Medicare
J5 MAC Part B

Iowa, Kansas, Missouri and Nebraska Providers

Top Written Correspondence FAQs For February, March, And April 2014

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WPS Medicare is publishing the following FAQs based upon topics we have identified as generating a high volume of written inquiries between February and April 2014. We hope the answers to the questions below help you maximize your time by reducing your need to contact Customer Service.

1. **I need to submit a corrected claim to Medicare. How do I indicate on the claim form that it is a corrected claim?**

   It is not necessary to indicate you are submitting a corrected claim. In fact, our Claims department does not correct claims at all. When a provider submits an original claim form marked “Corrected Claim,” Medicare treats it as a brand new claim, and it is processed “as is.” If any of the services on the original claim were denied, or if the original claim was missing procedure codes that should have been billed, Medicare will consider payment for those services based on the information available to us on the claim form and in the beneficiary’s processed claims history. This also means providers should not include any previously approved codes on the resubmitted claim. Since our claims processing system looks at the beneficiary’s claims history when processing any claim, the previously approved services will either be denied as duplicates, or in rare cases, they may be paid again by mistake resulting in an overpayment. Providers should only submit a “corrected claim” for services that were omitted from the original claim, or that were rejected and are being corrected (e.g., unprocessable claims).

   If a correction is needed on a paid service, providers should request a redetermination or a reopening, as appropriate. More information about redeterminations and reopenings can be found on our Appeals page. To access the information, select the Departments tab in the upper navigation, then select “Appeals.”

2. **One of the lines of service I submitted on my claim wasn’t processed. Why did Medicare delete one of the procedures I submitted on my claim?**

   Medicare does not delete lines of service on claims. In all likelihood, Medicare split your claim to facilitate its processing. In that case, the line you believe to be deleted was actually processed on a separate claim. Medicare often splits claims if one procedure is unprocessable, but the other procedures are not. The unprocessable procedure is rejected immediately, and a remittance notice is sent to the provider notifying them of the rejection. The other procedures continue to process normally. Since the Medicare payment floor requires Medicare contractors to hold payment on processed claims for a minimum number of days, the provider may not receive a remittance for the processed services until several weeks after unprocessable remittance notice is sent.

   The claim number of a split claim generally ends in the number “2.” If the claim is split additional times, each subsequent split will end in the next even number (i.e., 4, 6, 8, etc.). Providers can use our self-service tools to keep track of any claims Medicare may have split from the original claims. For more information about our self-service tools, select the Claims tab in the upper navigation, then select “Claims Tools.”

3. **What code should be submitted for the 2014 ePrescribing (eRx) Incentive Program? Medicare is no longer accepts the previous code, G8553.**

   The eRx incentive payment was only authorized for the years of 2009 through 2013. Effective for dates

of service on or after January 1, 2014, providers should no longer report G8553 on Medicare claims.

Section 132 http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Statute_Regulations_Program_Instructions.html of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized the eRx incentive program for eligible professionals who are successful electronic prescribers for 2009 through 2013. In 2014, Medicare will apply a 2 percent negative payment adjustment to all claims paid under the Medicare Physicians Fee Schedule (MPFS) for eligible professionals who were not successful electronic prescribers in 2013. You can find additional information on eRx on the CMS website.

4. **I am treating my patient for two different functional limitations. Can I report both to Medicare simultaneously?**

   No, only one functional limitation shall be reported at a given time for each related therapy plan of care. Providers can find additional information on MLN Matters MM8005 on these reporting requirements.

5. **We billed for an inpatient hospital visit performed by our physician. Our remittance notice appears to show Medicare made a payment, but we never received any money. The remit includes remark code, "N83- No appeal rights. Adjudicative decision based on the provisions of a demonstration project." What happened?**

   Some hospitals have elected to participate in the Model 4 Bundled Payments for Care Improvement (BPCI) initiative. If the requirements are met, the participating Model 4 hospital receives a bundled payment for the acute care hospital stay, which includes inpatient hospital services, Part B services furnished during the hospitalization, and hospital and Part B services for related readmissions. Since Medicare pays the hospital for professional services normally paid under the Physician Fee Schedule (PFS), the hospital is responsible for paying physicians and non-physician practitioners for their services. As such, physicians and non-physician practitioners should seek payment for professional provider services from the Model 4 hospital.

   For additional information, please refer to MLN Matters article MM8070 .

6. **We repeated several minor surgical procedures on our patient on the same day. We appended the 76 modifier to alert Medicare that they were repeat procedures and not duplicates, but Medicare rejected the lines containing the 76 modifier indicating the modifier was invalid. How should we bill repeat surgical procedures?**

   WPS Medicare does not recognize modifier 76 for surgery (type of service 2) codes. When multiple units of a surgical procedure are performed, providers should first determine if the code could be quantity-billed. If so, the claim should be submitted with multiple units per line. If the code cannot be quantity-billed, each unit should be submitted on a separate claim line. Indicate in the narrative field the total number of units performed on the date of service in question. For more information, see our article titled, "Proper Billing of the Same Surgical Procedure Code Multiple Times on the Same Day," which you can find by selecting the Resources tab in the upper navigation, then "Modifiers."

   You can determine whether a code can be quantity billed by reviewing our article, "Systems Quantity Billing for WPS Medicare." To locate this article, select the Claims tab in the upper navigation, then "Claims Submission." The article is located in the "General Claim Information" section.

7. **We submitted an appeal through the CMS Secure Net Access Portal (C-SNAP). We faxed our supporting documentation, but we received an e-mail stating the case was closed programmatically because the documentation wasn't received in your office. Several weeks letter, we learned our appeal was completed after all. What happened?**

   The C-SNAP appeals process is semi-automated. When a request is submitted indicating additional documentation will be sent, providers have about a week to fax the documentation to the appropriate fax number. Once the documentation is received, our staff members have to manually change the status of the C-SNAP case to indicate the documentation is received. If the documentation is not

received in the allotted time, C-SNAP automatically closes the case programmatically.

When an appeal request is closed programmatically and is later completed, this generally indicates our staff could not identify the C-SNAP Tracking Number on the documentation. This could be because the tracking number was not provided, or the number was not listed in a conspicuous place, or because we only received part of the documentation. When this occurs, the documentation is handled as a general inquiry and is sent to the Customer Service staff for handling. If our Customer Service staff members can match the documentation to the original request, the documentation is routed back to our Appeals staff for handling.

To avoid this situation from occurring, it is imperative that providers include a copy of the C-SNAP confirmation sheet that includes the C-SNAP Tracking Number. This is the sheet our sorting staff looks for in order to determine if the documentation is for a C-SNAP appeal. Providers risk having their documentation sorted incorrectly if the C-SNAP confirmation page is not included with the documentation.

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