2020

Medical Billing Training: Certified Professional Biller (CPB™)

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2233 South Presidents Dr., Suites F-C, Salt Lake City, UT 84120-7240
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Chapter 11

Government Carriers (Medicare, Medicaid, TRICARE)

We will review government carriers in this chapter, including Medicare, Medicaid, and TRICARE. We will discuss eligibility requirements, covered benefits, and standards.

The objectives for this chapter include:

- Explain Medicare eligibility requirements
- Identify the different parts of Medicare and what is covered under each
- Explain Medicaid eligibility requirements and coverage
- List Medigap coverage and claims filing requirements
- Identify TRICARE coverage and claims filing requirements

Medicare

Medicare is a health insurance program for people age 65 and older, people under 65 with certain disabilities, and people of any age with end-stage renal disease.

Medicare has four parts:

- **Part A: hospital insurance.** Part A helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities.
- **Part B: medical insurance.** Part B covers things not covered by Part A like physician's services, medical supplies, laboratory services, etc.
- **Part C: Medicare Advantage plans.** These are private plans (like HMOs and PPOs) run through Medicare that must at least be equivalent to regular Part A and Part B. Part C plans are managed by private companies contracted with CMS.
- **Part D: Prescription drug program.**

Part C plans, also called Medicare Advantage plans, are offered through private insurance companies approved by Medicare. They provide all the Part A and Part B coverage and cover medically necessary services. Some may also include Part D coverage. Private insurers contract with the Centers for Medicare & Medicaid Services (CMS) as a Medicare Administrative Contractor (MAC) to administer and process claims for Medicare Part A and Part B services. MACs are multi-state, regional contractors responsible for administering both Medicare Part A and Medicare Part B claims.

The card will list:

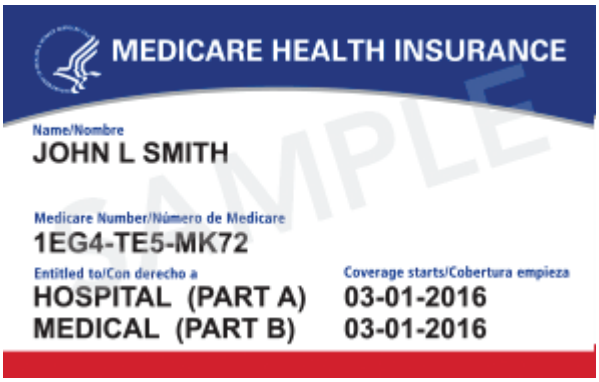
The patient name (below as John L Smith)

Effective date of coverage (below shown as 03-01-2016)

What parts of Medicare the patient has, either Part A or Part B. The card will not show if the patient has Part C or Part D coverage. A patient with Part C will not receive a membership card directly from Medicare, but through the private Medicare Advantage contractor.

The patient's Medicare beneficiary identifier number (MBI). The MBI is made up of 11 numbers and uppercase letters with no special characters. Positions 2, 5, 8, and 9 are always alphabetic. Each MBI is unique and does not have any special or hidden meaning.

Source: https://www.cms.gov/Outreach-and-Education/Look-Up-Topics/Medicare/New-Medicare-Card-Message.html



Source: https://www.cms.gov/medicare/new-medicare-card/nmc-home.html

Medicare Eligibility

People may be eligible for Part A Medicare at age 65 if:

- they receive or are eligible to receive Social Security benefits; or
- they receive or are eligible to receive railroad retirement benefits; or
- their spouse receives or is eligible to receive Social Security or railroad retirement benefits; or
- they or their spouse worked long enough in a government job where Medicare taxes were paid; or
- they are the dependent parent of a fully insured deceased child.

If a person does not meet the eligibility requirements, he or she may be able to get Part A by paying a monthly premium.

People may be eligible for Part A Medicare before age 65 if:

- they have been entitled to Social Security disability benefits for 24 months; or
- they receive a disability pension from the railroad retirement board and meet certain conditions; or
- they receive Social Security disability benefits because of Lou Gehrig's disease (ALS); or
- they worked long enough in a government job where Medicare taxes were paid and have been entitled to Social Security disability benefits for 24 months; or they are the child or widow or widower age 50 or older, including a divorced widow or widower, of someone who has worked long enough in a government job where Medicare taxes were paid and you meet the requirements of the Social Security disability program; or they have permanent kidney failure and you receive maintenance dialysis or a kidney transplant, and
- are eligible for or receive monthly benefits under Social Security or the railroad retirement system; or
- have worked long enough in a Medicare-covered government job; or
- are the child or spouse of a worker who has worked long enough under Social Security or in a Medicare-covered government job

People are eligible for Part B Medicare at age 65 if:

- they reside in the United States, and
- they are entitled to premium-free Part A benefits.

People who are not eligible for premium-free Part A benefits may be eligible for Part B Medicare if:

- they are a U.S. resident, and
- they are either citizens or aliens who have been lawfully admitted for permanent residence with five years continuous residence in the U.S. at the time of filing.

People are eligible for Medicare Part C and Part D when they are eligible for Medicare Part A.

To verify Medicare eligibility through EDI, the provider needs to have the following information from the patient:

- The beneficiary's last name and first name
- The beneficiary's date of birth
- Health Insurance Claim Number (HICN) (subscriber number) or Medicare Beneficiary's Identifier (MBI)
- The beneficiary's gender

Medicare Coverage/Exclusions

Medicare coverage is based on federal and state laws, national coverage determinations (NCDs) made by Medicare about whether a service is covered, and local coverage determinations (LCDs) made by the carriers in each state that processes claims for Medicare. The table below illustrates services covered under each part of the Medicare program.

Part A	Part B	Part C	Part D
• Hospital care • Skilled nursing facility care • Nursing home care • Hospice • Home health services • Inpatient care (for example, chemotherapy performed as inpatient)	• Clinical research • Ambulance services • Durable medical equipment • Mental Health • Certain preventive services • Doctor and other healthcare providers' services • Outpatient care (for example, chemotherapy performed as outpatient)	• All things covered under Part A except Hospice. Hospice is always covered under Part A • May offer vision, hearing, dental and/or health and wellness programs	• Prescription drugs Each plan has its own formulary

Medicare covers many preventive services and a biller needs to be aware of what is and is not covered. These services can be found on the CMS website, which lists the CPT® and ICD-10-CM codes applicable, frequency of coverage, along with patient responsibility (https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html):

- **Alcohol Misuse Screening and Counseling:** Medicare Part B covers this screening one time per year. This service is for use for adult Medicare patients who don't meet the criteria for alcohol dependency can get screened (G0442). If it is determined that the patient is misusing alcohol, four brief face-to-face counseling sessions may be covered per year (G0443). No specific ICD-10-CM code is required by Medicare, but the local MAC may have guidance.
- **Annual wellness visit (AWV):** This is allowed once every 12 months after the first 12 months of effective date of Medicare Part B coverage. HCPCS Level II code G0438 is billed for the initial, first, AWV and G0439 is billed for the subsequent AWVs annually. G0468 is reported annually for AWVs in Federally Qualified Health Centers (FQHCs). A specific ICD-10-CM code isn't required by Medicare, but the local MAC may have guidance.

  Advance Care Planning being furnished on the same day and by the same provider as the AWV. Advance Care Planning is an optional preventive service furnished with an AWV. The deductible and coinsurance for Advance Care Planning are waived when furnished with an AWV, which requires, appending modifier-33 to the code(s) for Advance Care Planning. Billing Advance Care Planning with CPT® code 99497 for the first 30 minutes, and 99498 for each additional 30 minutes

- **Bone mass measurements:** Medicare Part B covers bone mass measurements to check if the patient is at risk for broken bones. Patients may be at increased risk due to osteoporosis. Bone mass measurements are covered if the provider thinks the patient is at risk and if they have one of the following:
  - A woman whose provider says she's estrogen-deficient and at risk for osteoporosis based on her medical history and findings
  - A person with vertebral abnormalities as demonstrated by X-ray
  - A person receiving steroid treatments for more than 3 months
  - A person with primary hyperparathyroidism
  - A person taking osteoporosis drug therapy

  It is covered once every 24 months, unless medically necessary to perform sooner. CPT® codes 76977 (Ultrasound bone density), 77078 (CT bone mineral density), 77080 (Dual-energy X-ray absorptiometry, axial skeleton), 77081 (Dual-energy X-ray absorptiometry, appendicular skeleton), 77085 (Dual-energy X-ray absorptiometry, axial skeleton), Category III codes 0554T-0558T (Bone analysis), or HCPCS Level II code G0130 (Single energy X-ray study,

appendicular skeleton) are the billable codes, depending on the service provided. Medicare has identified specific ICD-10-CM codes covered and refers you to your local MAC for guidance.

- **Cardiovascular disease screening blood tests:** Medicare Part B covers cardiovascular disease screenings that check a patient's cholesterol and other blood lipid levels. All Medicare beneficiaries are covered once every five years. CPT® code 80061 (lipid panel) is covered which must include the following: 82465 (total serum cholesterol), 83718 (HDL cholesterol), and 84478 (triglycerides). Report ICD-10-CM code Z13.6 with the services.
- **Colorectal cancer screening:** Medicare Part B covers colorectal cancer screening test for all Medicare beneficiaries age 50 and older. The frequency limits and age of coverage are different on different tests.

  Colorectal cancer screening using multitarget sDNA test (81528) is billable for asymptomatic patients, age 50 to 85 years, and at average risk of developing colorectal cancer.

  Screening colonoscopies (G0105, G0121), fecal occult blood tests (FOBTs) (82270, G0328), flexible sigmoidoscopies (G0104), and barium enemas (G0106, G0120) are billable for all Medicare beneficiaries who fall into at least one of the following categories and frequency:

- Age 50 and older who are at normal risk of developing colorectal cancer
  - Multitarget sDNA test: once every 3 years.
  - Screening FOBT: once every 12 months.
  - Screening flexible sigmoidoscopy: once every 48 months (unless the beneficiary does not meet the criteria for high risk of developing colorectal cancer and the beneficiary has had a screening colonoscopy within the preceding 10 years, in which case Medicare may cover a screening flexible sigmoidoscopy only after at least 119 months have passed following the month that the beneficiary received the screening colonoscopy).
  - Screening colonoscopy: once every 120 months (10 years), or 48 months after a previous sigmoidoscopy. When a screening colonoscopy becomes a diagnostic colonoscopy, report anesthesia services with CPT® code 00811 with modifier PT and the deductible will be waived. Report this in addition to 00812.
  - Screening barium enema (when used instead of a flexible sigmoidoscopy or colonoscopy): once every 48 months.
- At high-risk of developing colorectal cancer
  - Screening FOBT: once every 12 months.
  - Screening flexible sigmoidoscopy: once every 48 months.
  - Screening colonoscopy: once every 24 months (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after at least 47 months). When a screening colonoscopy becomes a diagnostic colonoscopy, report anesthesia services with CPT® code 00811 with modifier-PT and the deductible will be waived. Report this in addition to 00812.
  - Screening barium enema (when used instead of a flexible sigmoidoscopy or colonoscopy): once every 24 months.

A patient is high risk if any of the following are true:

- The patient has had colorectal cancer in the past.
- The patient has a close relative who had colorectal polyps or colorectal cancer.
- The patient has a history of polyps.
- The patient has inflammatory bowel disease.

No specific ICD-10-CM code is required by Medicare, but the local MAC may have guidance. For multitarget sDNA test, report Z12.11 and Z12.12.

- **Counseling to prevent tobacco use for asymptomatic beneficiaries:** Medicare Part B covers tobacco use cessation counseling if a patient has not been diagnosed with an illness caused by tobacco use. Code 99406 is for more than three minutes up to 10 minutes and code 99407 is for greater than 10 minutes are billable to Medicare, two cessation counseling attempts, up to eight counseling sessions, per year are covered. An ICD-10-CM code from the F17 category, T65.2 subcategory, or Z87.891 should be reported with the services. Refer to your local MAC for additional guidance.
- **Screening for depression:** Medicare Part B covers depression screening for all Medicare beneficiaries. It must be performed in a primary care setting so follow-up treatments and referrals may be provided. Code G0444 *Annual depression screening, 15 minutes* is billable annually. No specific ICD-10-CM code is required by Medicare, but the local MAC may have guidance.
- **Diabetes screening tests:** Medicare Part B covers a blood screening test to check for diabetes for people at risk. A patient is at risk if they have hypertension, dyslipidemia, obesity, or a history of high blood sugar. Medicare will also cover the screenings if two or more of the following are true:
  - The patient is 65 or older.
  - The patient is overweight.
  - The patient has a family history of diabetes.

- The patient has a history of gestational diabetes (during pregnancy) or has had a baby who weighed more than nine pounds.

Codes 82947, 82950, and 82951 are billable, depending on what service is provided. Append modifier TS when billing for Medicare beneficiaries with pre-diabetes. Two screening tests per year are covered for beneficiaries who are diagnosed with pre-diabetes. One screening test per year is covered for patients who were previously tested but not diagnosed with pre-diabetes, or if never tested. ICD-10-CM code Z13.1 should be reported with the services.

- **Diabetes self-management training (DSMT):** Medicare Part B covers this service for patients with diabetes to teach them to manage their condition and prevent complications. Codes G0108 and G0109 are billed based on the number or individuals in the training. Up to 10 hours of initial training within a continuous 12-month period is covered. In subsequent years, up to two hours of follow-up training each year is covered. No specific ICD-10-CM code is required by Medicare, but the local MAC may have guidance.
- **Glaucoma screening:** Medicare Part B covers glaucoma screening for patients at high risk. Patients are considered high risk if any of the following is true:
  - The patient has diabetes.
  - The patient has a family history of glaucoma.
  - The patient is African-American and age 50 or older.
  - The patient is Hispanic-American and age 65 or older.

  Codes G0117 or G0118 is billable annually for covered beneficiaries who meet the high-risk criteria. ICD-10-CM code Z13.5 should be reported with the services.

- **Hepatitis B Virus (HBV) Screening:** Medicare Part B covers HBV screening for patients at high risk for HBV (G0499) when ordered by their primary care provider in a primary care setting. Patients are at high risk for hepatitis B if they are:
  - born in countries and regions with a high prevalence of HBV infection;
  - US-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection;
  - HIV-positive;
  - Men who have sex with men;
  - Injection drug users; or
  - Household contacts or sexual partners of persons with HBV infection.

  HBV screening is also covered at the first prenatal visit for pregnant women (86704, 86706, 87340, and 87341). Medicare has specific ICD-10-CM codes requires depending on the circumstance. Refer to the Medicare Preventive Service Guide for listed ICD-10-CM codes (https://www.cms.gov/Medicare/Prevention/Prevntion-GenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#HEP_B_SCREEN).

- **Hepatitis B Virus (HBV) vaccine and administration:** Medicare Part B covers hepatitis B vaccines for patients at intermediate or high risk. High-risk patients include:
  - End-stage Renal Disease (ESRD) patients;
  - Hemophiliacs who receive Factor VIII or IX concentrates;
  - Clients of institutions for the mentally retarded;
  - Persons who live in the same household as a Hepatitis B Virus (HBV) carrier;
  - Homosexual men;
  - Illicit injectable drug abusers; and
  - Persons diagnosed with diabetes mellitus.

  Intermediate risk groups include:
  - Staff in institutions for the mentally retarded; and
  - Workers in healthcare professions who have frequent contact with blood or blood-derived body fluids during routine work.

  Codes 90739, 90740, 90743, 90744, 90746, or 90747 are billable, depending on what service is provided. Code G0010 is billable for the administration of the vaccine. ICD-10-CM code Z23 should be reported with the services.

- **Hepatitis C Virus (HCV) Screening:** Medicare Part B covers hepatitis C antibody screening. It is covered once for patients born between 1945 and 1965 (use ICD-10-CM code Z11.59), and an initial screening if the patient had a blood transfusion before 1992, regardless of the year of birth. An initial screening is covered for patients with a current or past history of illicit injection drug use, and annually for those who continue with illicit injection drug use since their last negative HCV screening test. Code G0472 is billable for the antibody screening. ICD-10-CM codes Z72.89 and F19.20 should be reported with this service.
- **Human immunodeficiency virus (HIV) screening:** Medicare Part B covers voluntary HIV screenings for people at increased risk for the infection, including anyone who wants the screening test and pregnant women. Codes 80081, G0432, G0433, G0435, or G0475 are billable, depending upon the test given, annually for beneficiaries at increased risk. For pregnant women, three tests are covered: once when she is diagnosed, once during the third trimester, and once at labor, if ordered. ICD-10-CM code Z11.4 should be used as primary and with

the appropriate Z codes for the pregnancy status, and/or a code relating to the individual's lifestyle (for example, Z72.89) as secondary (if applicable) for the services.

- **Influenza virus vaccine and administration:** Medicare Part B covers one flu shot per flu season. Codes 90630, 90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90674, 90685, 90686, 90687, 90688, 90689, 90756, Q2034, Q2035, Q2036, Q2037, or Q2038 is billable, depending on the type of immunization provided. Code G0008 is billable for the administration of the vaccine. ICD-10-CM code Z23 should be reported with this service.
- **Initial preventive physical examination (IPPE):** This is also referred to as the "Welcome to Medicare" exam. It is available to any patient new to Medicare in the first 12 months of enrollment. An electrocardiogram (ECG) may also be performed at the visit or ordered at the visit and is covered under the examination. Codes G0402 (IPPE), G0403 (ECG for IPPE), G0404 (ECG tracing for IPPE), and G0405 (ECG interpretation and report for IPPE) are billable codes, depending on which service(s) are provided. G0468 is billable for FQHCs. No specific ICD-10-CM code is required by Medicare, but the local MAC may have guidance.
- **Intensive behavioral therapy for cardiovascular disease:** This is a cardiovascular disease risk reduction visit that includes: encouraging aspirin use when benefits outweigh the risk, screening for high blood pressure, and counseling to promote a healthy diet. It is covered annually and may also be referred to as the CVD risk reduction visit. HCPCS Level II code G0446 is the correct code to bill for the service. No specific ICD-10-CM code is required by Medicare, but the local MAC may have guidance.
- **Intensive behavioral therapy for obesity:** Medicare Part B covers intensive behavioral therapy for people with obesity, which is a body mass index of 30 or more. This is available to all Medicare beneficiaries who meet the criteria. Code G0447 (face-to-face individual counseling, each 15 minutes) and Code G0473 (face-to-face group counseling, 30 minutes) is covered. The allowable frequency is:
  - One visit every week for the first month.
  - One visit every other week for months two through six.
  - One visit every month for months seven through 12, under certain conditions (patient must have lost at least 6.6 pounds during the first six months).

  ICD-10-CM codes from the Z68 category should be reported with the services.

- **Lung Cancer Screening Counseling and Annual Screening:** Counseling and Annual Screening: Medicare Part B covers lung cancer screening for patients who meet all of the following:
  - Aged 55 through 77;
  - No signs or symptoms of lung cancer;
  - Tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
  - Current smoker or one who has quit smoking within the last 15 years;
  - Receive a written order for lung cancer screening with low dose CT scan (LDCT).

  For Medicare patients in their first year of coverage, before their first LDCT screening, they must receive a counseling and shared decision-making visit with a physician or NPP. In the subsequent years, the Medicare patient must receive a written order from a physician or NPP. Code G0296 is billable for the counseling and shared decision-making visit, and G0297 for the LDCT. ICD-10-CM codes F17.210, F17.211, F17.213, F17.218, F17.219, or Z87.891 are reported with these services.

- **Medical nutrition therapy:** Medicare Part B covers medical nutrition therapy if a Medicare patient has diabetes, kidney disease, or has had a transplant in the past three years and is referred by their provider. The services may be given by a registered dietitian or Medicare-approved nutrition professional, and include nutritional assessment and counseling to help a patient manage their diabetes or kidney disease. Codes 97802 (initial, individual, each 15 minutes), 97803 (re-assessment, individual, each 15 minutes), 97804 (group training, each 30 minutes), G0270 (subsequent intervention for change in diagnosis, individual, each 15 minutes), or G0271 (subsequent intervention for change in diagnosis, group, each 30 minutes) are billable. In the first year, three hours of one-on-one counseling and two hours in subsequent years is covered. No specific ICD-10-CM code is required by Medicare, but the local MAC may have guidance.
- **Pneumococcal vaccine and administration:** Medicare Part B covers pneumococcal vaccination and administration once per patient's lifetime. Code 90670 or 90732 is billable for the pneumococcal vaccine, depending on which is provided. Code G0009 is billable for the administration of the vaccine. ICD-10-CM code Z23 should be reported with the service.
- **Prostate cancer screening:** Medicare Part B covers prostate cancer screening in the form of a prostate specific antigen (PSA) blood test or digital rectal examination (DRE). This is available to all men age 50 and over. Code G0102 (DRE) and G0103 (PSA) are billable codes, depending on the service provided. Medicare covers this service annually. ICD-10-CM code Z12.5 should be reported with the service.
- **Screening for Cervical Cancer with Human Papillomavirus (HPV) tests:** Medicare Part B covers screening for cervical cancer with human papillomavirus

(HPV) once every five years for all females aged 30 to 65 years who are without symptoms. The appropriate lab test must be performed in addition to a pelvic examination and a Pap test. Code G0476, HPV combo assay, CA screen, is billable for the lab test; and the appropriate HCPCS Level II code is billable for the pelvic examination and Pap test. ICD-10-CM codes Z11.51 for the screening and either Z01.411 encounter for gynecological exam with abnormal findings, or Z01.419 encounter for gynecological exam without abnormal findings are reported with these services.

- **Sexually transmitted infections (STIs) screening and high intensity behavioral counseling (HIBC) to prevent STIs:** Medicare Part B covers sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and/or Hepatitis B. Codes 86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87590, 87591, 87850, 87800, 86592, 86593, 86780, 87340, and 87341 are billable, depending on the test provided. One annual screening is covered for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant. One annual screening is covered for men for gonorrhea. Up to two screenings are allowed for chlamydia and gonorrhea for pregnant women at increased risk. One screening per pregnancy for syphilis in pregnant women and up to two additional screenings if the patient is at increased risk for STIs. One screening per pregnancy for hepatitis B and one additional screening if the patient remains at risk. Code G0445 is billable for semiannual high intensity behavioral counseling to prevent STIs performed on a face-to-face, individual basis. This is covered for up to two sessions annually. ICD-10-CM code Z11.3 or Z11.59 should be reported with the service along with any applicable pregnancy code.
- **Screening mammogram:** Medicare Part B covers screening mammograms and digital technologies to check for breast cancer. Women age 40 and over are eligible for a screening mammogram once every 12 months. Medicare also covers a baseline mammogram for women between 35 and 39 on Medicare. 77063 *Screening digital breast tomosynthesis; bilateral* and 77067 *Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed* are billable. Append modifier GG if billing a screening mammogram and a diagnostic mammogram on the same day. This will show that a screening mammography turned into a diagnostic mammography. ICD-10-CM codes N63.10, N63.15, N63.20, N63.25, or Z12.31 should be reported for the services.
- **Screening pap tests:** Medicare Part B covers Pap tests and pelvic exams to check for cervical and vaginal cancers. This benefit is available to all female Medicare patients annually if the patient is high risk, or every two years for non-high-risk women. A woman is considered high risk if any of the factors exist:
  - She has had an abnormal pap test.
  - She has had cervical or vaginal cancer in the past.
  - She has a history of sexually transmitted disease.
  - She began having sex before the age of 16.
  - She has had five or more sexual partners.
  - Her mother took DES (diethylstilbestrol), a hormonal drug, when pregnant with the patient.

  The correct codes to bill are G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, or Q0091 for the screening cervical or vaginal Pap smear by type. ICD-10-CM codes for high risk patients are reported with Z72.51, Z72.52, Z72.53, Z77.29, Z77.9, Z91.89, and Z92.89; low risk patients are reported with Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, and Z12.89.
- **Screening pelvic examinations:** Medicare Part B covers pelvic exams with clinical breast exam. The frequency range is the same as with the screening Pap tests. The high-risk qualifiers are the same as with the screening Pap smear. Code G0101, Cervical or vaginal cancer screening; pelvic and clinical breast examination, is the correct code to bill the service. ICD-10-CM codes for high risk patients are reported with Z77.29, Z77.9, Z91.89, Z92.89, Z72.51, Z72.52, and Z72.53; low risk patients are reported with Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, and Z12.89.
- **Ultrasound screening for abdominal aortic aneurysm:** Medicare Part B covers a one-time abdominal aortic aneurysm ultrasound for at risk patients. A patient is considered at risk if they have a family history of abdominal aortic aneurysm or if the patient is a man age 65 to 75 who has smoked at least 100 cigarettes in their lifetime. The ultrasound is reported with 76706. No specific ICD-10-CM code is required by Medicare, but the local MAC m ay have guidance.

Medicare, like many other insurance programs, does not cover everything. Non-covered services are the responsibility of the patient. Medicare has four categories of items and services that are not covered under the program:

1. Services and supplies that are not medically reasonable and necessary
2. Non-covered items and services
3. Services and supplies that have been denied as bundled or included in the basic allowance of another service
4. Items and services reimbursable by other organizations or furnished without charge

Non-covered items and services are statutorily excluded, which means that they are enacted, created, or regulated by statute, or Medicare guidelines. Statutorily excluded services are not reimbursed by Medicare.

Services that are not covered by Medicare include:

- Long-term care (custodial care)
- Most dental care
- Eye examinations related to prescribing glasses
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and fitting exams
- Routine foot care

Participating vs. Non-participating Regulations

There are three contractual options for providers in regard to contracting with Medicare. Providers may sign a participating agreement (PAR) to accept Medicare's allowed charge as payment in full for all Medicare patients (accept assignment). Participating providers are listed in the Medicare Participating Physician's Directory (MedParD) sent to all Medicare patients annually. They can collect up to the Medicare allowed fee on assigned claims and receive automatic crossover of Medigap secondary claims. Medicare Administrative Contractors (MACs) provide toll-free claims processing lines to PAR providers and process their claims more quickly. A mid-level provider may also bill incident-to a PAR provider for certain services. Requirements for incident-to services can be found in the Medicare Claims Processing Manual and are discussed below.

Whether the provider is PAR or non-PAR, the claims for the following services are required to accept assignment:

- Clinical diagnostic laboratory services and physician lab services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians/nutritionists, anesthesiologist assistants, and mass immunization roster billers;
- Ambulatory surgical center services;
- Home dialysis supplies and equipment paid under Method II for dates of service prior to January 1, 2011;
- Drugs and biologicals; and
- Ambulance services.

Non-participating (non-PAR) providers have a fee schedule set at 95 percent of Medicare approved amounts for PAR providers. Non-PAR providers can charge above the Medicare approved amount with a limiting charge. The limiting charge is set at 115 percent of the Medicare approved amounts for non-PAR providers. Because Medicare approved amounts for non-PAR providers is set 5 percent lower than PAR providers, they only receive 9.25 percent more. Non-participating providers must still submit a claim to Medicare for their services and the patient receives the payment from Medicare. Non-PAR providers may choose to accept Medicare assignment on a case-by-case basis except for clinical laboratory claims. They will still only receive the 95 percent of the PAR approved amount, though as they are still non-PAR providers. The difference between the provider's charge and Medicare's limiting charge cannot be billed to the patient (referred to as balance billing).

Example of a service for which the Medicare fee schedule approved amount is $200

Payment Arrangement	Total Payment Rate	Payment Amount from Medicare	Payment Amount from Patient
PAR physician	100 percent Medicare fee schedule = $200	$160 (80 percent) MAC direct to physician	$40 (20 percent) paid by patient or supplemental insurance (for example, Medigap)
Non-PAR/ assigned claim	95 percent Medicare fee schedule = $190	$152 (80 percent) MAC direct to physician	$38 (20 percent) paid by patient or supplemental insurance (for example, Medigap)
Non-PAR/ unassigned claim	Limiting charge/109.25 percent Medicare fee schedule = $218.50	$0	$152 (80 percent) paid by MAC to patient + $38 (20 percent) paid by patient or supplemental insurance + $28.50 balance bill paid by patient = $218.50

When surgical services are provided to Medicare beneficiaries by a non-PAR provider that exceed $500, the non-PAR provider must have the patient sign a surgical disclosure. A non-PAR provider who performs an elective surgical procedure for a Medicare beneficiary for which the charge is at least $500 and the provider does not accept assignment for the claim, the provider must provide the Medicare beneficiary with a surgical disclosure. The form includes the physician's estimated actual charge for the procedure, an estimated approved charge under this part for the procedure, the excess of the physician's actual charge over the approved charge, and the coinsurance amount applicable to the procedure.

Physicians may also choose to opt-out of Medicare and privately contract to provide healthcare services to patients outside the Medicare system. Opt-out physicians may charge whatever they desire to patients as they are not subject to Medicare's fee schedule or limiting charge. An opt-out physician does not file any claims to Medicare (except in emergency cases) and receives no Medicare payment either directly or indirectly. They are prohibited from receiving payments individually, as an employee of an organization, a partner in a partnership, under reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare Advantage plan (capitation). A private contract must be signed by the patient stating they understand that the patient is giving up Medicare payment for services furnished by the provider. Once a provider opts out of Medicare, they cannot submit Medicare claims for any patient for a two-year period.

The private contract must meet specific requirements that the provider and patient enter into for services. It must be in writing and signed by the beneficiary before any item or service is provided. The contract must not be entered into at a time when the beneficiary is facing an emergency or an urgent health situation. The contract must also state specifically that by signing the private contract, the beneficiary (patient):

- Gives up all Medicare payment for services furnished by the "opt-out" provider
- Agrees not to bill Medicare or ask the provider to bill Medicare
- Is liable for all of the provider's charges, without any Medicare balance billing limits
- Acknowledges that Medigap or any other supplemental insurance will not pay toward the services
- Acknowledges that he or she has the right to receive services from providers for whom Medicare coverage and payment would be available

The provider also must file an affidavit that meets specific requirements and submit to the local MAC at 30 days before the first day of the next calendar quarter. The affidavit agrees that the provider will forgo receiving any payment from Medicare for items or services provided to any Medicare beneficiary for the following two-year period either directly or indirectly (as described above). If the provider was a participating provider and is changing to opt-out, they must file the affidavit with carriers that have jurisdiction over claims that they would otherwise file with Medicare no later than 10 days after the first private contract is entered into with a beneficiary. The providers then have a 90-day period after the effective date of the first opt-out affidavit during which they can revoke the opt-out and return to Medicare, if they wish. It would be as if they had never opted out.

Incident-to Guidelines

Incident-to services are performed incident-to the physician's services. Medicare defines incident-to as "those services that are furnished incident-to physician professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home."

Incident-to services are not recognized in a facility setting. Services performed by ancillary staff in a hospital are considered hospital expense. When the physician's office is part of an institution, the office must be confined to a separately identifiable part of the facility and cannot be construed to extend throughout the entire facility. Only services performed in the office, to outpatients, can be considered for incident-to.

To qualify as incident-to services, the following requirements must be met:

- Services must be part of your patient's normal course of treatment. For example, a three-month follow-up appointment to manage a patient with diabetes and no complications.
- The reporting physician must personally perform the initial service and remain actively involved in the care.
- The reporting physician (or any physician member of the same group practice) must provide direct supervision. This requires the physician to be present in the office suite and available to aid if necessary. The physician is not required to be physically present in the treatment room.

Incident-to services are performed by midlevel providers known as Non- Physician Practitioners (NPPs) which are Physician Assistants (PAs), Nurse Practitioners (NPs), Clinical Nurse Specialist (CNS), Clinical Psychologists, Clinical Social Workers, and Certified Nurse Midwives (CNMs).

If you meet the requirements for incident-to billing, the claim is submitted under the physician's name as if he personally performed the service and the reimbursement will be at 100 percent. Services performed by NPPs that are not incident-to are billed under the NPPs own NPI numbers, in which case they are reimbursed at 85 percent.

When submitting incident-to claims, make sure to submit it under the supervising physician. For example, in a group practice, Doctor A established the care plan for which the Advanced Registered Nurse Practitioner (ARNP) is providing the follow up service. Doctor A may not be in the office the day of the incident-to service, but Doctor B is in the office providing the necessary supervision. In this case, bill the incident-to service under Doctor B. This is important because if incident-to services are audited, the auditor will request the medical record as well as the schedule for the dates of service to make sure the physician who the claim was billed under was in the office.

NPI and Credentialing

All providers who bill Medicare or any other insurer must have a National Provider Identifier (NPI) number. A National Provider Identifier, or NPI, is a unique 10-digit identification number required by HIPAA. In the past, providers had different identification numbers for each payer, but the introduction of the NPI is a single identifier for all payers to improve efficiency of the healthcare system. It will also help reduce fraud and abuse. It is an intelligence-free number, meaning that there is no personal identifying information other than a name and business address.

Information needed to complete an NPI application includes:

- Provider's name and credentials
- Provider's birth information (date, state, country)
- Gender
- Social Security number
- IRS Individual Taxpayer Identification number
- Organizations the provider is affiliated with
- Business mailing address information
- Business practice location information
- Other provider identification numbers (Medicare UPIN, Medicare OSCAR/Certification, Medicare PIN, Medicare NSC, Medicaid)
- Provider taxonomy code and state license information

All healthcare providers who are covered entities must obtain an NPI. Obtaining an NPI can be done through the National Plan and Provider Enumeration System (NPPES) website (https://nppes.cms.hhs.gov/#/). This is applicable for individuals or organizations. An NPI doesn't: 1) ensure a provider is licensed or credentialed; 2) guarantee payment by a health plan; 3) enroll a provider in a health plan; 4) make a provider a covered provider; 5) require a provider to conduct HIPAA transactions; or 6) change or replace the current Medicare enrollment or certification process.

Council for Affordable Quality Healthcare (CAQH) is a non-profit alliance that streamlines the gathering of provider data collection, maintenance, and distribution. CAQH can be used as a single source where provider credentialing data can be stored and used to apply at multiple health plans. This saves time in completing credentialing applications and minimizes paperwork.

Advance Beneficiary Notice (ABN)

An Advance Beneficiary Notice (ABN), also called a waiver of liability, is a written notice given by a physician or provider to a Medicare patient before providing certain Part B or Part A items or services. An ABN must be issued when the office believes Medicare may not pay for an item or service, Medicare usually covers the item or service, and Medicare may not consider the item or service medically reasonable and necessary for this patient in this instance.

Medicare defines medically necessary services as those 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
- Not excluded under another provision of the Medicare Program

Hospices, Home Health Agencies (HHAs), and Durable Medical Equipment (DME) suppliers must also follow additional guidelines for ABNs. Reasons to have an ABN signed for these providers includes:

- Medicare considers the care to be custodial care
- Outpatient therapy services are in excess of the therapy cap amounts and do not qualify for a therapy cap exception
- A patient is not terminally ill (only applies to Hospice providers)
- Home health services requirements are not met (individual is not confined to the home, individual does not need intermittent skilled nursing care, etc.) for HHA providers

ABNs are not required for statutorily excluded care or for services that Medicare never covers. An ABN must be issued in the standardized notice format and can't exceed one page in length. It is to be provided only to patients enrolled in Original (Fee-For-Service) Medicare.

The ABN must be reviewed with the patient and signed by the patient before the item or service is rendered to be valid. If it is not, the patient cannot be billed for the service if Medicare does not approve it.

On the following page is Form CMS-R-131, or the ABN. It is also available in Spanish.

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

The ABN is broken down into the following items. The alpha characters are shown for guidance and should not be seen on an issued ABN.

Notifier(s) (A): this section should contain the name, address, and telephone number of the provider. If the billing entity is different from the entity that obtains the ABN, more than one entity may be entered. The beneficiary must be able to identify the entity to contact for billing inquiries.

Patient Name (B): The patient name should be entered as it appears on their Medicare card, including the middle initial.

Identification Number (C): This is an optional field that may be used to include the patient's medical record number or date of birth. The patient's Medicare Beneficiary Identifier (MBI), or Social Security Number should not be used as these must not appear on the ABN,

Body (D, E, F): Table

Blank (D): The general description of the item/service for which the ABN is being obtained.

Reason Medicare May Not Pay (E): This portion should contain the reason why it is believed that Medicare may not cover each item or service in language the beneficiary can understand. Commonly used reasons for noncoverage include:

- Medicare does not pay for this test for your condition.
- Medicare does not pay for this test this often (frequency denial). Frequency limits indicate that Medicare will only pay for a certain quantity of a specific item or service in a given time period for a particular diagnosis.
- Medicare does not pay for experimental or research use tests.

For the ABN to be valid, at least one reason must apply to each item or service listed, but the same reason may apply to multiple items or services.

Estimated Cost (F): This must be completed so the patient can make an informed decision about whether to receive potentially non-covered services. In estimating a cost, a good faith effort must be made to provide a reasonable estimate for all the items or services listed. Medicare expects the estimate to be within $100 or 25 percent of the actual costs. For example, a cost may be listed as an estimate "Between $150 $300" that comes to $250. Routinely grouped items or services may be bundled into a single-cost estimate.

Options (G): In this section, the patient or their representative must choose one, and only one, option listed. Medicare does not allow the provider to make the selection.

Option 1 – This option states that the patient wants to receive the item or service at issue and accepts financial responsibility. The beneficiary agrees to make payment at the time of service if requested. The claim must be submitted to Medicare to obtain a denial that may be appealed by the beneficiary. This option should be chosen if the patient has a secondary policy so that the claim will be sent for adjudication. If the patient pays at the time of service and Medicare or the secondary insurance pays on the claim, any amounts over the deductible and co-insurance owed must be refunded to the patient.

Option 2 – This option states that the patient wants to receive the item or service at issue and accepts financial responsibility. The beneficiary agrees to make payment at the time of service, if requested. A claim will not be filed to Medicare and the patient has no appeal rights.

Option 3 – This option states that the patient does not want to receive the item or service in question, so there is no charge to the patient, no claim is filed, and no appeal rights are afforded to the patient.

Additional Information (H): This space is used for any additional clarification or information.

Signature and Date Box (I, J): Once the patient has reviewed and understands the information on the ABN, the patient or their representative should complete the signature and date box. If a patient representative signs the ABN, they should indicate representative after the signature and print their name if it is not legible.

If the patient refuses to choose an option or sign the ABN, it should be annotated on the original ABN form and kept on file. The provider may refuse to perform the service but should take the consequences (health of the patient, safety of the patient, civil liability) in to account.

An ABN should generally be kept on file for five years from the date of service, unless state law requires a longer one. This applies even in the case of patient refusal to sign, refusal to choose an option, or refusal of services. Electronic retention is acceptable.

The following modifiers are used with claims for items or services submitted when an ABN has been signed:

GA Waiver of Liability Statement Issued as Required by Payer Policy, Individual Case: This modifier is appended when a mandatory ABN is issued as required and is on file. It is not submitted with the claim but must be presented upon request. When this modifier is appended and the service is denied, Medicare will notify the patient that they are liable for the item or service.

GX Notice of Liability Issued, Voluntary Under Payer Policy: This modifier is appended when a voluntary ABN is issued for a service Medicare never covers as it is statutorily excluded or not a Medicare benefit. This may be used with modifier GY.

GY Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit: This modifier is appended when an item or service is statutorily excluded or is not a Medicare benefit. It may be used with modifier GX. This modifier is appended when a denial from Medicare is needed to send the claim to the secondary insurance.

GZ Item or Service Expected to Be Denied as Not Reasonable and Necessary: This modifier is appended when the ABN is not obtained.

EXAMPLE

A Medicare patient presents for a binaural behind the ear hearing aid. He has a secondary insurance that he states will cover the hearing aid, even though Medicare will not. For the secondary insurance to adjudicate the claim, there must be a response form the primary insurance first, whether it was paid or denied. Code V5140 *Binaural behind the ear hearing aid* with modifier GY. This lets Medicare know that the office understands that the item is excluded, but needs the claim adjudicated to receive the denial to submit to the secondary insurance for possible payment.

Medicare as Secondary Payer (MSP)

Medicare is normally the primary payer. A primary payer is one that has the primary responsibility for paying a claim. Sometimes Medicare is the secondary payer and the claims should be submitted to the primary insurance first, then to Medicare. Common situations in which Medicare is a secondary payer are:

- Working aged covered by a group health plan through current employment or spouse's current employment
- An individual aged 65 or older who is covered under a group health insurance plan through their current employer or their spouse's current employer and the employer has 20 or more employees. The group health plan is primary, and Medicare is secondary.
- An individual aged 65 or older who is self-employed and covered by a group health plan through their current employment or their spouse's current employment, and the employer has 20 or more employees. The group health plan is primary and Medicare is secondary.

Is disabled and covered by a group health plan

- An individual who is disabled and covered by a group health plan through their current employment, or a family member's current employment, and the employer has 100 or more employees. The group health plan is primary, and Medicare is secondary.

Has end-stage renal disease (ESRD) and a group health plan

- An individual has ESRD and is covered by a group health plan and is in the first 30 months of eligibility or entitlement to Medicare. The group health plan is primary, and Medicare is secondary. This is applicable for the 30-month coordination period for ESRD.
- An individual has ESRD and is covered by a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA plan) and is in the first 30 months of eligibility or entitlement to Medicare. COBRA pays as the primary and Medicare is secondary. This is applicable for the 30-month coordination period for ESRD.

Was in an accident or occurrence in which no-fault or liability insurance is involved

- If an individual is entitled to Medicare and was in an accident or other situation where no-fault or liability insurance is involved, the no-fault or liability insurance is primary for accident or other situation related healthcare services and Medicare is secondary.

Workers' Compensation Insurance

- If an individual is entitled to Medicare and is covered under Workers' Compensation because of a job-related illness or injury, Workers' Compensation is the primary for healthcare items or services related to job-related illness or injury claims.

In cases of no-fault, liability, and workers' compensation claims, Medicare may make a conditional payment if it appears that the other carriers will not pay promptly (litigation, etc.). A conditional payment is when Medicare pays for the services for which another payer may be responsible, so the patient will not have to pay for the services personally. Medicare is repaid when a settlement, judgment, award, or other payment is made.

Federal law takes precedence over state laws and private contracts, so MSP provisions apply when billing for services. The Medicare Secondary Payer Manual contains an MSP Questionnaire for providers to use to determine when Medicare is the secondary payer to another insurance carrier.

EXAMPLE

A Medicare patient presents to the office for follow-up after being in an auto accident. She has a claim number from the auto insurance. The biller calls and verifies that the auto insurance is responsible. The claim for services should be submitted to the auto insurance first. Medicare is the secondary payer for this case.

Medicare Claims Filing Requirements

Any Medicare participating provider must file claims and accept assignment. Accepting assignment means the provider agrees to take the Medicare approved fee schedule amount as payment in full for the services rendered. The Patient Protection and Affordable Care Act (ACA) amended the period for filing Medicare fee-for service claims. Claims must be filed within one calendar year, 12 months, after the date of service. CMS offers four exceptions to the 12-month claim filing period:

- Administrative error: Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider, or supplier received notice that an error or misrepresentation was corrected.
- Retroactive Medicare entitlement: Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider, or supplier received notice of Medicare entitlement retroactive to or before the date of the furnished service.
- Retroactive Medicare entitlement involving state Medicaid agencies: Medicare will extend the timely filing limit through the last day of the sixth month following the month in which a state Medicaid agency recovered payment from a provider or supplier.
- Retroactive Disenrollment from a Medicare Advantage (MA) Plan or Program of All-inclusive Care of the Elderly (PACE) Provider Organization: Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the MA plan or PACE provider organization recovered its payment from a provider or supplier.

Medicare-Medicaid crossover claims follow Medicare timely filing requirements.

EXAMPLE

At the time, a service was furnished the beneficiary was only entitled to Medicaid benefits. Subsequently, the beneficiary receives notice of Medicare entitlement effective retroactive to before the date of the furnished service, which was 14 months prior. The state Medicaid agency recoups its money from the office and the office cannot submit a claim to Medicare because the timely filing limit has expired. Medicare allows for an exception due to the retroactive Medicare entitlement involving a state Medicaid agency exception.

Medicare Claims Completion Guidelines

The Administration Simplification Compliance Act (ASCA) requires that Medicare claims be submitted electronically unless providers meet certain exceptions. Claims for Medicare Part B services are submitted on a CMS-1500 form using the specific code sets adopted by HIPAA. This includes HCPCS Level II codes, CPT® codes, ICD-10-CM codes, and National Drug Codes (NDC). Codes must be valid for the date of service billed. Modifiers may be appended when appropriate. All ICD-10-CM coding guidelines should be followed. CMS publishes guidelines for appropriate completion of the CMS-1500 form in the Medicare Claims Processing Manual in chapter 26.

The exceptions that allow a provider to submit claims on paper include:

- Small provider claims: This refers to providers that have fewer than 25 full-time equivalent employees and are required to bill a Medicare intermediary are classified as small, or Providers with fewer than ten full-time equivalent employees and are required to bill a Medicare Administrative Contractor or Durable Medical Equipment are classified as small.
- Roster billing of inoculations covered by Medicare. The exception is a provider that agreed to submit to Medicare electronically as a condition for submission of flu shots administered in multiple states to a single MAC
- Dental claims
- Claims submitted by the Medicare beneficiary
- Claims for services provided outside the United States by non-U.S. providers

A full listing of all exceptions can be found at https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCA-SelfAssessment.html.

CMS has a standard enrollment form that must be completed before submitting any electronic claims or other EDI transactions to Medicare. The form may be submitted by the provider, billing service, or clearinghouse. The form is submitted to the

local MAC or DME MAC, depending on the type of services provided. The provider agrees to certain provisions for submitting Medicare claims electronically to MACs, including:

- That the provider will be responsible for all Medicare claims submitted to a designated CMS contractor by itself, its employees, or its agents
- That it will submit claims only on behalf of those Medicare beneficiaries who have given their written authorization to do so, and to certify the required beneficiary signature or legally authorized signatures, on behalf of the beneficiary is on file
- That it will ensure every electronic entry can be readily associated and identified with an original source document (routing slip, superbill, encounter form, charge slip, etc.). Each source document must reflect the following information:
  - Beneficiary's name
  - Beneficiary's health insurance claim number or Medicare Beneficiary Identifier (MBI) number
  - Date(s) of service
  - Diagnosis/nature of illness
  - Procedure/service performed
- That it will retain all original source documentation and medical records pertaining to any such Medicare claim for a period of at least six years, three months after the bill is paid.
- That it will submit claims that are accurate, complete, and truthful
- That it will affix the CMS-assigned NPI number of the provider on each claim submitted
- That it will research and correct claim discrepancies

Common Medicare Denials

Common denials from Medicare include:

- Patient cannot be identified as a Medicare patient – the beneficiary's name must be identical to the way it is listed on the Medicare card. For example, if the card states the patient's name is Cassandra Post, entering Cassie instead of Cassandra can result in a denied claim. The Medicare Beneficiary Identifier (MBI) must also be correct. Beginning January 1, 2020, you can no longer submit claims with the Health Insurance Claim Number (HICN). Remember, MBIs do not contain the letters S, L, O, I, B, and Z. Using an HICN after January 1, 2020, transposing characters, or using an incorrect letter will result in a denial.
- The Medicare card for railroad retirees will have a Railroad Medicare logo. These claims should be sent to Palmetto GBA, Railroad Medicare Services.
- Item 32 requires you to indicate the place where the service was rendered – the name and address where the services were rendered is entered in item 32, unless the services are provided in the patient's home. The complete address includes a nine-digit ZIP code.
- E/M codes and POS codes do not match—the E/M code category must match the place of service code. For example, an emergency department visit reported with place of service 11 which is for an office visit would be denied. The emergency department visit requires a place of service 23 which is for an emergency room at a hospital.
- Diagnosis codes are invalid or truncated – Diagnosis codes are typically updated each year. In addition, diagnosis codes must be coded to the highest level of specificity. If a code requires seven characters, all seven characters should be listed for the code to be valid. For example, a traumatic displaced fracture of the head of the left radius, initial visit, would require seven characters (S52.122A). Only reporting S52.122 would be considered a truncated code.
- Procedure code or modifier is invalid on the date of service, claims are being submitted with deleted procedure codes – CPT® and HCPCS Level II codes are updated annually. The codes reported must be a valid code for the date of service reported. For example, CPT® code 11100 reported for date of service 05/15/2019 would be incorrect. 11100 is a deleted code.

Medicare Appeals Process

Medicare allows for minor errors and omissions to be corrected on a claim without pursuing the formal appeals process. When a claim is incomplete (missing information required for processing) or invalid (incorrect information, such as an invalid HICN or MBI), the claim is returned as unable to process or returned to the provider (RTP). When this occurs, the MAC is required to return notice to the provider containing the explanation of the error(s). This can be done through a remittance notice remark or reason. In this case, the additional information can be added or the invalid information can be corrected in writing, online, or via telephone when the claim was suspended. The provider also has an option to submit a corrected claim or an entirely new claim if the claim information was not kept in the CMS system.

If a claim has already been processed, a provider can request a reopening of the claim to correct clerical errors such as:

- mathematical mistakes;
- transposed procedure or diagnostic codes;
- an error in data entry;
- misapplication of a fee schedule;
- computer errors;

- denial of claims as duplicates when the claim is not a duplicate; or
- incorrect data items, such as a provider number, use of a modifier, or date of service.

Reopening a claim can be performed by telephone. When calling for a reopening, the biller must have the provider's name and identification number, the beneficiary's last name, first initial, and Medicare HICN or MBI.

Another option for healthcare professionals who are participating providers is to appeal Medicare (Parts A and B) denials. Under original Medicare there are five levels of the claims appeal process. All requests for appeals must be in writing.

Level 1—Redetermination

The first level of appeal after initial determination on a claim is the redetermination. A redetermination is an examination of the claim by Medicare Administrative Contractor (MAC) personnel. The personnel who reviews the redetermination is different from the personnel who made the initial claim determination.

A redetermination request must be filed within 120 days from the date of receipt of the Remittance Advice, which lists the initial determination. There is no minimum monetary threshold required to request a redetermination.

The request for redetermination must be a written request or filed on form CMS-20027. The instructions are provided on the remittance advice and the contractor-specific instructions can be found on the CMS website by looking up the contractor's information at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html.

The following elements listed below are required for the redetermination:

- Beneficiary's name
- Medicare Health Insurance Claim (HIC) number or Medicare Beneficiary's Identifier (MBI)
- Specific service(s) 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

In addition to the above information on the written request, the supporting documentation should also be attached. Generally, the decision on the issue will be sent within 60 days of receipt of the redetermination request. You will receive notice of the decision via a Medicare Redetermination Notice (MRN) from your MAC, or if the initial decision is reversed and the claim is paid in full, you will receive a revised RA.

Level 2—Reconsideration

If dissatisfied with the redetermination decision a reconsideration by a Qualified Independent Contractor (QIC) can be requested.

The request for reconsideration must be filed with a QIC within 180 days of receipt of the redetermination. This request must be submitted on the standard CMS-20033, which is sent with the Medicare Redetermination Notice (MRN) or with a written request including the following information:

- Beneficiary's name
- Beneficiary's Medicare health insurance claim (HIC) number or Medicare Beneficiary's Identifier (MBI)
- Specific service(s) and item(s) for which the reconsideration is requested, and the specific date(s) of service
- Name and signature of the party or representative of the party
- Name of the contractor that made the redetermination

The request should clearly explain why the disagreement with the redetermination and include any and all documentation that supports the service. A copy of the MRN also needs to be included. The reconsideration may include a review of medical necessity issues by a panel of physicians or other healthcare professionals. Generally, the decision will be sent within 60 days of receipt of the reconsideration.

Level 3—Administrative Law Judge

If the reconsideration is not fully favorable the next step is to request a hearing with the Administrative Law Judge (ALJ) within 60 days of receipt of the reconsideration decision. To request a hearing, the amount remaining in controversy must meet the threshold requirement, which is recalculated each year.

The reconsideration letter includes the details regarding the procedure for requesting an Administrative Law Judge (ALJ) hearing. Request for an ALJ Hearing or Review of Dismissal – OMHA-100 (Office of Medicare Hearings and Appeals) may be used to file a request. You must send a copy of the ALJ hearing request to all other parties to the QIC reconsideration. The ALJ sets hearing preparation procedures.

The ALJ hearings are generally held by video-teleconference or by telephone; however, you may ask for an in-person hearing. The ALJ decision will generally be issued within 90 days of receipt of the hearing request.

Level 4—Appeals Council

When dissatisfied with the ALJ's decision, a request for review by the Medicare Appeals Council is the next level. There are no requirements regarding the amount of money in controversy.

The request must be submitted in writing within 60 days of receipt of the ALJs decision and must specify the issues and findings that are being contested. You must send a copy of the Appeals Council review request to all the parties included in the ALJ's decision. The Appeal Form DAB-101 should be submitted. Generally, the decision will be issued within 90 days of receipt of a request for review.

Level 5—Judicial Review

The final level of appeal for Medicare is to request a Judicial Review in federal District Court. The threshold for review in federal district court is calculated each year. A request must be made within 60 days of receipt of the Medicare Appeals Council's decision.

CMS provides the following tips for filing an appeal:

1. Starting at Level 1, consolidate into one appeal as many similar claims as possible;
2. File timely requests with the appropriate contractor;
3. Include a copy of the decision letter(s) issued at the previous level;
4. Include a copy of the demand letter(s) if appealing an overpayment determination;
5. Include a copy of the Appointment of Representative (AOR) form if representing a provider/supplier/beneficiary;
6. Respond promptly to the contractor requests for documentation; and
7. Sign your request for appeal.

Section Review 11.1

1. A Medicare patient is seen by her physician. The physician has opted out of the Medicare program. The patient and physician have a private contract. The charges for the services rendered are $300.00. Medicare's approved amount would be $200.00. What can the office charge this patient?

   A. $160.00 (80 percent of the approved amount)
   B. $218.50 (115 percent of the approved amount for non-Par providers)
   C. $300.00
   D. $250.00

2. A Medicare patient has prescription drug coverage but does not have Medicare Advantage. What Medicare coverage does the patient have for his medications?

   A. Part A
   B. Part B
   C. Part C
   D. Part D

3. A Medicare patient presents for her pelvic, Pap, and breast examination (PPB). The patient is not sure when she had her last PPB. As she is checking out, the front desk rep has her sign an ABN. The service is billed and denied for frequency. Can the patient be balance billed? Why or why not?

   A. Yes. It does not matter when you get an ABN signed.
   B. No. The ABN must be signed before the service is performed.
   C. Yes, as long as the patient has met her deductible.
   D. No. An ABN is not required, but the patient is required to pay at time of service or the bill has to be written off.

4. A Medicare patient presents with an injury sustained at his part-time job. His injury status is verified by his company. After services are rendered, in what order are the claims submitted?

   A. The workers' compensation is primary, and Medicare is secondary.
   B. Either may be filed first, whichever pays better.
   C. Medicare is primary, and workers' compensation is secondary.
   D. The patient must pay for services and file claims himself.

5. A Medicare patient receives services from a participating provider on January 6, 2018, but the charges are missed and were not entered into the computer. How long does the office have to bill Medicare for the services?

   A. 3 months
   B. 12 months
   C. 6 months
   D. 1 month

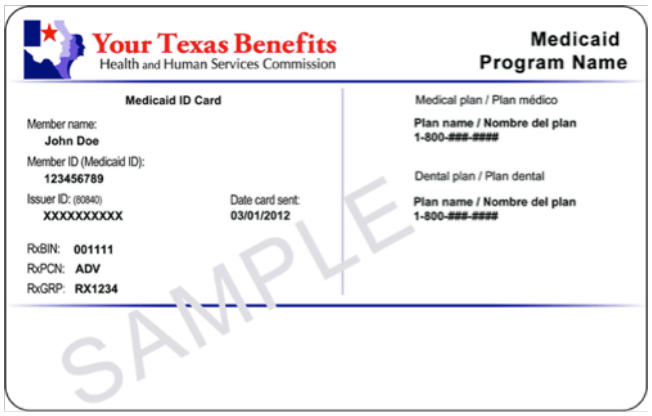
Medicaid

Medicaid is a health insurance program for low-income individuals and families that cannot afford healthcare costs. There are different types of Medicaid coverage available for individuals with different needs. Primary oversight is performed federally, but each state establishes its own eligibility standards, determines the type and scope of services, sets the rate of payment for services, and administers its own Medicaid program.

Medicaid cards will look different, depending on the state in which the patient lives. They will contain varying information. Below are a couple of examples from different states.

This card is an example of enrollees in the Family Planning Program through Maryland Medicaid.

Source: https://mmcp.health.maryland.gov/medicaidmarge/Issues%20by%20Number/issue_111.pdf



This card is an example for a Texas Medicaid enrollee. More information on the Texas Medicaid Card can be found at https://hhs.texas.gov/sites/default/files/documents/services/quick-answers/Sample-Card-Image.pdf.

This is an example of a Florida Medicaid Identification Card. More information on using Florida Medicaid can

be found at https://ahca.myflorida.com/medicaid/pdffiles/Publications/USING_FLORIDA_MEDICAID_FOR_YOUR_HEALTH_CARE_BROCHURE-112016.pdf.

Medicaid Eligibility

Medicaid and the Children's Health Insurance Program (CHIP) cover about 72.5 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities, according to the Medicaid.gov website. The minimum eligibility level is based on the federal poverty level (FPL). The annual FPL can be found at https://www.medicaid.gov. A person may be eligible for Medicaid if:

- A U.S. citizen or provide proof of eligible immigration status, unless applying for emergency services;
- A Social Security number or have applied for one; or
- Meets the requirements for the Temporary Assistance for Needy Families (TANF) program; or
- Children under the age of 6 whose family incomes are at or below 133 percent of the federal poverty level (FPL); or
- Pregnant women with family income at or below 133 percent of the FPL; or
- Receive Supplemental Security Income (SSI); or
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act; or
- Fall under a special protected group such as those who lose cash assistance due to earnings from work or from increased Social Security benefits; or
- Children born after September 30, 1983, are under 19, and in families with incomes at or below the FPL.

States may choose to provide Medicaid coverage to other groups that share some characteristics with those above, but are more broadly defined, like the aged, blind, or disabled adults with incomes below the FPL, or low-income institutionalized individuals.

CMS provides a List of Medicaid Eligibility Groups, which include a list of:

- Mandatory categorically needy (for example, low income families)
- Optional categorically needy (for example, independent foster care adolescents)
- Medically needy (for example, medically needy pregnant woman)

The ACA established federal regulations for modernized, data driven approach to verify financial and non-financial information needed to determine Medicaid, CHIP, and marketplace eligibility in 2014. States now rely on electronic data sources to confirm information included on the application, promote program integrity, and minimize the amount of paper documentation that people need to provide.

Medicaid eligibility should be verified at every visit as it can change from month to month. Infants born to pregnant women who are receiving Medicaid at the time of delivery are automatically eligible for Medicaid until their first birthday.

Because eligibility is on a month to month basis, some Medicaid state agencies require that the provider check eligibility each time the patient is seen. The provider manual for the state agency will direct the provider as seen in the NCMMIS Provider Claims and Billing Assistance Guide.

EXAMPLE

NCCMMIS Provider Claims and Billing Assistance Guide

Chapter 10

10.1 Verifying Eligibility

A beneficiary's eligibility status may change from month to month if financial and household circumstances change. For this reason, **providers are required to verify a Medicaid beneficiary's eligibility each time a service is rendered**. Providers may verify a beneficiary's eligibility in various methods outlined in the subsection below, **Verification Methods**.

Medicaid Benefits

Much like eligibility standards, there are federal regulations stipulating mandated benefits for Medicaid. State Medicaid agencies can choose to provide other optional benefits through the state Medicaid program. Medicaid programs must provide the mandatory benefits to eligible individuals to receive

matching federal funds known as Federal Medical Assistance Percentage (FMAP). CMS provides this table:

Mandatory Benefits

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing Facility Services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

Optional Benefits

- Prescription Drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive and rehabilitative services
- Podiatry services
- Optometry services
- Dental Services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Private duty nursing services
- Personal Care
- Hospice
- Case management
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
- Services in an intermediate care facility for the mentally retarded
- State Plan Home and Community Based Services- 1915(i)
- Self-Directed Personal Assistance Services- 1915(j)
- Community First Choice Option- 1915(k)
- TB Related Services
- Inpatient psychiatric services for individuals under age 21
- Other services approved by the Secretary
- Health Homes for enrollees with chronic conditions – Section 1945

Source: https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The EPSDT benefit provides comprehensive and preventive healthcare services for enrolled children under the age of 21. The program provides for:

Early—Assessing and identifying problems early

Periodic—Checking children's health at periodic, age-appropriate intervals

Screening—Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems

Diagnostic—Performing diagnostic tests to follow up when a risk is identified

Treatment—Control, correct, or reduce health problems found

State Medicaid agencies must inform all Medicaid-eligible individuals under the age of 21 that EPSDT services are available, provide or arrange for the provision of screening services for all children, arrange for corrective treatment as determined by health screenings, and report EPSDT performance information annually. EPSDT is made up of the following services:

Screening Services:

- Comprehensive health and developmental history
- Comprehensive unclothed physical examination
- Appropriate immunizations according to the Advisory Committee on Immunization Practices
- Laboratory tests, including lead toxicity screening
- Health education with anticipatory guidance including child development, health lifestyles, and accident and disease prevention

Vision Services:

- At a minimum, diagnosis and treatment for defects in vision, including eyeglasses. These services must be provided according to a periodicity schedule developed by the state and at other intervals as medically necessary.

Dental Services:

- At a minimum, dental services must include relief of pain and infections, restoration of teeth, and maintenance of dental health that meet dental standards. Each state must develop a dental periodicity schedule in consultation with recognized dental organizations involved in child health.

Hearing Services

- At a minimum, hearing services must include diagnosis and treatment for defects in hearing, including hearing aids.

Other necessary healthcare services:

- Each state is required to provide any additional healthcare service covered under the federal Medicaid program and found to be medically necessary to treat, correct, or reduce illnesses and conditions discovered regardless of whether the service is covered in a state's Medicaid plan. The state is to determine medical necessity on a case-by-case basis.

Diagnostic services:

- If a screening exam indicates the need for further evaluation of an individual's health, diagnostic services must be provided. Necessary referrals should be made without delay and there should be follow-up to ensure the enrollee receives a complete diagnostic evaluation. Each state should develop quality assurance procedures to assure that comprehensive care is provided to Medicaid recipients.

Treatment:

- Necessary healthcare services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

Periodicity schedules for periodic screening, vision, and hearing services must be provided at intervals that meet reasonable standards of medical practice. States must consult with recognized medical organizations involved in child healthcare in developing their schedules. States may instead use a nationally recognized pediatric periodicity schedule. A separate dental periodicity schedule is also required from each state.

Prior Authorization

Medicaid has a formulary for their drugs as other health plans do. If a provider wants to prescribe a drug that is not on the formulary or listed as a drug that needs to be monitored, they must receive prior authorization. The Clinical Prior Authorization Program was implemented to manage drug classes that require additional monitoring, ensuring drugs are being prescribed for the right patients and the appropriate reasons, and monitor drug expenditures.

The following page is an example of a prior authorization form for anti-obesity medications from New Hampshire Medicaid.

Reset Form

New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form
Anti-Obesity Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female

Drug Name **Strength**

Dosing Directions **Length of Therapy**

SECTION II: PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – – –

SECTION III: CLINICAL HISTORY

1. **Patient's Diagnosis:**
2. **Has the patient failed to lose weight on a low calorie diet (1,200 kcal/day women, 1,600 kcal/day men) AND exercise regimen after at least a 3-month trial?** ☐ Yes ☐ No
   Please explain:
3. **Does the patient have BMI ≥ 30 kg/m^2 with no risk factors, or > 27 kg/m^2 with at least one (1) high risk factor, or two (2) other risk factors?** ☐ Yes ☐ No
4. **Patient's BMI:** **Weight:** **Height:** **Date:**
5. **Waist Circumference:**
6. **Does the patient have any of the following high risk factors?** ☐ Sleep apnea ☐ Type 2 diabetes ☐ Coronary heart disease ☐ Atherosclerotic disease
7. **Does the patient have any of the following risk factors?**
   ☐ Hypertension ☐ Dyslipidemia ☐ Cigarette smoking ☐ Osteoarthritis
   ☐ Gallstones ☐ Stress incontinence ☐ Gynecologic abnormalities ☐ Age (men > 45 years, women > 55 years or postmenopausal)
   ☐ Family history of premature heart disease ☐ Impaired fasting glucose concentration
8. **Are there any contraindications to the use of this drug for this patient?** ☐ Yes ☐ No
   If yes, please explain:
9. **Is there any additional information that would help in the decision-making process? If more space is needed, please use another page.**

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Phone: 1-866-675-7755
Fax: 1-888-603-7696

Revision Date: 08/01/2016

Magellan Rx MANAGEMENT℠

State Medicaid agencies may also require authorizations for certain medical procedures. Whether the procedure requires a prior authorization is often stated in the medical policy for that procedure.

EXAMPLE

Excerpt from NC Division of Medical Assistance's medical policy for surgery performed for Blepharoplasty/Blepharoptosis

NC Division of Medical Assistance

Medicaid and Health Choice

Coverage Policy No: 1A-9—Blepharoplasty/Blepharoptosis (Eyelid Repair)

Revised Date: October 1, 2015

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid and NCHC shall require prior approval for blepharoplasty and blepharoptosis eyelid repair. The provider shall obtain prior approval before rendering blepharoplasty and blepharoptosis eyelid repair.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; AND

b. all health records and any other records that support the beneficiary has met the specific criteria in Subsection 3.2.1 of this policy; AND

c. medical documentation that the eyelid ptosis obstructs vision including visual field examination results, unless the beneficiary is unable to test; OR has exposure keratitis of the lower eyelid; OR

d. medical documentation that the beneficiary has exposure keratitis of the lower eyelid; OR

e. medical documentation to substantiate medical necessity for surgery including the following:

1. beneficiary complaints of interference with vision or visual fields, difficulty reading due to eyelid drooping, looking through eyelashes, or seeing upper eyelid skin;

2. relevant medical history;

3. physical examination findings; and

4. results of pertinent diagnostic tests or procedures; OR

5.2.2 Specific

None Apply

5.3 Additional Limitations or Requirements

None Apply

Source: https://files.nc.gov/ncdma/documents/files/1a9.pdf

A medical biller is required to be able to locate and apply medical policies for prior authorization.

Medicaid Claims Filing Requirements

Medicaid cannot make payments to recipients, so the provider that performed the service is required to file a claim and agree to accept assignment (accept the allowed amount as payment in full). Some states require providers to submit claims electronically, unless a claim requires attachments, while others allow providers to choose how they wish to submit. Timely filing requirements will also vary from state to state. For example, Texas has a 95-day filing limit, Rhode Island and North Carolina have a 365-day filing limit, and Illinois has a 180-day filing limit. Be aware of the filing limits for their individual states.

Medicaid is always considered the payer of last resort. This means that if the patient has any other insurance coverage, Medicaid will be secondary to that coverage. Medicaid will require the explanation of benefits or the electronic equivalent to be filed with the claim.

Medicaid Claims Completion Guidelines

Claims for Medicaid professional services are submitted on a CMS-1500 form using the specific code sets adopted by HIPAA. This includes HCPCS Level II codes, CPT® codes, ICD-10-CM codes, and National Drug Codes (NDC). Codes must be valid for the date of service billed. Modifiers may be appended when appropriate. All ICD-10-CM coding guidelines should be followed. Each state publishes guidelines for appropriate completion of the CMS-1500 form, including general and specific requirements for clean claim completion and submission.

To be successful in billing Medicaid state agencies, there are some general rules you can follow:

1. Verify eligibility of the patient at each visit, including whether they have a copay. Collection of the copay is easier when the patient is in the office.

2. If your state has different Medicaid plans, verify which plan the patient is enrolled in.

3. Adhere to prior authorization requirements. Each state should have a list of treatments or items covered by Medicaid that will require prior authorization. The prior authorization should be obtained prior to rendering the service.

Each state Medicaid plan provides updates to providers for billing regulations and guidelines regularly. Some may provide updates weekly, monthly, or quarterly. Billers must keep up to date on the billing regulations for Medicaid for their state. Once the update is published, it must be adhered to.

Common denials for Medicaid claims include:

- Recipient not eligible—it is imperative the eligibility for Medicaid is verified at each visit.
- Recipient covered by another payer—Medicaid is always the payer of last resort. When the patient is covered by any other payer, that payer must be filed prior to Medicaid.
- Frequency of service exceeded—Medicaid will sometimes put limits on the number of times a procedure or service can be performed. Refer to the provider manuals and medical policies to verify limits on procedures and services.
- Diagnosis invalid for date of service—Diagnosis codes are updated annually. Codes must be valid for the date of service they are filed for. In addition, codes must be complete and cannot be truncated.

Each state will have their appeals process listed on their website as well. Many states provide an appeal form to be completed.

Medigap

Medigap refers to a Medicare supplemental policy that is sold by private insurance companies to help cover some of the costs that original Medicare does not cover, like deductibles, copayments, and coinsurances. Some policies may offer coverage for services not covered by Medicare, like coverage if a patient is injured or becomes ill while traveling outside the United States. Medigap policies usually don't cover prescription drugs, long-term care, vision care, dental care, hearing aids, eyeglasses, or private duty nurses. Patients pay a separate premium to the Medigap insurer.

The Omnibus Budget Reconciliation Act of 1990 requires all Medigap insurance policies to conform to minimum standards including standardized benefits and consumer protection requirements. Every Medigap policy must follow federal and state laws and be clearly identified as Medicare Supplement Insurance. In most states, Medigap insurance companies may only sell standardized policies identified by the letters A through N. Each policy must offer the same basic benefits regardless of the company that sells it. Different policies are available in different states. Three states—Wisconsin, Massachusetts, and Minnesota—have different types of standardized policies.

Below is a table of the basic benefits offered by each standardized plan:

Medigap Benefits	Medigap Plans									
	A	B	C	D	F	G	K	L	M	N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50 percent	75 percent	Yes	Yes
Blood (first 3 pints)	Yes	Yes	Yes	Yes	Yes	Yes	50 percent	75 percent	Yes	Yes
Part A hospice care coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50 percent	75 percent	Yes	Yes
Skilled nursing facility care coinsurance	No	No	Yes	Yes	Yes	Yes	50 percent	75 percent	Yes	Yes
Part A deductible	No	Yes	Yes	Yes	Yes	Yes	50 percent	75 percent	50 percent	Yes
Part B deductible	No	No	Yes	No	Yes	No	No	No	No	No
Part B excess charges	No	No	No	No	Yes	Yes	No	No	No	No

Foreign travel exchange (up to plan limits)	No	No	80 percent	80 percent	80 percent	80 percent	No	No	80 percent	80 percent
Medicare Part B preventive care coinsurance	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Out-of-pocket limit	None	None	None	None	None	None	$5,560 in 2019	$2,780 in 2019	None	None

Medigap Claims Processing

Information and instructions on processing of Medigap claims can be found in the Medicare Claims Processing Manual, chapter 28—Coordination with Medigap, Medicaid, and other complimentary insurers. If the Medicare beneficiary has authorized payment to be made to the physician or provider, Medicare must transfer the Medicare claims information to the Medigap insurer. This is indicated by the signature on file notice in box 13 on the CMS-1500 form. A claim in which a beneficiary assigns their benefits under a Medigap policy to a participating physician, provider, or supplier is called a mandated Medigap transfer. The transfer of the claims information to the Medigap insurance is called cross-over.

Other information required on the CMS-1500 to process a Medigap claim include:

- Item 9a—The policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP.
- Item 9d—The Coordination of Benefits Agreement (COBA) Medigap claim-based Identifier (ID).

If the above information is not complete and accurate the claim cannot be forwarded. If a physician is a non-PAR provider, Medicare will not forward the claim and it will be the patient's responsibility.

When block 9 (items above) is completed and accurate and the physician is a participating provider, the following remittance notice will be sent on the explanation of Medicare benefits (EOMB):

> MA18—The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.

When information is missing or incorrect in block 9, MACs do not forward a transaction record to the Medigap carrier and the following remittance notice is sent on the EOMB:

> MA19—Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer.

TRICARE/CHAMPVA

TRICARE, formerly known as CHAMPUS, is the Department of Defense (DOD) healthcare program for military families and retirees. The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is the healthcare program in which the Department of Veterans Affairs covers spouses, widows and widowers, and the children of a veteran who is rated permanently and totally disabled due to a service-connected disability, died of a service-connected disability, or died on active service and the dependents are not eligible for TRICARE. In specific instances, veterans may themselves qualify for CHAMPVA, also.

Case management is offered for patients with chronic, high-risk, high-cost catastrophic or terminal illnesses at no charge for short term or long-term care needs. The DOD defines case management as a collaborative process under the population health continuum, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes. Case managers are usually nurses or social workers who help patients and their families with individual care plans. The case managers support and coordinate care between interdisciplinary health teams in multiple care settings. They ensure ongoing care remains as consistent as possible for TRICARE beneficiaries.

TRICARE case managers perform many duties, including:

- Identifying and facilitating needed services and equipment in collaboration with the beneficiary's primary care managers.
- Decreasing provider's administrative tasks by assisting with referrals, authorizations, and locating specialists when needed.
- Educating beneficiaries about TRICARE benefits.
- Educating beneficiaries about their disease process.
- Promoting positive lifestyle changes that may affect the beneficiary's disease, such as diet, exercise, stress management, and the importance of keeping appointments.

- Providing a point of contact to assist both beneficiaries and primary care managers with problem solving, acting as a beneficiary advocate, and assisting in communicating with caregivers on behalf of the beneficiary

Types of Plans

TRICARE offers coverage choices for health plans: TRICARE Prime®, TRICARE SelectSM, TRICARE for Life, TRICARE Reserve Select®, TRICARE Retired Reserve®, TRICARE Young Adult, and US Family Health Plan.

To be eligible for TRICARE Prime, you need to live within a Prime Service Area, or within 100 miles of a primary care manager. All active duty service members and their families are eligible for TRICARE Prime, as well as retired service members and their families, (until Medicare eligible based on age), activated Guard/Reserve members and their families, nonactivated Guard/Reserve members and their families who qualify for care under the Transitional Assistance Management Program, retired Guard/Reserve members at age 60 and their families (until Medicare eligible based on age), survivors, Medal of Honor recipients and their families, and qualified former spouses. This is a managed care option, with the enrollees choosing a primary care manager (PCM) who coordinates patient care, maintains patient health records, and refers patients to specialists, when necessary. With TRICARE Prime, there is no annual deductible and no annual enrollment fee for active duty members and their families unless active duty families use the point-of-service option. All other beneficiaries pay annual enrollment fees and network copayments. But, TRICARE Prime allows enrollees to receive non-emergency healthcare services from any TRICARE authorized civilian provider, in or out of network without a referral from the primary care manager. All active duty members must enroll in TRICARE Prime. Additional Prime options for active duty service members include TRICARE Prime Remote, TRICARE Prime Overseas, and TRICARE Prime Remote Overseas.

TRICARE Select is a fee-for-service option that allows the enrollees the most choices. This is an option for active duty family members, retired service members and their families, family members of activated Guard/Reserve members, non-activated guard/reserve members and their families who qualify for care under the Transitional Assistance Management Program, retired Guard/Reserve members at age 60 and their families, Survivors, Medal of Honor recipients and their families, and qualified former spouses. Enrollees may see any TRICARE-authorized provider. These providers are not required to participate in the TRICARE network, but they must be certified as an authorized provider by the managed care support contractor (MCSC) in the region they are in. Non-network providers may determine whether they are participating or nonparticipating with TRICARE on a claim-by-claim basis. There is no enrollment requirement or annual fee, but there is a deductible and coinsurance for outpatient care. Enrollees are not required to have a primary care manager or request a referral to see a specialist. Active duty service members pay nothing out-of-pocket for any type of care. Active duty family members only pay for care when using a Prime plan if they get care without a referral, when they use TRICARE Select, or if they use a network pharmacy or TRICARE Home Delivery. There is no cost for services received at a Military Treatment Facility (MTF) except for a small per diem when using impatient services. Enrollees may have to file their own claims. Additional Select options include Tricare Select Overseas.

TRICARE for Life is a Medicare-wrap around coverage for TRICARE eligible beneficiaries who have Medicare Part A and B. Enrollment is automatic if the member has Medicare Part A and B, but you must pay Medicare Part B premiums. TRICARE for Life pays after Medicare in the U.S. and U.S. Territories but is the first payer in all other overseas areas. Coverage is available worldwide and the member may see any provider they want; however, cost may increase if seeing Veteran's Administration providers or providers who opt-out of Medicare, because they are not allowed to bill Medicare. At age 65, retired service members and their families become eligible for TRICARE for Life but are not able to enroll in TRICARE Prime.

TRICARE Reserve Select is a premium-based plan available worldwide. This plan is for members of the Selected Reserve and their families who are not on active duty orders, not covered under Transitional Management Program, and who are not eligible for or enrolled in the Federal employees Health Benefits (FEHB) program. Members can see any TRICARE-authorized provider but will have higher costs if seeing a non-network provider and may have to file their own claims. This option requires monthly premiums, an annual deductible, and cost share for covered services. TRICARE Retired Reserve is the same type of plan for select Retired Reserve members, their family members, and select Survivors of retired Reserve members.

TRICARE Young Adult is an option for qualified adult children that can be purchased after eligibility for regular TRICARE coverage ends at age 21 or 23 if enrolled in college. To qualify for enrollment, the young adult has to be at least age 21 but no older than 26, unmarried, and enrolled in an approved institution of higher learning. There are two options available for purchase: TRICARE Young Adult Prime and TRICARE Young Adult Select.

US Family Health Plan is a TRICARE plan option available through community-based, not-for-profit healthcare systems,

currently available is six areas for the U.S. Listed here are the six areas of the U.S.:

- John Hopkins Medical
- Martin's Point of Health Care
- Brighton Marine Health Center
- St. Vincent Catholic Medical Centers
- CHRISTUS Health
- Pacific Medical Centers (Pacmed Clinics)

US Family Health Plan enrollment is available to:

- Active duty family members
- Retired service members and their family
- Family members of Activated National Activated Guard/ Reserve members
- Survivors
- Qualified former spouses
- Medal of honor recipients and their family
- Retired National Guard Reserve members at age 60 and their families
- Non-activated National Guard/Reserve members and their families who qualify for care under the Transitional Assistance Management Program

CHAMPVA is a fee-for-service insurance. Enrollees may see any provider they choose and do not need a primary care manager. There is a deductible and coinsurance for care. To be eligible for CHAMPVA, you cannot be eligible for TRICARE, and you must be in one of these categories:

1. The spouse or child of a veteran who has been rated permanently and totally disabled for a service-connected disability by a VA regional office.
2. The surviving spouse or child of a veteran who died from a VA-rated service-connected disability.
3. The surviving spouse or child of a veteran who was at the time death rated permanently and totally disabled from a service-connected disability.
4. The surviving spouse or child of a military member who died in the line of duty, not due to misconduct (in most of these cases, these family members are eligible for TRICARE, not CHAMPVA).

CHAMPVA pays 75 percent of the allowable amount for covered outpatient services.

TRICARE members have access to Beneficiary Counseling and Assistance Coordinators (BCACs). BCACs are available to answer questions and help the member solve healthcare related problems. They also assist the member in obtaining medical care. BCACs are located at most MTFs and TRICARE regional offices.

For a member to be eligible for TRICARE, registration in the Defense Enrollment Eligibility Reporting System (DEERS) is required. Incorrect information in the DEERS database can cause problems with TRICARE claims as well as other health-care benefits, so it is critical the service member and their family maintain their DEERS information.

Providers must verify TRICARE eligibility at the time of service. Providers must ensure beneficiaries have valid Common Access Cards (CACs), uniformed services ID cards or eligibility authorization letters. Check the expiration dates on CACs and ID cards and make copies of both sides of the cards for files. Providers should use the sponsor's Social Security number (SSN) (9-digits) or DoD Benefits number (DBN) (11-digits) when verifying the card bearer's TRICARE eligibility and filing claims. New ID cards no longer include SSNs, and some may not include DBNs. The DoD ID number is a 10-digit number on the ID card and it is not used for eligibility or for filing claims.

Source: http://www.cac.mil/

All providers who see TRICARE patients must be a TRICARE-authorized provider. There are two types of TRICARE providers; network providers and non-network providers. A network provider is one who has a signed contract with the regional TRICARE Managed Care Support Contractor (MCSC). A network provider agrees to provide care to TRICARE beneficiaries at the negotiated rate, accept the negotiated rate and the copay as payment in full, and file claims with TRICARE.

Providers who choose not to sign a contract with the TRICARE MCSC who choose to see TRICARE patients must be certified by the MCSC. These providers are considered non-network providers. Non-network providers do not agree to accept the TRICARE allowable charge or file beneficiary claims. A non-network provider can choose to participate on a claim-by-claim basis.

TRICARE/CHAMPVA Claims Processing

TRICARE and CHAMPVA both have a one-year timely filing limit. There are exceptions allowed for retroactive benefit issues, when the time frame for filing goes back to your eligibility date. In those cases, once notified, 180 days are allowable on submitting a claim. Claims for TRICARE and CHAMPVA professional services are submitted on a CMS-1500 form using the specific code sets adopted by HIPAA. This includes HCPCS Level II codes, CPT® codes, ICD-10-CM codes, and National Drug Codes (NDC). Codes must be valid for the date of service billed. Modifiers may be appended when appropriate. All ICD-10-CM coding guidelines should be followed.

Common denials for TRICARE include:

1. Not eligible on DEERS—When a TRICARE member is not recognized, a denial is received stating they are not eligible on DEERS. Confirm that the military member's ID number and name are correct on the EOB. Confirm that the beneficiary or patient information is correct on the EOB. If either the sponsor information or the beneficiary/patient information is incorrect, resubmit the claim with the correct information. If the information is correct, the member will need to be contacted to update his or her information on DEERS.

2. No authorization—Certain services are required to have an authorization. When the service does not have an authorization, it is denied. If an authorization is obtained, the provider can request a claim review from the TRICARE MCSC.

3. Not medically necessary—When a claim is denied not medically necessary, and the provider believes it should be covered, the provider can request a review of the claim.

TRICARE Appeals

TRICARE allows for a review of a claim without opening an appeal. If there is a concern about how a claim is processed, the provider can request a claim review by sending a letter with the reason for requesting the claim review, a copy of the claim, the remittance advice, supporting medical records, and any new information needed for the review. Common reasons for a claim review include:

- Allowed amount disputes
- Charges denied as "Included in a paid service"
- Charges denied as "Requested information not received"
- Claim denied as "Provider not authorized"
- Claim Check denials
- Coding issues
- Cost-share and deductible issues
- Eligibility denials
- Other health insurance issues
- Penalties for no authorization
- Point-of-service disputes (Exception: Point-of-service for emergency services is appealable.)
- Third party liability issues
- Timely filing limit denials
- Wrong procedure code

Only charges denied as services not covered by TRICARE or not medically necessary can be appealed through TRICARE. Appeals can be submitted through the MCSC website, using the appeal form provided by the MCSC, or submitting a letter to the MCSC. The appeal should include:

- the patient's name, address, phone number, and sponsor's Social Security number
- printed name of the person submitting the appeal and the relationship to the patient
- the reason you are disputing the denial
- a copy of the EOB or provider remittance
- additional documents supporting the appeal

RBRVS/RVU Concepts

In 1988, CMS funded a study evaluating the resources and costs associated with delivery of physicians' services. The results led to the introduction in 1992 of the Resource-based Relative Value Scale (RBRVS), which quantifies and reimburses physicians' services relative to one another. It incorporates three components of physician services—physician work, practice expense (PE), and professional liability insurance (PLI). The physician work component comprises about 50.9 percent of the total RVU, the PE comprises about 44.8 percent of the total RVU, and the PLI comprises about 4.3 percent of the total RVU.

A relative value unit (RVU) is assigned to each of the work, PE and PLI components. The RBRVS system applies to CPT® codes, so the work RVU + PE RVU + PLI RVU = Total RVU. The total RVU is multiplied by a conversion factor (CF) to obtain the reimbursement for that code. The CF is the dollar amount by which each CPT® code's total RVU value is multiplied to obtain the reimbursement for a given service. The CF is updated annually by CMS. The 2019 CF is $36.0391.

Medicare reimbursement is determined for each CPT® code by taking the total RVUs for the service and multiplying by the conversion factor. Then, a geographic adjustment factor (GAF) also called the Geographic Practice Cost Index (GPCI) is applied for locality code differences for the components (work, practice expense, and PLI) nationally.

The formula looks like this:

[(Work RVU x Work GPCI) + (PE RVU x PE GPCI) + (PLI RVU x PLI GPCI)] = Total RVU x Conversion Factor = Medicare payment

Example of 99284 in 2019 for Arizona

Step 1. (2.56) (1.000) + (0.53) (0.971) + (0.23) (0.834) = 3.26645 (Total RVUs)

Step 2. RVUs x Conversion factor = Medicare payment

(3.26645) ($36.0391) = $117.72 Medicare payment for Arizona

There are also RVUs for the same components for when services are provided at a place of service other than the physician's office.

For billing purposes, the RBRVS also contains a lot of important information besides the RVU components. Understanding them will help with appeals to health plans.

Status Codes

A status code reflects Medicare coverage and payment policy. It can indicate if a service is payable, noncovered, bundled into another service, etc. Following are the status codes:

A = Active code (Payable under the physician fee schedule (PFS)

B = Bundled code (Payment for covered services that are always bundled into payment for other services)

C = Carrier-priced code (CMS contractor establishes RVUs and payment amounts for these services)

E = Excluded by regulation (No payment made under PFS)

I = Not valid for Medicare purposes (Medicare uses another code for the reporting of any payment for these services)

M = Measurement codes (Indicates PQRS code. No payment and no RVUs attached with these codes)

N = Non-Covered service (No Medicare payment is made for these services. RVUs may be shown, but they are not used by Medicare)

P = Bundled/Excluded codes (No separate payment is made and no RVUs attached with these codes)

Q = Therapy functional information code (Used for reporting purposes. No separate payment is made for these services)

R = Restricted coverage (Special coverage instructions apply. If no RVUs are shown, the service is carrier-priced)

T = Paid as only service (These services are only paid if there are no other services payable under the PFS billed on the same day by the same provider)

X = Statutory exclusion (These codes represent items or services that are not within the statutory definition of a physician service, so no payment may be made under the PFS)

For example, code 12051 Repair, intermediate, wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.5 cm or less carries a status of A, which means it is an active code with payment available under the PFS.

PC/TC Indicator

This indicates a service's technical and professional component breakdown. The indicators are as follows:

0 = Physician service codes

1 = Diagnostic tests or radiology services

2 = Professional component only codes

3 = Technical component only codes

4 = Global test only codes

5 = Incident-to codes

6 = Laboratory physician interpretation codes

7 = Private practice therapist's service

8 = Physician interpretation codes

9 = Not applicable

This can help in understanding if modifiers TC or 26 are applicable.

EXAMPLES

Code 71100, X-ray of ribs has an indicator of 1, indicating it is a diagnostic test or radiology service. It is listed three times in the RBRVS table as such:

71100 – 0.97 total RVU

71100 TC – 0.65 total RVU

71100 26 – 0.32 total RVU

Note: RVU values based on 2019 CMS National Payment Amount.

Each listing contains the appropriate RVU breakdown for the type of service (professional, technical, or global) that it represents.

Code 93040 *Rhythm ECG, 1–3 leads, with interpretation and report* has an indicator of 4, indicating it is a global test only code. The code incorporates the technical and professional components and should not be billed with either a TC or a 26 modifier.

Code 93041 *Rhythm ECG, 1–3 leads, tracing only without interpretation and report* has an indicator of 3, indicating it is a technical component only code. It should not be billed with a 26 and the TC is unnecessary as the code is technical by nature.

Code 93042 *Rhythm ECG, 1–3 leads, interpretation and report only* has an indicator of 2, indicating it is a professional component only code. It should never be billed with a TC and the 26 modifier is unnecessary as the code is professional by nature.

Global Surgery Indicators

This field shows how many global days, if any, are applicable to the code. The indicators are as follows:

000 = Global surgery period includes day of procedure only (Endoscopic or minor procedures on same day are included)

010 = Global surgery period includes day of and 10 days after surgery (Minor procedures with a preoperative evaluation on day of procedure and a 10-day postoperative period are included in the listed RVUs for the code)

090 = Global surgery period includes day before, day of, and 90 days after surgical procedure (Major surgery with a one-day preoperative period, day of the procedure, and a 90-day postoperative period included in the listed RVUs for the code)

MMM = The usual global surgery period does not apply; used for maternity codes (includes delivery and postpartum services)

XXX = Global surgery period concept does not apply

YYY = Global surgery period concept determined by local Medicare carrier

ZZZ = Code falls within global surgery period for another service (Service always included in the global period of the other service)

The global surgery days' field allows the biller to understand information regarding the billing of E/M visits, such as when a related E/M is billable, or when modifier 24, unrelated E/M service during the postop period should be appended so an unrelated visit is not denied.

The three fields following the global surgery days' field breakdown the percentage of payment for the preoperative, postoperative, and intraoperative portions of the surgery. For example, CPT® code 21050 *Condylectomy, temporomandibular joint* has 90 global days in the RBRVS table. The breakdown for payment is shown as 10 percent for the preoperative work, 69 percent for the intraoperative work, and 21 percent for the postoperative work.

The next fields on the table indicate whether certain modifiers may be used and what type of payment will be made.

- Multiple procedure—indicates the applicable payment adjustment rule for multiple procedures. The indicators are:

  0 = No payment adjustment rules for multiple procedures apply.

  1 = Standard payment adjustment rules in effect before January 1, 1996 for multiple procedures apply (100 percent for the first procedure, 50 percent for the second, 25 percent for the third and any additional procedures).

  2 = Standard payment adjustment rules for multiple procedures apply (100 percent for the first, 50 percent for all additional procedures).

  3 = Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (another code with the same base endoscopic procedure code).

  4 = Special rules for the technical component of diagnostic imaging procedures apply if procedure is billed with another diagnostic imaging procedure in the same family 100 percent for first procedure, 50 percent for each additional procedure).

  5 = Subject to 20 percent of the practice expense component for certain therapy services (25 percent reduction if an institutional setting).

  6 = Special rules for the technical component of multiple diagnostic cardiovascular services. Full payment for the service with the highest payment under the MPFS. Payment of 75 percent% for subsequent services by the same physician, or physicians of the same group, to the same patient on the same day.

  7 = Special rules for the technical component of multiple ophthalmology services. Full payment for the service with the highest payment under the MPFS. Payment of 80 percent% for subsequent services by the same physician, or physicians of the same group, to the same patient on the same day.

  9 = Concept does not apply.

- Bilateral surgery—indicates services subject to payment adjustment for bilateral procedures. The indicators are:
  - 0 = 150 percent payment adjustment for bilateral procedures **does not apply**. The bilateral adjustment is inappropriate for these codes because of physiology or anatomy or because the code description specifically states the procedure is unilateral and there is an existing code for a bilateral procedure.
  - 1 = 150 percent payment adjustment for bilateral procedures applies. Payment is based on 150 percent of the fee schedule amount of the single code.
  - 2 = 150 percent payment adjustment for bilateral procedures **does not apply**. RVUs are already based on the procedure being performed as a bilateral procedure because the code descriptor specifically states that the procedure is bilateral, the code descriptor states that the procedure may be performed whether unilaterally or bilaterally, or the procedure is usually performed as a bilateral procedure.
  - 3 = The usual payment adjustment for bilateral procedures does not apply. Payment is based on 100 percent of the fee schedule amount for **each** side. This is generally radiology procedures or diagnostic tests which are not subject to the special payment rules for other bilateral surgeries.
  - 9 = Concept does not apply.
- Assistant at Surgery—indicates services where an assistant at surgery is never paid for per the Medicare Claims Manual. The indicators are:
  - 0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.
  - 1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant surgery may not be paid.
  - 2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.
  - 9 = Concept does not apply.
- Co-surgeons—indicates services for which two surgeons, each in a different specialty, may be paid. The indicators are:
  - 0 = Co-surgeons not permitted for this procedure.
  - 1 = Co-surgeons could be paid, but supporting documentation is required to establish the medical necessity of two surgeons for the procedure.
  - 2 = Co-surgeons permitted, and no documentation required if the two-specialty requirement is met.
  - 9 = Concept does not apply.
- Team Surgery—indicates services for which team surgeons may be paid. The indicators are:
  - 0 = Team surgeons not permitted for this procedure.
  - 1 = Teams surgeons could be paid, but supporting documentation is required to establish medical necessity of a team. These are paid by report.
  - 2 = Team surgeons permitted. These are paid by report.
  - 9 = Concept does not apply.

The last field in the global surgery indicators is the Endoscopic Base Code field. It identifies the endoscopic base code for any code with a multiple surgery indicator of 3.

EXAMPLE

Colonoscopy codes 45379–45393, 45398 are listed in the table with the endoscopic base code of 45378. If any code from 45379–45392 is billed alone with 45378, no payment for the base code (45378) is made. If two or more codes from the same family are billed, the first code is paid in full. The fee schedule amount for the base code (45378) is subtracted from all additional endoscopic procedures, then the difference is paid.

Consider the following fee schedule:

Code 45378, Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure) - $330.84

Code 45382, Colonoscopy, flexible; with control of bleeding, any method - $729.07

Code 45385, Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique - $446.16

If codes 45382 and 45385 are both billed together, payment will be made as such:

45382 - $729.07

45385 - $115.32 ($446.16 - $330.84)

$844.39

Understanding the ins and outs of the RBRVS table and the Medicare Physician Fee Schedule (MPFS) database can assist a biller with appeals and understanding when proper payment has or has not been made.

Section Review 11.2

1. A patient has Medicare and a Medigap policy. Box 13, signature on file, is checked off on the electronic claim submission. An EOMB is received with remittance notice MA19. What does the office need to do?

   A. Nothing. This means the claim has been crossed over to the Medigap plan.

   B. The biller must file the secondary insurance as the cross-over claim is not going to be sent due to missing information.

   C. The biller must check the claim filed for missing information, add the missing information, and send back to Medicare for processing.

   D. Nothing. The notice means that the patient is responsible for the bill.

2. Which coverage under TRICARE is a Medicare wrap around plan?

   A. TRICARE for Life

   B. TRICARE Reserve Select

   C. TRICARE Prime

   D. CHAMPVA

3. A 21-year-old patient presents for fillings for two of his teeth. Are these services covered under EPSDT?

   A. No, because these types of services are not covered.

   B. Yes, if the patient lives in a state that covers dental services.

   C. No, because the patient is not under the age of 21.

   D. Yes, all services are covered under Medicaid.

4. Look at the portion of the fee schedule below.

CODE	DESCRIPTION	STATUS CODE	GLOB DAYS	PRE OP	INTRA OP	POST OP	MULT PROC	BILAT SURG	ASST SURG	CO-SURG	TEAM SURG
12020	Closure of split wound	A	10	0.1	0.8	0.1	2	0	1	0	0
12021	Closure of split wound, with packing	A	10	0.1	0.8	0.1	2	0	1	0	0
12031	Intmd rpr s/a/t/ ext 2.5 cm/<	A	10	0.1	0.8	0.1	2	0	1	0	0
12032	Intmd rpr s/a/t/ ext 2.6-7.5	A	10	0.1	0.8	0.1	2	0	1	0	0
12034	Intmd rpr s/a/t/ ext 7.6-12.5	A	10	0.1	0.8	0.1	2	0	1	0	0
12035	Intmd rpr s/a/t/ ext 12.6-20	A	10	0.1	0.8	0.1	2	0	1	0	0
12036	Intmd rpr s/a/t/ ext 20.1-30	A	10	0.1	0.8	0.1	2	0	1	0	0
12037	Intmd rpr s/a/t/ ext >30.0 cm	A	10	0.1	0.8	0.1	2	0	0	1	0

Using the portion of the schedule above, what is true about the codes?

A. Code 12032 has restricted coverage.

B. Code 12035 may be billed with modifier 50.

C. Code 12034 may not be billed with modifier 62.

D. Code 12037 can never be billed as a co-surgery under any circumstances.

5. What is true regarding Medigap policies?

A. They cover everything that Medicare does not.

B. They cover deductibles, copayments, and coinsurances usually.

C. All Medigap policies are the same and offer the same coverage.

D. Medigap policies must cover patients if they are injured outside of the United States.

Glossary

Accept Assignment—A provider agrees to accept the amount allowed by the insurance company as payment in full.

Advance Beneficiary Notice (ABN)—A notice Medicare requires for healthcare providers to issue to Medicare patients as a definite way to make them aware to the fact that Medicare may not pay for certain services or tests prior to having the services or tests performed in an outpatient setting.

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)—Healthcare program in which the Department of Veterans Affairs covers spouses, widows(ers), and the children of a veteran who is rated permanently and totally disabled due to a service-connected disability, died of a service-connected disability, or died on active service and the dependents are not eligible for TRICARE.

Crossover Claim—The transfer of processed claim data from Medicare operations to Medicaid (or state) agencies and Medigap insurers.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)—Medicaid benefit that provides comprehensive and preventive healthcare services for enrolled children under the age of 21.

Medigap—Medicare supplemental policy that is sold by private insurance companies to help cover some of the costs that Original Medicare does not cover.

National Provider Identifier (NPI)—A unique 10-digit identification number required by HIPAA for all healthcare providers in the United States. Providers must use their NPI to identify themselves in all HIPAA transactions.

Non-Participating Provider—A physician, hospital, or other healthcare entity that does not have a participating agreement with an insurance plan's network.

Participating Provider—A physician, hospital, or other healthcare entity that is part of an insurance plan's network.

Relative Value Unit (RVU)—Measure of value used by Medicare in the resource based relative value system.

Resource Based Relative Value System (RBRVS)—A system of payments to physicians for treating Medicare patients that considers the work done by the physicians, malpractice insurance, and practice expenses including staff salaries, overhead, supplies, and equipment.

TRICARE—The Department of Defense healthcare program for military families and retirees.