

Medicare Billing



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Agenda

2

- Top Claim Submission Errors
- Part A Adjustments
- Provider Statistical and Reimbursement (PS&R)
- Cost Reports
- Appeals
- Medicare Updates

Disclaimer

3

This resource is not a legal document. This presentation was prepared as a tool to assist our providers. This presentation was current at the time it was created.

Although every reasonable effort has been made to assure accurate information, responsibility for correct claims submission lies with the provider of services. Reproduction of this material for profit is prohibited

Top Claim Submission Errors

4

Denial Description	Total Claims Denied	Reason Code
Value code must be blank; value amount must be greater than zero	2,274	14610 (Returned to Provider)
Exact duplicate transaction submitted	2,187	38200 (Rejected)
Incorrect type of bill frequency code	1,478	31093 (Returned to Provider)
Claim overlaps a hospice election period	521	C7010 (Rejected)
Diagnosis code V0481 is present without condition code A6.	276	32200 (Returned to Provider)

www.cahabagba.com/part_a/claims/errors.htm

Date Span: January – March 2011

Claims Processing Issues Log

5

- Open and closed issues
- Updated frequently
- Check Issues Log before calling PCC

J10 A/B MAC Claims Processing Issue Log Part A Open Issues
 The following list provides you with the most current status of issues affecting processing of claims. Please check here often for updates before contacting the [Provider Contact Center](#) with questions.

Date Reported	Providers/Workload Impacted	Issue/Reason Code	Description	Updates/Work Around/Scheduled Fix	Resolution Date
03/15/11	Provider billing therapy HCPCS codes listed in CR 7050	Claims submitted with the following therapy HCPCS codes: 92508, 97018, 97124, 92507, 97019, 97150, 92509, 97022, 97110, 92506, 97024, 97530, 92507, 97028, 97531, 92507, 97028, 97535, 97110, 97032, 97537, 92509, 97033, 97532, 98128, 97034, 97750, 97051, 97035, 97755, 97032, 97036, 97750, 97009, 97110, 97751, 97004, 97112, 97752, 97612, 97113, 00281, 00283, 00329	Coinsurance payment is incorrectly calculated.	The issue has been reported to the system programmer. The issue will be corrected with installation of CR7050B. A production implementation date has not yet been determined. Once the fix is installed, previously submitted claims will be adjudicated. No provider action is required.	
3/16/11	Outpatient Part A Claims	71109	CMB issued instruction for contractors to hold claims billed with HCPCS codes 97597 & 97599	The claims will be held until the Integrated Outpatient Code Editor has been updated.	

www.cahabagba.com/part_a/claims/processing_issues.htm

MSP Adjustment Forms

6

- MSP Adjustment Form
 - New downloadable forms
 - Used to request MSP adjustments
 - Print and sign form
 - Attach documentation

Cahaba GBA Medicare Secondary Payer (MSP) Adjustment Form - Part A

Instructions: This form should be used to request Medicare Secondary Payer adjustments. Complete this request by typing information directly on the form for each claim you wish to have adjusted. After typing the information, print the form, sign it and send your request to the appropriate address below.

Select State:

<input type="checkbox"/> Alabama Part A MSP P.O. Box 12647 Birmingham, AL 35202-0647	<input type="checkbox"/> Georgia Part A MSP P.O. Box 03867 Birmingham, AL 35202-0387	<input type="checkbox"/> Tennessee Part A MSP P.O. Box 12645 Birmingham, AL 35202-0645
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Provider Information:

Name: _____

NPI/PTAN Provider #: _____

Address: _____

Phone #: _____

Beneficiary Information:

- Visit the Cahaba GBA website for more information
www.cahabagba.com/part_a/claims/msp/msp_adjust.htm

Part A Claim Adjustments

7

- Change in policy effective November 1, 2010
- Cahaba will no longer accept adjustment referrals via telephone
- Providers should now adjust using DDE or PC-Ace Pro32
- Paper Adjustments:

Cahaba GBA
Part A Paper Adjustments
PO Box 83019
Birmingham, AL 35283

Provider Statistical & Reimbursement Reports

8

- Live February, 2009
- Used for all cost reports with fiscal year ends 01/31/09 and after
- FYE prior to 01/31/09 use legacy PS&R
- CMS Publication 100-06, Chapter 8, Section 10.1 eliminates the requirement for MAC to provide PS&R reports to providers unless “the provider cannot access the system and informs the contractor of this issue”

Online PS&R Access

9

- Register for user ID in IACS system
- First person to register from organization is designated as Security Official
- Security Official can approve users but cannot access the PS&R
- Chain providers must register each provider within the chain individually

<https://psr-ui.cms.hhs.gov/psr-ui>

Online PS&R Usage Tips

10

- Request paid date approximately 30 days prior to cost report due date
- Sign on at least every 60 days to avoid revocation of user ID
- Run reports prior to the PS&R needed for cost report filing
- Detail PS&R

Website Resources

11

- IACS webpage:
 - <http://www.cms.hhs.gov/IACS/>
- To register in IACS, use the following web link:
 - <https://applications.cms.hhs.gov>
- More information regarding the IACS process is located in a series of Medicare Learning Network articles:
 - <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SEO747.pdf>
 - <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SEO753.pdf>
 - <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SEO754.pdf>
- Information pertaining to the PS&R and registration requirements:
 - www.cms.hhs.gov/PSRR

Cost Report Filing Tips

12

- All documents filed electronic with the exception of the cost report certification page
- Mail electronic file in the same package with certification page
- Place check at top of package, if applicable
- Obtain PS&R from online PS&R system within 30 days of cost report due date
- Review cost report reminder letter for any changes to filing requirements
- Include cover letter with cost report, including phone number of provider contact for questions

Cost Report Receipt

13

Cost Reports:

https://www.cahabagba.com/part_a/financial/cost_report_balance.htm

To follow-up on the receipt of Medicare Cost Reports, please send an email to:

CRINQAL@CAHABABGA.COM

Cahaba's Cost Report Webpage

14



The screenshot shows the Cahaba Government Benefit Administrators, LLC website. The header includes the company logo, a search bar with a dropdown menu set to 'Part A', and the CMS logo. The navigation menu includes Home, Part A, Part B, HH+H, FAQ, and Contact Us. The main content area is titled 'Part A > Financial > Cost Reporting' and features a section for 'Cost Reporting' with a brief description of Medicare-certified providers' requirements. Below this is a section for 'More Information About Filing Medicare Cost Reports' with a bulleted list of links: 'Cost Report Filing Details', 'Cost Reporting Tips & FAQ's', 'Provider Statistical and Reimbursement Data Information', and 'Provider Based Determinations'. The page footer indicates it was last updated on May 8, 2008.

Cost Report Lookup Tool

15



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PAAR Lookup

Wednesday, April 6, 2011

Please select one of the options below

www.cahabagba.com/part_a/financial/cost_report_balance.htm


Cost Report Reopening Policy

16

- Cost report reopening policy was revised effective April 1, 2011
- Must meet or exceed a threshold resulting in a \$10,000 impacted change in reimbursement to the cost report
- Threshold applied on an individual provider cost report basis
- Reopenings@cahabagba.com

Welcome to Cahaba University


Cahaba GBA has enhanced Cahaba University!



We are offering the quickest, most convenient way to learn more about the Medicare program at your own pace!

This learning resource applies only to Medicare Part A and Part B providers

Cahaba University is an educational program designed to provide a broad variety of Medicare related training to meet the needs of Medicare health care providers and suppliers. It is powered by Centra, a learning management system that will allow registered users to manage their own learning. Cahaba University allows for a blended e-learning environment. Blended meaning that users are allowed to register for Webinars, as well as assign self-paced learning tracks. It also provides centralized management and access to content created by the Provider Outreach and Education department for the provider community.




To begin, new users will ["Create A New Account"](#). The account is unique to the user and will enable you to track your learning.

[Cahaba University New Account Tutorial](#)

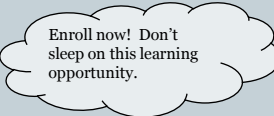

You are now ready to enter the first phase of the [Cahaba University](#)

We encourage our providers to bookmark this page for future updates.



For any questions or concerns regarding technical issues, you may email us at cahaba@mednetco.com

- More than 30 free courses offered
- Available 24/7
- Recorded educational events

Appealing Medicare Decisions

18

- Once an initial claim determination is made, providers have the right to appeal
- All appeal requests must be made in writing
- Each level has its own unique requirements and processes

www.cahabagba.com/part_a/education_and_outreach/educational_materials/quick_appeals.pdf

Common Errors

19

- Appeals submitted with no signature
- Appeals submitted with no medical records
- When a line item is medically denied and a correction needs to be made to a non-medically denied line item, send a hardcopy adjustment
- A medically denied line item must be appealed

Appeal Letters

20

- Appeal letters can only be sent to the address in FISS
- The letter cannot be faxed
- Providers can request additional letters through the PCC, however all letters must be sent to the address in FISS
- Reason code 56900- if documentation is sent in response to this reason code, the Appeals department will not send a letter to the provider
- If past 125 days, a dismissal letter would be sent

Appeals Calculator

21

Home > Part A > Appeals > Appeals Calculator Main Page

Appeals Calculator

The Appeals Calculator is a helpful tool used to determine the date your appeal request must be received to meet timeliness guidelines. Simply select the appropriate level of appeal, enter the date of the decision notice, and click on "Find Deadline." The date in which your appeal request must be received by Cahaba will display in the yellow row.

Select Level of Appeal:

*= Required

Page last updated: October 4, 2010



Preventive Services

22

- Effective for dates of service on or after January 1, 2011
- Medicare will cover annual wellness visits (AWV)
- Initial Preventive Physical Exam (IPPE) and AWV will be paid at 100%
- Deductible and coinsurance/copayment waived
- TOB 71x and 77x paid on all inclusive rate

Provider Screening and Risk Based Categories

23

- New process goes into effect March 25, 2011
- Three categories for provider/supplier enrollment applications
 - Limited
 - Moderate
 - High
- Ensures only legitimate providers and suppliers enroll into Medicare Program

Provider Enrollment Application Fee

24

- Effective March 25, 2011, fees are assessed for Provider Enrollment applications
- Application fee \$505 for CY 2011
- Fee applies to all institutional providers
- Must be submitted via paper check
- Hardship exception requests will be accepted
 - Case by case basis

Timely Filing

25

- Maximum submission of Medicare claims reduced to 12 months
- Dates of service on or after January 1, 2010 must be received within one calendar year beyond date of service

<http://www.cms.gov/MLN MattersArticles/downloads/MM6960.pdf>

Overview of HIPAA 5010

26

- Compliance deadline January 1, 2012
- Version 5010 contains significant improvements and addresses a variety of unmet business needs
- Only X12 Version 5010 can accommodate ICD-10 codes

HIPAA 5010

27



Free Webinars
 April 4, 2011 - April 8, 2011
 Test Education Week - SAVE THE DATE

[Register Now](#)

Free Webinars - Register Now

5010 Testing for Small Practices - Monday April 4, 1pm Eastern
 This session will review key steps small practices (less than 10 physicians) should take to prepare for 5010 including what, how and when to test with their vendors, clearinghouses, and payers. It will discuss the experience of one provider who has already begun testing.

Speakers:

- Jackie Griffin, Manager, Gateway EDI
- Alisa Taylor, Medical Billing Specialist, Alamogordo Urology

5010 Testing for Large Practices and Facilities - Tuesday April 5, 1pm Eastern
 Several providers representing large practices and hospitals will discuss how they are planning to test with clearinghouses and payers and lessons learned from initial testing experiences. They will discuss pre-testing

Sponsors



www.getready5010.org

ICD -10

28

- Transition October 1, 2013
- Must be used on all HIPAA transactions
- ICD-10-CM/PCS consists of two parts:
 - 1. ICD-10-CM for diagnosis coding
 - 2. ICD-10-PCS for inpatient procedure coding
- No payment made on claims with ICD-9 codes on or after 10/1/2013



Partial Code Freeze

29

- Last regular, annual updates to both ICD-9-CM and ICD-10 will be made on October 1, 2011
- On October 1, 2012 there will be only limited code updates to both ICD-9-CM & ICD-10 code sets to capture new technology and new diseases.
- On October 1, 2013 there will be only limited code updates to ICD-10 code sets to capture new technology and new diseases.

RHC Resources

30

- Medicare Claims Process Manual: Chapter 9
<http://www.cms.gov/manuals/downloads/clm104c09.pdf>
- Medicare Benefit Policy IOM: Chapter 13
<http://www.cms.gov/manuals/Downloads/bp102c13.pdf>
- Rural Health Clinics Educational Materials
https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/rhc.htm

Thank you For attending!



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