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HEALTH ENTERPRISES, LLC

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Medicare Part A
Indian Health Service (IHS)
Outpatient Billing
and Corrections

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DM

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Important

The information contained in this presentation was current as of February 2010 and can be found in the *Part A Indian Health Service Manual* and *DDE Claims Correction Manual*. All manuals can be downloaded from:

http://www.trailblazerhealth.com/Publications/Manuals/

Agenda

- Outpatient
  - Definitions
  - Medical necessity
  - “Incident to” services
  - Lab and X-Ray-only visits
  - Comprehensive Error Rate Testing (CERT) error
  - Outpatient Services
- Claims Corrections
- Adjustments
- Void/Cancel

Outpatient Definitions

Outpatient:

- A person who is not admitted by the hospital as an inpatient, but *registered* on the hospital records as an outpatient

Outpatient services:

- Facility services and supplies covered during an outpatient encounter

Medical Necessity

Medical necessity is defined as services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member and are not excluded under another provision of the Medicare program.

- Medical necessity is documented on the claim by the use of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes.

Medical Necessity (Continued)

Services denied by the Medicare program as not medically necessary or reasonable fall into these general categories:

- Experimental and investigational
- Not safe and effective
- Limited coverage based on certain criteria
- Obsolete tests
- Number of services exceeds the norm and no medical necessity demonstrated for the extra number of services

Medical Necessity (Continued)

Medicare has a number of policies, including National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) that describe coverage criteria (medical necessity).

NCDs are established by Centers for Medicare and Medicaid Services (CMS) and located on the CMS Web site in two locations:

- Medicare Coverage Center
- Internet-Only Manual (IOM) Pub. 100-03

Medical Necessity (Continued)

LCDs are established by TrailBlazer[SM] and located on our Web site. Examples of services that the IHS performs and are covered under an LCD include foot care, physical therapy, ophthalmology, and wound care.

CMS has given Medicare contractors the authority to develop LCDs and/or expand certain NCDs.

- Example of an NCD expanded with LCD: Frequency of Cholesterol Testing.

Medicare notifies the providers of limited coverage and medical necessity in the *TrailBlazer eBulletins* that are posted each month to the TrailBlazer Web site. These eBulletins can be found on the Publications Web page.

‘Incident to’ Services

“Incident to” a physician’s professional services means the services or supplies are furnished by the hospital or Critical Access Hospital (CAH) or under arrangements made by the hospital or CAH. The services and supplies must be furnished as an integral, although incidental, part of the physician’s or Nonhysician Practitioner’s (NPP) professional service in the course of diagnosis or treatment of an injury or illness.

This does not mean that each occasion of service by an NPP need also be the occasion of the actual rendition of a personal professional service by the physician responsible for care of the patient. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient’s progress and, where necessary, to change the treatment regimen.

‘Incident to’ Services (Continued)

The services and supplies must be furnished under the order of a physician or other practitioner practicing within the extent of the Social Security Act, the Code of Federal Regulations and state law, and furnished by hospital personnel under the direct supervision of a physician or NPP as defined at 42 CFR 410.27(f) and 482.12. For pulmonary rehabilitation, cardiac rehabilitation and intensive cardiac rehabilitation services, direct supervision must be furnished by a doctor of medicine or osteopathy, as specified at 42 CFR 410.47 and 410.49, respectively.

A hospital service or supply would not be considered incident to a physician’s service if the attending physician merely wrote an order for the services or supplies and referred the patient to the hospital without being involved in the management of that course of treatment.

Refer to IOM Pub. 100-02, Chapter 6, Section 20.5.2.

‘Incident to’ Services (Continued)

Medicare requires that documentation submitted to support billing “incident to” services must clearly link the services of the auxiliary personnel to the services of the physician or NPP.

For “incident to” services that are billed and undergoing medical review, documentation sent in response to the request should clearly show the link.

Evidence of the link include:

- Cosignature or legible identity and credentials of both the practitioner who provided the service and the physician on documentation entries.

‘Incident to’ Services (Continued)

- Some indication of the supervising physician’s involvement with the patient’s care. This indication could be satisfied by:
  - Notation of supervising physician’s involvement (the degree of which must be consistent with clinical circumstances of the care) within the text of the associated medical record entry.
  - Documentation from other dates of service (e.g., initial visit, etc.) other than those requested, establishing the link between the two providers.

Failure to provide such information may result in an overpayment.

Lab and X-Ray Only Visits

CMS issued Joint Signature Memorandum (JSM) 10066 on November 30, 2009, clarifying face-to-face encounters:

"If the beneficiary must return on a different day to receive a medically necessary procedure or test that was ordered by the physician or non-physician practitioner during the initial visit, the medically necessary return visit would qualify for the All-Inclusive Rate (AIR) and should be billed as an encounter even if the beneficiary did not interact with a physician or non-physician practitioner during the return visit."

Remember:

- Must be medically necessary
- "Incident to" guidelines

CERT Error

Error Description	Revenue Code	HCPCS/ CPT	CERT Review Comments	Resolutions
Insufficient Documentation	851	99211	Insufficient documentation; missing documentation to support a clinic visit that may not require the presence of a physician. Submitted documentation supports visit was for laboratory services only, without notation of other face-to-face services.	Submit all records pertaining to the lab-only visit. For Code 99211 services performed by ancillary staff and billed as an "incident to" service, the documentation should demonstrate the "link" between the nonphysician service and the precedent physician service to which the nonphysician service is incidental. Therefore, documentation of Code 99211 services provided "incident to" should include the identity and credentials of both the individual who provided the service and the supervising physician. Documentation of a Code 99211 service provided "incident to" should also indicate the supervising physician's involvement with the patient care. Refer to the "incident to" guidelines located in IOM Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Sections 20.5.1 and 20.5.2. TrailBlazer has posted a job aid titled "Documentation Requirements for CPT 99211."

Outpatient Services

Two types of services:

- Therapeutic services assist the physician in treatment of the patient:
  - Clinic visits
  - “Incident to” services
  - Emergency room visits
- Diagnostic services, such as diagnostic X-rays or laboratory services that help determine the nature and severity of an ailment or injury

Section 630 of MMA

Section 630 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 expanded coverage to IHS facilities to allow payment consideration on all Part B items or services for a 5-year period. This included:

- Clinical laboratory services.
- Surgical dressing, splints and casts.
- Drugs (i.e., injections and medicine used in equipment).
- Preventive services.
- Ambulance.
- Durable Medicare Equipment (DME) supplies.

The five-year period ended December 31, 2009.

House Bill 4313, which will continue these services indefinitely, is pending. Until this is passed, claims for these services should be held.

Reimbursement

Outpatient care:

- Acute care hospital
  - AIR
- CAH
  - 101% of the all-inclusive facility-specific per diem rate
- Federally Qualified Health Center (FQHC)
  - Lower of national capped amount or clinic-specific cost per encounter

Reimbursement (Continued)

Inpatient Part B Ancillary:

- Acute care hospital
  - AIR
- CAH
  - 101% of the all-inclusive facility-specific per diem rate
- FQHC
  - Outpatient services only. No inpatient; therefore, no ancillary

Claim Requirements

Outpatient Services

- Type of Bill (TOB):
  - 131 Acute
  - 851 CAH
  - 731 FQHC (effective April 1, 2010, use 771)
  - 121 Ancillary
- Appropriate revenue code:
  - 0510 Clinic visit (acute and CAH)
  - 0521 Clinic visit (FQHC)
- Appropriate HCPCS code:
- Date of service
- Unit
- Total charge

Claim Requirements (Continued)

Revenue Code (FL 42)	HCPCS Code (FL 44)	Date of Service (FL 45)	Service Units (FL46)	Charge (FL 47)
0510	99213	08/10/2009	1	181.00
0001			1	181.00

Physical Therapy

Physical, occupational and speech therapy, along with audiology services, are not considered a part of Section 630.

IHS was given the authority to submit these services through the Benefits Improvement Protection Act of 2000 (BIPA), Section 432.

Continue to submit these services on a monthly basis (except audiology), including all outpatient services rendered to the patient during the month.

Revenue Code (FL 42)	HCPCS Code (FL 44)	Date of Service (FL 45)	Service Units (FL46)	Charge (FL 47)
0510	99213	08/10/2009	1	181.00
0420	97110 GP	08/13/2009	2	146.00

Multiple Visits

- Visits with more than one health professional and multiple visits with the same health professional that take place during the same day at a single location within the hospital (including the hospital-based satellite) constitute a single visit.
- The only exception to the “all-inclusive” encounter is when the patient has an emergency room visit on the same day with an unrelated condition.
  - One claim can be submitted with two detail lines: one for the clinic visit HCPCS code and one for the ER HCPCS code.
  - Report condition code G0 (zero).
  - Report two unrelated diagnoses.
- If the services are billed separately on two bills, one of the bills will reject and deny as a duplicate bill.
  - An adjustment to the paid claim will be required to receive the appropriate payment.

Outpatient Services

Revenue Code (FL 42)	HCPCS Code (FL 44)	Date of Service (FL 45)	Service Units (FL46)	Charge (FL 47)
0510	99213	08/10/2009	1	180.00
0510	99283	08/10/2009	1	180.00

Remarks: First Diagnosis (DX) goes with clinic visit; second DX goes with ER visit.

Condition code G0 identifies multiple medical visits on same day, same revenue code, but distinct, independent visits.

Covered or Noncovered?

Patient sees her family practitioner with a complaint of dizziness and episodes of fainting when standing from a sitting position. This has been happening for two days. No complaints of earache or ringing in the ears. Blood pressure checks a little high but within range. Mother has diabetes and father had high blood pressure. Physician orders laboratory tests that require patient to fast after midnight. Physician advises that once he/she has laboratory results, he/she will contact patient. Patient to return the following day for tests.

Patient returns the next morning, checks into the outpatient clinic and is taken to the laboratory for blood draw.

Physician receives results that afternoon and contacts patient. She is hypoglycemic. He/she counsels her on diet changes and wants to see her in two weeks.

Does this meet medical necessity? – Yes
Does this meet “incident to”? – Yes
Can the AIR be billed for the initial visit and the lab visit? – Yes

Covered or Noncovered? (Continued)

Patient's daughter brings her in to see physician because she is complaining of a sore throat and earache. Patient has a slight temperature of 100 degrees, throat is red and swollen, and there is inflammation in the middle ear. Doctor diagnoses otitis media and orders an injection of Rocephin.

The daughter states they have been waiting all afternoon to see the physician and now it's time to go pick up her child from school. She will bring her mother back tomorrow for the injection.

Does the return visit constitute billing the AIR? – No

Covered or Noncovered? (Continued)

Patient is seen by physician with complaint of coughing, difficulty breathing and body aches. Physician orders chest X-ray to see if there is any pneumonia. The clinic does not have X-ray equipment and the patient must go to the IHS hospital in the next town. The clinic calls to make an appointment for the patient but the hospital can't get the patient in until the following day. The physician prescribes antibiotics, advises the patient to go have the X-ray the following day and to follow up with him/her next week.

Does this meet medical necessity? – Yes
Does this meet "incident to"? – Yes
Can the hospital file an AIR? – Yes

Online Claims Correction

Do you adjust a Return to Provider (RTP) ("T" status) claim?

All RTP bills are considered inactive in the system; therefore, only a correction of error(s) will reactivate the claim for processing. Because of this, an RTP bill cannot be adjusted or voided. RTP bills are maintained in a file and are available for correction for 120 days. The RTP claims will remain in the "T" status for 120 days. An update to the system will occur every Saturday and move RTP claims over 120 days to Inactive (I) status. RTP claims are no longer accessible after 120 days and must be re-entered entirely to be processed for payment.

Claim adjustments can be made to Paid ("P" status) or Rejected ("R" status) claims; however, if a claim in "P" status is partially denied due to medical review, the claim cannot be adjusted online.

Online Claims Corrections (Continued)

The Claims Correction option (FISS Main Menu option 03) allows you to:

- Correct UB-04 claims in the RTP status (T B9997)
- Adjust paid or rejected claims
- Cancel paid claims

```
MAP1704          TRAILBLAZER HEALTH ENTERPRISES, LLC      ACPMA051 08/04/09
CB91070        CLAIM AND ATTACHMENTS CORRECTION MENU      C20093CE 13:54:59

                          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:

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

RTP

Paid/Rej

Paid/Rej

Online Claims Correction (Continued)

To correct an RTP, from the main menu select Inpatient or Outpatient under the Claims Correction section. The next screen will be MAP 1741. You can enter the Health Insurance Claim (HIC) number that needs to be corrected, or select from the list of RTP claims.

```
MAP1741            TRAILBLAZER HEALTH ENTERPRISES, LLC     ACPMA051 03/09/10
LS00434   SC            CLAIM SUMMARY INQUIRY              C20101YE 13:43:05

                            NPI 1xxxxxxxxx

      HIC              PROVIDER                 S/LOC T B9997   TOB 13
 OPERATOR ID LS00434    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

  123456789A      0xxxxx             T B9997   137           092809 092809   012210
   SMITH          M           43.00              021110         30949     26


      PROCESS COMPLETED   ---   PLEASE CONTINUE
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD
```

Online Claims Correction (Continued)

After selecting the claim to correct, you will be on Page 1 or MAP 1711.
An example of an RTP correction would be updating the patient's HIC:

- Tab to Process New HIC.
- Type **Y,** then tab and enter corrected HIC.
- Press F9.
- The claim will return to MAP 1741 if the correction was accepted. If not, press F1 to see if there are any other reason codes that need to be corrected.

```
 MAP1711    PAGE 01    TRAILBLAZER HEALTH ENTERPRISES, LLC     ACPMA051 03/09/10
 LS00434    SC               INST CLAIM UPDATE                 C20101YE 14:33:54

HIC xxxxxxxxx   TOB 131   S/LOC S B0100   OSCAR xxxxxx         SV:    UB-FORM
NPI 1xxxxxxxx  TRANS HOSP PROV            PROCESS NEW HIC  Y  xyxxyxyxyA
PAT.CNTL#: AB123          TAX#/SUB: xxxxxxxxx      TAXO.CD: xxxxxxxxx
 STMT DATES FROM 102308  TO 102308  DAYS COV      N-C       CO       LTR
 LAST SMITH                       FIRST M               MI    DOB 01161923
 ADDR 1 123 MAIN ST                   2 ANYWHERE
 3 US                                 4                                CARR:
 5                                    6                                 LOC:
ZIP 12345      SEX F MS   ADMIT DATE        HR    TYPE 1 SRC 1 D HM      STAT 01
   COND CODES 01     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 74820 2847
  DCN
       V A L U E  C O D E S  -  A M O U N T S  -  A N S I    MSP APP IND
01                         02                        03
04                         05                        06
07                         08                        09

32200 32415                                                   <== REASON CODES
        PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT  PF9-UPDT
```

Recommendations

Medicare receives duplicate RTPs with the same error as identified on the initial bill. This causes the claim to be returned more than once and slows down a provider's cash flow.

Please note the following recommendations:

- Verify and make all necessary corrections based on the reason code(s).
- Work RTP claims daily.
- Direct Data Entry (DDE) corrections can be entered when the RTP status/location is T B9997.
- Rekeyed bills do not duplicate against the original bill in the RTP file since these bills are not active in the system. All unworked RTP bills are inactivated from the RTP file in 120 days with no effect on processing.
- When correcting an RTP, information can be added that was originally omitted along with making the necessary corrections.
- With the DDE system, claims do not always clear all edits when the first RTP is generated. The claim could RTP if further errors are identified.

Adjustments

Sometimes a claim may need to be adjusted after it has been paid or rejected to make changes (i.e., add or remove services).

Adjustments are a four-step process:

1. Enter a claim change reason code on claim Page 1.
2. Enter an adjustment reason code on claim Page 3.
3. Make the necessary changes to the claim on the applicable page(s) and add remarks on claim Page 4, if necessary.
4. Press F9 to send the adjustment.

Adjustments (Continued)

Claim scenario example:

- Patient was seen in the clinic for a medical reason.
- Patient also received a Pneumococcal Pneumonia Vaccine (PPV).
- Provider billed the clinic visit.
- Provider did not bill the vaccine visit.
- Provider later discovered that the PPV was also administered.

Adjustments (Continued)

Claim scenario example:

- Provider must wait until the clinic visit appears on a remittance advice.
  - The claim may show it has been approved and is going to be paid, but until a check is issued, it is still in a processing stage.
- Adjust the claim to add the charges for the PPV.
  - Add the revenue and Health Care Financing Administration Common Procedure Coding System (HCPCS) codes for the PPV and the administration of the PPV.
  - Add Condition Code A6.
  - Add the diagnosis for the PPV to the claim.

Main Menu

```
MAP1701            TRAILBLAZER HEALTH ENTERPRISES, LLC        ACPMA051 07/24/09
CB91070                         MAIN MENU                     C200935E 09:10:00

                        01     INQUIRIES

                        02     CLAIMS/ATTACHMENTS

                        03     CLAIMS CORRECTION

                        04     ONLINE REPORTS

   ENTER MENU SELECTION:

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

Correction Menu

From the Claim and Attachments Correction Menu, select Inpatient (30) or Outpatient (31).

```
MAP1704          TRAILBLAZER HEALTH ENTERPRISES, LLC      ACPMA051 07/24/09
CB91070        CLAIM AND ATTACHMENTS CORRECTION MENU      C200935E 09:12:05

                      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:


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

Claim Summary Inquiry

Enter the HIC number, your National Provider Identifier (NPI) and dates of service. Press Enter.

```
MAP1741                TRAILBLAZER HEALTH ENTERPRISES, LLC     ACPMA051 07/24/09
CB91070   SC                CLAIM SUMMARY INQUIRY              C200935E 09:28:51
                               NPI
      HIC                 PROVIDER                 S/LOC P         TOB 13
 OPERATOR ID CB91070      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
```

Claim Summary Inquiry (Continued)

Tab to the claim you want to adjust, type **S** and press Enter.

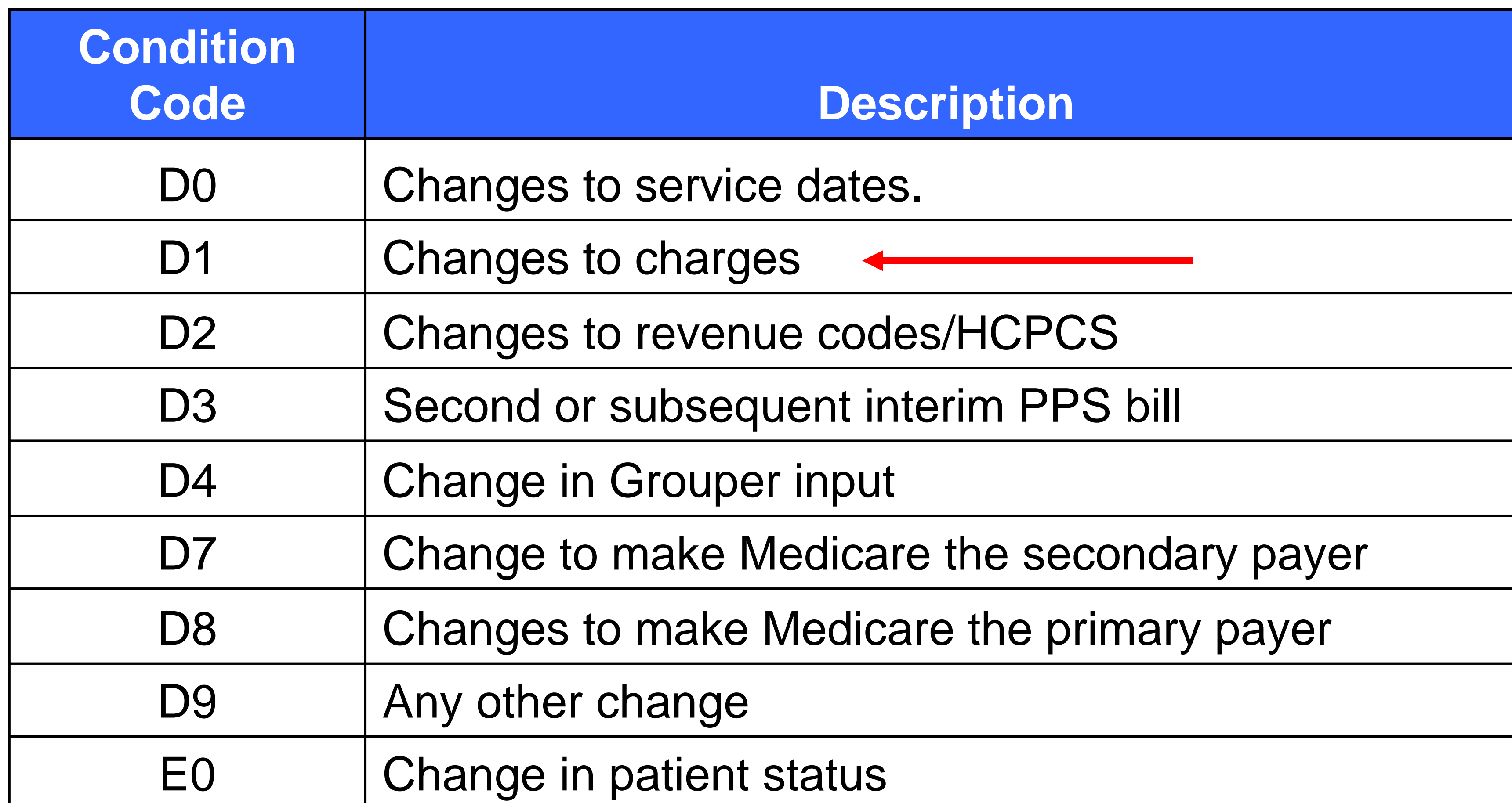
```
MAP1741              TRAILBLAZER HEALTH ENTERPRISES, LLC     ACPMA051 07/24/09
CB91070   SC                 CLAIM SUMMARY INQUIRY           C200935E 09:13:57
                                NPI
      HIC                 PROVIDER                S/LOC P        TOB 13
 OPERATOR ID              FROM 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
                                  P B75IH    131    051909 051909 051909   062309
                          E      215.00     172.00  070709          37192

                                  P B75IH    131    042409 042409 042409   062409
                          J      215.00     172.00  070809          37192

                                  P B75IH    131    042209 042209 042209   062409
                          C      215.00     172.00  070809          37192

                                  P B75IH    131    042909 042909 042909   062409
                          C      215.00     172.00  070809          37192

                                  P B75IH    131    050609 050609 050609   062409
                          C      215.00     172.00  070809          37192
      PROCESS COMPLETED  ---   PLEASE CONTINUE
  PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```

Claim Page 1

Tab to the condition code and enter the claim change reason code and any other condition code that may be required (e.g., A6 for flu and/or pneumonia).

```
 MAP1711    PAGE 01     TRAILBLAZER HEALTH ENTERPRISES, LLC      ACPMA051 07/24/09
 CB91070    SC                INST CLAIM ADJUSTMENT              C200935E 09:23:37
 HIC                 TOB 137  S/LOC S B0100 OSCAR                 SV:     UB-FORM
NPI            TRANS HOSP PROV                  PROCESS NEW HIC
PAT.CNTL#:                          TAX#/SUB:                 TAXO.CD:
 STMT DATES FROM 051909  TO 051909
 LAST                               FIRST                MI B  DOB 01041929
 ADDR 1                                    2
 3                               4                                    CARR:
 5                               6                                     LOC:
ZIP            SEX F MS   ADMIT DATE 051909 HR 11 TYPE 2 SRC 1 D HM 1100 STAT 01
   COND CODES 01 D1 02 A6 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 20917501165801TXA
      V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
01 A2       43.00 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
```

Condition Codes



Condition Code	Description
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	Changes to make Medicare the primary payer
D9	Any other change
E0	Change in patient status

Claim Page 2

Add Revenue Code 0636 for the PPV.

```
MAP1712    PAGE 02    TRAILBLAZER HEALTH ENTERPRISES, LLC      ACPMA051 07/24/09
CB91070    SC                   INST CLAIM ADJUSTMENT          C200935E 09:40:42
                                                     REV CD PAGE 01
HIC                  TOB 137  S/LOC S B0100  PROVIDER

                                       TOT     COV
CL   REV   HCPC MODIFS             RATE UNIT    UNIT   TOT CHARGE NCOV CHARGE SERV DT
 1 0510 99211                   215.000 00001 00001       215.00              051909
 2 0001                                                   215.00
   0636 90732                           1       1      25.00                  051909

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

Claim Page 2 (Continued)

Add Revenue Code 0771 for the administration of the PPV.

```
MAP1712    PAGE 02     TRAILBLAZER HEALTH ENTERPRISES, LLC      ACPMA051 07/24/09
CB91070    SC                INST CLAIM ADJUSTMENT              C200935E 09:40:42
                                                   REV CD PAGE 01
HIC                  TOB 137  S/LOC S B0100  PROVIDER

                                    TOT     COV
CL  REV  HCPC MODIFS           RATE UNIT    UNIT  TOT CHARGE NCOV CHARGE SERV DT
 1 0510 99211               215.000 00001 00001       215.00             051909
 2 0001                                               215.00
   0636 90732                       1       1      25.00                 051909
   0771 G0009                       1       1      15.00                 051909









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

Claim Page 2 (Continued)

Change the total charges.

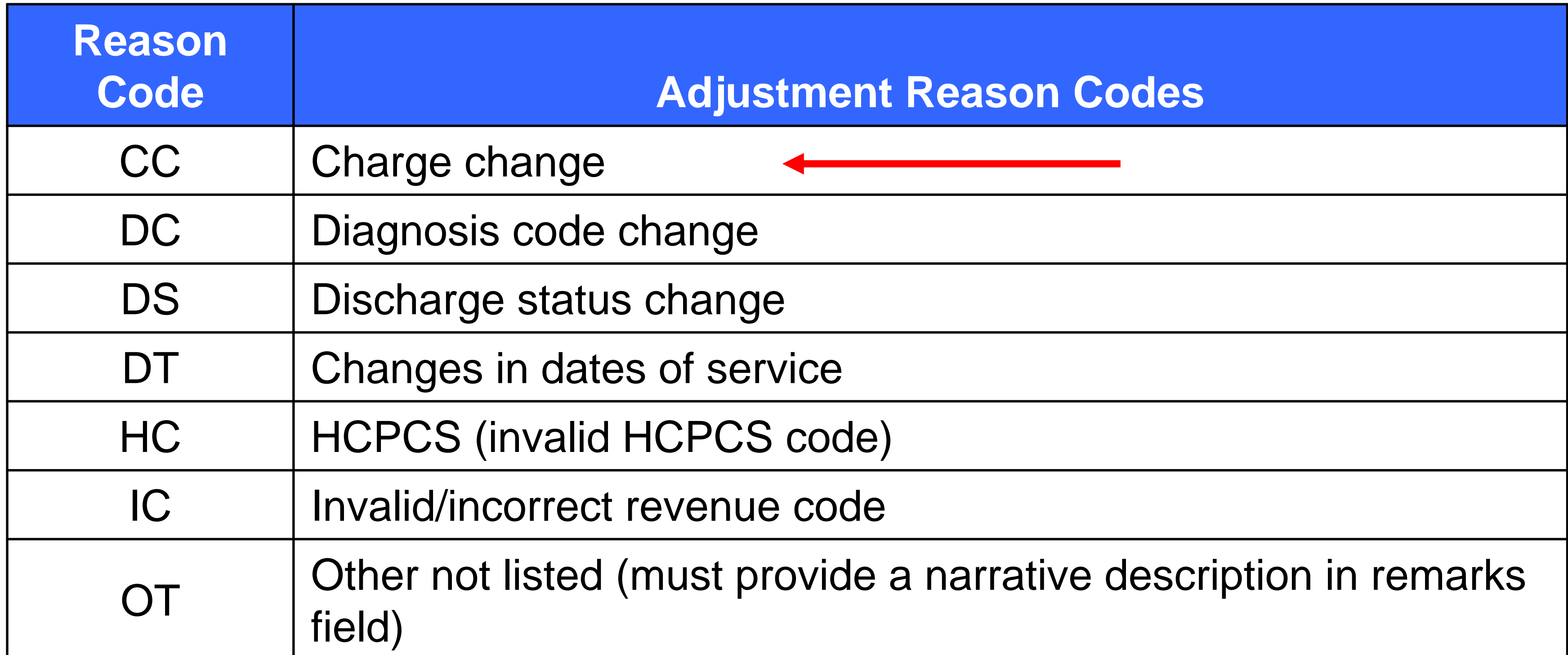
```
MAP1712    PAGE 02    TRAILBLAZER HEALTH ENTERPRISES, LLC     ACPMA051 07/24/09
CB91070    SC               INST CLAIM ADJUSTMENT             C200935E 09:40:42
                                                   REV CD PAGE 01
HIC                 TOB 137  S/LOC S B0100  PROVIDER

                                       TOT    COV
CL  REV  HCPC MODIFS           RATE UNIT   UNIT  TOT CHARGE NCOV CHARGE SERV DT
 1 0510 99211               215.000 00001 00001       215.00             051909
 2 0001                                          255.00
   0636 90732                         1      1   25.00                   051909
   0771 G0009                         1      1   15.00                   051909

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

Claim Page 3

Tab to the adjustment reason code and enter code.

```
MAP1713   PAGE 03    TRAILBLAZER HEALTH ENTERPRISES, LLC     ACPMA051 07/24/09
CB91070   SC                  INST CLAIM ADJUSTMENT              C200935E 09:25:05
HIC                TOB 137  S/LOC S B0100  PROVIDER
                                                    OFFSITE ZIPCD:
 CD  ID     PAYER                       OSCAR          RI AB                EST AMT DUE
A Z        MEDICARE                                     Y Y                       215.00
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 36610      2 V431       3 V5871      4 V0382      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
NDC CODE
ESRD HOURS 00  ADJUSTMENT REASON CODE CC  REJECT CODE        NONPAY CODE
ATT PHYS        NPI               LN                    FN            MI
OPR PHYS        NPI 0000000000    LN                    FN            MI
OTH PHYS        NPI 0000000000    LN                    FN            MI
      PROCESS COMPLETED  ---   PLEASE CONTINUE
           PRESS PF3-EXIT  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Adjustment Reason Codes



Reason Code	Adjustment Reason Codes
CC	Charge change
DC	Diagnosis code change
DS	Discharge status change
DT	Changes in dates of service
HC	HCPCS (invalid HCPCS code)
IC	Invalid/incorrect revenue code
OT	Other not listed (must provide a narrative description in remarks field)

Note: A complete list of adjustment codes is available at: http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf.

Remarks

On claim Page 4, enter a remark explaining why you are making an adjustment (e.g., this claim is being adjusted to add pneumonia vaccine and administration). A remark must be made if you use a D9 and/or OT reason code.

```
MAP1714    PAGE 04    TRAILBLAZER HEALTH ENTERPRISES, LLC      ACPMA051 08/04/09
CB91070    SC                INST CLAIM UPDATE                 C20093CE 14:15:29
                                                    REMARK PAGE 01
HIC                   TOB 711   S/LOC S B0100   PROVIDER

REMARKS


  THIS CLAIM IS BEING ADJUSTED TO…






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

                                                      <== REASON CODES
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Void/Cancel

A void transaction indicates the elimination of a previously submitted bill. A voided bill is sometimes followed with a new corrected bill when an adjustment was not appropriate. Once a claim has been voided or canceled, no other processing can occur on that bill.

```
MAP1704            TRAILBLAZER HEALTH ENTERPRISES, LLC    ACPMA051 07/24/09
CB91070          CLAIM AND ATTACHMENTS CORRECTION MENU    C200935E 09:12:05

                        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:


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

Void/Cancel (Continued)

Follow the same steps in locating the claim as you would in performing a correction or adjustment.

Voids/cancels are a three-step process:

1. Enter a claim change reason code on claim Page 1.
   - D5 – Cancel only to correct HIC
   - D6 – Cancel to repay duplicate or correct an error
2. Enter an adjustment reason code on claim Page 3. Examples:
   - DS – Discharge status change
   - OT – Other change (remark required)

   It is recommended that a remark be included explaining why the claim was voided/canceled.
3. Press F9 to save the cancellations. You should be returned to Screen 1741.

Questions

Education Makes the Difference Education Makes the Difference

Medicare Part A
IHS Outpatient Billing and Corrections

Thank you for attending.