

Idaho RHC & CAH Conference

Rural Health Clinics

Medicare Part A Education

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- Issues Affecting Reimbursement
 - Flu and Pneumonia Vaccines
 - CR 6445
 - Encounter Reminders
 - CERT
 - Top Reasons for RTPs
 - MSP Denials
 - Medicare Appeals
 - LCD and NCD
 - Limitation on Recoupment - 935 Process
- Resources
- Items of Interest

- Identify facility vulnerabilities to minimize unnecessary payment delays and/or recoupment
- Identify processes to prevent repeated errors

- Costs of flu and pneumonia vaccines and related administration are separately reimbursable at annual cost settlement
 - Include information on Cost Report Worksheet; do not submit claims
- If only reason for clinic visit is vaccine, do not bill for visit

- Initial Preventative Physical Examination (IPPE)
IPPE not subject to Part B deductible effective 1/1/09
 - Revenue code 052X AND HCPCS G0402
- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) not subject to Part B deductible effective 1/1/07
 - Revenue code 052X and HCPCS G0389

- Physician services = professional services performed by a physician for a patient
 - Diagnosis, therapy, surgery, consultation, and interpretation of tests (EKG, x-rays)
- Services performed at the clinic are payable only to the clinic

- Physicians employed by the RHC/FQHC may not bill the Carrier for services provided to RHC/FQHC patients.
 - Services performed at the hospital are not RHC/FQHC services
- Non-RHC-FQHC physician employees may bill the Carrier for services furnished to beneficiaries in POS other than RHC/FQHC

- Consultations are covered in RHC/FQHC if provided by a second physician (or consultant) at the request of the attending physician
- Must include H&P exam; written report furnished to attending physician to include in patient's record

- Concurrent care is covered if:
 - Medical necessity requires multiple physicians to play an active role in the patient's treatment, i.e., the patient has more than one medical condition requiring diverse specialized services

- Laboratory services
- DME
- Ambulance services
- Technical components of diagnostic tests

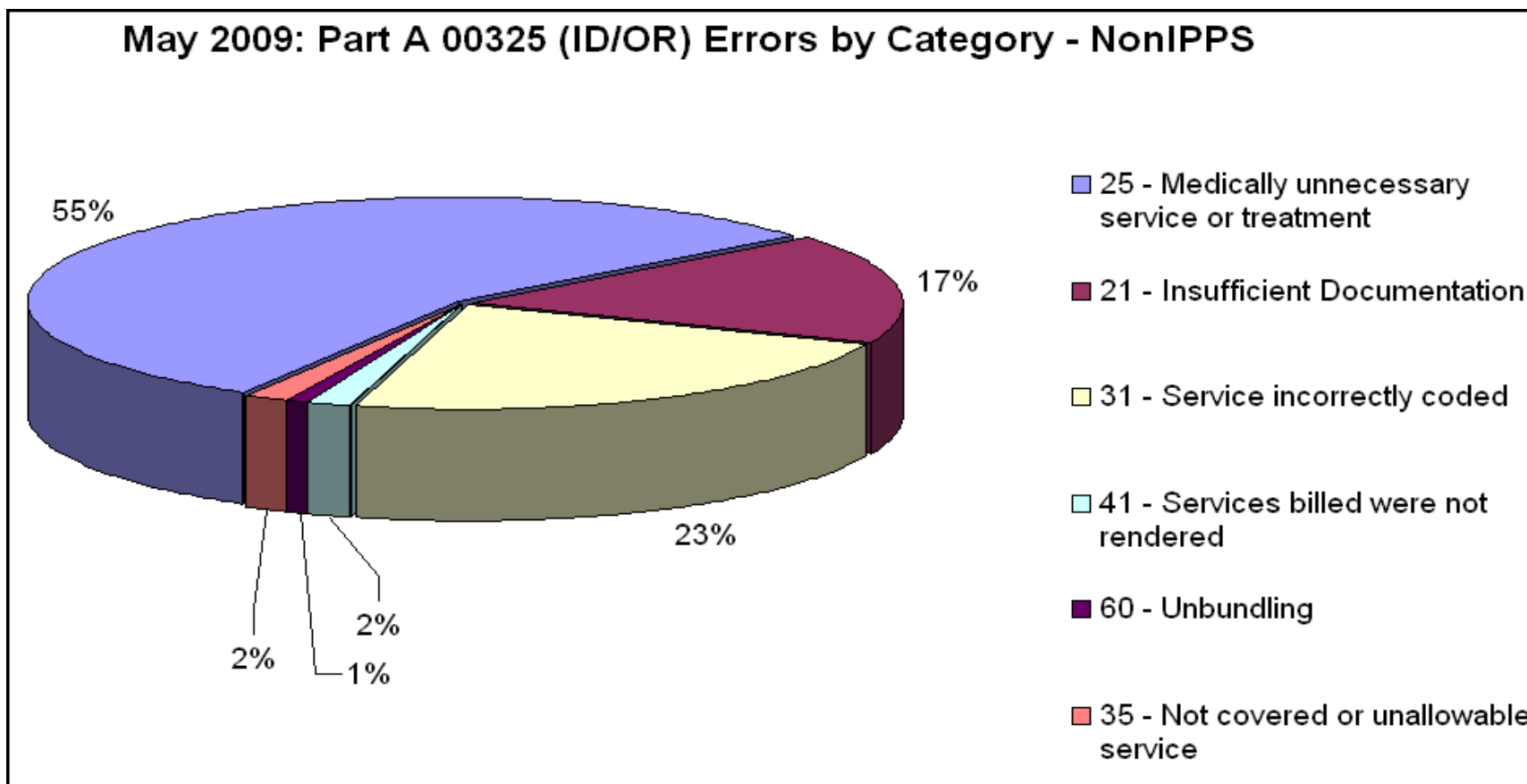
- Technical component of the following preventative services:
 - Screening pap smears, pelvic exams, and mammograms
 - Prostate cancer screening
 - Diabetes outpatient self-management training services
 - Colorectal cancer screening tests
 - Bone mass measurements
 - Glaucoma screening

Comprehensive Error Rate Testing (CERT)

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

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

Error codes for Non IPPS claims reviewed



- Missing MD orders
- Incorrectly coded CPT
- Insufficient documentation
- Incorrectly coded units of service
- Received MD order but no legible identification of person reviewing/completing order

- Noridian processes
- Submit additional information
 - Noridian
 - Fax information with CID # to CDC also
- **Do not adjust** CERT denied claims

Where to Get More Information

- Websites:
 - CMS:
 - www.cms.hhs.gov/cert
 - Noridian:
 - www.noridianmedicare.com
 - www.noridianmedicare.com/p-meda/claims/cert/docs/cert_brochure.pdf

Top Idaho Return to Provider (RTP) Errors

- U6803
 - An MSP auxiliary record exists, no MSP is indicated on claim, but dates of service match.

- 38105
 - Whether any rev code lines are equal or not, outpatient types of bills cannot have overlapping dates when the provider numbers are equal.

- 19301
 - If the operating physician is required or if an operating NPI is present, the physician's last name and first name must be present. If any name is present, the NPI must be present.
- 30905
 - No record of processing an original claim for this adjustment. Verify HICN, x-reference DCN, DOS, and/or provider number.

- 37544
 - Provider submitted adjustment is due to change in charges. Condition code D1 is present and all charges equal the original.
- U6802
 - MSP Indicated on claim, no direct match on auxiliary record iteration, but dates match on claim.

MSP Denials

- MSP Inquiries
 - Requests to review MSP-related denials
 - Requests for secondary allowances
 - NAS MSP Form located “Forms” Tab
 - Send to MSP department
 - Fax: 1-888-440-6731 or mail
 - Please do not send as a redetermination request, unless specifically related to MSP claims

- Include in MSP requests (when not using form)
 - Medicare Health Insurance Claim Number (HIC#)
 - Internal Control Number (ICN)
 - Paper billers: Copy of Remittance Advice (RA)
 - Copy of primary insurance plan's Explanation of Benefits (EOB)
 - Any other documentation that supports request

Appeals Process

- Five Levels of Appeal
 - Redetermination
 - Reconsideration
 - Administrative Law Judge (ALJ) Hearing
 - Departmental Appeal Board Review
 - Judicial Review in US District Court

- First level of appeal:
 - Request to review a claim when there is a dissatisfaction with original determination
 - Redetermination is an independent re-examination of initial claim determination
 - All redetermination requests must be submitted in writing

- Redetermination requests must be received within 120 days from the remittance advice date
- Monetary Threshold - \$0.00
- NAS will complete Redetermination requests within 60 calendar days from date request is received within our office

Redeterminations Calculator

- Type remittance advice date into box
- Click “Find Submission Deadline” button
- Displays day needed to submit a timely redetermination

Redetermination Time Limit Calculator

The redetermination submission deadline is 12/30/2009



- CMS 20031 - Transfer (Assignment) of Appeal Rights
 - <http://www.cms.hhs.gov/cmsforms/downloads/cms20031.pdf>
- Provider or supplier may not have right to appeal in some situations, may ask beneficiary to transfer appeal rights
- Transfers appeal rights for item or service listed in Section I of form only
 - Permanent unless cancelled in writing

- **Written Request/Letter**
 - Must contain all of the following information:
 - Beneficiary Name
 - Medicare Health Insurance Claim (HIC) number
 - Specific service and/or item(s) for which a redetermination is being requested
 - Specific date(s) of service
 - Name and signature of the party or the authorized or appointed representative of the party
 - All pertinent medical documentation

Who May Request a Redetermination?

- Beneficiary
- Representative payee for Beneficiary
- Physician, provider or supplier accepting assignment
- Physician or supplier not accepting assignment where:
 - A claim was denied or reduced as not being reasonable and necessary, the physician has already collected payment from the patient for services rendered, and where the physician didn't know the claim would deny as not being reasonable and necessary.
- Medicaid State agencies or party authorized to act on behalf of Medicaid state agency for Medicare Part B claim determinations

- Form CMS – 20027
 - <http://www.cms.hhs.gov/CMSForms/>
 - <https://www.noridianmedicare.com>
 - Appeals and Forms tab

- Noridian Redetermination Form
 - <https://www.noridianmedicare.com>
 - Appeals & Forms tab

- Second level of appeals process
 - Request to review when there is dissatisfaction with the redetermination
 - Handled by a Qualified Independent Contractor (QIC)
 - No Monetary Threshold

- Requests must be filed within 180 days of date of Medicare Redetermination Notice
- QIC has 60 days from date of receipt to complete request
 - All requests are completed on-the-record
- NAS has 30 days from date of receipt to effectuate request

- Written Request/Letter
 - Must contain all of the following information:
 - Beneficiary name
 - Medicare Health Insurance Claim (HIC) number
 - Specific service and/or item(s) for which the reconsideration is requested
 - Specific date(s) of service
 - Name and signature of the party or the authorized or appointed representative of the party
 - Name of the contractor that made the determination

- Form CMS-20033
- <http://www.cms.hhs.gov/cmsforms/>
- <https://www.noridianmedicare.com>
 - Appeals & Forms tab

- Third level of appeals process
- Request to review when there is dissatisfaction with the decision made by the QIC
- No letter is sent unless Beneficiary is liable

- Requests made on/after 01/01/08
 - Monetary Threshold must be at least \$120
- 60 days from date of receipt of reconsideration decision
- No more than 90 days after request received by entity specified in QIC's notice of reconsideration

- CMS 20034A/B –Request for Medicare Hearing by an ALJ
- <http://www.cms.hhs.gov/cmsforms/>
- <https://www.noridianmedicare.com/>
 - Appeals and Forms tab

- Fourth level of appeals process
- Evaluates requests for review, and makes final decisions whether to review, or to decline to review the decisions of ALJs as well as orders of dismissals by ALJs
- No Monetary Threshold
- Request must be no later than 60 days from date of receipt of ALJ decision

Federal Court (Judicial) Review

- Fifth Level of appeals process
- Medicare contractor may have responsibilities for decisions made at Federal Court Level
- DOS on/after 01/01/08
 - Monetary Threshold must be at least \$1,180

- Written Assurance from Provider Required
 - Payment has not been received on denied services
 - Payments received have been refunded
 - Responses due within 10 days

Top Reasons for Appeal Dismissals

- **No Signature on Request**
- **Missing or invalid information**
 - Request for redetermination must include:
 - The beneficiary's name
 - The Medicare Health Insurance Claim Number of the beneficiary
 - The specific service(s) and or item(s) or which the redetermination is being requested
 - The specific dates of service (include all from and through dates)
 - The name and **signature** of the person filing the redetermination request
 - Include all pertinent medical documentation

■ **Timely Filing**

- Request for redetermination must be filed within 120 days after the date of the notice of initial determination
- Time limit may be extended if good cause for the late filing is shown

Reference: **MCPM, Chapter 29 section 30.7 and 40.1.5**

- Rejected claims or line items cannot be appealed
 - Corrections to rejected claims/line items must be adjusted by the provider
 - Requests received will be forwarded to the Provider Contact Center to be processed as correspondence

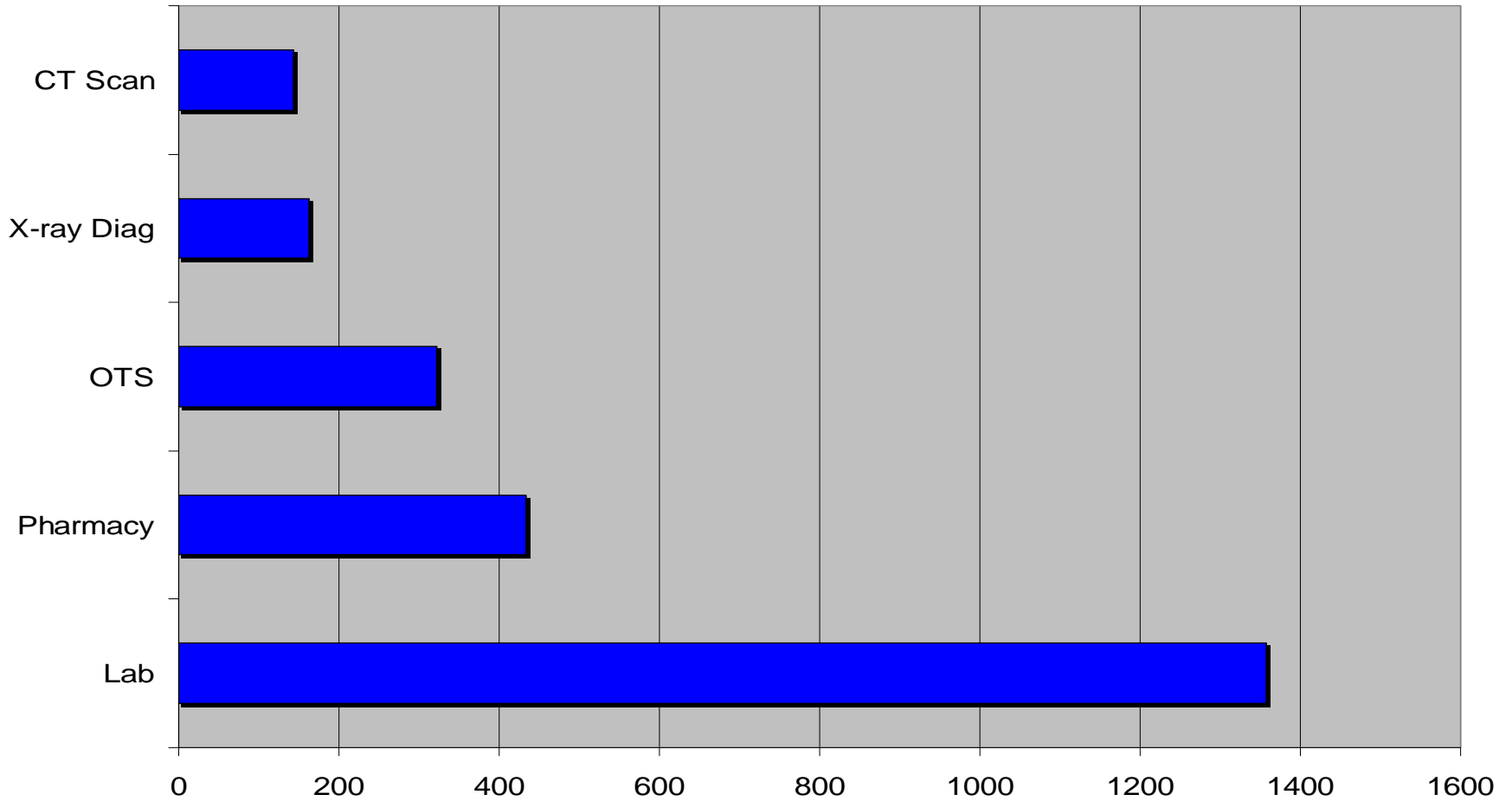
Appeals Issues and Reminders

- Service is documented in medical record
- Check correct DOS
- Check for correct beneficiary
- Include documentation with request
- Legible physician's signature

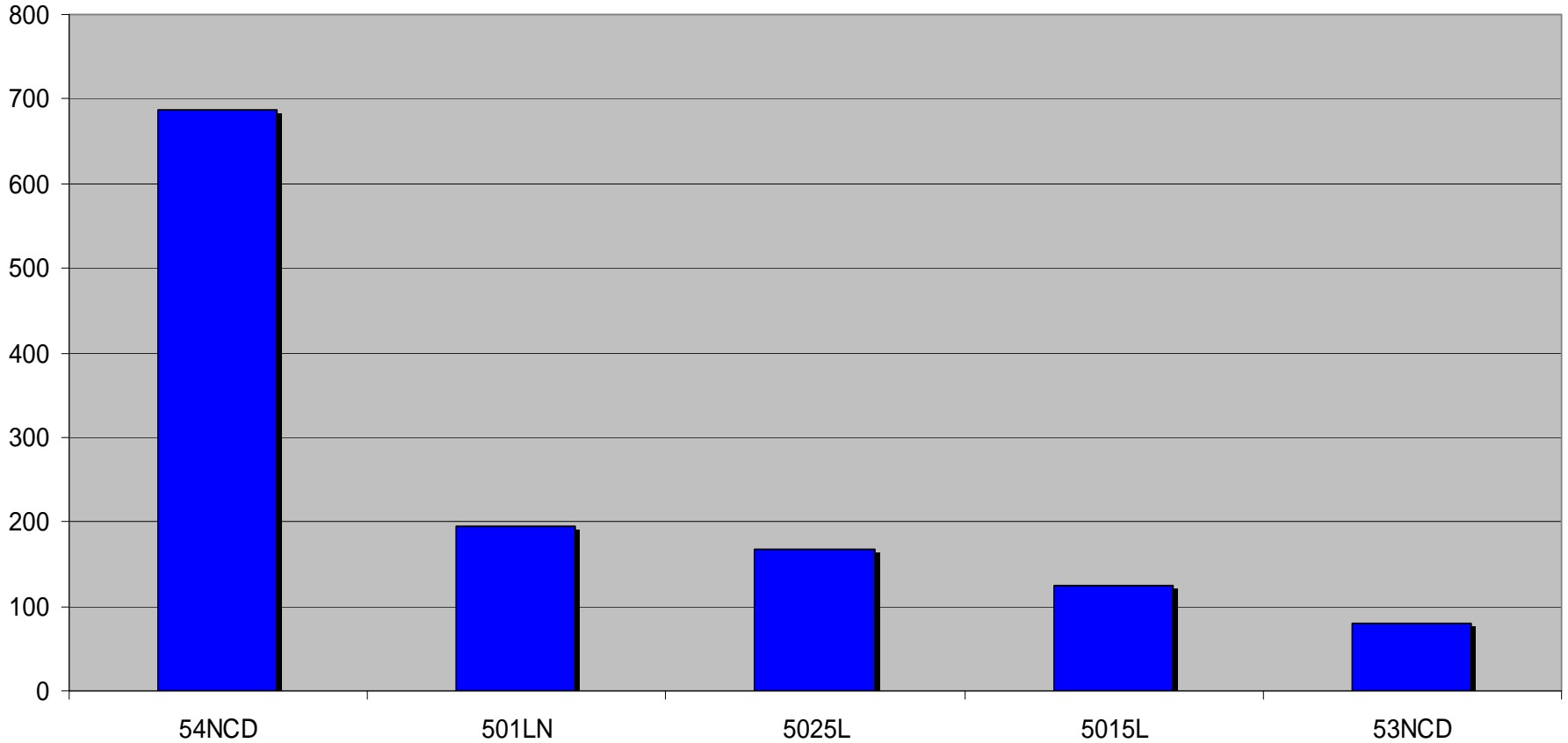
- List of required documentation on NAS website
 - AK, ID, OR, WA, MN
 - https://www.noridianmedicare.com/p-meda/appeals/med_doc_require.html

- Know the coverage guidelines/policies impacting the services provided
 - National Coverage Determinations (NCDs)
 - #1 reason for redeterminations
 - Local Coverage Determinations (LCDs)
 - Issue ABN's to patients when services are not covered

Legacy States Types of Services Denied




Legacy States Top Edits Appealed



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MAP171D      M E D I C A R E  A  O N L I N E  S Y S T E M  C L A I M  P A G E  02
SC           U B 9 2  C L A I M  I N Q U I R Y
DCN         H I C           R E C E I P T  D A T E  0 5 3 0 0 6  T O B
STATUS     L O C A T I O N       T R A N  D T           S T M T  C O V  D T  0 1 1 3 0 6  T O  0 1 1 3 0 6
PROVIDER ID      B E N E  N A M E
NONPAY CD      G E N E R  H A R D C P Y  8      M R  I N C L D  I N  C O M P           C L  M R  I N D
TPE-TO-TPE     U S E R  A C T  C O D E  N      W A I V  I N D           M R  R E V  U R C           D E M A N D
REJ CD        M R  H O S P  R E D           R C N  I N D           M R  H O S P - R O           O R I G  U A C
MED REV RSNS   5 4 N C D
OCE MED REV RSNS
  3   H C P C / M O D  I N      S E R V           -----REASON-CODES-----
REV  H C P C  M O D I F I E R S      D A T E  C O V - U N T      C O V - C H R G      A D R
0301 82962           011306           F M R  5 4 N C D
ORIG           O R I G  R E V           M R           O D C  5 4 N C D
OCE OVR 2 CWF OVR   N C D  O V R   N C D  D O C   N C D  R E S P  4  N C D #  1 9 0 . 2 0   O L U A C
      N O N           N O N   D E N I A L  O V E R  S T / L C   M E D   -----ANSI-----
LUAC  C O V - U N T   C O V - C H R G   R E A S   C O D E  O V E R   T E C   A D J   G R P   -----REMARKS-----
  N           1           5 5 . 6 5  5 4 N C D           0       5   5 0   C O
  
```


 Press F1 to view reason code description

```

TOTAL      1      55.65      LINE ITEM REASON CODES
37192
                                <== REASON CODES
PRESS PF2-1712  PF3-EXIT  PF5-UP  PF6 DOWN  PF7-PREV  PF8-NEXT  PF10-LEFT
  
```

MAP1881		M E D I C A R E A O N L I N E S Y S T E M							OP: NDORROE	
SC		REASON CODES INQUIRY							DT: 040104	
PLAN REAS	NARR	EFF	MSN	EFF	TERM	EMC	HC/PRO	PP	CC	
IND CODE	TYPE	DATE	REAS	DATE	DATE	ST/LOC	ST/LOC	LOC	IND	
1 54NCD	E	080100	15.4	040104		S MSPR7	S MSPR7			
TPTP A	B	NPCD A	B N	HD CPY A	B 8	NB ADR	CAL DY		C/L L	

-----NARRATIVE-----

LINE LEVEL REASON CODE TO INDICATE THAT NONE OF THE DIAGNOSES ON THE CLAIM SUPPORT THE MEDICAL NECESSITY OF THE SERVICE, AND NO DOCUMENTATION TO SUPPORT MEDICAL NECESSITY WAS PROVIDED. THE PROVIDER IS LIABLE AS THERE WAS NO 32 OCCURRENCE CODE OR GA MODIFIER PRESENT ON THE CLAIM TO INDICATE THE BENEFICIARY SIGNED A WAIVER OF LIABILITY FOR THE SERVICE.

PROCESS COMPLETED --- NO MORE DATA THIS TYPE
PRESS PF3-EXIT PF6-SCROLL FWD PF8-NEXT

- Do not include late charges or additional coding beyond the denied line
 - Causes additional editing of claim
 - Potential claim errors, Return To Provider (RTP)
 - Appeal cannot be finalized
 - Adjustments needed should be done after the appeal finalizes

Adjusting or Canceling a Medically Reviewed Claim

- Adjustments
 - Can be done through Direct Data Entry (DDE)
 - Cannot affect the line item(s) medically reviewed
 - Add remarks stating 'not adjusting denied lines'
 - Coding
 - Use adjustment condition code and reason code as applicable to the adjustment

Adjusting or Canceling a Medically Reviewed Claim

- **Cancels**
 - Acceptable reasons
 - The 72-hour diagnosis related group (DRG) window
 - An incorrect health insurance claim number (HIC)
 - An incorrect provider number
 - Coding
 - Condition code D5
 - Incorrect HIC or provider number
 - Condition code D6
 - 72-hour DRG window
 - *Add remarks stating reason for cancel

- Rejected claims or line items cannot be appealed - Status location “R”
 - Corrections to rejected claims/line items must be adjusted by the provider
 - Requests received will be forwarded to the Provider Contact Center to be processed as correspondence
- Providers can initiate an adjustment for the rejected line/claim

Medical Request Cooperation

- Cooperation is essential with medical record requests between:
 - Physician's Offices
 - Labs
 - Hospitals
- When needed, all entities must work together to obtain records for patients

- Complete listing of Reason and Remark Codes (PR, CO, OA)
- Distributed and maintained by the Washington Publishing Company (WPC)
- <http://www.wpc-edi.com/products/codelists/alertservice>

Limitation on Recoupment 935 Process

- Change Request (CR) 6183 – Effective September 28, 2008
- Key Items to CR 6183
 - Appeal rights are now allowed on contractor-initiated adjustments
 - Contractors may not recoup overpayments until a decision on redetermination/reconsideration has been made

- Requires CMS to change:
 - Way contractors recoup certain overpayments
 - How interest is paid when an overpayment is reversed at Administrative Law Judge (ALJ) or judicial levels of appeal

Overpayments Subject to Process

- Post-pay denial of claims for benefits under Part A for which a written demand letter was issued
- Post-pay denial of claims for benefits under Part B for which a written demand letter was issued
- MSP recovery where provider received duplicate primary payment and a written demand letter was issued
- MSP recovery based on provider's failure to file proper claim with third party plan
- Final claims associated with HHA request for Anticipated Payment (RAP) under HH PPS but not RAP itself

- Part A NAS initiated adjustments
 - If adjustment results in refund to provider – NAS will follow underpayment policies
 - If adjustment is an overpayment and if claim meets the 935 rules, claim is available for limitation on recoupment protections
- Part B claims adjusted in a normal manner

- Triggered by NAS adjusting claim
- Letter explains the amount of overpayment and the claim involved
- Explains rebuttal and the appeal process
- Explains recoupment process and timeframe
- **IMPORTANT NOTE** – Providers will see the adjustment on the remittance advice when letter generated – but money will not be recouped at that time

Sample Demand Letter

Dear Medicare Provider,

An adjustment(s) has been entered on the following claim(s) which has resulted in an overpayment due to Medicare. The adjustment falls under the provisions of 935 of the MMA. Please review the claim(s) listed below. For further claim detail please consult the Medicare Remittance Advice dated the same date as this letter. This letter is considered the first request for this Medicare overpayment.

Total Due Medicare: \$ \$5,900.55

We request that you refund this amount in full. If payment in full is not received, an acceptable extended repayment request is not submitted, or a valid and timely appeal is not received within 30 days from the date of this letter, all payments due to you, including claims, cost report settlements, or interim payments, will be withheld. Please note that interest will accrue on the outstanding balance 31 days from the date of this letter. If you intend to send a check, please contact us immediately at 877-908-8437.

Submit your check payable to Noridian Administrative Services, to the following address:

Noridian Administrative Services
Part A Provider Audit - 935 Appeals
PO Box 6744
Fargo, ND 58108-6744

- If you do not agree with proposed recoupment you must submit a statement within **15 days** of the notice of the impending recoupment action
 - Rebuttals are sent to
 - PO Box 6744
 - Fargo ND 58108-6744
- Rebuttal process occurs **prior** to a provider requesting an appeal
- Rebuttal process is not an appeal

Reading Remits for the Process

Electronic Remittance Example

- In the Electronic Remittance the PLB3 segment will contain the provider adjustment code: CS:CS935 and the amount which could be withheld from future payments
- The following 3 slides show an example of this in PC-print

Electronic Remittance Example

CSCS4.txt - PC Print for Windows

File Edit View Admin Help

X12 SL **PS** BS AC SC

Medicare National Standard Remittance Advice

NPI: 1780608216
CHECK / EFT NUMBER: EFT0383462

=====

PAYMENT SUMMARY

PAYMENT TOTAL: 85899.34 BILLING CYCLE: 01/09/2009
TOTAL CLAIMS: 65 TOTAL PIP CLAIMS: 0

FINANCIAL ADJUSTMENTS

CS/CS935: -5900.55

Electronic Remittance Example

Medicare National Standard Intermediary Remittance Advice		
FPE: 03/31/2009		
PAID: 01/09/2009		
CLM#: 27		
NPI:	TOB: 118	
<hr/>		
PATIENT:	PCN:	
HIC:	SVC FROM: 07/21/2008 MRN:	
PAT STAT: <u>CLAIM</u>	STAT: 22	THRU: 07/23/2008 ICN: 1
<hr/>		
CHARGES:	PAYMENT DATA: 378=DRG	0.000=REIM RATE
-6641.10=REPORTED	-6924.55=DRG AMOUNT	0.00=MSP PRIM
PAYER		
0.00=NCVD/DENIED	-1401.50=DRG/OPER/CAP	0.00=PROF
COMPONENT		
283.45=CLAIM ADJS	0.00=LINE ADJ AMT	0.00=ESRD AMOUNT
-6641.10=COVERED	0.00=OUTLIER	0.00=PROC CD AMOUNT
DAYS/VISITS:	0.00=CAP OUTLIER	-6641.10=ALLOW/REIM
-2=COST REPT	-1024.00=CASH DEDUCT	0.00=G/R AMOUNT
0=COVD/UTIL	0.00=BLOOD DEDUCT	0.00=INTEREST
0=NON-COVERED	0.00=COINSURANCE	0.00=CONTRACT ADJ
0=COVD VISITS	0.00=PAT REFUND	0.00=PER DIEM AMT
0=NCOV VISITS	0.00=MSP LIAB MET	-5900.55=NET REIM AMT
ADJ REASON CODES: <u>CR 45</u>	283.45 1 -1024	
REMARK CODES: <u>MA02</u>		

Electronic Remittance Example

Medicare National Standard Intermediary Remittance Advice

FPE: 03/31/2009
PAID: 01/09/2009
CLM#:

NPI: TOB:

PATIENT: PCN:
HIC: SVC FROM: 07/21/2008 MRN:
PAT STAT: CLAIM STAT: 4 THRU: 07/23/2008 ICN:

CHARGES: PAYMENT DATA: 378=DRG 0.000=REIM RATE
6641.10=REPORTED 0.00=DRG AMOUNT 0.00=MSP PRIM PAYER
6641.10=NCVD/DENIED 0.00=DRG/OPER/CAP 0.00=PROF

COMPONENT

0.00=CLAIM ADJS 0.00=LINE ADJ AMT 0.00=ESRD AMOUNT
0.00=COVERED 0.00=OUTLIER 0.00=PROC CD AMOUNT
DAYS/VISITS: 0.00=CAP OUTLIER 0.00=ALLOW/REIM
0=COST REPT 0.00=CASH DEDUCT 0.00=G/R AMOUNT
0=COVD/UTIL 0.00=BLOOD DEDUCT 0.00=INTEREST
0=NON-COVERED 0.00=COINSURANCE 0.00=CONTRACT ADJ
0=COVD VISITS 0.00=PAT REFUND 0.00=PER DIEM AMT
0=NCOV VISITS 0.00=MSP LIAB MET 0.00=NET REIM AMT

REMARK CODES: MA44 N469

Paper Remittance Example

UNORIDIAN ID-OR-A		901 40TH STREET S, SUITE 1			FARGO		ND 581086726		VER# 4010-AI	
		PART A			PAID DATE: 01/09/2009		REMIT#:		PAGE: 4	
PATIENT NAME	PATIENT CNTRL NUMBER	RC	REM	DRG#	DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT ADJ		
HIC NUMBER	ICN NUMBER	RC	REM	OUTCD CAPCD	NEW TECH/ECT	COVD CHGS	ESRD NET ADJ	PER DIEM RTE		
FROM DT	THRU DT	NACHG	HICHG	TOB	RC	REM	PROF COMP	MSP PAYMT	INTEREST	PROC CD AMT
CLM STATUS	COST	COVDY	NCOVDY	RC	REM	DRG AMT	DEDUCTIBLES	DENIED CHGS	PRE PAY ADJ	NET REIMB
		94	MA02	220		.00	.00	.00		101036.08
						.00	104581.33	.00		.00
12/09/2008	12/16/2008					.00	.00	.00		.00
1	7	7				37025.87	.00	.00		3545.25
		94	MA02	690		.00	.00	.00		10063.21
						.00	10572.25	.00		.00
12/13/2008	12/16/2008					.00	.00	.00		.00
1	3	3				5316.26	.00	.00		509.04
		45	MA02	378		.00	.00	.00		283.45
		1				.00	6641.10-	.00		.00
07/21/2008	07/23/2008					.00	.00	.00		.00
22	2-	2-	118			6924.55-	1024.00-	.00		5900.55-
		B8	MA44	378		.00	.00	.00		6641.10
			N469			.00	.00	.00		.00
07/21/2008	07/23/2008					.00	.00	.00		.00
4			11P			.00	.00	6641.10		.00

How to Stop Recoupment

- Recoupment can proceed on day 41 from 1st demand letter if:
 - Payment is not received in full
 - Acceptable request for an extended repayment schedule
 - Valid request for redetermination is not date stamped by day 30 from the demand letter
 - **IMPORTANT** – If request isn't received before 30th day Medicare can begin to recoup money on 41st day from the Medicare demand letter

- 935 Appeals sent to:
 - PO Box 6744
Fargo ND 58108-6744
- Be specific on your request that you are appealing

Timeframe for Redetermination

Table 1: Timeframe for Medicare Recoupment Process After the First Demand Letter

Timeframe	Medicare Contractor	Provider
Day 1	Date of Demand Letter (Date demand letter mailed)	Provider receives notification by first class mail of overpayment determination
Day 1-15	Day 15 deadline for Rebuttal request. No recoupment occurs	Provider must submit a statement within 15 days from the date of demand letter.
Day 1-40	No recoupment occurs	Provider can appeal and potentially limit recoupment from occurring
Day 41	Recoupment begins	Provider can appeal and potentially stop recoupment

- Upon valid request for redetermination of overpayment NAS will:
 - Cease/not initiate recoupment
 - Retain amounts recouped if already recouped funds, and apply it to interest and then to principal
 - Continue to collect other debts owed, but not withhold or place in suspense any monies related to this debt, while in appeal status

- Redetermination can have 3 possible outcomes
 1. Full reversal – Contractor adjust overpayment and amount of interest charged

2. Partial Reversal – Partially favorable

- NAS recalculates correct amounts of both underpayment and overpayment
- Make appropriate payments to providers if due
- Revised demand letter for newly calculated overpayments
 - Letter states contractor can begin recoupment no earlier than 61 days from the date of the revised overpayment redetermination

3. Full Affirmation

- Upholds overpayment determination
- NAS will issue revised 2nd demand letter, which states NAS can begin recoup no earlier than 61st calendar day from redetermination notice

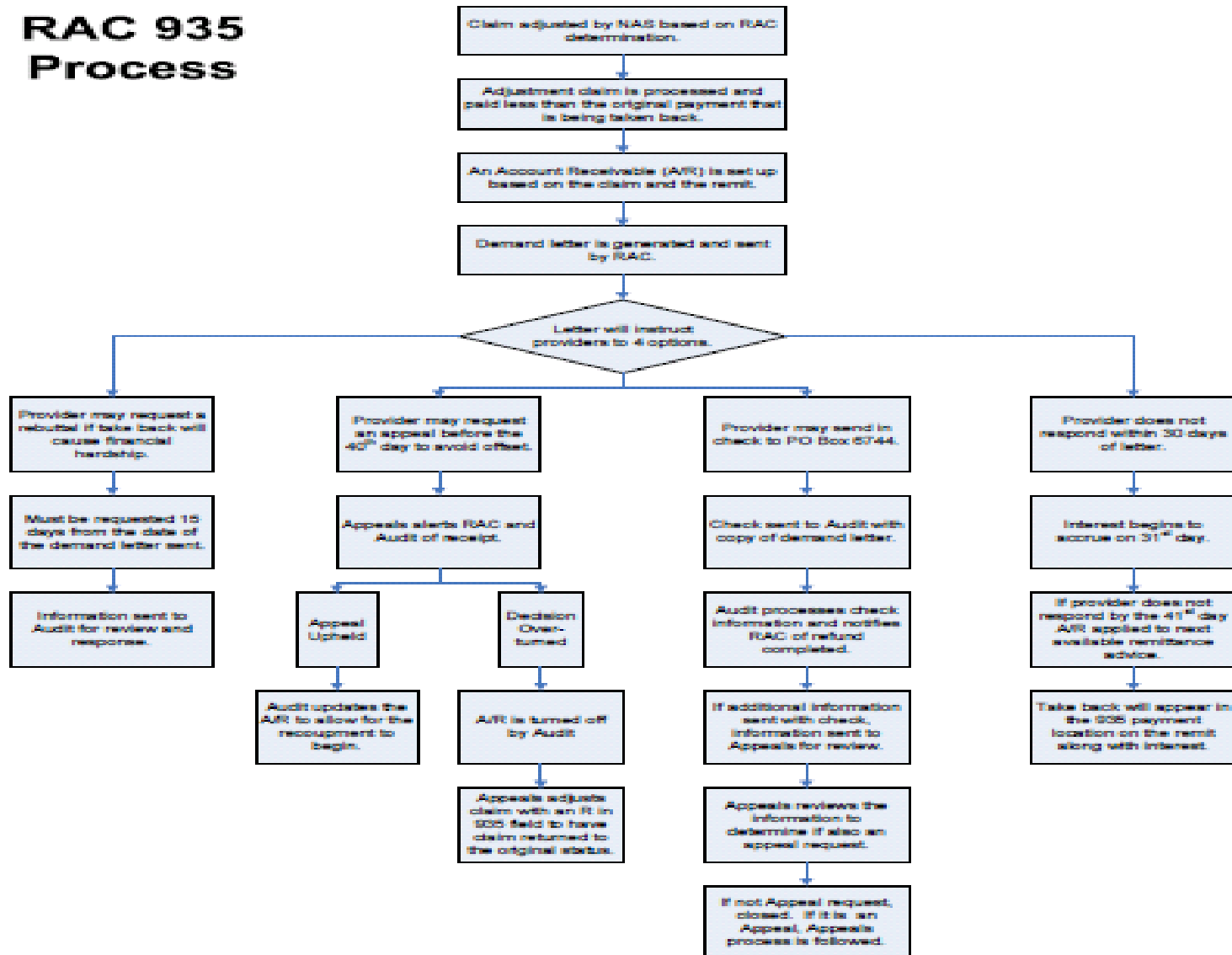
- File reconsideration to the QIC within 60 days of the appropriate letter
 - Cease/not initiate recoupment
 - Retain any amounts recouped
 - Continue to collect debts not related to this debt while in appeal status
- 3 possible outcomes
 - Full Reversal
 - Partial reversal
 - Affirmation

Third Level Appeal – Administrative Law Judge (ALJ)

- NAS would continue to recoup until the debt is satisfied in full

RAC – 935 Process Flow Chart

RAC 935 Process



Items of Interest

- CR 6395, effective July 1, 2009
 - Individual no longer required to be physically present in a CAH at the time the specimen is collected
 - Must be an outpatient of the CAH and be receiving services directly from the CAH
 - Must be either receiving services in the CAH on the same day the specimen is collected, or the specimen must be collected by an employee of the CAH or of a facility provider-based to the CAH.
 - Billed with an 851 type of bill.

- MSP claims, adjustments, cancels and RTP corrections cannot be done through DDE
- Check with vendor to ensure vendor is not downloading “electronic” claims into DDE screens for submission
- Electronic claim instructions found on NAS EDISS web site
<http://www.edissweb.com/>

Resources



[contact us](#) [about us](#)

Noridian Administrative Services is a long-term, dedicated partner of CMS in the administration of various Medicare programs across the United States.

Part A

Alaska
Idaho
Minnesota
Oregon
Washington

Arizona
Montana
North Dakota
South Dakota
Utah
Wyoming

Part A Quick Links...

Part A Quick Links...

Part B

Alaska
Oregon
Washington

Arizona
Montana
North Dakota
South Dakota
Utah
Wyoming

Part B Quick Links...

Part B Quick Links...

MAC J6 Implementation

Illinois

Minnesota

Wisconsin

Home Health /
Hospice

Durable Medical Equipment

Claims processing of Durable Medical Equipment, Prosthetics, Orthotics and Supplies for Jurisdiction D.

Pricing, Data Analysis and Coding

DME Quick Links...

CAP for Part B Drugs and Biologicals

Competitive Acquisition Program for Part B Drugs and Biologicals gives physicians an option to acquire drugs from vendors selected in a competitive bidding process.

CAP Quick Links...

Beneficiaries

Beneficiaries are eligible for Medicare benefits at age 65. Visit www.medicare.gov for complete information.

Beneficiary Quick Links...

Electronic Data Interchange

Electronic Data Interchange allows for Medicare Part A, Part B, and the Competitive Acquisition Program for Part B Drugs claims processing through electronic means.

EDISS collection: Available

EDI Quick Links...




Publications
Enrollment
Coverage / MR
Training / Events
Appeals
Claims
Audit / Reimbursement
Forms
Contact

Home / Medicare Part A

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Provider Enrollment
can now be done online!

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News and Publications →

- ⊞ [What's New / Latest Updates](#)
- ⊞ [MN / ND Emergency Flood Information](#)
- ⊞ [Bulletins](#)
- ⊞ [E-mail List Sign-up](#)
- ⊞ [Fee Schedules](#)
- ⊞ [Frequently Asked Questions](#)
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Enrollment →

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- ⊞ [Appeals Overview](#)
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Claims →

- ⊞ [Audit and Reimbursement](#)
- ⊞ [Comprehensive Error Rate Testing](#)
- ⊞ [Fraud and Abuse](#)

Production Alerts - view all

- [Urinalysis CPT Codes denied inappropriately when billed with urine cultures](#)
- [Providers unable to enter ESRD CMS-382 forms via DDE.](#)

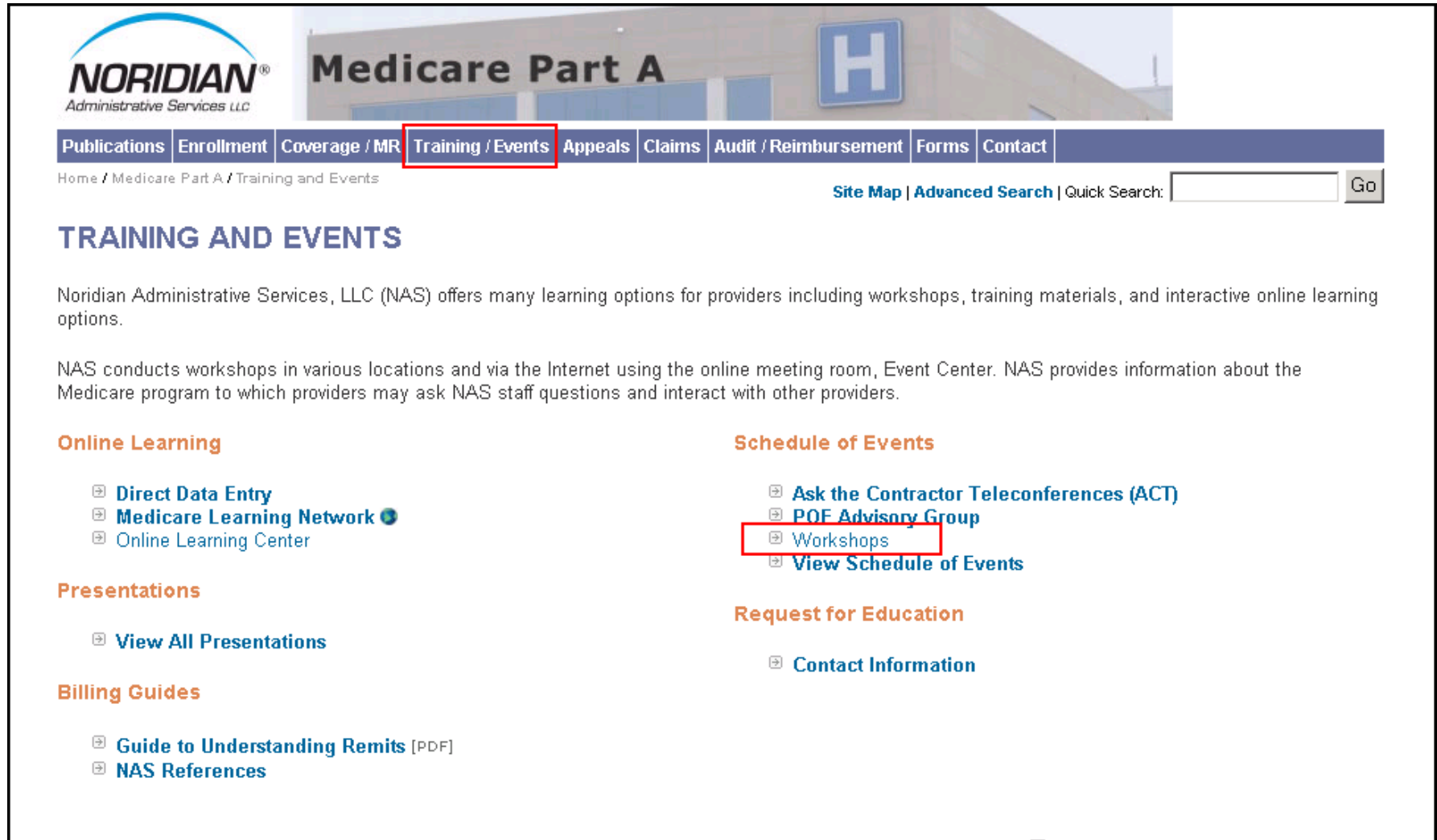
⊞ [RAC Region B](#) - read more

- [MN](#)

⊞ [RAC Region D](#) - read more

NAS, LLC Proprietary

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The screenshot shows the website interface for NORIDIAN Administrative Services LLC. At the top left is the company logo. Below it is a navigation menu with tabs for Publications, Enrollment, Coverage / MR, Training / Events (highlighted with a red box), Appeals, Claims, Audit / Reimbursement, Forms, and Contact. A breadcrumb trail reads 'Home / Medicare Part A / Training and Events'. To the right of the breadcrumb is a search bar with a 'Go' button. The main heading is 'TRAINING AND EVENTS'. Below this, there is a paragraph of introductory text. Further down, there are two columns of links. The left column is titled 'Online Learning' and includes links for Direct Data Entry, Medicare Learning Network (with a globe icon), and Online Learning Center. The right column is titled 'Schedule of Events' and includes links for Ask the Contractor Teleconferences (ACT), POF Advisory Group, Workshops (highlighted with a red box), and View Schedule of Events. Below these are sections for 'Presentations' (View All Presentations) and 'Billing Guides' (Guide to Understanding Remits [PDF], NAS References). At the bottom right, there is a 'Request for Education' section with a link for Contact Information.

- Current Procedural Terminology (CPT)
 - <http://www.ama-assn.org>
- Health Care Professional Coding System (HCPCS)
 - <http://www.ahacentraloffice.org>
- International Classification of Diseases 9th Revision (ICD-9)
 - <http://www.ahacentraloffice.org>

- Additional Resources:
 - National Correct Coding Initiative (NCCI)
 - Outpatient Code Editor (OCE)
 - IOM 100-2 Medicare Benefit Policy Manual
 - IOM 100-3 Medicare Coverage National Determinations Manual (NCD's)
 - IOM 100-4 Medicare Claims Processing Manual
 - <http://www.cms.hhs.gov/manuals/>
- Change Requests & Clarifications
 - <http://www.cms.hhs.gov/transmittals/>
- Local Coverage Determinations
 - <http://www.noridianmedicare.com>

- **Provider Contact Center**
 - 1-877-908-8437
 - Hours 8:00 am – 4:00 pm (within each time zone)
- **Interactive Voice Response (IVR)**
 - Monday - Friday 6:00 am - 8:00 pm CT
 - Saturdays 7:00 am - 3:00 pm CT

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

- www.cms.hhs.gov/manuals
- www.noridianmedicare.com
 - Quick Reference Guide 2010
 - New DDE Manual
 - Updating OLC
- Ask the Contractor Teleconference
- NAS Coverage call
- CMS Rural Open Door Forums

What Questions Do You Have?

Thank You!