

The Journey to Medicare Billing Starts Here



Table of Contents

Section 1: Appeals

Section 2: Duplicate Claim Rules

Section 3: HER and PQRS Incentives

Section 4: Incident to Services

Section 5: Local Coverage Determinations (LCDs)

Section 6: Medically Unlikely Edits (MUEs)

Section 7: National Provider Identifier (NPI)

Section 8: Prepayment Review of Evaluation and Management Services

Section 9: Remittance Advice Terms

Section 10: Sequestration

Section 11: The Global Surgical Package

Section 1: Appeals

If you have received a claim denial from your Medicare contractor you do have the right to submit an appeal. If you do not take assignment on the claim, your appeal rights can be limited.



See section at the bottom on **Clerical Reopening** when an appeal is not indicated.

First level of appeal: Redetermination

A redetermination is an examination of a claim by fiscal intermediary (FI), carrier, or MAC personnel who are different from the personnel who made the initial claim determination. The appellant (the individual filing the appeal) has 120 days from the date of receipt of the initial claim determination to file an appeal. A redetermination must be requested in writing. A minimum monetary threshold is not required to request a redetermination.

Second level of appeal: Reconsideration

A party to the redetermination may request a reconsideration if dissatisfied with the redetermination decision. A qualified independent contractor (QIC) will conduct the reconsideration. The QIC reconsideration process allows for an independent review of medical necessity issues by a panel of physicians or other health care professionals. A minimum monetary threshold is not required to request a reconsideration.

Third level of appeal: Hearing by an administrative law judge (ALJ)

If at least \$140 remains in controversy following the qualified independent contractor's (QIC's) decision, a party to the reconsideration may request an administrative law judge (ALJ) hearing within 60 days of receipt of the reconsideration decision. Appellants must send notice of the ALJ hearing request to all parties to the QIC for reconsideration. ALJ hearings are conducted by the Office of Medicare Hearings and Appeals (OMHA).



By [clicking here](#) you will find information on the OMHA website.

Fourth level of appeal: Review by the Medicare Appeals Council

If a party to an ALJ hearing is dissatisfied with the ALJ's decision, the party may request a review by the Medicare Appeals Council. There are no requirements regarding the amount of money in controversy. The request for Medicare Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ's decision, and must specify the issues and findings that are being contested.



By [clicking here](#) you will find information on the Medicare Operations Division/Medicare Appeals Council.

Fifth level of appeal: Judicial review

If \$1,400 or more is still in controversy following the Medicare Appeals Council's decision, a party may request judicial review before a Federal District Court judge. The appellant must request a Federal District Court hearing within 60 days of receipt of the Medicare Appeals Council's decision.

- The Medicare Appeals Council's decision will contain information about the procedures for requesting judicial review.



Additional resources

Within the CMS websites you will find information related to the five levels in the Part A and Part B appeals process.

- [CMS Appeals Web resources](#) 
- [CMS Appeals process flowchart](#) 

CMS resource materials available for download

- [MLN - The Medicare Appeals Process Brochure](#) 

CMS Internet-only manuals: Publication 100-04

- [Chapter 29](#) — Appeals of Claims Decisions
- [Chapter 34](#) — Reopening and Revision of Claim Determinations and Decisions



Minor errors or omissions on some **Part B claims** can be corrected for reprocessing using the **clerical reopening** process.



There are two ways to initiate this process:

- Telephone reopening requests via the [interactive voice response \(IVR\)](#) allows providers/customers to request telephone re-openings on certain claims. For the IVR reopening request help sheet, [click here](#) .
- For reopening requests in writing, use the [clerical reopening](#) .



Common clerical errors consist of:

- Mathematical or computational mistakes
- Transposed procedure or diagnostic codes
- Inaccurate data entry
- Misapplication of a fee schedule
- Computer errors
- Denial of claims as duplicates which party believes incorrectly identified as duplicate
- Incorrect data items such as provider number, modifier, date of service

Section 2: Duplicate Claim Rules

Each Medicare claims processing system contains criteria to evaluate all claims received for potential duplication. The claims can be placed into two categories: exact duplicate or suspect duplicate. Each category is processed uniquely by the Medicare contractor.



CMS has recently updated the Medicare Claims Processing Manual, Chapter 1, Section 120: “Detection of Duplicate Claims” based on change request (CR) 8121.



An exact duplicate claim is denied or rejected, if missing applicable modifiers, automatically by the claims processing system.



For exact duplicate denials, professional providers do have appeal rights, but institutional and DME providers do not.



If a claim is deemed suspect by the initial system review, the claim is suspended for further review by the Medicare contractor.



If suspect duplicate is denied after review, all providers have right to appeal.



See Section 1: “Appealing a Medicare Denial”



Due to the nature of the service, some claims may only appear to be duplicates. Proper coding of the service with the applicable condition codes or modifiers will identify the claim as a separate payable service, not a duplicate. An example could be modifiers “LT” and “RT” for bilateral procedures.



By utilizing an advanced **Medical Practice Management Billing Software** like [Iridium Suite](#) from **Medical Business Systems**, duplicate claims submissions are easily prevented. A configurable [Claim Scrubber](#) as found in **Iridium Suite** will check each service entered and alert the user immediately if the same service is already on record. This gives the user the opportunity to determine if the service is a true duplicate or if the service qualifies for an appropriate addition of a modifier.



See below for details on the process Medicare utilizes to identify duplicate claims.

Provider of Service	 Exact Duplicate	 Suspect Duplicate
Institutional 	Claim matches identically on the following data: 1. Health insurance claim (HIC) number 2. Type of bill 3. Provider identification number 4. From date of service 5. Through date of service 6. Total charges (on the line or on the bill) 7. HCPCS, CPT-4, or procedure code/modifiers	Claim matches on the following data: 1. Beneficiary information 2. Provider identification 3. Same date of service or overlapping dates of service
Professional 	Claim matches identically on the following data: 1. HIC number 2. Provider number 3. From date of service 4. Through date of service 5. Type of service 6. Procedure code 7. Place of service 8. Billed amount	The criteria for identifying suspect duplicate claims submitted by physicians and other suppliers vary according to the type of billing entity, type of item or service being billed, and other relevant criteria.
DME 	Claim matches identically on the following data: 1. HIC number 2. From date of service 3. Through date of service 4. Place of service 22 5. HCPCS 6. Type of service 7. Billed amount 8. Supplier	The criteria for identifying suspect duplicate claims submitted by physicians and other suppliers vary according to the type of billing entity, type of item or service being billed, and other relevant criteria.

You can find the official instruction, CR 8121, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by [clicking here](#).

Section 3: Incentives for EHR and PQRS

Ideally, the only responsibility of a physician is to provide the best care to his/her patients. Unfortunately, medicine is a business, so the topic of reimbursement will always rear its ugly head.



Providers of Part B services on the **MPFS** can **increase reimbursement** and **avoid future penalties** by taking advantage of Medicare incentives for **EHR** and **PQRS** reporting. Below you will find guidance on both of these programs to help improve your bottom line.



To qualify for Medicare PQRS incentive payments, EPs must sufficiently report on the applicable quality information measures. In the PQRS 2013 program, there are several hundred measures.



To help navigate through this complex process, you can access the “Getting Started” page of the CMS PQRS website by [clicking here](#).



Advanced Practice management software like [Iridium Suite](#), has an integrated PQRS claim scrubber. The practice can configure the **medical billing system** to automatically request that the physician sets up **PQRS** measures for each patient. The claim scrubber also recognizes which billing codes are potential **PQRS** denominators and automatically suggests the **PQRS** numerator codes that should be added to the claim. The biller simply accepts these suggestions and the claim scrubber automatically adds the proper **PQRS** charge codes to the claim.



To qualify for the Medicare EHR incentive payments eligible professionals (EPs) must utilize certified meaningful use EHR technology. Proof of meaningful use can only be demonstrated by reporting clinical quality measures (CQMs) as well as the meaningful use measures.



Providers wishing to purchase certified EHR software can access a list of options on the CMS site by [clicking here](#).



In 2013, EPs may satisfy the meaningful use objective to report CQMs to CMS by reporting them through:

- Medicare and Medicaid EHR Incentive Programs’ web-based Registration and Attestation System



EPs who choose to report CQMs through the CMS Attestation system must still report information on individual quality measures or measure groups using one of the four reporting options in order to also participate in PQRS.

- Participation in the PQRS-Medicare EHR Incentive Pilot, which utilizes the 2013 PQRS EHR Measure Specifications.



EPs who participate in the pilot may submit their meaningful use objectives through the CMS Attestation system, and then complete a single submission of CQMs to receive credit for both programs.



EPs who successfully participate in PQRS and EHR can receive an incentive in 2013 and avoid the 2015 payment adjustment for both programs.



Participating in both the PQRS and EHR programs in 2014 and beyond is being simplified by CMS with the alignment of several of key components.



Here are the changes affecting PQRS and EHR in 2014:

- PQRS and EHR programs will align on the same set of eCQMs (64 total) and the same electronic specifications
- All Medicare-EPs beyond their first year of demonstrating meaningful use will be required to electronically report their CQM data to CMS for the EHR program
- Submitting data electronically using 2014 certified EHR technology will meet the standards for both EHR and PQRS programs
- Participating EPs will have the option to submit patient-level data (via QRDA I) or aggregate data (via QRDA III) using the same reporting mechanism for electronic reporting for both programs.

[Click here](#) to read about how your **EHR** can communicate with your **medical billing software**.

Section 4: Incident to Services

Many terms used in the “rules” for medical billing seem like they belong more in a law book, than a billing guide.



That is how I start to feel when reading about billing “Services and Supplies Furnished Incident to a Physician’s/NPP’s Professional Service.”



For my enlightenment and hopefully yours, I have attempted to glean the basics from about 10 pages in section 60 of the *Medicare Claims Processing Manual*, Chapter 15 “Covered Medical and Other Health Services”.



Let’s start with an easy concept: An incident to service or supply is a service or supply not covered in one of the other benefit categories. The other benefit categories are:

- Drugs and Biologicals
- Sleep Disorder Clinics
- Diagnostic X-Ray, Diagnostic Laboratory and Other Diagnostic Tests
- X-Ray, Radium and Radioactive Isotope Therapy
- Surgical Dressings, Splints, Casts, and Other Devices Used for Reductions of Fractures and Dislocations
- Durable Medical Equipment
- Prosthetic Devices
- Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes
- Therapeutic Shoes for Individuals with Diabetes
- Dental Services
- Clinical Psychologist Services
- Clinical Social Worker (CSW) Services
- Nurse Midwife (CNM) Services
- Physician Assistant (PA) Services
- Nurse Practitioner (NP) Services
- Clinical Nurse Specialist (CNS) Services
- Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech Language Pathology Services) Under Medical Insurance



To see the details of services that fall into these benefit categories, you can access the *Medicare Claims Processing Manual*, Chapter 15 by [clicking here](#).



Well, now that has narrowed things down quite a bit. Let's look at the next part that makes a service or supply "incident to". It is considered:

- Integral to the performance of the *physician's professional service
- Commonly rendered without a separate *physician fee and furnished in *physician's offices or clinics



Supplies commonly considered "incident to": gauze, ointments, bandages, oxygen

- Furnished by the physician or by **auxiliary personnel under the *physician's *** direct supervision



Services of auxiliary personnel are considered incidental to a physician service when they assist in rendering the service, and the charge is included in the physician's bill. This also applies if auxiliary personnel perform a subsequent service as part of a course of treatment initiated by the supervising physician.

*Physician: includes physician, physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, clinical psychologist.

**Auxiliary Personnel: personnel whether employee, leased employee, or independent contractor that acts under the supervision of a physician. May include services by Non-physician practitioners: certified nurse midwives, clinical psychologists, clinical social workers, physician assistants, nurse practitioners, and clinical nurse specialists.

***Direct supervision: the physician must be present in the office suite and immediately available to assist the auxiliary personnel in performing the service.



Special Rules for Homebound Patients and Incident to Services

In medically underserved areas the shortage of medical personnel to provide certain medical services to homebound patients allows for an exception to the direct supervision rule. In these circumstances, nurses, technicians and other physician extenders may provide these services under the *general supervision requirement instead of the direct physician supervision requirement.

*General supervision means that the physician is not physically present at the place of residence when the service is performed, but is under his/her overall supervision and control.



Services that can be covered incident to under general supervision: Injections, venipuncture, EKGs, therapeutic exercises, insertion and irrigation of sterile catheter, changing of catheters and collection of catheterized specimen for urinalysis and culture, dressing changes, replacement and/or insertion of nasogastric tubes, removal of fecal impaction, sputum collection for stain and cultures, paraffin bath therapy for hands and/or feet, teaching and training the patient for care of colostomy, ileostomy, or tracheostomy, testing urine, care of diabetic feet and blood pressure monitoring.



The specific criteria for “Service Incident to a Physician’s Service to Homebound Patients under General Physicians Supervision”:

- The patient is *homebound

*Homebound: a patient is considered homebound if they possess a normal inability to leave home, such that leaving the home would require a considerable and taxing effort.

- The service is an integral part of the physician’s service to the patient and done under general physician supervision.
- The physician orders the service, maintains contact with the employee and upholds all responsibility for the service.
- The physician or clinic has an associated expense and their bill includes the fee for the rendered procedure.
- Any service performed is medically necessary and reasonable and unavailable by a Home Health Agency.

Section 5: Local Coverage Determinations (LCDs)



Each Fiscal Intermediary (FI) has the authority to produce their own “Local Coverage Determination” (LCD), based on national guidelines. The LCD basically defines under which circumstances a particular procedure is covered under the patient's Medicare benefits. As new procedures are developed, the FI will then set out to create an LCD. The FI will also review existing LCDs to see if changes are necessary based on treatment advances, statistical data, industry standards, etc.



How do LCDs affect you? If a procedure is planned, but, the criteria of the LCD are not met, you will get a very swift denial that turns into months of waiting for responses to appeals. If you are familiar with the parameters of the LCD, you may be able to avoid the denial or at least have the exact medical documentation needed that addresses the specific potential cause for denial. Most LCDs do contain the “Medically Necessary” clause. If your documentation can prove that the case is an “exception” to the rule and the procedure is medically necessary, you will likely be successful in your appeal.



The websites for all FIs include a search for LCDs. You can quickly and easily enter a CPT or HCPC code to get the most recent version of the LCD. Many times you can also enroll for automated email updates regarding new or changing LCDs. This also allows you to become involved in the creation/modification of the LCD, as the FI offers comment periods before making them active.



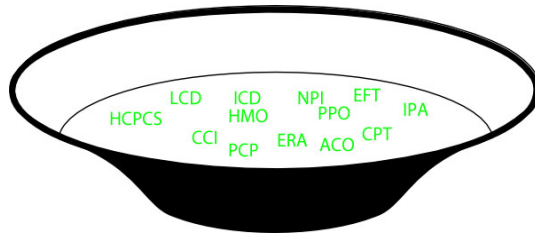
Use the appropriate link below to access your Medicare Fiscal Intermediary LCD website:

Cahaba Government Benefit Administrators	http://www.cahabagba.com/part-b/medical-policy/local-coverage-determinations-lcds-and-articles/
First Coast Service Options	http://medicare.fcso.com/Landing/139800.asp
National Government Services	http://www.ngsmedicare.com/wps/portal/ngsmedicare/mpc?CONTRACTTYPE=Jurisdiction%2013%20Providers&LOB=Part%20B&utm_source=homepage&utm_medium=partb&utm_campaign=medical_policy

NHIC	http://www.medicarenhic.com/ne_prov/policies.shtml
Noridian Administrative Services	https://www.noridianmedicare.com/partb/coverage/active.html
Novitas Solutions	https://www.novitas-solutions.com/policy/index.html
Palmetto GBA (J1)	http://www.palmettogba.com/palmetto/providers.nsf/docsCat/Providers~Jurisdiction%201%20Part%20B~Medical%20Policies~LCDs%20and%20NCDs?open&expand=1&navmenu=Medical^Policies
Palmetto GBA (J11)	http://www.palmettogba.com/palmetto/providers.nsf/docsCat/Providers~Jurisdiction%2011%20Part%20B~Medical%20Policies~LCDs%20and%20NCDs?open&expand=1&navmenu=Medical^Policies
Trailblazer Health	http://www.trailblazerhealth.com/Tools/LCDs.aspx?DomainID=1
Wisconsin Physician Services (J5)	http://www.wpsmedicare.com/j5macpartb/policy/active/index.shtml
Wisconsin Physician Services (J8)	http://www.wpsmedicare.com/j8macpartb/policy/active/index.shtml
Wisconsin Physician Services (Legacy)	http://www.wpsmedicare.com/part_b/policy/active/index.shtml

Section 6: Medically Unlikely Edit (MUE)

Working in medical billing is like being in a bowl of alphabet soup.



One of the probably less common acronyms is **MUE**: Medically Unlikely Edit. A medically unlikely edit (MUE) is an automated claim processing edit that compares the number of units submitted for a procedure code against the designated maximum units that are typically reported for that code on the vast majority of appropriately reported claims.



The edit is applied to services billed by a single provider/supplier to a single beneficiary on the same date of service.



The MUE program was developed by CMS in an effort to reduce the paid claims error rate for Medicare claims that result from various circumstances such as:

- clerical entries
- incorrect coding based on:
 - anatomic considerations
 - procedure code descriptors
 - procedure coding instructions
 - established CMS policies
 - nature of a service/procedure
 - unlikely clinical treatment



You can locate a listing of most MUE values on the CMS website:
<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html>



CMS does not publish MUE values for some codes. Some MUE values are confidential and may not be published.



CMS fiscal intermediaries and Part A/Part B Medicare administrative contractors (A/B MACs) process claims with the fiscal intermediary shared system (FISS). They adjudicate MUEs against each line of a claim rather than the entire claim. If a procedure code is reported more than once, each line with that code is separately adjudicated against the MUE. They will deny the entire claim line if the unit of service (UOS) on the claim line exceeds the MUE value for the procedure code listed on the claim line.



For Example CPT Code 77300 is submitted on one service line for 11 units, if the MUE is 10, then all 11 are denied, instead of a just denying the one unit over the limit.



When there is a need to report medically reasonable and necessary units of service in excess of an MUE value modifiers can be used to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE value.



The modifiers noted below will accomplish this purpose.

- 76 -- Repeat procedure by same physician
- 77 -- Repeat procedure by another physician
- Anatomic modifiers (e.g., RT, LT, F1, F2, 50)
- [When is it appropriate to bill modifier 50?](#)
- 91 -- Repeat clinical diagnostic laboratory test
- 59 -- Distinct procedural service (Note: Modifier 59 should be utilized only if no other modifier describes the service.)



Effective April 1, 2013, CMS converted some claim line MUEs to date of service (DOS) MUEs. The total units of service (UOS) from all claim lines for a HCPCS/CPT code with the same date of service will be summed and compared to the MUE value. Claims denied based on DOS MUEs may be appealed using similar processes to claim line MUE denials. CMS does not publish which codes have DOS MUEs. Since all UOS for a HCPCS/CPT code on all claim lines with the same date of service are summed, reporting additional UOS on separate claim lines with a HCPCS/CPT modifier will not result in payment of UOS in excess of the MUE value.

Section 7: National Provider Identifier



What is NPI and how is it used?



The **NPI** is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard and a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions adopted under HIPAA. This means all individual health care providers, health care groups, and health care facilities must apply for an NPI to be used on all its transactions with health care payers



How do I apply for an NPI?



There are three ways to apply:

1. **Online** at the NPPES website: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>
2. **Paper Application** Form CMS-10114 at: <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10114.pdf> or you may also request the form from the NPI Enumerator by calling (800) 465-3203, sending an e-mail to customerservice@npienumerator.com, or sending a letter to: NPI Enumerator, P.O. Box 6059 Fargo, ND 58108-6059
3. **Electronic File Interchange (EFI)** – You may agree to have an EFI Organization (EFIO) submit application data on your behalf (i.e., through a bulk enumeration process) if an EFIO requests permission to do so.



What is the difference between an NPI and:



→ Tax ID/EIN?



The Tax ID/EIN is the number issued to a business for taxation purposes. Multiple NPI numbers can be linked to one Tax ID number. An example is a medical practice with 3 providers. Each provider as well as the practice entity will have an NPI for a total of 4, but there will be only one Tax ID issued by the IRS.



→ UPIN?



The UPIN (Unique Physician Identification Number) was a six-character alphanumeric identifier used by Medicare to identify doctors in the United States as the predecessor of the NPI. They were discontinued in June, 2007 therefore they currently have no relevance in the submission of any health care transactions.



→ PIN or PTAN?



A **PIN** (Provider Identification Number) is a unique number issued by a specific payer, for example Medicaid or Blue Cross/Blue Shield, to identify a health care provider, group or facility. These are becoming obsolete in many cases and have been replaced by the NPI on all health care transactions. A **PTAN** (Provider Transaction Access Number) is an identification number utilized only by Medicare. The individual and group will both be issued a PTAN upon application to a Medicare contractor. While only the NPI can be submitted on claims, the PTAN is a critical number directly linked to the provider or supplier's NPI. The PTAN and NPI are both required when making inquiries to the Medicare contractor regarding claims, enrollment issues, etc.



Where can I look up NPI numbers?



You can access the complete NPI Registry at:

<https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do>.



This website allows you to search for both individual and organizational providers. The search fields consist of name, address and NPI number if already known. This is a public access website, so anyone can search for NPI numbers. They are not private or confidential



What is the difference between Group NPI and Individual NPI?



When an individual health care provider is not a sole-practitioner, the individual NPI must be linked to the group NPI along with the other providers in the practice. When services are rendered, the payment will be issued to the group, not the individual. This is represented by specific fields on the HCFA 1500 form. Based on the **5010** standard, field 24J contains the **rendering individual provider NPI number** and field 33 contains the billing entity **group provider NPI number**.



For more information about the NPI, visit [National Provider Identifier Standard \(NPI\) | Centers for Medicare & Medicaid Services](#) on the CMS website. You may also refer to the Medicare Learning Network® (MLN) publication titled “The National Provider Identifier (NPI): What You Need to Know” located at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/NPIBooklet.pdf> and Chapter 10 of the “Medicare Program Integrity Manual” (Publication 100-08) located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html> on the CMS website.

Section 8: Prepayment Review of Evaluation and Management Services



Evaluation and Management services are the most commonly provided service and the most likely to be subject to miss-coding. **CMS** and individual **MAC**'s have published numerous guides, fact sheets and even an interactive coding tool to assist providers in selecting the proper level of the **E and M** service.



Follow these links for helpful information on **E and M** coding:

[Documentation Guidelines for Evaluation and Management \(E/M\) Services](#)

[Evaluation and Management Services Guide](#)

[E/M Review Checklist and Score Sheet Tool](#)



This brought to my attention, maybe there are other **MAC**'s currently scrutinizing the same or similar services in their jurisdictions. And, maybe there are providers out there that are unaware that they are undergoing a "**Prepayment Review**" when they are passing on their charge code to office staff. So, with that in mind, I researched the information found on each **MAC** website and compiled a location and procedure list. Since the procedures selected are known to be both performed at a high volume and have a high error rate, by reviewing the criteria for these codes, a provider can ensure he/she is compliant when making a code selection.

MAC	Jurisdiction/State(s)	CPT Code(s)	Specific Provider Types Effected
Cahaba Government Benefit administrators	J10: Alabama, Georgia, Tennessee	99214-99215 99223, 99233	Unspecified
Cigna Government Services	J15: Ohio	99310	Unspecified
First Coast Service Options	J9: Florida	99201-99205 99211-99215 (when billed with a 24 modifier)	Unspecified
First Coast Service Options	J9: Florida	99215	General practice Optometry Osteopathic manipulative medicine Pediatric medicine Podiatry
National Government Services	J6: Illinois, Wisconsin, Minnesota	99205, 99215 99223, 99233	Unspecified

National Government Services	J13: Connecticut, New York	*99223 **99233 ***99215	* General Surgery ** Cardiology and Gastroenterology ***Hematology/Oncology
Palmetto GBA  Click here for results	J1: California		
	Northern California	*99204 **99205	*Family Practice and Ophthalmology ** Internal Medicine and Neurology
	Southern California	*99204 **99205	*Otolaryngology **Internal Medicine and Neurology
Palmetto GBA  Click here for results	J11: North Carolina, South Carolina, Virginia, West Virginia	99233	Unspecified
Wisconsin Physicians Service Ins. Corp.	J8: Indiana	99233	Unspecified

Section 9: Remittance Advice Terminology



This guide can help you find your way through a Medicare Remittance Advice also known as an Explanation of Benefits (EOB), allowing you to accurately apply the appropriate payment, contractual write-off and patient responsibility.

Medicare Terms	Definitions	Terms Used by Other Payers
Remittance Advice or Notice	Title given to the report issued by the payer summarizing the processing details of the claim.	Explanation of Benefits, Explanation of Payment, Remittance Advice, Statement of Payments
Billed/Billed Amt	Represents the fee charged for the services.	Charge Amount, Charges, Requested Amount, Submitted Expenses.
Allowed/Allowed Amt	Equals the amount of the fee that is allowed per the contracted rate with the payer.	Eligible Expense or Amount, Approved, Covered Charges.
Deductible/Deductible Amt	Indicates if any of the allowed fee was applied to outstanding deductible on the patient's policy.	Annual Deductible.
Coins/Coins Amt	Indicates the amount of the allowed fee that the patient must pay per their policy terms.	Customer or Patient Liability. Out of Pocket Amount (OOP). Commercial payers may also indicate Copayment on a service which is a flat rate charged independent of the fee.
Grp/RC-Amt/Total RC Amt	Grp stands for Group and RC stands for Reason Code. These are codes that abbreviate the basis for any amounts not paid by the payer. See section below for further details.	Remark Codes, Adjustment Grp and Reason Code, Not Covered Reason, Payment Codes.
Prov Pd/Prov Pd Amt	This is the amount of money paid for the claim.	Amount Paid, Payment, Benefits Paid, Pay Amount, Net \$, Total Benefit, Policy Pays.
HIC	The health insurance identification number for the patient.	Subscriber ID, Member Number, Policy Number.
ICN	This is the Internal Control Number assigned to the claim once processed by the payer. This is used for their internal tracking.	Claim Number, Payer Claim Control Number.
Pt Resp	This is the amount of money the patient can be billed for the services on the claim.	Customer or Patient Liability. Out of Pocket Amount (OOP). This will typically be the summary of Deductible, Coinsurance and Copayment amounts applied to the services.
Prov Adj(Prev Pd,Interest,Late Filing Charge)	When the payer has additional adjustments to apply to the provider's portion of the payment, this area is used. It may increase the base payment as in the case of interest paid. It would decrease the base payment if a portion of the service had been previously paid on another ICN.	Penalty, Recoupment.



A Claim Adjustment Group Code consists of two alpha characters that assign the responsibility of a Claim Adjustment on the insurance Explanation of Benefits.

Code Abbreviation	Full Code Description	Indicated Action
CO	Contractual Obligation	This represents amount of the fee that must be written off as uncollectable based on provider's agreement with the payer. It will most commonly indicate the amount billed over the allowed payer fee schedule amount. As a contracted provider, contractual obligation amounts cannot be passed on to the patient,
CR	Corrections and Reversal	This code is mainly utilized to indicate a service has been reprocessed by the payer. It would apply if a denial was overturned indicating additional payments were sent. It can also be used when the payer overturns an original payment, making the provider aware of an overpayment on the service.
OA	Other Adjustment	You can relate this to a "miscellaneous" category. The Reason Code that is attached will be the key to understanding the impact and proper processing of this adjustment. It will be typically seen on a secondary payer EOB to show the amount paid by the primary carrier and how it affected the payment issued.
PI	Payer Initiated Reductions	A payer may use this code to explain monies withheld from the claim payment. If a provider has an outstanding refund due the payer, they can withhold payments on new services.
PR	Patient Responsibility	Of all the codes, this is probably the most logical. Any amounts to be passed on the patient, or in some cases a secondary payer, will have this indicator. It would apply to Deductible, Copayment and Coinsurance .



These Group Codes are combined with Claim Adjustment Reason Codes that can be numeric or alpha-numeric, ranging from 1 to W2. Claim Adjustment Reason Codes communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code.



For a complete list of **Claim Adjustment Reason Codes**, visit Washington Publishing Company's website by [clicking here](#).



Each **Remark Code** will corresponds to either a standard message found in the Remittance Advice Remark Code List or will reference a payer specific message that will be shown on the EOB.



For a complete list of **Remark Codes**, visit Washington Publishing Company's website by [clicking here](#).

Section 10: Sequestration



Here are the five things you should know about sequestration:



What is sequestration?



It is the mandatory 2% payment reduction in the Medicare fee-for-service (FFS) program required by the Budget Control Act of 2011.



Who does it affect?



All providers of medical services that are reimbursed under the Medicare fee-for-service (FFS) program (i.e., Part A and Part B) are subject to the 2% reduction. This also includes those entities that bill for durable medical equipment (DME), prosthetics, orthotics, and supplies.



When does it begin?



Medicare FFS claims with dates of service or dates of discharge on or after April 1, 2013. Reduced claim payments for DME, prosthetics, orthotics and supplies will be based upon whether the date of service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.



How is the 2% calculated?



The reduction is taken from the calculated payment amount, after the approved amount is determined and the deductible and coinsurance are applied.



Example:

1. A provider bills a service with an approved amount of \$100.00.
2. Medicare normally would pay 80 percent of the approved amount (\$100.00 x 80 percent = \$80.00).
3. The patient is responsible for the remaining 20 percent coinsurance amount of \$20.00 (\$100.00 - \$80.00 = \$20.00).
4. However, due to the sequestration reduction, 2 percent of the \$80.00 calculated payment amount is not paid, resulting in a payment of \$78.40 instead of \$80.00 (\$80.00 x 2 percent = \$1.60).



Currently the 2% reduction is noted on the explanation of payment as Claim Adjustment Reason Code 223. (CARC 223 is defined as adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.) CMS has developed a new CARC to reflect payment reductions due to sequestration: 253 - Sequestration - Reduction in Federal Spending. This code will be implemented Jan 6, 2014.



Where do I get more information?



You can contact your local Medicare Administrative Contractor for further information.



Documentation was issued by CMS on March 8, 2013 and can be found by [clicking here](#).

Section 11: The Global Surgical Package and E/M Services



A **global surgical package** references the **CMS** payment policy that may “bundle” the reimbursement of a related **Evaluation and Management service** as part of a “surgical procedure”. The rationale for the bundling is simple; the **E and M service** is a necessary part of the larger surgical service being provided.



The “**global period**” has 7 unique designations that are related to the specific surgical service performed and are indicated on the [Medicare physician fee schedule database \(MPFSDB\)](#). You are able to search by a single HCPCS code, a list of up to five codes, or a range of codes. The results when downloaded to an excel spreadsheet show the global period indicator in column “AL”.

	A	B	C	AL
1	HCPCS CO	MODIFIER	SHORT DESCRIPTION	GLOBAL
2	21045		Extensive jaw surgery	90
3	21076		Prepare face/oral prosthesis	10
4	21116		Injection jaw joint x-ray	0
5	36591		Draw blood off venous device	XXX
6	37185		Prim art m-thrombect add-on	ZZZ
7	59400		Obstetrical care	MMM
8	69300		Revise external ear	YYY



The 7 categories shown above consist of:

- 3 numeric indicators: 0, 10, or 90 days specifying the post-operative timeline that is considered the “**global period**”. **CMS** has provided the following details in regards to each period:

000 -- Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; **evaluation and management services on the day of the procedure generally not payable.**

010 -- Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; **evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.**



Calculate the global period by counting the day of surgery and 10 subsequent days to equal **11 days**.

090 -- Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.



Calculate the global period by counting the day before, day of and 90 subsequent days after the surgery to equal **92 days**.

- 4 alphabetic codes: MMM, XXX, YYY, ZZZ that are used to furnish additional necessary information about the status of the surgical codes as they related to the CMS **global surgery** reimbursement guidelines.

MMM -- Maternity codes; usual global period does not apply.

XXX -- Global concept does not apply.

YYY -- Carrier determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.



Each FI/MAC sets its own rules.

ZZZ -- Code related to another service and is always included in the global period of the other service.



Used for codes that are typically referred to as an “add-on” code that is always billed with another service.

This article has provided a great starting point for understanding the Global Surgery rules that affect the billing of Evaluation and Management services.



If you are interested in expanding your knowledge of this topic, you can find a wealth of information by following these **CMS** links:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.pdf>

<http://www.cms.gov/manuals/downloads/clm104c12.pdf>