

Idaho State Office Of Rural Health Rural Health Clinics

Medicare Part A Education
October 2008

NAS Part A Education Contacts

Manager

- Denise Christianson (701) 277-2009

Team Leaders

- Julie Ausman (503)-944-8826

Education Representatives

- Contact information and state assignments on NAS website under Contact tab
- Denise Arnold
- Karen Newton

- **Provider Contact Center**
 - 1-877-908-8437
 - Monday – Friday 8:00 am – 4: 00 pm within each time zone
- **Beneficiary Call Center**
 - 1-800-Medicare
 - 24 hours a day, 7 days a week

Interactive Voice Response

- 1-866-497-7857
- Hours of operation
 - General services
 - 24 hours a day, 7 days a week
 - Mandatory services
 - Monday – Friday 6:00 am – 8:30 pm (CT)
 - Saturday 6:00 am – 5:00 pm (CT)
 - Effective May 5, 2008

- Part A/B patient eligibility
- Deductible status
- Claim status
- Check status
- Check history
- Remittance information
 - Effective April 1, 2008

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Medicare Part A

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

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SCHEDULE OF EVENTS

(updated 10/20/08)

Which month would you like to view?

Which events would you like to view?

- Ask the Contractor Teleconferences
- Web-Based Workshops
- Face-to-Face Workshops
- Provider Outreach and Education Advisory Group
- Open Door Coverage Meetings

Schedule of Events

November 2008

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3	4	5	6 1:00 pm CT Present on Admission Indicators	7	8
9	10	11	12 11:00 am CT Provider Based Billing	13	14	15
16	17	18 11:00 am CT Physician Certification of Outpatient Therapy Services	19	20 2:00 pm CT Navigating the NAS website (Medicare Part A and B)	21	22
23	24	25	26	27	28	29
30						

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Email Listing

Benefits of Email Listing

- Most up to date information
- Sent via email
- No cost to providers
- Upcoming workshop information
- New manuals and quick reference guide notifications

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Let's appeal CERT errors!
Submit a redetermination for claims or lines denied for CERT.

[read more](#) →

News and Publications →

- ⊞ [What's New / Latest Updates](#)
- ⊞ [E-mail List Sign-up](#)
- ⊞ [Frequently Asked Questions](#)
- ⊞ [Bulletins](#)
- ⊞ [Fee Schedules](#)
- ⊞ [Health Professional Shortage Area and Physician Scarcity Area](#)
- ⊞ [More...](#)

Enrollment →

- ⊞ [Enrolling and Forms](#)
- ⊞ [Electronic Funds Transfer](#)
- ⊞ [More...](#)

Coverage →

Training →

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- ⊞ [Provider Outreach and Education Advisory Group](#)
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Claims →

- ⊞ [Comprehensive Error Rate Testing](#)
- ⊞ [Reopenings and Redeterminations](#)
- ⊞ [Medicare Secondary Payer](#)
- ⊞ [Audit and Reimbursement](#)
- ⊞ [Fraud and Abuse](#)
- ⊞ [More...](#)

Production Alerts - view all

- [CAH Method 2 outpatient claims editing with reason code W7017](#)

NPI Information - read more

- On April 24, 2007, CMS announced the Medicare FFS NPI Contingency Plan. For more information visit the [CMS NPI website](#).

What's New - read more

- [Bone Mass Measurements Coverage Information](#)
9/20/2007
- [Modifications to Medical Review Service Specific Edits](#) 9/20/2007
- [Termination of Medical](#)

JOIN NAS MEDICARE E-MAIL LISTS

Be the first to receive Medicare news and information! Benefits of becoming a subscriber include having the following information delivered to you every Tuesday and Friday:

- Latest news and information from NAS and CMS
- Up-to-date Medicare regulations
- Workshop and educational event notices
- Medical policy updates
- Payment and reimbursement updates
- NAS hours of availability and related notifications

Step 1: Identification

E-mail Address:*

Password:*

Repeat Password:*

Step 2: Profile

First Name: *

Last Name:*

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Address <https://www.noridianmedicare.com/>

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

Part A

- Alaska
- Idaho
- Minnesota
- Oregon
- Washington

Arizona
Montana
North Dakota
South Dakota
Utah
Wyoming

Part B

- Alaska
- Colorado
- Hawaii
- Iowa
- Nevada
- Oregon
- Washington

- Arizona
- Montana
- North Dakota
- South Dakota
- Utah
- Wyoming

STOP NPI Alert!

Medicare may stop paying your claims.

Select "NPI Information" from the Quick Links dropdown menu of your state to read more.

Part A Quick Links...

- Part A Quick Links...
- Home Page
- Email List Signup
- NPI Information
- News & Publications
- What's New
- Bulletins
- Fee Schedules
- Coverage
- Enrollment
- Enrolling in Medicare
- Beneficiaries

Medical Equipment

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 for Part B Drugs and Biologicals

Electronic Data Interchange allows for claims processing through electronic means.

Electronic Data Interchange

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

EDISS needs your NPI

System Status

- IVR: Available
- Contact center: Available
- EDISS collection: Available

Windows taskbar: Start, Noridian Ad..., Inbox - Micros..., Please review ..., Microsoft Pow..., SnagIt Captur..., 96%, Local intranet zone, 6:14 AM

14 Rural Health Clinic (RHC)/Federally Qualified Health Centers (FQHC)

Learn the billing requirements, answers to commonly asked questions, guidelines and processing information to assist your facility with your Medicare claims submission.

Resources - NAS

-  [Part A RHC/FQHC Manual](#)
-  [FQHC/RHC Presentation March 2007](#)
-  [RHC UB-92 Form Example](#)

Resources - External

-  [CMS RHC / FQHC Claims Processing Manual](#)

Activities

-  [Rural Health Clinic Lesson 1](#)
-  [RHC Lesson 2 Billing](#)
-  [RHC Pre-Workshop Quiz](#)

Discussions

Production Alert Example

News and Publications	Enrollment	Coverage	Training	Claims	Forms	Contact
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PRODUCTION ALERT - MAMMOGRAPHY - HOLDING OF 13X TYPE OF BILL (TOB) CONTAINING DIAGNOSTIC AND/OR SCREENING SERVICES

Applies To: OPPS providers who submit 13X TOBs with Mammography Services

Procedure Code(s): Revenue code 401 and 403 for screening/diagnostic mammography on TOB 13X.

Background

Claims containing screening/diagnostic revenue codes 401 and 403 are not processing through the Fiscal Intermediary Standard System (FISS) for dates of service October 1, 2004, through March 31, 2005. Per CMS, Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs) are to hold all 13X TOB claims until FISS is modified in June 2007.

Reference: Joint Signature Memorandum (JSM)/Technical Determination Letter (TDL) 07067.

Recent NAS Action

07/23/07: As directed, Noridian Administrative Services (NAS) is currently holding claims billed with diagnostic/screening mammography services in status location SM13XM for reason code 70180. The modification to the FISS system with the July release did not resolve the issue, NAS is currently investigating further resolution with the data center/FISS.

Provider Action

Continue to submit claims; however, NAS must hold any claim in status location SM13XM that contain revenue code 401 and/or 403 on 13X TOBs.

Date Reported: 07/23/07

Date Resolved: Ongoing

Tracking#: (000002)



Medicare Administrative Contract (MAC) Jurisdiction 3
Medicare Part A
 Arizona, Montana, North Dakota,
 South Dakota, Utah, Wyoming

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- ☒ **More...**

Training →

- ☒ Workshops
- ☒ Presentations
- ☒ Manuals
- ☒ **Provider Outreach and Education Advisory Group**
- ☒ **Schedule of Events**
- ☒ Online Learning
- ☒ More...

Production Alerts - view all

- **NAS/EDISS System Update**
- **E-mail List Distribution Technical Difficulties**
- **Mammography - Holding of 13X Type of Bill (TOB) Containing Diagnostic and/or Screening Services**

NPI Information - read more

- On April 24, 2007, CMS announced the Medicare FFS NPI Contingency Plan. For more information visit the [CMS NPI website](#)

FQHC/RHC Regulations

- CMS Internet Only Manual (IOM)
www.cms.hhs.gov/manuals
- Medicare Benefit Policy Manual, Chapter 13, RHC/FQHC
- Medicare Claims Processing Manual, Chapter 9, RHC/FQHC
- NAS website, Training/Events, Manuals
www.noridianmedicare.com

- Provider must verify name and Medicare numbers on the presented card
- Providers may verify HIC numbers through DDE, HIQA, or IVR to ensure valid information
- Ensure beneficiary has Part B entitlement

Charges to Beneficiaries

- Provider Based & Independent RHC
 - Part B Annual Deductible
 - \$131.00 in 2007
 - \$135.00 in 2008
 - Part B Coinsurance
 - 20% of customary charge for RHC service
 - 20% of allowable charge for non-RHC service, if subject to coinsurance
 - 20% of encounter rate unless billed charges are less
 - 37.5% of charges for 0900 rev code + 20% coinsurance

Charges to Beneficiaries

- FQHC
 - Part B Annual Deductible only for 0780 revenue code
 - \$131.00 in 2007
 - \$135.00 in 2008
 - Part B Coinsurance
 - 20% of allowable charge for non-RHC service, if subject to coinsurance
 - 20% of encounter rate unless billed charges are less
 - 37.5% of charges for 0900 rev code + 20% coinsurance

- Physician's services
- Services and supplies incident to physician's services
- Services of NP, PA
 - Including clinical nurse midwives
- Services and supplies incident to NP/PA
- Visiting nurse services to the homebound

- Clinical psychologist and clinical social worker services
- Services and supplies incident to clinical psychologist and clinical social workers

- 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

- 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

Skilled Nursing Facility Visits

- Reference: Medicare Change Request (CR) 3575
 - Physician services for beneficiaries in Part A stay in SNF separately billable effective 1/1/05

- Services and supplies are furnished incident to physician's services
 - Furnished as an incidental, integral part of a professional service
 - Commonly rendered either without charge or included in the RHC/FQHC bill

- Commonly furnished in a physician's office
- Services provided by clinic employees other than non-physician practitioners (PN/NP/CNM and CP/CSW) under the direct, personal supervision of a physician
- Furnished by a clinic employee (staff)
- Supplies such as bandages, tongue depressors are included in the office visit as packaged services

- Payment allowed for services as permitted under state licensure laws
 - No separate payment made for ordering or referring services
 - Bundled into the RHC/FQHC visit with other facility services when face-to-face encounter occurs
 - Not separately billable to Carrier
 - Payment made under all-inclusive rate

- Non-Physician directed clinics
 - Must have arrangement with a physician who provides supervision and guidance of PA and NPs
 - Must be consistent with state laws
 - Must have one on-site supervisory visit every two weeks

- Physician directed clinics
 - Must meet general supervision of PA and NPs by one (or more) of the clinic center's staff physicians

Visiting Nurse Services

- Covered if service area listed as shortage of Home Health (HH) agencies
- Services rendered to homebound patients
- Patient furnished part-time/intermittent nursing care by RN, LPN, or licensed vocational nurse

Visiting Nurse Services

- Needs to be an employee of RHC/FQHC
- Services furnished under written plan of treatment (POT)
 - Review once every 60 days by supervising physician of RHC/FQHC

- General exclusions from Medicare
 - E.g. dental, cosmetic surgery, routine services
- Not reasonable and necessary for:
 - Diagnosis
 - Treatment of illness or injury
 - Improved functionality of malformed limb

- Payment for covered RHC services (physician, PA, NP, CNS, CP, CSW, and visiting nurse) are under an all-inclusive rate for each visit
- All RHCs based in hospitals with less than 50 beds are eligible to receive an exception to the per visit payment limit
 - IOM 100-04, Chapter 9, Section 20.6.3

- Each provider's interim rate is based on the all-inclusive rate per visit
- Established by your Medicare Contractor
 - Determined by dividing your total allowable cost by the number of total visits for RHC/FQHC services
 - Rate may be adjusted during reporting period

Payment Calculations

- The upper payment limit for RHC for 1/1/08 – 12/31/08 is \$75.63 per visit
- The upper payment limit for FQHC for 1/1/08 – 12/31/08 is \$117.41 (urban) and \$100.96 (rural) per visit

Filing a Claim

- Bill type 71x
- Revenue centers allowable 521, 522, 524, 525, 527, 528, 780, and 900 (*maximum unit of 1 per day*)
- **No** HCPCS required, if billing HCPC use appropriate for revenue code

- Bill type 73x
- Revenue centers allowable 519, 521, 522, 524, 525, 527, 528, 780 and 900 (*maximum unit of 1 per day*)
- **No** HCPCS required, if billing HCPC use appropriate for revenue code

- **Reference:** CR 4210 effective 7/1/06
 - 0521 – Clinic visit by member to RHC/FQHC
 - 0522 – Home visit by RHC/FQHC practitioner
 - 0524 – Visit by RHC/FQHC practitioner to SNF beneficiary **in** a Part A stay

- **Reference:** CR 4210 effective 7/1/06
 - 0525 – Visit by RHC/FQHC practitioner to beneficiary **not** in a Part A SNF stay or NF, ICF, etc.
 - 0527 – RHC/FQHC visiting nurse services to beneficiary home in HH shortage area
 - 0528 – Visit by RHC/FQHC practitioner to other non-RHC/FQHC site, e.g. scene of accident

MA Wrap Around Payment FQHC Only

- Medicare Advantage (MA) Clinic Supplemental Payments
 - Bill type 73x
 - Revenue code – only allowed to bill 0519
 - Only bill if practitioner providing a covered FQHC service
 - Reimbursement is on an interim average MA per-visit rate
 - Deductible/coinsurance do not apply

Face to Face Encounters

- Provider-Based Facilities
 - Lab services drawn in RHC/FQHC are billed through the hospital as a non-patient 14x bill type, reimbursed on the fee schedule
 - Bill all **non-RHC/FQHC technical** services through the hospital provider number on 13x, 85x, or 14x type of bill (A-00-36 7/28/00)
 - Bill all **non-RHC professional** services under practitioner's provider number to the Carrier

- Independent Facilities
 - Lab services drawn in RHC/FQHC are billed on 1500 claim form to Carrier, reimbursed on the fee schedule
 - Bill all **non-RHC/FQHC technical** services to Carrier on 1500 claim form
 - Bill all **non-RHC professional** services under practitioners provider number to the Carrier
 - Preventative services – technical component billed to Carrier on 1500 claim form

- Telemedicine services – originating site fee is allowable for RHC/FQHC
 - Bill types 71x, 73x
 - Revenue code – 0780
 - HCPC – Q3014 is required

Smoking & Tobacco Cessation Counseling Services

- Reference: CR 3834 5/20/05
 - G0375 – Smoking & Tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
 - G0376 – Smoking & Tobacco use cessation counseling visit; intensive, greater than 10 minutes
 - Only 8 are paid in a 12 month period
 - Bill under 52x revenue code paid as all-inclusive

Behavior Health Services

- Bill type 71x, 73x
- Revenue code 0900
- HCPC not required

Preventative Services Billing

- Professional component included in the 52x rev code for provider based/independent facilities
- Technical component billed to Hospital on UB04 for provider-based and on a 1500 claim for for independent facilities

SERVICE	HCPCS/CPT CODES	ICD-9-CM CODES	WHO IS COVERED	FREQUENCY	BENEFICIARY PAYS
Initial Preventive Physical Examination (IPPE) <i>Also known as the "Welcome to Medicare Physical Exam"</i>	G0344 – IPPE G0366 – EKG for IPPE G0367 – EKG Tracing for IPPE G0368 – EKG Interpret & Report	No specific diagnosis code required for IPPE & corresponding EKG Contact local Medicare Contractor for guidance	All Medicare beneficiaries whose first Part B coverage began on or after January 1, 2005	Once in a lifetime benefit per beneficiary <i>Must be furnished no later than 6 months after the effective date of the first Medicare Part B coverage begins</i>	Copayment/coinsurance Deductible
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	G0389 – Ultrasound exam AAA screen	No specific code Contact local Medicare Contractor for guidance	Medicare beneficiaries with certain risk factors for abdominal aortic aneurysm <i>important – Eligible beneficiaries must receive a referral for an ultrasound screening for AAA as a result of an IPPE</i>	Once in a lifetime benefit per eligible beneficiary, effective January 1, 2007	Copayment/coinsurance No deductible
Cardiovascular Disease Screenings	80061 – Lipid Panel 82465 – Cholesterol 83718 – Lipoprotein 84478 – Triglycerides	Report one or more of the following codes: V81.0, V81.1, V81.2	All asymptomatic Medicare beneficiaries <i>12-hour fast is required prior to testing</i>	Every 5 years	No copayment/coinsurance No deductible
Diabetes Screening Tests	82947 – Glucose, quantitative, blood (except reagent strip) 82950 – Glucose, post-glucose dose (Includes glucose) 82951 – Glucose Tolerance Test (GTT), three specimens (Includes glucose)	V77.1 <i>Report modifier "TS" (follow-up service) for diabetes screening where the beneficiary meets the definition of pre-diabetes</i>	Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes <i>Beneficiaries previously diagnosed with diabetes are not eligible for this benefit</i>	<ul style="list-style-type: none"> 2 screening tests per year for beneficiaries diagnosed with pre-diabetes 1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested 	No copayment/coinsurance No deductible
Diabetes Self-Management Training (DSMT)	G0108 – DSMT, individual session, per 30 minutes G0109 – DSMT, group session (2 or more), per 30 minutes	No specific code Contact local Medicare Contractor for guidance	Medicare beneficiaries at risk for complications from diabetes, recently diagnosed with diabetes, or previously diagnosed with diabetes <i>Physician must certify that DSMT is needed</i>	<ul style="list-style-type: none"> Up to 10 hours of initial training within a continuous 12-month period Subsequent years: Up to 2 hours of follow-up training each year 	Copayment/coinsurance Deductible
Medical Nutrition Therapy (MNT)	97802, 97803, 97804, G0270, G0271 <i>Services must be provided by registered dietitian or nutrition professional</i>	Contact local Medicare Contractor for guidance	Medicare beneficiaries diagnosed with diabetes or a renal disease	<ul style="list-style-type: none"> 1st year: 3 hours of one-on-one counseling Subsequent years: 2 hours 	Copayment/coinsurance Deductible
Screening Pap Tests	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091	V76.2, V76.47, V76.49, V15.89, V72.31	All female Medicare beneficiaries	<ul style="list-style-type: none"> Annually if high-risk, or childbearing age with abnormal Pap test within past 3 years Every 24 months for all other women 	Copayment/coinsurance for Pap test collection <i>(No copayment/coinsurance for Pap lab test)</i> No deductible
Screening Pelvic Exam	G0101 – Cervical or vaginal cancer screening; pelvic and clinical breast examination	V76.2, V76.47, V76.49, V15.89, V72.31	All female Medicare beneficiaries	<ul style="list-style-type: none"> Annually if high-risk, or childbearing age with abnormal Pap test within past 3 years Every 24 months for all other women 	Copayment/coinsurance No deductible
Screening Mammography	77052, 77057, G0202	V76.11 or V76.12	All female Medicare beneficiaries age 40 or older	Annually	Copayment/coinsurance
			Female Medicare beneficiaries ages 35 - 39	One baseline	No deductible

SERVICE	HCPCS/CPT CODES	ICD-9-CM CODES	WHO IS COVERED	FREQUENCY	BENEFICIARY PAYS
Bone Mass Measurements	G0130, 77078, 77075, 77080, 77081, 77083, 76977	Contact local Medicare Contractor for guidance	Medicare beneficiaries at risk for developing Osteoporosis	Every 24 months More frequently if medically necessary	Copayment/coinsurance Deductible
Colorectal Cancer Screening	G0104 – Flexible Sigmoidoscopy G0105 – Colonoscopy (high risk) G0106 – Barium Enema (alternative to G0104) G0120 – Barium Enema (alternative to G0105) G0121 – Colonoscopy (not high risk) G0122 – Barium Enema (non-covered) G0328 – Fecal Occult Blood Test (alternative to 82270) 82270 – Fecal Occult Blood Test	Use appropriate code Contact local Medicare Contractor for guidance	<ul style="list-style-type: none"> Medicare beneficiaries age 50 and older Screening colonoscopy: Individuals at high risk; no minimum age requirement No minimum age for having a barium enema as an alternative to a high risk screening colonoscopy if the beneficiary is at high risk 	<ul style="list-style-type: none"> Fecal Occult: Annually Flexible Sigmoidoscopy: Every 4 years or once every 10 years after having a screening colonoscopy Screening Colonoscopy: Every 24 months at high risk; every 10 years not at high risk Barium Enema: Every 24 months at high risk; every 4 years not at high risk 	<p>No copayment/coinsurance or deductible for Fecal Occult Blood Tests</p> <p>For all other tests copayment/coinsurance apply No deductible</p>
Prostate Cancer Screening	G0102 – Digital Rectal Exam (DRE)	V76.44	All male Medicare beneficiaries 50 or older (coverage begins the day after 50th birthday)	Annually	Copayment/coinsurance Deductible
	G0103 – Prostate Specific Antigen Test (PSA)	V76.44	All male Medicare beneficiaries 50 or older (coverage begins the day after 50th birthday)	Annually	No copayment/coinsurance No deductible
Glaucoma Screening	G0117 – By an optometrist or ophthalmologist G0118 – Under the direct supervision of an optometrist or ophthalmologist	V80.1	Medicare beneficiaries with diabetes mellitus, family history of glaucoma, African-Americans age 50 and over, or Hispanic-Americans age 65 and over	Annually for beneficiaries in one of the high risk groups	Copayment/coinsurance Deductible
Influenza (Flu)	90655, 90656, 90657, 90658, 90660 – Flu Vaccine G0008 – Administration	V04.81 V06.6 – When purpose of visit was to receive both Flu and PPV vaccines	All Medicare beneficiaries	Once per flu season in the fall or winter Medicare may provide additional flu shots if medically necessary	No copayment/coinsurance No deductible
Pneumococcal	90669 – Pneumococcal conjugate vaccine 90732 – Pneumococcal Polysaccharide Vaccine (PPV) G0009 – Administration	V03.82 V06.6 – When purpose of visit was to receive both PPV and Flu vaccines	All Medicare beneficiaries	Once in a lifetime Medicare may provide additional vaccinations based on risk	No copayment/coinsurance No deductible
Hepatitis B (HBV)	90740, 90743, 90744, 90746, 90747 – HBV Vaccine G0010 – Administration 90471 or 90472 – Administration (OPPS hospitals only)	V05.3	Medicare beneficiaries at medium to high risk	Scheduled dosages required	Copayment/coinsurance Deductible
Smoking and Tobacco-Use Cessation Counseling	99406 – counseling visit; intermediate, greater than 3 minutes up to 10 minutes 99407 – counseling visit; intensive, greater than 10 minutes Effective 1/1/08	Use appropriate code Contact local Medicare Contractor for guidance	Medicare beneficiaries who use tobacco and have a disease or adverse health effect linked to tobacco use or take certain therapeutic agents whose metabolism or dosage is affected by tobacco use	2 cessation attempts per year; Each attempt includes maximum of 4 intermediate or intensive sessions, up to 8 sessions in a 12-month period	Copayment/coinsurance Deductible

- Influenza, pneumococcal pneumonia, and hepatitis vaccines are **reimbursed separately through the cost report**. Costs for supplies, labor, or the vaccine are logged, rather than submitted on a claim.
- If the vaccine administration is the only service provided, no encounter can be billed.

Preventative Primary Services

- Only billable in FQHC
 - Reference: IOM Medicare Benefit Policy Manual, Chapter 13, Section 40.1
 - Furnished by physician, NP, PA, CNMW, CP, CWSW who is employee of clinic
 - Included in 52x revenue code

Preventative Primary Services

- Only billable in FQHC
 - Medical social services
 - Nutritional assessment and referral
 - Preventative health education
 - Children's eye/ear examinations
 - Prenatal and post-partum care
 - Prenatal services
 - Well child care, including periodic screening

Preventative Primary Services

- Only billable in FQHC
 - Immunizations, including tetanus-diphtheria booster and influenza vaccine
 - Voluntary family planning services
 - Taking patient history
 - Blood pressure measurement
 - Weight management
 - Physical examination targeted to risk
 - Visual acuity screening

Preventative Primary Services

- Only billable in FQHC
 - Hearing screening
 - Cholesterol screening
 - Stool testing for occult blood
 - Risk assessment and initial counseling regarding risks
 - Women only – breast exam, referral for mammography, thyroid function test

Rural Health Clinic Claim

1 Medicare Billing										2										3a PAT. CNTL. # 12345					4 TYPE OF BILL 711																			
1820 Main Street																				5 MED. REC. #																								
Fargo, ND 58103																				5 FED. TAX NO. NN-NNNNNNN					6 STATEMENT COVERS PERIOD FROM 102007 THROUGH 102007					7														
8 PATIENT NAME a Doe, John										9 PATIENT ADDRESS a 111 East Bridge Street																																		
b										b Fargo										c ND					d 58104					e														
10 BIRTHDATE 04211941					11 SEX M		12 DATE 010107			13 HR 2		14 TYPE 1		15 SRC 1		16 DHR 01		17 STAT		18 19 20 21 22 23 24 25 26 27 28										19 ACCT STATE					30									
31 OCCURRENCE CODE					32 OCCURRENCE DATE					33 OCCURRENCE CODE					34 OCCURRENCE DATE					35 OCCURRENCE SPAN FROM					36 OCCURRENCE SPAN THROUGH					37														
38										39 VALUE CODES CODE					40 VALUE CODES AMOUNT					41 VALUE CODES CODE					42 VALUE CODES AMOUNT																			
a										b					c					d																								
42 REV. CD.					43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE					45 SERV. DATE					46 SERV. UNITS					47 TOTAL CHARGES					48 NON-COVERED CHARGES					49				
1 0521																				102007					1					\$85.00														
2 0001																														\$85.00														

1 Medicare Billing		2		3a PAT. CNTL. # 12345		4 TYPE OF BILL 731	
1920 Main Street				3b MED. REC. #			
Fargo, ND 58103				5 FED. TAX NO. NN-NNNNNNN		6 STATEMENT COVERS PERIOD FROM 102007 THROUGH 102007	
8 PATIENT NAME a Doe, John		9 PATIENT ADDRESS a 111 East Bridge Street					
b		b Fargo				c ND	d 58104
10 BIRTHDATE 04211941	11 SEX M	12 DATE 010107			13 HR 2	14 TYPE 1	15 SRC 1
16 DHR	17 STAT 01	18-28 CONDITION CODES					
31 OCCURRENCE CODE		32 OCCURRENCE CODE		33 OCCURRENCE CODE		34 OCCURRENCE CODE	
DATE		DATE		DATE		DATE	
35 OCCURRENCE SPAN CODE		36 OCCURRENCE SPAN CODE		37 OCCURRENCE SPAN CODE		38	
FROM		FROM		FROM		FROM	
THROUGH		THROUGH		THROUGH		THROUGH	
39 VALUE CODES CODE		40 VALUE CODES CODE		41 VALUE CODES CODE		42	
AMOUNT		AMOUNT		AMOUNT		AMOUNT	
a		b		c		d	
b		c		d		e	
c		d		e		f	
d		e		f		g	
42 REV. CD. 0521		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE 102007	
0001						46 SERV. UNITS 1	
						47 TOTAL CHARGES \$85.00	
						48 NON-COVERED CHARGES \$85.00	
						49	

Appeals

Redetermination Decision Letter

- Paragraph:
 - 1 – Explains services being reviewed
 - 2 – States the decision of the review
 - 3 – Explains what to do if either party is dissatisfied with decision
 - 4 – Explains each party is receiving a copy of the decision letter
- Summary of Facts:
 - Gives specific details of the Redetermination

Redetermination Decision Letter

- Decision – explains the outcome
- Explanation of Decision – explains logic of decision and gives reasons
- Who is Responsible – outlines party responsible for charges
- What to Include in Appeal – details missing documentation
- Special Note & Note – Explains criteria for evidence and documentation presentation

- On 01/15/08 we received a request for a redetermination.
- A letter of appeal, UB, remit, and medical records were submitted with the request.

Decision

We have concluded that the above claim is not covered by Medicare. We have also concluded that the provider is responsible for payment for this service.

Explanation of the Decision

Per the National Coverage Determination (NCD), the service being denied did not have a payable code. The services were denied because we did not find a payable code for 85610 per NCD 190.17. Please refer to the CMS NCD Manual for further billing guidelines.

Who is Responsible for the Bill?

The provider will still have to pay for the denied charges.

What to Include in Your Request for an Independent Appeal:

Include all medical records, doctor's orders, and nurse's notes. Also include the remit, patients' names, hic and date of service. A copy of the appeal letter, reason for appeal and any other supporting records as to why the service was performed should also be submitted.

Special Note to Medicare Physicians, Providers, and Suppliers Only:

Any additional evidence should be submitted with the request for reconsideration. All evidence must be presented before the reconsideration is issued. If all evidence is not submitted prior to the issuance of the reconsideration decision, you will not be able to submit any new evidence to the Administrative Law Judge or further appeal unless you can demonstrate good cause for withholding the evidence from the Qualified Independent Contractor.

NOTE: You do not need to resubmit documentation that was submitted as part of the redetermination. This information will be forwarded to the QIC as part of the case file utilized in the reconsideration process.

Sincerely,
Jane Smith

Intermediary
Medicare Part A

CC: John Doe

Top Reasons for Appeal Dismissals

- 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
 - Must provide information to support the late filing
 - Request will be dismissed if good cause is not found
 - MCPM, Chapter 29 section 30.7 and 40.1.5

- Appeals Calculator

Located on Noridian's website at:

- https://www.noridianmedicare.com/p-meda/claims/reopening_redetermination.html
- https://www.noridianmedicare.com/macj3a/claims/reopening_redetermination.html

Redetermination Time Limit Calculator



Find Submission Deadline

Redetermination Time Limit Calculator

The redetermination submission deadline is
04/01/2008



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

Medical Documentation Requirements

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MEDICAL DOCUMENTATION REQUIREMENTS

Appeal requests should include all pertinent medical documentation pertaining to the charges in question. The following list may be used as a guideline and is not all-inclusive when submitting documentation.

Item	Documentation Required
Adding modifiers	Office notes, operative reports, progress reports (If you are adding modifier GA, a copy of the Advanced Beneficiary Notice [ABN] is also required)
Ambulance Services	Trip report (when possible include the hospital records, such as the ER report, history and physical, discharge summary or information from the nursing home, such as chart notes)
Chemotherapy Injections	Office Notes, Medication Administration Record and current drug studies.
Cosmetic Surgery Blepharoplasty Breast Reduction	Office notes and/or consultation report, operative report visual fields, photographs and amount of grams being reduced.
Inpatient Stays	Progress Notes, nurse's notes, physician's orders and all records.
Dental Services	Office notes, operative report and pathology report.
Radiology	Radiology report and office notes.
Dialysis	Dialysis flow sheets.
E/M services	Office notes or progress reports along with physician's orders and operative reports.
Erythropoietin (EPO)	Office Notes, Medication Administration Record and lab results.
Injections (see also chemotherapy injections)	Medication administration record, office notes and physician orders.
Lab Services- Ex: PSA, cholesterol, lipid, pap, occult blood, thyroid (list is not all inclusive)	Office notes and laboratory report (may need notes from referring physician if clinical indications for ordering the test are not listed on the report).

- Redetermination request forms are available at:
 - www.noridianmedicare.com/p-meda/forms
and
www.cms.hhs.gov/forms



Medicare Administrative Contract (MAC) Jurisdiction 3

Medicare Part A

Arizona, Montana, North Dakota,
South Dakota, Utah, Wyoming

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FORMS

Most of the forms on this page are external links to the [CMS Web site](#). This is a collection of commonly used Medicare forms. A more complete listing of Medicare forms can be found by using the "CMS Forms Catalog" link on this page.

Enrollment

- [CMS 588 EFT Form Tutorial](#)
- [CMS 588 EFT Form Instructions](#)
- [CMS 855A - Application for Institutional Providers](#)
- [CMS 588 - Electronic Funds Transfer Authorization](#)
- [CMS 460 - Medicare Participating Physician or Supplier](#)

Appeals

- [Redeterminations/Inquiries* - New Interactive Form!](#)
- [CMS 20027 - Medicare Redetermination Request Form](#)
- [CMS 20031 - Transfer \(Assignment\) of Appeal Rights](#)
- [CMS 20033 - Medicare Reconsideration Request Form](#)
- [CMS 20034A/B - Request for Medicare Hearing by an ALJ](#)

To show text fields, please select "Highlight Fields" above.

Medicare Part A Inquiries/Redetermination Form

To assure that your inquiry/redetermination is directed to the proper department, please provide the following information.

Please select the state where the service was rendered:

- Helpful Hints:
- 1) ONE REQUEST FORM PER BENEFICIARY AND ISSUE
 - 2) For immediate response to claim status/tracer questions, please call the IVR, (866) 497-7857.
 - 3) Provider Address or Assignment changes, please contact Provider Enrollment.

Required Information: (Redetermination requests with incomplete information will be dismissed.)

Medicare Number:

Patient Name:

Date(s) of Service:

Claim total amount billed:
(not just amount of code to review)

Date of Initial Claim Determination:

Provider Number:

NPI Number:

DCN Number:

Provider Name:

Contact Person:

- 31577
 - The total number of units for revenue codes 520,521,522, and 91X exceed the number of days in the statement covers billing period
- 32273
 - For independent FQHC claims there cannot be more than one revenue code 0520 with charges greater than zero

- 32116
 - The receipt date of claim is on or after NPI implementation date and NPI is not present
- 32103
 - The NPI number on the claim is not on the crosswalk
- 39011
 - Claim has filed the timeliness of submission edit

Comprehensive Error Rate Testing (CERT)

NORIDIAN
Administrative Services LLC

Medicare Part A

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CLAIMS

Production Alerts

- There are no alerts at this time.

Noridian Administrative Services works closely with the provider community to make claim billing and submission as efficient as possible. We've included a variety of information below to cover the different aspects of claims processing.

Service Date	Deadline
Jan – Sept 2006	12/31/2007
Oct – Dec 2006	12/31/2008
Jan – Sept 2007	12/31/2008
Oct – Dec 2007	12/31/2009

Comprehensive Error Rate Testing (CERT)

- CERT Information

Electronic Claims Submission

- Electronic Data Interchange (EDI)
- Direct Data Entry
- Remittance Advice Remark and Reason Code Lists

Preventive Services

Fraud and Abuse

- Reporting Fraud and Abuse

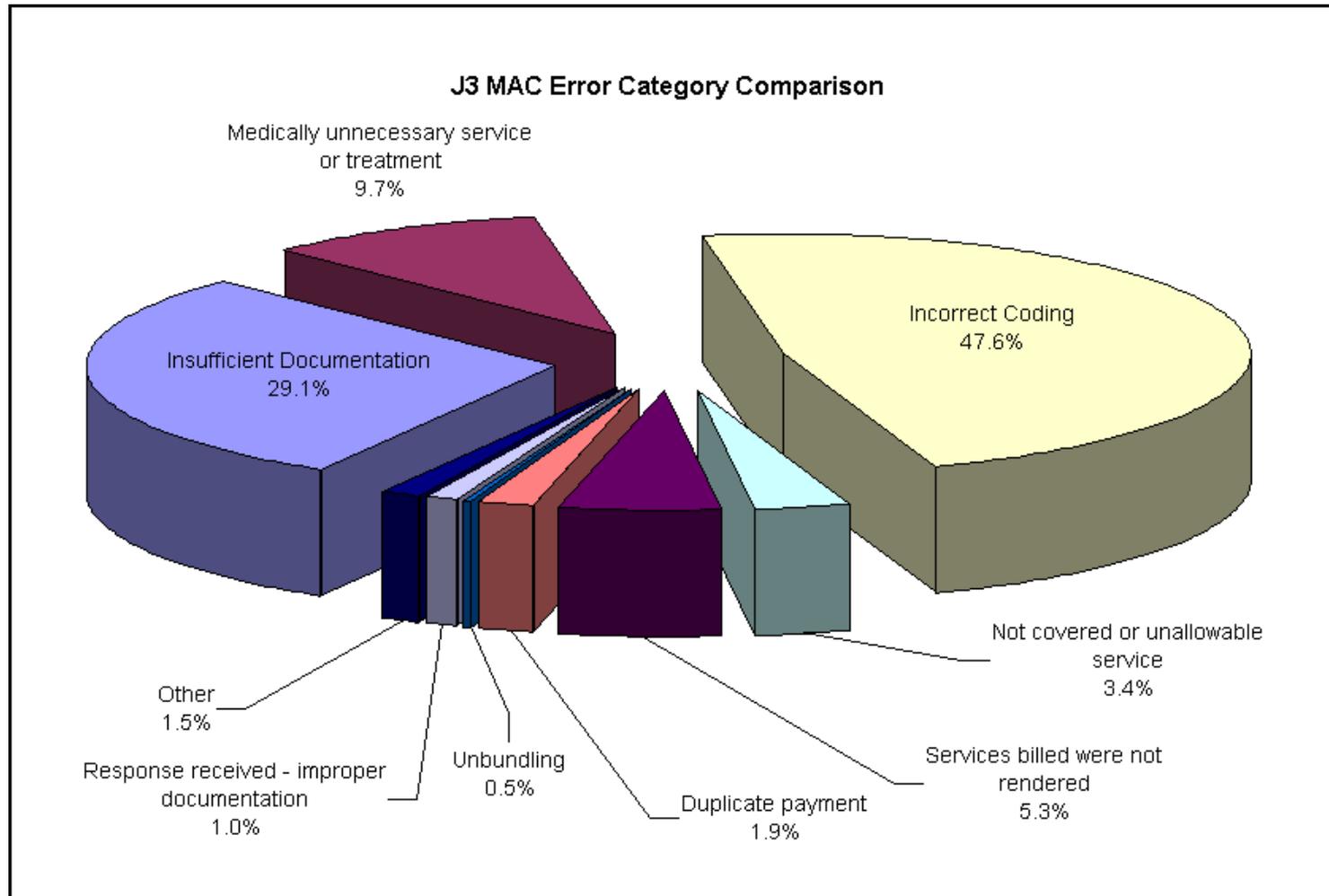
Benefit Protection

- Self Disclosure & Voluntary Refunds Process

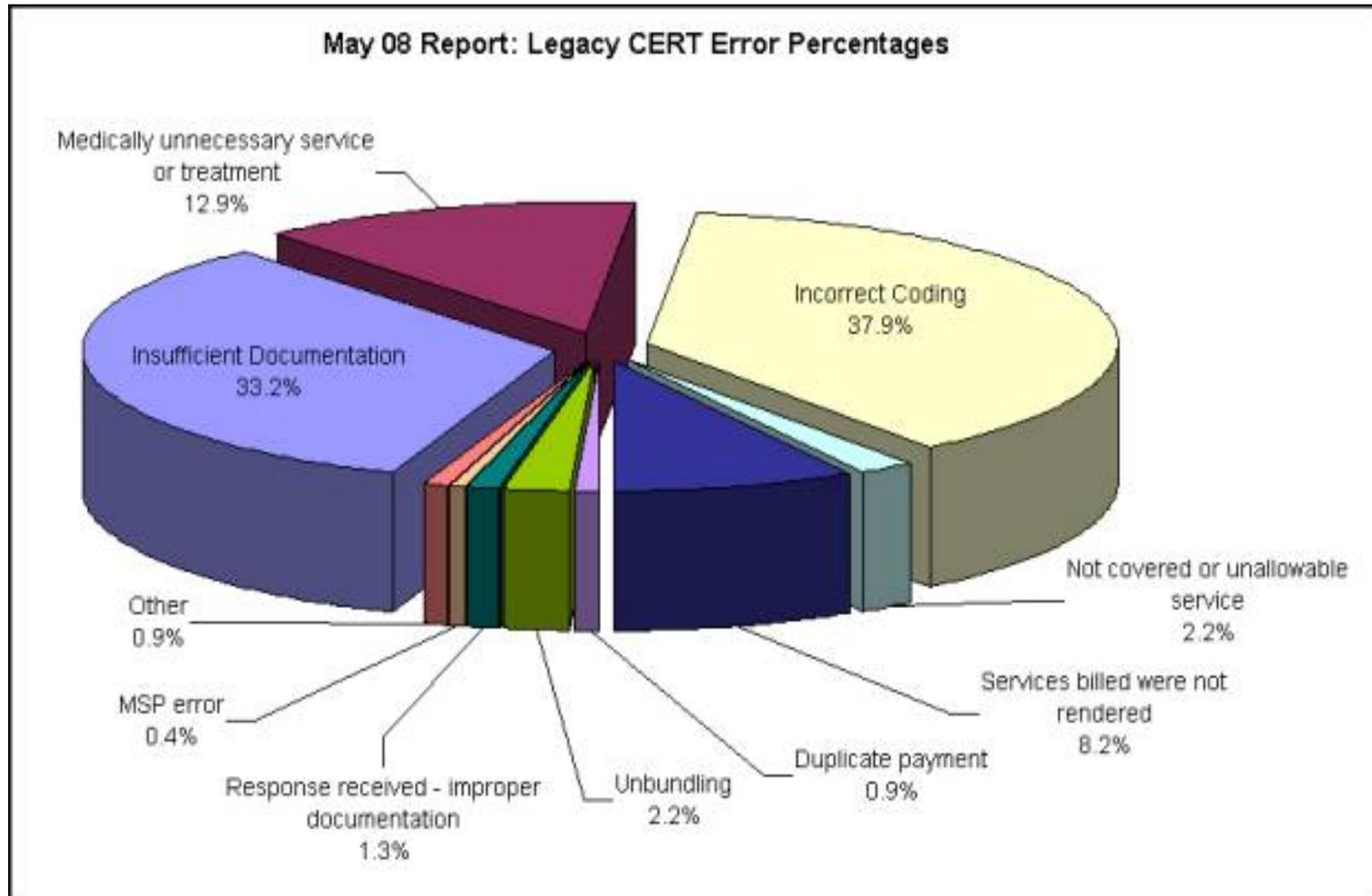
Claim Resources

- Reason Code List
- 2008 Claiming & Deductible Dates (pdf)

J3 MAC CERT Error Categories



Legacy CERT Error Categories



- Why was the claim denied?
 - See pg 4 of claim.
- Where do I send CERT requested medical records
 - fax (240)568-6222
- Can I appeal?
 - Yes!
- Do I need to adjust the claim?
 - No, NAS processes the adjustment.

Appeal, Appeal, Appeal!

- If you disagree with the outcome of the CERT review, appeal the claim!
- Appeals will be processed by NAS
- No amount is too small, and the outcome may dramatically reduce your facility error rate
- If denial is appropriate, notify NAS that no appeal will be made



Medicare

Noridian Administrative Services, LLC
CERT Contact/Address Change
ATTN: Rachel Guy
Fax: 701-277-6789

Provider/Facility Name: _____
Medicare Provider Number(s): _____
Provider CERT Contact Name: _____
Provider CERT Contact E-mail Address: _____
Provider CERT Contact Telephone Number: _____
Provider CERT Contact Fax Number: _____
Provider CERT Contact Mailing Address: _____ City: _____ State: _____ Zip: _____
Compliance Officer Print Name: _____
Signature: _____ PH #: _____



Where to Get More Information

- Websites:
 - CMS:
 - www.cms.hhs.gov/cert
 - Noridian:
 - www.noridianmedicare.com



Thank you for attending!