

MEDICARE PART A BULLETIN

August 24, 1998

General Medicare Bulletin G-345

TO: All Medicare Providers

FROM: Program Relations

SUBJECT: **PROVIDER/ CUSTOMER SERVICE TOP QUESTIONS AND ANSWERS**

ATTENTION MEDICARE BUSINESS OFFICE MANAGER: Please distribute to all appropriate health care facility personnel.

It is our desire to improve the intermediary and provider communication process by publishing a bulletin on the top questions and answers received by the Customer Service area on a quarterly basis. Therefore, we have gathered the TOP QUESTIONS and ANSWERS from providers for this quarter.

This will give providers an opportunity to establish a communication process which will allow them to see and hear other providers' questions and get the right answer. This will also allow providers and the intermediary to work on specific questions and topics, and to implement continuous improvement for the Medicare program, which includes providers, beneficiaries, and the intermediary.

These are the TOP QUESTIONS & ANSWERS for this quarter.

Q1. How do I bill a claim if Medicare IS NOT primary?

- A. You would bill the claim just like any other claim with the following exception: In form locator 39-41, show a value code for the type of insurance that was primary. Next to the value code, you would enter the amount paid by the Primary payor. In form locator 50, line A, = Code and the name of Primary Insurer
line B = Code "Z" Medicare Secondary
line C = If patient has a third coverage

Q2. How do I find out who the Primary Insurance is if the patient isn't sure?

- A. The following questions can be asked of the patient which will help identify the primary payor. Is the patient working? Spouse working? Retired? If so, when? Is this accident-related? Is an attorney involved? Were they injured on the job?

Q3. Why did my claim reject for the XXXX reason code?

- A. For DDE users, this information is available on-line. For all other users the information is available via the Bulletin Board System (BBS).
The reason code for the reject should be looked up and instructions followed accordingly.

Q4. My claim rejected stating that the name and Medicare number don't match, what should I do?

A. Call the Customer Service number (904) 355-8899, representatives can verify information via the Common Working File (CWF) and may be able to update the in house file. However, if there is a problem with CWF, a system change request will need to be completed and forwarded to the Contractor responsible for correction. This will take longer. Representatives are available: Monday through Thursday, 9:00 am - 4:25 pm and Fridays, 9:00 am - 12:00 noon. Our busiest times are between 11:30 am - 12:15 pm.

Q5. We (the hospital) billed a service as noncovered or billed a covered service that was denied. The patient signed an Advanced benefit notice (ABN). Is the patient responsible?

A. If the patient was clearly made aware before the services were rendered that they would not be covered by Medicare, then YES, the patient is responsible.

Q6. How do you make changes to a claim in Direct Data Entry (DDE)?

A1. If the claim was "Returned to Provider" (RTP), you would access "Claim Correction." Select the claim and make the necessary corrections based on the reason codes. When correction is complete "F9" to resend claim.

A2. If the claim needs to be adjusted, you would access "Claim Adjustment." Enter the condition code and adjustment reason code for the type of adjustment that you are making on the claim. Make all necessary adjustment corrections to the claim. Make sure that comments are made as to why the claim is being adjusted in the remarks section. Once completed "F9" to resend the claim.
(Note: The system will automatically change the TOB to a XX7.)

A3. To cancel a claim, you would access "Claim Cancel." Enter condition code to indicate the type of cancel being made and enter an explanation for the cancel in the "Remarks" field. Once completed, "F9" to resend the claim. (Note: The system will change the TOB to a XX8.)

Q7. I run a billing office, and we always get calls from patients/beneficiaries who state they spoke with Medicare and were told that we billed their claim wrong. Why does this happen?

A. When a customer calls the Medicare office, Customer Service Representatives (CSR's) review their claim with them. If a service is billed as noncovered by the hospital, the CSR will advise the customer. The CSR will also ask the caller if he or she signed an ABN advising that the services would be noncovered by the Medicare program. If the caller doesn't remember signing the ABN, the caller is advised to call the hospital's billing office.

Q8. I bill for SNF services. When I tried to enter my claims, I got an error message asking for the new PPS coding. I called Customer Service and they told me I had to use the

codes. My Fiscal Year End (FYE) isn't until 12/31/98. What's wrong?

- A. The representative you spoke with is correct. Although you don't begin billing PPS until the cost report following your FYE, per HCFA Transmittal No. A 98-16, if your Fiscal Year Start Date is on or after July 1, 1998, SNFs are required to report billing data with the new revenue code and a Health Insurance PPS (HIPPS) rate code for all inpatient claims to their fiscal intermediaries.

Q9. I started billing PPS in August. I'm so confused!! Where do I start?

- A. A manual was offered to all providers during the summer training overview of the "Prospective Payment System." You should start by referring to the manual. Towards the back of the book under "BILLING," you will more than likely find the answers to your questions. Examples of commonly-asked questions are:
- Claims must be submitted in sequential order.
 - You still have a maximum of 100 SNF days per benefits period.
 - You must start using the appropriate Revenue and HIPPS codes.
 - Information related to Leave of Absence. (See Billing, pg. 11)
 - Modifiers (See Billing, pg. 15)

Q10. I tried to get a status of my pending claims and the CSR told me I had to use the Audio Response Unit (ARU). Why would they not help me?

- A. Since this is considered a "routine inquiry" (ie..shouldn't require the assistance of a CSR) the CSR's have been advised to refer providers to the ARU. By using the ARU to check on your pending claims, it allows the CSR's to be available for more complex inquiries.

Q11. When I'm in DDE, how do I get to the different host sites on CWF ?

- A. Refer to page E.18 in your DDE manual. To access CWF, follow the sign on directions until you see the message "sign-on is complete." Instead of keying FSS0, you would key HIQA. A screen with the different Host site ID's will appear across the bottom. Complete the fields as indicated. (Note: The REQUESTOR ID is always "1" The PRINTER DEST and APP DATE are always blank, and the INTER NO will always be "00090") then press enter. The inquiry screens display current Medicare entitlement information. There are three pages of data in HIQA.

Questions regarding this bulletin may be addressed to the Medicare Part A Customer Service Department by calling (904) 355-8899.