococcal vaccine and influenza vaccine.

– Condition code:

- A6

# Billing Guidelines for Vaccines (Cont.)

- Billing guidelines for hepatitis B virus:
  - Revenue codes:
    - 0636 Pharmacy, drugs requiring detailed coding.
    - 0771 Preventive care services, vaccine administration.
  - CPT/HCPCS codes:
    - 90740<sup>©</sup> Hep B vaccine, ill pat 3 dose im.
    - 90743<sup>©</sup> Hep B vaccine, adol, 2 dose, im.
    - 90744<sup>©</sup> Hep B vaccine, ped/adol 3 dose im.
    - 90746<sup>©</sup> Hep B vaccine, adult, im.
    - 90747<sup>©</sup> Hep B vaccine, ill pat 4 dose im.
    - G0010 Administration of hepatitis B vaccine.
  - Diagnosis code:
    - V053 Hepatitis B vaccine.

# Flu and Clinic Example

a		4		3a PAT. CNTL #		Required		4 TYPE OF BILL																	
Street Address		Pay-to Name		b. MED. REC. #		Recommended		851																	
City, State, ZIP Code		Street Address or Post Office Box		5 FED. TAX NO. SubID		6 STATEMENT COVERS PERIOD FROM		7 THROUGH																	
Telephone; Fax; Country Code		City, State, ZIP Code		XX-XXXXXXXX		MMDDYY		MMDDYY																	
8 PATIENT NAME a		9 PATIENT ADDRESS a		Street Address or Post Office Box																					
b Patient Last, First, Middle Initial		b City		c State		d ZIP Code		e Country Code																	
10 BIRTHDATE		11 SEX		ADMISSION DATE 12 DATE 13 HR		14 TYPE 15 SRC		16 DHR		17 STAT		18		19		20		21		22		23 ACDT STATE		30	
MMDDCCYY X		X		XX		A6																			
31 OCCURRENCE CODE		32 OCCURRENCE CODE		33 OCCURRENCE CODE		34 OCCURRENCE CODE		35		36 OCCURRENCE SPAN		37													
DATE		DATE		DATE		DATE		CC		THROUGH		THROUGH													
a		b		c		d		e		f		g		h		i		j		k		l		m	
38		39 VALUE CODES		40 VALUE CODES		41 VALUE CODES																			
		CODE		CODE		CODE		AMOUNT		AMOUNT		AMOUNT													
a																									
b																									
c																									
d																									

Condition code A6 will allow Medicare to process claim without patient liability.

# Flu and Clinic Example (Cont.)

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0636		90656	011009	1	10: 00		
0771		G0008	011009	1	15: 00		
0510		99212	011009	1	181: 00		
0001	PAGE # OF #	CREATION DATE	012009	TOTALS →	216: 00		

# Repetitive Services

# Repetitive Services

- IHS/tribal services that fall under repetitive services are:
  - Physical Therapy (PT)
  - Occupational Therapy (OT)
  - Speech-Language Pathology (SLP)
- For a complete listing of repetitive services, refer to CMS Pub. 100-04, Chapter 1, Section 50.2.2:  
<http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>



# Physical Therapy

- PT billing:
  - Occurrence codes:
    - 11 – Onset of symptoms and illness
    - 29 – The date a plan was established or last reviewed for PT
    - 35 – The date treatment began for PT
  - Value code 50
    - Report the number of visits from onset
  - Revenue code 0420
  - Modifier GP

# Occupational Therapy

- OT billing:
  - Occurrence codes:
    - 11 – Onset of symptoms and illness
    - 17 – The date a plan was established or last reviewed for OT
    - 44 – The date treatment began for OT
  - Value code 51
    - Report the number of visits from onset
  - Revenue code 0430
  - Modifier GO

# Speech-Language Pathology

- SLP billing:
  - Occurrence codes:
    - 11 – Onset of symptoms and illness.
    - 30 – The date a plan was established or last reviewed for SLP.
    - 45 – The date treatment began for SLP.
  - Value code 52.
    - Report the number of visits from onset.
  - Revenue code 0440.
  - Modifier GN.

# Repetitive Services

- When a patient has a clinic visit during a month when therapy services are being provided, IHS/tribal providers are required to include the outpatient visit on the monthly repetitive claim.
- If two separate claims are submitted, only one claim will be processed.
- Second claim will be rejected as a duplicate claim. An adjustment will need to be initiated on the processed claim.

# Provider Example

- Claims summary for one patient.
- All clinics were canceled and remarks section reads, “Canceling to submit PT on one claim.”
- No claim was ever submitted to show three clinic visits and the therapy services.
- A provider loss in revenue of \$579 for the clinic visits.
- A provider loss in revenue of a minimum of \$125 for the therapy visits.

# Provider Example (Cont.)

```
MAP1151          M E D I C A R E  A  O N L I N E  S Y S T E M
SC              CLAIM SUMMARY
HIC            S/LOC      TOB 131  FROM DTE 030107  TO DTE 040107
PROV          DCN SRCH   All three clinic claims were cancelled.  HIC 9TH POS      SEL

SEL   HIC      PROV   S/LOC  REC D  TOB   ADM DT  FRM DT  THRU DT
      DCN                                TOT CHG  TRAN DT  PD DT  CAN DT  REAS TT  FL  NPC  POST  PAY

          P B9997 032007 131   031307 031307 031307
        193.00 092507 040307 092807 37192

          P B9997 040907 131   030607 030607 030607
        193.00 092507 042307 092807 37192

          P B9997 073107 131   032707 032707 032707
        201.00 092907 081407 100407 37192
```

PROCESS COMPLETED --- NO MORE DATA THIS TYPE  
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR PRESS PF3 TO EXIT

# Provider Example (Cont.)

```

MAP1033          M E D I C A R E - A   O N L I N E   S Y S T E M          PAGE 03
SC              UB92 CLAIM INQUIRY          REV CD PAGE 01
DCN            HIC              RECEIPT DATE 060408 TOB 138
STATUS P LOCATION B9997      TRAN DT 060608      STMT COV DT 031607   TO 031607
  ESRD HRS:      PAT TERM ILL:      MULTI-LAB:      BENEFIT SAVINGS: N
                SERV              TOT      COV
CL  REV  HCPC MODS DATE      RATE  UNIT  UNIT  TOT CHRG  COV CHRG  NCOV CHRG
1  0510  99211    0316    193.000    1    1    193.00   193.00
2  0001
  
```

```

                                     =====
                                     TOTALS      1      1      193.00      193.00      0.00
37204                                     <== REASON CODES
      PRESS PF2-103I  PF3-EXIT  PF5-UP  PF6 DOWN  PF7-PREV  PF8-NEXT  PF11-RIGHT
  
```





# Loss of Revenue

- Example:
  - The provider should submit one claim with the three clinic visits and the therapy visits for the month of March.
  - Provider will receive the All-Inclusive Rate (AIR) for the three clinic visits and the Medicare Physician Fee Schedule (MPFS) for the therapy services.
  - Income revenue of at least \$700.

# How to Void a Claim

# Voiding Claims

- Steps to adjust/void claims:
  - Void all but one claim that was billed during the month.
  - When the voided claims show up on a remittance advice, adjust the remaining claim to include:
    - The two voided clinic visits.
    - All therapy visits within that month.

# Voiding Claims (Cont.)

- To void/cancel a claim, remember that:
  - A void/cancel transaction can be processed electronically.
  - A bill can only be voided if it has finalized and is reflected on the remittance advice.
  - A void transaction indicates the elimination of a previously submitted bill.
  - It must be for a specific provider, specific statement dates, patient, payer, etc.
  - A void bill is sometimes followed with a new corrected bill when an adjustment is not appropriate.

# Voiding Claims (Cont.)

- Cancellations are a three-step process:
  - Press “Tab” to the Condition Code field and indicate why the claim is being cancelled by entering the claim change reason code in the first available Condition Code field on claim page 1.
  - Add remarks if necessary as to why the claim is being cancelled.
  - Press “F9” to save the cancellations.

# Voiding Claims (Cont.)

- To void/cancel a paid claim:
  - Enter the Claim Cancels option that matches your provider type and press “Enter.”
  - The S/LOC field defaults to “P.”

# Voiding Claims (Cont.)

MAP1701

TRAILBLAZER HEALTH ENTERPRISES, LLC  
MAIN MENU FOR REGION ACPMA051

- 01 INQUIRIES
- 02 CLAIMS/ATTACHMENTS
- 03 CLAIMS CORRECTION
- 04 ONLINE REPORTS

ENTER MENU SELECTION: 03

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

# Voiding Claims (Cont.)

```
MAP1704          TRAILBLAZER HEALTH ENTERPRISES, LLC
                  CLAIM AND ATTACHMENTS CORRECTION MENU

                  CLAIMS CORRECTION
INPATIENT          21
OUTPATIENT         23
SNF                25
HOME HEALTH        27
HOSPICE            29

                  CLAIM ADJUSTMENTS      CANCELS
INPATIENT          30          50
OUTPATIENT         31          51
SNF                32          52
HOME HEALTH        33          53
HOSPICE            35          55

                  ATTACHMENTS
PACEMAKER          42
AMBULANCE          43
THERAPY            44
HOME HEALTH        45

ENTER MENU SELECTION: 51

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```



# Void/Cancel Procedures

```
MAP1741          M E D I C A R E  A  O N L I N E  S Y S T E M
SC              CLAIM SUMMARY INQUIRY
                Type Provider
                NPI
                HIC          PROVIDER          S/LOC P          TOB 13
OPERATOR ID     FROM DATE          TO DATE          DDE SORT
MEDICAL REVIEW SELECT
                HIC          PROV/MRN   S/LOC          TOB  ADM DT  FRM DT  THRU DT  REC DT
SEL  LAST NAME  FIRST INIT  TOT CHG  PROV REIMB PD DT  CAN DT  REAS NPC #DAYS
```

PLEASE ENTER DATA - OR PRESS **PF3** TO EXIT  
PRESS **PF3**-EXIT **PF5**-SCROLL BKWD **PF6**-SCROLL FWD

# Void/Cancel Procedures (Cont.)

```

MAP1741          M E D I C A R E  A  O N L I N E  S Y S T E M
SC              CLAIM SUMMARY INQUIRY
                NPI
                HIC          PROVIDER          S/LOC P          TOB 13
                OPERATOR ID   FROM DATE          TO DATE          DDE SORT
                MEDICAL REVIEW SELECT
                HIC          PROV/MRN   S/LOC          TOB   ADM DT  FRM DT  THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB  PD DT   CAN DT  REAS NPC  #DAYS
s
                P B7516   131   032408 032408 032408   042908
                133.98   77.58  051308   37192
                P B7591   137   011906 011906   082907
                247.00   175.85 090407   37205
                P B9996   131   060908 060908   062008
                215.00   97.26 071808   37192
                P B9996   131   060308 060308   062508
                215.00   97.26 071808   37192
                P B9996   131   113007 113007   062508
                201.00   56.00 071808   37192
                PROCESS COMPLETED --- PLEASE CONTINUE
                PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
    
```

Type a "S" beside the claim line to cancel.

# Void/Cancel Procedures (Cont.)

- Enter the claim change reason code in the first available Condition Code field on claim page 1. Valid claim change reason codes for cancellations are:
  - D5 – Cancel only to correct an HIC number or CMS Certification Number (CCN).
  - D6 – Cancel only to repay a duplicate payment or correct an error.

**Note:** No other changes can be made on a void.
- Press “F8” twice to forward to claim page 3.

# Void/Cancel Procedures (Cont.)

```

MAP1711          M E D I C A R E  A  O N L I N E  S Y S T E M          CLAIM PAGE 01
SC              INST CLAIM ADJUSTMENT                          SV:
HIC            TOB 138  S/LOC S B0100          OSCAR              UB-FORM
NPI            TRANS HOSP PROV                    PROCESS NEW HIC
PAT.CNTL#:      TAX#/SUB:      TAXO.CD:
STMT DATES FROM 032408  TO 032408  DAYS COV          N-C          CO          LTR
LAST           FIRST           MI          DOB
ADDR 1         2
      3         4
      5         6
ZIP            SEX  MS  ADMIT DATE 032408  HR 08  TYPE 2  SRC 1  D  HM 0800  STAT 01
COND CODES 01 D6 02   03   04   05   06   07   08   09   10
OCC CDS/DATE 01      02      03      04      05
              06      07      08      09      10
SPAN CODES/DATES 01      02      03
04            05      06      07
08            09      10      FAC.ZIP
DCN
VALUE CODES - AMOUNTS - ANS I  MSP APP IND
01 A2        26.80 PR 2   02      03
04            05      06
07            08      09

PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL  FWD  PF8-NEXT  PF9-UPDT
    
```

Enter claim change  
reason code.

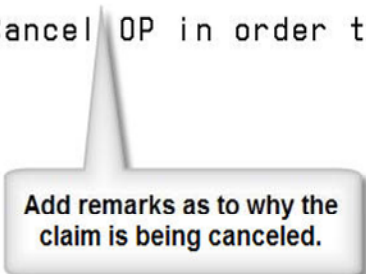
# Void/Cancel Procedures (Cont.)

MAP1714 M E D I C A R E A O N L I N E S Y S T E M CLAIM PAGE 04  
SC INST CLAIM ADJUSTMENT REMARK PAGE 01

HIC TOB 138 S/LOC S B0100 PROVIDER

REMARKS

Cancel OP in order to include therapy visits onto monthly claim.



Add remarks as to why the claim is being canceled.

47 PACEMAKER 48 AMBULANCE 40 THERAPY 41 HOME HEALTH  
58 HBP CLAIMS (MED B) E1 ESRD ATTACH  
ANSI CODES - GROUP: CO ADJ REASONS: 45 APPEALS: MA13

PROCESS COMPLETED --- PLEASE CONTINUE  
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-NEXT PF9-UPDT

# Void/Cancel Procedures (Cont.)

- Press “F9.”
- If the system automatically takes you back to MAP 1741, you have successfully submitted the void.
- Select the next claim to cancel, or press “F3” to return to the Claims Correction Menu.
- If you are not returned to MAP 1741 automatically, errors exist. Press “F1” to see the narrative for the reason code that displays in the lower left corner of the screen.
- When you have finished reviewing the narrative, press “F3” one time to return to the claim. Make your correction and press “F9.” Repeat the process (F1, F3, F9) until you return to MAP 1741.

# Claims Adjustment

# Adjusting Claims

- Adjustments are a four-step process:
  - Enter a claim change reason code on claim page 1.
  - Enter an adjustment reason code on claim page 3.
  - Make your adjustment on the applicable page(s) and add remarks on claim page 4 if necessary.
  - Press “F9” to save the adjustment.



# Adjusting Claims (Cont.)

- Main Menu:
  - To adjust paid claims, enter the claims adjustment option that matches your provider type and press “Enter.”
  - The Claim Summary Inquiry screen (MAP 1741) will appear.

# Adjusting Claims (Cont.)

MAP1701

TRAILBLAZER HEALTH ENTERPRISES, LLC  
MAIN MENU FOR REGION ACPMA051

- 01 INQUIRIES
- 02 CLAIMS/ATTACHMENTS
- 03 CLAIMS CORRECTION
- 04 ONLINE REPORTS

ENTER MENU SELECTION: 03

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

# Adjusting Claims (Cont.)

MAP1704

TRAILBLAZER HEALTH ENTERPRISES, LLC  
CLAIM AND ATTACHMENTS CORRECTION MENU

CLAIMS CORRECTION

INPATIENT	21
OUTPATIENT	23
SNF	25
HOME HEALTH	27
HOSPICE	29

CLAIM ADJUSTMENTS

INPATIENT	30
OUTPATIENT	31
SNF	32
HOME HEALTH	33
HOSPICE	35

CANCELS

50
51
52
53
55

ATTACHMENTS

PACEMAKER	42
AMBULANCE	43
THERAPY	44
HOME HEALTH	45

ENTER MENU SELECTION: 31

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

# Adjusting Claims (Cont.)

- Claim Summary screen:
  - Enter the provider's NPI.
  - Press "Enter."
  - The S/LOC field defaults to "P" to display claims in a "P" (Processed) status/location.
  - To display claims in an "R" (Reject) status/location, type "R" in the S/LOC field.

# Adjusting Claims (Cont.)

```
MAP1741          M E D I C A R E A O N L I N E S Y S T E M
SC              CLAIM SUMMARY INQUIRY
                Type Provider
                NPI.
                HIC          PROVIDER          S/LOC P          TOB 13
                OPERATOR ID  FROM DATE      TO DATE          DDE SORT
                MEDICAL REVIEW SELECT
                HIC          PROV/MRN   S/LOC   TOB   ADM DT FRM DT THRU DT REC DT
                SEL LAST NAME  FIRST INIT TOT CHG  PROV REIMB PD DT  CAN DT REAS NPC #DAYS
```

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT  
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD

# Adjusting Claims (Cont.)

- Type the beneficiary's HIC number in the HIC field.
- Press "Tab" to the S/LOC fields and enter "B9997" after the "P" or "R."
- Change the type of bill, if necessary.
- You may also enter the "from" and "through" dates. Press "Enter."
- To select a claim, press "Tab" until the cursor moves under the SEL field and is to the left of the HIC number of the claim you want to adjust.
- Type "S" in the SEL field and press "Enter." After pressing "Enter," claim page 1 (MAP 1711) appears.

# Adjusting Claims (Cont.)

```

MAP1741          M E D I C A R E  A  O N L I N E  S Y S T E M
SC              CLAIM SUMMARY INQUIRY
                NPI
                HIC          PROVIDER          S/LOC P          TOB 13
                OPERATOR ID   FROM DATE          TO DATE          DDE SORT
                MEDICAL REVIEW SELECT
                HIC          PROV/MRN   S/LOC          TOB   ADM DT  FRM DT  THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB  PD DT   CAN DT  REAS NPC #DAYS
s
                P B7516   131   032408 032408 032408   042908
                133.98   77.58  051308   37192
                P B7591   137   011906 011906   082907
                247.00  175.85  090407   37205
                P B9996   131   060908 060908 060908   062008
                215.00   97.26  071808   37192
                P B9996   131   060308 060308 060308   062508
                215.00   97.26  071808   37192
                P B9996   131   113007 113007 113007   062508
                201.00   56.00  071808   37192
                PROCESS COMPLETED --- PLEASE CONTINUE
                PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
    
```

Type a "S" to select the claim for adjustment.

# Adjusting Claims (Cont.)

- Claim page 1:
  - Press “Tab” to the Condition Code field and indicate why the claim is being adjusted by entering the claim change reason code in the first available Condition Code field on claim page 1.
  - Only one code is allowed per claim.
  - Press “F8” to page 3.



# Adjusting Claims (Cont.)

Valid claim change reason codes are:

- D0 – Changes 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.
- 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.

# Adjusting Claims (Cont.)

```

MAP1711          M E D I C A R E  A  O N L I N E  S Y S T E M          CLAIM PAGE 01
SC              INST CLAIM ADJUSTMENT                          SV:
HIC            TOB 137  S/LOC S B0100          OSCAR              UB-FORM
NPI            TRANS HOSP PROV                    PROCESS NEW HIC
PAT.CNTL#:      TAX#/SUB:          TAXO.CD:
STMT DATES FROM 032408  TO 032408  DAYS COV          N-C          CO          LTR
LAST           FIRST           MI          DOB
ADDR 1         2
      3         4
      5         6
ZIP            SEX  MS  ADMIT DATE 032408  HR 08  TYPE 2  SRC 1  D  HM 0800  STAT 01
COND CODES 01 D9 02    03    04    05    06    07    08    09    10
OCC CDS/DATE 01        02        03        04        05
              06        07        08        09        10
SPAN CODES/DATES 01    02        03
04            05    06
08            09    10        FAC.ZIP
DCN
VALUE CODES - AMOUNTS - ANS I  MSP APP IND
01 A2        26.80 PR 2    02    03
04            05    06
07            08    09
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT  PF9-UPDT
  
```

Enter a claim change reason

Enter Occurrence Codes and dates.

Enter Value code and number of visits from onset.

PF8-NEXT

# Adjusting Claims (Cont.)

```

MAP1713          M E D I C A R E  A  O N L I N E  S Y S T E M          CLAIM PAGE 03
SC              INST CLAIM ADJUSTMENT
HIC            TOB 137  S/LOC S B0100  PROVIDER

                                OFFSITE ZIPCD:
  CD  ID    PAYER          AR          RI  AB          EST  AMT  DUE
  A  Z          MEDICARE          Y  Y          133.98
  B                                     0.00
  C                                     0.00
DUE FROM PATIENT          0.00          0.00

MEDICAL RECORD NBR          COST RPT DAYS          NON COST RPT DAYS
DIAGNOSIS CODES  1 7295          2 7068          3 3558          4          5
                   6          7          8          9          END OF POA IND
ADMITTING DIAGNOSIS          E CODE          HOSPICE TERM ILL IND
IDE
PROCEDURE CODES AND DATES  1          2          3          4          5          6

ESRD HOURS 00  ADJUSTMENT REASON CODE OT  REJECT CODE          NONPAY CODE
ATT PHYS          NPI          LN          FN          MI
OPR PHYS          NPI          LN          FN          MI
OTH PHYS          NPI          LN          FN          MI
PROCESS COMPLETED  ---  PLEASE CONTINUE
PRESS PF3-EXIT  PF7-PREV  PF8-NEXT  PF9-UPDT
  
```

Add diagnosis codes for the added clinic and therapy visits.

Enter Adjusment reason code.

# Adjusting Claims (Cont.)

## Claim page 2:

- Key the added revenue code line after the 0001 line.
  - Add all therapy visits under revenue code line 0001.
  - Add any other clinic visits that occurred during the month.
- Correct the total charge amount to reflect the addition of the revenue code charges.

# Adjusting Claims (Cont.)

MAP1712 M E D I C A R E A O N L I N E S Y S T E M CLAIM PAGE 02  
 SC INST CLAIM ADJUSTMENT REV CD PAGE 01

HIC TOB 137 S/LOC S B0100 PROVIDER

CL	REV	HCPC	MODIFS	RATE	TOT UNIT	COV UNIT	TOT CHARGE	NCOV CHARGE	SERV DT
1	0510	99211		215.000	00001	00001	215.00		030508
2	0001						909.00		
3	0510	99213		215.000	00001	00001	215.00		030708
4	0420	97110	GP	25.250	00015	00015	66.00		031508
5	0420	97001	GP	66.000	00001	00001	66.00		031708
6	0420	97110	GP	25.250	00001	00001	66.00		031808
7	0420	97110	GP	25.250	00001	00001	66.00		032208
8	0510	99212		215.000	00001	00001	215.00		032408

Correct the total charge amount.

Under the 0001 line, add all clinic visits and therapy visits for the month of March.

PROCESS COMPLETED --- PLEASE CONTINUE  
 PRESS PF2-171D PF3-EXIT PF5-UP PF6-DOWN PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT

# Adjusting Claims (Cont.)

- Press “Home” so that the cursor is placed in the upper right corner of the screen (the Claim Page field).
- Press “Enter.” FISS will automatically reorder the revenue code that you added to appear before the 0001 line.
- Press “F8” to claim page 4.

# Adjusting Claims (Cont.)

MAP1712 M E D I C A R E A O N L I N E S Y S T E M CLAIM PAGE 02  
SC INST CLAIM ADJUSTMENT REV CD PAGE 01

HIC TOB 137 S/LOC S B0100 PROVIDER

CL	REV	HCPC	MODIFS	RATE	TOT UNIT	COV UNIT	TOT CHARGE	NCOV CHARGE	SERV DT
1	0420	97001	GP	66.000	00001	00001	66.00		031708
2	0420	97110	GP	25.250	00015	00015	66.00		031508
3	0420	97110	GP	25.250	00001	00001	66.00		031808
4	0420	97110	GP	25.250	00001	00001	66.00		032208
5	0510	99211		215.000	00001	00001	215.00		030508
6	0510	99212		215.000	00001	00001	215.00		032408
7	0510	99213		215.000	00001	00001	215.00		030708
8	0001						909.00		

PROCESS COMPLETED --- PLEASE CONTINUE  
PRESS PF2-171D PF3-EXIT PF5-UP PF6-DOWN PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT

# Adjusting Claims (Cont.)

## Claim page 4:

- Add remarks, if necessary, explaining why the claim is being adjusted.
- Press “F9” to submit the claim.



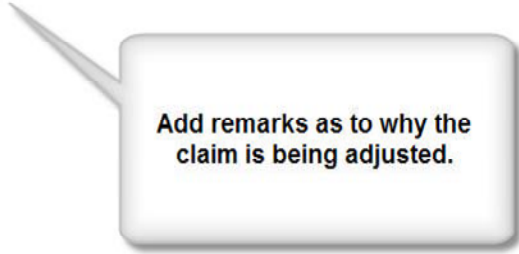
# Adjusting Claims (Cont.)

MAP1714                      M E D I C A R E   A   O N L I N E   S Y S T E M       CLAIM PAGE 04  
 SC    I N S T   C L A I M   A D J U S T M E N T       R E M A R K   P A G E   0 1

HIC    T O B   1 3 7    S / L O C   S   B 0 1 0 0    P R O V I D E R

REMARKS

Added clinic visits and therapy on one claim.



47 PACEMAKER          48 AMBULANCE          40 THERAPY          41 HOME HEALTH  
 58 HBP CLAIMS (MED B)          E1 ESRD ATTACH  
 ANSI CODES - GROUP: CO    ADJ REASONS: 45    APPEALS: MA13

PROCESS COMPLETED --- PLEASE CONTINUE  
 PRESS PF3-EXIT   PF5-SCROLL BKWD   PF6-SCROLL FWD   PF7-PREV   PF8-NEXT   PF9-UPDT

# Safeguard Programs

Three main contractors for Medical Review (MR) are:

- A/B Medicare Administrative Contractor (MAC) – TrailBlazer (Dallas):
  - Correctness of payment.
- Zone Program Integrity Contractor (ZPIC) – Health Integrity (Dallas/Baltimore):
  - Fraud.
- Recovery Audit Contractor (RAC) – Connolly Consulting (Connecticut):
  - Recovery of incorrect payments.

# Safeguard Programs (Cont.)

- Smaller role in MR:
  - CERT:
    - Nationwide error rate calculation.
  - QIO – varies by state:
    - Quality reviews.

# CERT

## What is CERT?

- Comprehensive Error Rate Testing (CERT).
- CMS' process to determine how accurately Medicare contractors review and process claims.

# CERT Methodology

CERT contractors use the following methodology:

- Random selection is made from a sample of claims submitted within a specific calendar year.
- Medical records are requested from providers who submitted the claims.
- The claims and medical records are reviewed for compliance with Medicare coverage, coding and billing rules.

# RAC

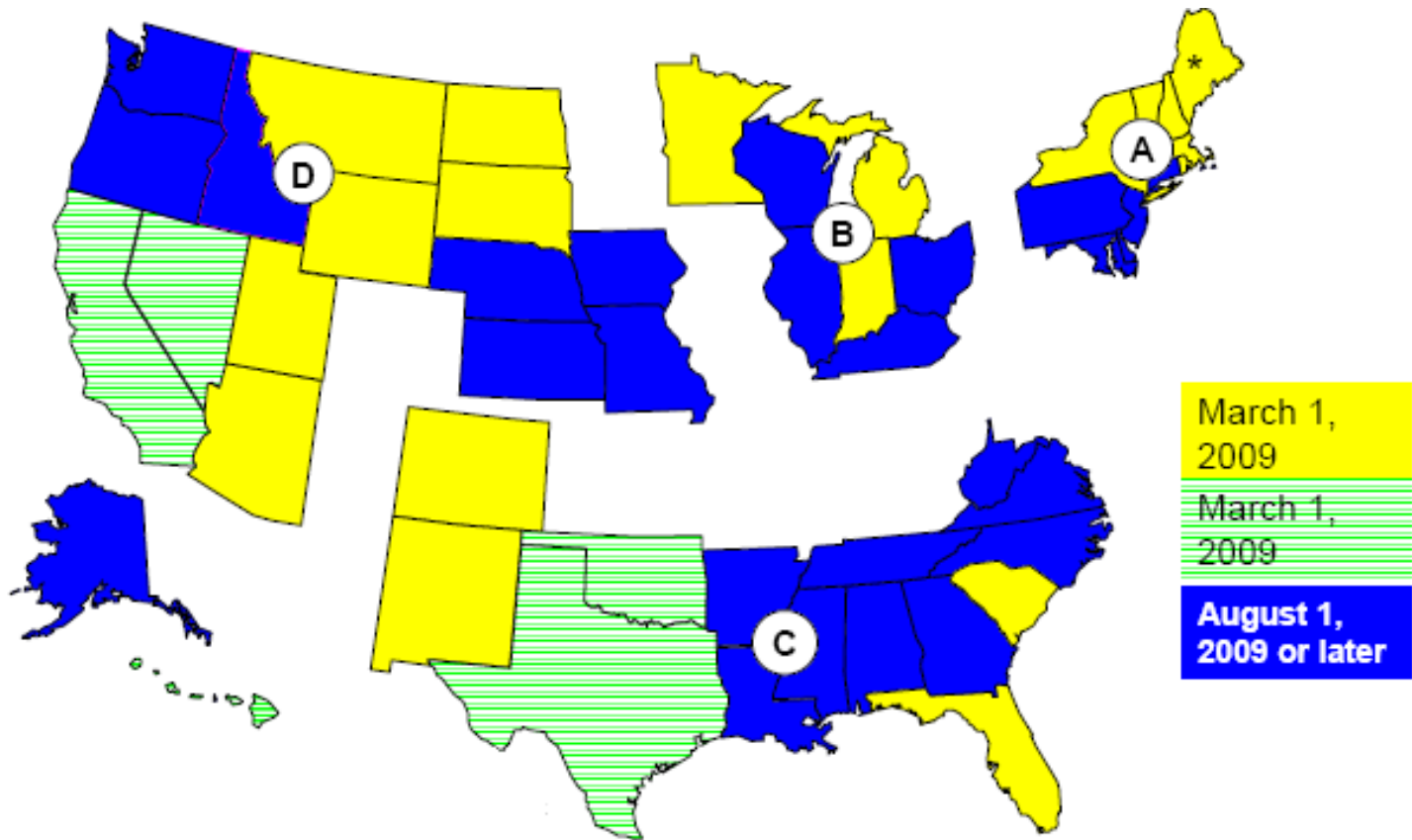
## RAC Permanent Program:

- Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC program permanent and required the Secretary to expand the program to all 50 states by no later than 2010.
- The goal of the recovery audit program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries.

# RAC (Cont.)

- Improper payments may be overpayments or underpayments.
- Health care providers that might be reviewed include hospitals, physician practices, nursing homes, home health agencies, durable medical equipment suppliers, and any other provider/supplier that bills Medicare Part A and B.
- The RACs are paid on a contingency basis.

# RAC (Cont.)



- A - Diversified Collection Services
- B - CGI Technologies and Solutions
- C - Connolly Consulting Associates
- D - Health Data Insights



# ZPIC

- CMS awarded the ZPIC contract for Zone 4 to Health Integrity, LLC.
- Beginning February 1, 2009, Health Integrity will perform the integrity functions for Medicare Parts A and B, Durable Medical Equipment (DME), home health and hospice, as well as the Medicare Medicaid Data Match project.
- These efforts will include the following six tasks:
  - Performing data analysis and data mining.
  - Conducting medical reviews in support of benefit integrity.
  - Supporting law enforcement and answering complaints.
  - Investigating fraud and abuse.
  - Recommending recovery of federal funds through administrative action.
  - Referring cases to law enforcement.

# ZPIC (Cont.)

## Health Integrity, LLC:

- Develops innovative data analysis methodologies for detecting and preventing abusive use of services early.
- Develops high-quality fraud case referrals for law enforcement .
- Identifies appropriate corrective actions.

# ZPIC (Cont.)

## Offices located in:

- Dallas, Texas
  - San Antonio, Texas
  - Houston, Texas
  - Brownsville, Texas
  - Denver, Colorado
  - Oklahoma City, Oklahoma
  - Albuquerque, New Mexico
- Health Integrity staff include: data analysts, nurse reviewers and fraud investigators.
- To contact Health Integrity, call (972) 383-0000 or visit <http://www.healthintegrity.org/>

# Indian Health Service

Thank you for attending.  
[j4.ih@trailblazerhealth.com](mailto:j4.ih@trailblazerhealth.com)