Railroad Medicare's
Quick Reference Guide

A Palmetto GBA publication designed to improve communications and enhance service levels between providers and the Railroad Medicare program.

www.PalmettoGBA.com/RR

Disclaimer

The contents of the Railroad Medicare Quick Reference Guide are subject to change without notice. Please visit our website for the most current updates at www.PalmettoGBA.com/RR

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GETTING STARTED WITH RAILROAD MEDICARE

Palmetto GBA is the Railroad Specialty Medicare Administrative Contractor (RRB SMAC) and processes Part B claims for Railroad Retirement beneficiaries nationwide. All RRB SMAC claims are processed by Palmetto GBA in Augusta, Georgia.

Because we are independent from the local Part B Medicare Administrative Contractors (MACs), there are many important things to remember when billing Railroad Medicare. This guide is designed to help you get started with Railroad Medicare and to clarify how billing to us, while different, can be easy and successful.

PROVIDER ENROLLMENT

To start the process, you must first request a Railroad Medicare PTAN. A Railroad Medicare Provider Transaction Access Number (PTAN) cannot be issued unless you are already enrolled with your local Part B Medicare Administrative Contractor (MAC). Once you are enrolled with your local MAC, you can request a Railroad PTAN in one of the following ways:

For Electronic Submitters

Change Request (CR) 3440 mandates that all providers submit claims electronically. Only providers that meet the exceptions listed in CR 3440 can be granted a waiver to submit paper claims.

Once you have a pending claim(s), you may complete the Request for Railroad Medicare PTAN for Electronic Submitters form located at: www.PalmettoGBA.com/RR/PTAN.

Please type your information into the web form prior to pressing the PRINT button. Any forms printed blank or photocopied and then handwritten will cause processing delays.

Do not save this form; a new web form must be entered for each submission. The data entered into the form will be used to index and locate your request for tracking purposes.

Fax the completed form to 803-382-2417.

Please allow 45 business days for the completion of your enrollment request. Do not submit additional requests for the same provider. If, after the 45 business days, you need to check the status of your PTAN request form, you may call 888-355-9165. Press 3 for Provider Enrollment, and then to speak to a Provider Enrollment Specialist, press 0.

After we authenticate your information with the local MAC's provider enrollment file, we will send you a letter detailing your Railroad Medicare PTAN data.

NOTE: If the information obtained on your enrollment request does not match your local Part B MAC's files, you will receive a letter informing you that the request cannot be completed.

Please do not submit any claims or a Railroad Medicare Electronic Data Interchange (EDI) Enrollment form until you have received your Railroad Medicare PTAN.

For Paper Submitters

Providers that meet the CMS requirements to be waived from filing electronically may submit their initial paper claims to Railroad Medicare to obtain a PTAN. Once a CMS-1500 (02/12) claim form has been submitted to Railroad Medicare, we will obtain your enrollment information from your local MAC and issue the provider a Railroad Medicare PTAN if all information is verified on your enrollment file.

Prior to submitting claims to Railroad Medicare, please make sure that the information submitted on the CMS-1500 (02/12) claim form is consistent with the information on file with your local MAC. This includes the Tax Identification Number (TIN) in Item 25 and the legal business name and payment address in Item 33. If the claim information is incomplete or cannot be verified, you will receive a letter informing you that the request cannot be completed.

CHANGES TO AN EXISTING RAILROAD MEDICARE PTAN

- Please complete all changes with your local MAC first before submitting the change(s) to Railroad Medicare.

- You may submit changes on letterhead and you must include your Railroad Medicare PTAN, NPI, TIN and contact information.

- If the change is for an address change (Remit/Payment or Practice location), please include your prior/old address and your new address.

- Do *not* submit changes on the "Request for Railroad PTAN" form; this form should only be used for new Railroad Medicare provider request.

- Fax the request to 803-382-2415 or submit the request to:

    > Railroad Medicare
    > Attention: Provider Enrollment
    > PO Box 10066
    > Augusta, GA 30999

- Providers/Suppliers may also call our Provider Enrollment telephone line at 888-355-9165 to report any changes. Press 3 for Provider Enrollment, and then to speak to a Provider Enrollment Specialist, press 0.

ELECTRONIC FUNDS TRANSFER (EFT)

Medicare regulations require payments be received through electronic funds transfer (EFT) for providers newly enrolled in the Railroad Medicare program or providers making changes to their existing enrollment records.

EFT allows a financial institution to deposit Railroad Medicare payments directly into a designated account. There is no charge by Railroad Medicare for this service, and EFT deposits will appear on bank statements. With EFT, you prevent the possibility of checks being lost or delayed in the mail and eliminate the need for staff to prepare daily bank deposits.

NOTE: *Providers who receive payment by EFT will continue to receive the standard provider remittance notices (SPRs) unless they elect to receive electronic remittance advices (ERAs).*

When you enroll or are making an update to your existing record with Railroad Medicare, we will use the information from your CMS-588 form on file with your local Part B MAC. You will receive a notification with the effective date of the EFT payments from Railroad Medicare. Once you have been established to receive EFT, you are no longer eligible to receive your payments via paper checks.

You can send an email to our Railroad Medicare EFT specialists for answers on topics including:

- Assistance with establishing EFT
- Status of EFT requests
- Verify EFT effective dates
- Request EFT notification letters
- Update banking information

Send your questions to: RRBEFT.ADMIN@palmettogba.com

SUBMITTING CLAIMS ELECTRONICALLY

ADMINISTRATIVE SIMPLIFICATION COMPLIANCE ACT (ASCA)

The Administrative Simplification Compliance Act (ASCA) requires electronic claim submissions (except for certain rare exceptions) in order for providers to receive Medicare payment. Providers must submit their claims electronically using the X12 Version 5010 and NCPDP Version D.0 standards. For more information about ASCA requirements, please see the CMS website at www.cms.gov and Medicare Learning Network® (MLN) Matters article MM3440.

USING RAILROAD MEDICARE PART B ELECTRONIC INTERCHANGE SERVICES

Palmetto GBA has prepared an EDI enrollment packet for Railroad Medicare electronic claim submitters. It contains forms, instructions and explanations for each service offered by our Electronic Data Interchange (EDI) department. There are interactive forms available on our website to assist you with completing each EDI enrollment form. Please visit our website www.palmettogba.com/RR/EDI to download a copy of the EDI enrollment packet.

The Palmetto GBA EDI Operations department will send a tracking number via email (see example below) to the email address and submitter email address listed on the forms once your Railroad EDI enrollment request has been processed. You may utilize the Railroad Medicare EDI Request for Enrollment Status Form to request the status of your enrollment. *Please allow 20 business days for processing. Remember - Palmetto GBA cannot process incomplete applications or agreements.*

Your request for the following: "RAILROAD EDI ENROLLMENT FORMS" has been received. The following tracking # has been assigned to your request:

TRACKING #: [TRACKING NUMBER] for [PROVIDER NAME] [PROVIDER EMAIL]

Please allow 48 hours before checking the status of your request. Visit the Palmetto GBA website periodically at http://www.palmettogba.com/internet/EDITrack.nsf for the status of your request. Processing times may vary upon request type.

If you are a Railroad Medicare submitter and have a question about your status, please email RRB.EDI@PalmettoGBA.com or call our EDI Help Desk at 888-355-9165. Press 2 for EDI, and then for technical assistance with electronic billing, Electronic Remittance Advice (ERA) and other EDI issues, press 0.

To request a status update, click on the form link from your email. Enter your tracking number, and you will receive an immediate response to your request.

You may also request an EDI Enrollment status by selecting Claims Submission or Remittance Linkage options from the **EDI Enrollment Status Update Tool**.

Claims Submission Enrollment

To complete the Claims Submission portion, enter the PTAN (Provider ID) and the Submitter ID on the form and the application will return an enrollment date for claims submission linkage. **Note**: The Claims Submission Date is an approximation of the date that the Submitter ID and PTAN were linked for claims submission. This date may actually have occurred prior to the date listed. If Submitters are able to currently submit for this PTAN, please continue to do so.

Electronic Remittance Linkage

To complete the Electronic Remittance Linkage, enter the PTAN and the Submitter ID/Receiver ID on the form, and it will return an enrollment date for electronic remittance linkage.

   Note: This linkage can only occur for one Submitter ID/Receiver ID. A PTAN cannot have multiple linkages for electronic remittances.

If you are a provider waiting for a Railroad Medicare provider number (PTAN), please wait before submitting any EDI enrollment forms. You must have a Railroad Medicare provider number before completing any EDI paperwork. If you do not have a provider number, please complete a Request for Railroad Medicare PTAN for Electronic Billers form. The form is available on our website www.palmettogba.com/rr/ptan or you may call our Provider Enrollment department toll-free at 888-355-9165 to apply.

HOW TO SUBMIT CLAIMS ELECTRONICALLY

PC-ACE Pro32 Software is a Windows-based, self-contained claim entry system for submission of ANSI 837 v5010 claims files for all Medicare lines of business. The only requirement for obtaining a copy of the software is that you must have an active Submitted ID. The software may be downloaded from our website by following the links under EDI to the Software and Manuals Section.

OTHER OPTIONS

Another option that may be available to you is electronic claims submission through your automated billing system. If you currently use a computer billing system that submits claims to other Medicare MACs and insurers, that system may also be capable of submitting your Railroad Medicare claims. Please check with your software vendor to see if electronic billing is available. Vendor software can enable you to bill your claims electronically and can provide other office accounting functions, such as Electronic Remittance Notices. Electronic Remittances save time by posting automatically to your patients' accounts. When choosing a system, it is important to consider whether you plan on using the computer for billing only or if you intend to use the computer for both billing and office accounting functions.

We look forward to assisting you with any questions you may have. Additional electronic submission information can be downloaded from the Palmetto GBA website at www.PalmettoGBA.com/RR or by contacting the Palmetto GBA EDI Help Desk at 888-355-9165. Press 2 for EDI, and then for technical assistance with electronic billing, Electronic Remittance Advice (ERA) and other EDI issues, press 0.

ELECTRONIC REMITTANCE ADVICE

In an effort to advance toward an electronic environment, CMS Change Request 4376 mandated that Part B MACs and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) stop sending standard paper remittances to providers that have been receiving 835 or electronic remittance advice (ERA) transactions, either directly or through a billing agent, clearinghouse, or other entity representing you, for 45 days or more.

CMS has developed MREP (Medicare Remit Easy Print) software to enable physicians and suppliers to read and print the HIPAA-compliant ERA from their computer. Remittance advices printed from the MREP software mirror the current SPR format. MREP uses the HIPAA-compliant 835 format that is sent to you from your MAC.

With the MREP software, you will be able to:

- Navigate and view the ERA using your personal computer

- Search and find ERA/claims information easily

- Print the ERA in the SPR format

- Print and export reports about the ERAs including denied, adjusted, and deductible applied claims

- Archive, restore and delete imported ERAs

The MREP software is available to physicians and suppliers free of charge. Additional information is available on our website at www.PalmettoGBA.com/RR. From our home page, select EDI, then "Software & Manuals."

GET EDI UPDATES

You can register to receive EDI news from Palmetto GBA by registering on the Palmetto GBA website at www.PalmettoGBA.com/RR. From our home page, select "Email Updates" and follow the on-screen instructions. After setting up your profile, you will be notified by email when new or important information related to the topics you selected is added to our website. Be sure your profile is set up to receive information on future EDI topics.

EDI Medicare Secondary Payer

Physicians and other suppliers must use the appropriate loops and segments to identify the other payer paid amount, allowed amount, and the obligated to accept payment in full amount on the 837 as identified by the following:

Primary Payer Paid Amount:
For line level services, physicians and other suppliers must indicate the primary payer paid amount for that service line in loop ID 2430 SVD02 of the 837.

For claim level information, physicians and other suppliers must indicate the other payer paid amount for that claim in loop ID 2320 AMT02 AMT01=D of the 837.

Primary Payer Allowed Amount:
For line level services, physicians and other suppliers must indicate the primary payer allowed amount for that service line in the Approved Amount field, loop ID 2400 AMT02 segment with AAE as the qualifier in the 2400 AMT01 segment of the 837.

For claim level information, physicians and other suppliers must indicate the primary payer allowed amount in the Allowed Amount field, Loop ID 2320 AMT02 AMT01 = B6.

Obligated to Accept as Payment in Full Amount (OTAF):
For line level services, physicians and other suppliers must indicate the OTAF amount for that service line in loop 2400 CN102 CN 101 = 09. The OTAF amount must be greater than zero if there is an OTAF amount, or if OTAF applies.

For claim level information, physicians and other suppliers must indicate the OTAF amount in loop 2300 CN102 CN101 = 09. The OTAF amount must be greater than zero if there is an OTAF amount, or if OTAF applies.

Primary Payer Paid Amount:
For line level services, physicians and other suppliers must indicate the primary payer paid amount for that service line in loop ID 2430 SVD02 of the 837.

For claim level information, physicians and other suppliers must indicate the other payer paid amount for that claim in loop ID 2320 AMT02 AMT01=D of the 837.

Primary Payer Allowed Amount:
For line level services, physicians and other suppliers must indicate the primary payer allowed amount for that service line in the Approved Amount field, loop ID 2400 AMT02 segment with AAE as the qualifier in the 2400 AMT01 segment of the 837.

For claim level information, physicians and other suppliers must indicate the primary payer allowed amount in the Allowed Amount field, Loop ID 2320 AMT02 AMT01 = B6.

For claim level information, physicians and other suppliers must indicate the OTAF amount in loop 2300 CN102 CN101 = 09. The OTAF amount must be greater than zero if there is an OTAF amount, or if OTAF applies.

MSP Types and Code Lists:

The MSP type of the primary insurance must be entered in loop 2000B, SBR, 05 (Insurance Type Code) field. If a MSP type is submitted that does not correspond to the information Medicare has on the beneficiary's file, the claim will be rejected.

MSP categories for other coverage include:

12 Working Aged; age 65 or over, employer's group plan has at least 20 employees

13 End-Stage Renal Disease (ESRD); 30-month initial coordination period in which other insurance is primary

14 No-Fault situations; Medicare is secondary if illness/injury results from a no-fault liability

15 Workers' Compensation (WC) situations

16 Federal, other

41 Black Lung Benefits

42 Veterans Administration (VA); either Medicare or VA may pay, not both

43 Disability; under age 65, person or spouse has active employment status and employer's group plan has at least 100 employees

47 Liability situations; Medicare is secondary if illness/injury results from a liability situation

SUBMITTING PAPER CLAIMS – TIPS AND REMINDERS

CMS transitioned providers to the CMS-1500 (02/12) version paper claim form in April 2014. Claims submitted on previous versions of the form will be rejected as unprocessable.

All paper claims are scanned and read by OCR (Optical Character Recognition) software. This software is used to translate images of scanned claims with handwritten, typewritten or printed text. OCR is a powerful alternative to keying claims from paper. It allows us to process claims as quickly and accurately as possible. Successful scanning begins with the proper submission of claim.

Here are some tips to keep in mind when completing the CMS-1500 (02/12) claim form:

- Print claims using 10, 11 or 12 point Courier or Arial font.
- Use capital letters. Mixed case can throw off character recognition (ex. '5' can become 'S').
- Use black ink. Red ink and highlighting cannot be read by the OCR equipment.
- 25% of the paper claims sent to us are either too light or too dark to be read accurately by our optical scanning equipment. Please ensure ink used on the claim is not too light or too dark.
- Do not use dot-matrix print.
- Avoid touching characters. Be sure there is adequate spacing between characters.
- Check the alignment of data on your printed claims before submitting them. Information should be contained within the specifically designated fields.
- Do not use whiteout/correction tape to make corrections for resubmitted claim data.
- Do not use rubber stamps or any other form of stamps to submit information on the claim
- Do not enter any data in item 17a, the shaded portion of item 24J, item 32b or item 33b. Claims submitted with data in these legacy provider fields will be returned to the provider.
- Claims that are too light, too dark, misaligned or not legible may be returned to the provider.

Palmetto GBA has created an interactive CMS-1500 (02/12) Form Tool to assist providers in correctly completing the paper claim form. On this tool, you can click on each field of the claim form to see instructions for completing that field. You can access the interactive form in the Self Service Tools section of our website homepage at www.PalmettoGBA.com/RR.

Here are tips for completing some specific fields of the CMS-1500 (02/12) claim form:

- **Item 1a** is for the beneficiary's Health Insurance Claim (HIC) number. Make sure the HIC that you enter is a Railroad Medicare number. All Railroad Medicare HIC numbers begin with 1, 2 or 3 letters followed by 6 or 9 digits.
- **Items 2 and 5** are specifically for the patient information. The name of the person who received the services must be indicated in Item 2. To reduce the possibility of claim rejections, it is imperative that the name match exactly as typed on the Railroad Medicare card.
- **Items 4 and 7** are for the insured's information. If the patient is the same as the insured, you may put the word 'SAME' in Items 4 and 7.
- **Item 11** is for insurance that is primary to Medicare. Block 11 cannot be left blank on paper claims.
  - If there is no insurance primary to Medicare, enter the word 'NONE'.
  - If there is insurance that is primary to Medicare, enter the insured's policy or group number and complete Items 11a-11c as well as Items 4, 6 and 7.

- **Item 17** is used to report the ordering or referring provider.
  - In the space to the left of the dotted vertical line, before the provider's name, enter a valid two-letter qualifier to identify the role of the provider. Choose the appropriate qualifier: DN (referring provider), DK (ordering provider) or DQ (supervising provider).
  - Enter the provider's name in the order of first name then last name.
  - Submit the provider's complete name spelled as it appears on the CMS Ordering and Referring File at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html.
  - Include a hyphen in the last name only if the last name is hyphenated on the CMS file
  - Do not submit middle initials or suffixes such as MD, DO, Jr, etc.
  - Do not submit Dr. before the name
- **Item 17a** is for the ordering/referring provider's NPI.
- **Item 17b** must be left blank. Do not enter your Railroad PTAN or any other number in the shaded area.
- **Item 21** is for the diagnosis code(s) and the ICD indicator.
  - In the ICD Indicator field, enter either a 9 for ICD-9 codes or 0 for ICD-10 codes. Claims submitted without a valid ICD indicator will be rejected as unprocessable.
  - You can enter up to 12 diagnosis codes in priority order in the fields coded from A to L, and displayed in left to right order on the claim form.
- **Item 24E** is for the diagnosis pointer. Enter the appropriate diagnosis code reference letter (A-L) from Item 21 that corresponds with the primary diagnosis for date of service and procedure performed. Enter only one reference number/letter per line item. If multiple services are performed, enter the primary reference number/letter for each service.
- **Item 24J** is for the rendering provider's NPI number. The shaded portion must be blank. Do not enter your Railroad PTAN or any other number in the shaded area.
- **Item 24d** requires only a valid five (5) character HCPCS or CPT-4 procedure code plus modifier(s). Do not type a description of the procedure code(s).   Up to four modifiers are allowed per service line.
- The **Item 24 A-J** service area can have no more than six (6) lines of service and no more than one service per line.
  - The shaded memo fields of the 24 A-J service area should be blank. These fields are not used by Medicare with the exception of NDC information for physician-administered drugs for Medicare/Medicaid patients.
- **Item 29** should only be used to report the total amount the patient paid on covered services. Do not use this field to report the amount a primary insurance paid.
- **Item 32** requires the name and complete address of where the services were rendered. Cannot be a PO Box.
- **Item 32b** must be left blank. Do not enter your Railroad PTAN or any other number in the shaded area.
- **Item 33** requires your legal business name and complete payment address.
- **Item 33a** is for the NPI of the billing provider or group.
- **Item 33b** must be blank. Do not enter your Railroad PTAN or any other number in the shaded area.
- In **Item 32 and Item 33** enter the address using the postal address code format (Company Name on Row 1, Company Address on Row 2, and City/State/Zip on Row 3) to help increase readability.
- In **Item 32 and Item 33** do not submit a phone number below the address. Phone numbers below the address are often picked up as PTANs or zip codes by the scanners.

NATIONALLY ACCEPTED MEDICARE MODIFIERS

Problems can occur when modifiers are used incorrectly. The following table provides some useful hints of when to use the modifier, and a brief description of the modifier. While this list is not all- inclusive, it is comprised of modifiers most commonly seen by Railroad Medicare, as well as other nationally accepted modifiers. Railroad Medicare only recognizes national modifiers. Local MAC assigned modifiers will cause denials. Some modifiers are informational only and do not affect claim payment with Railroad Medicare. Refer to the Healthcare Common Procedure Coding System (HCPCS) Level II Code Book, the Current Procedural Terminology (CPT) Book, and the Railroad Medicare Modifier Lookup self-service tool on our website for additional modifiers and/or more information.

- Our system can accept four modifiers. If more than four modifiers are needed to describe the service, modifier 99 should be used on the claim line. Each modifier should then be entered on the claim in Item 19 of the CMS-1500 (02/12) form or the Narrative section of the ANSI 5010 EMC Claim.

AMBULANCE

HCPCS Modifier	Description
D	Diagnostic or Therapeutic site other than "P" or "H" when these are used as origin codes (treatment facility)
E	Residential, domiciliary, custodial facility (other than a 1819 facility) (Nursing Home)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital based dialysis facility (free-standing)
N	Skilled Nursing Facility (SNF, 1819 facility, ECF)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	(Destination code only) Intermediate stop at a physician's office en-route to the hospital (includes HMO non-hospital facility, clinic, etc.)
GM	Multiple patients on one ambulance trip.
QL	The patient is pronounced dead after the ambulance was called (it is not necessary to use destination codes as the following outlines).

Ambulance providers should combine two alpha characters to create a modifier that describes the origin and destination of the ambulance service. The first position alpha character = origin; the second position alpha character = destination. The two alpha character combinations must be billed in item 24D of the CMS-1500 (02/12) claim form or the equivalent field of the ANSI 5010 EMC claim.

AMBULATORY CARDIAC MONITORING

HCPCS Modifier	Description
QC	Single channel monitoring
QD	Recording and storage in solid state memory by a digital recorder
QT	Recording and storage on tape by an analog tape recorder

AMBULATORY SURGICAL CENTER (ASC)

CPT Modifier	Description
73	Discontinued outpatient hospital/ ambulatory surgical center (ASC) procedure prior to the administration of anesthesia
74	Discontinued outpatient hospital/ ambulatory surgical center (ASC) procedure after the administration of anesthesia
TC	Technical Component - Must be reported for facility charges associated with HCPCS codes that have both a technical and professional component (e.g., radiology services) under the Medicare Physician Fee Schedule (MPFS)

AMBULATORY SURGICAL CENTER (ASC), CONT.

HCPCS Modifier	Description
FB	Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (including: covered under warranty, replaced due to defect and free samples)
FC	Partial credit received for replaced device - Report this modifier with the facility charge for the surgery when a device is furnished with a partial credit for a replacement device
SG	Ambulatory surgical center (ASC) facility service. Not required for dates of service on or after January 1, 2008

ANESTHESIA

HCPCS Modifier	Description
AA	Anesthesia services performed personally by anesthesiologist
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures
G8	Monitored anesthesia care for deep, complex, complicated, or markedly invasive surgical procedure
G9	Monitored anesthesia care for patient who has history of severe cardio-pulmonary condition
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QS	Monitored anesthesia care service (can be billed by a CRNA or a physician)
QX	CRNA service: with medical direction by a physician
QY	Medical direction of one CRNA by an anesthesiologist
QZ	CRNA service: without medical direction by a physician
CPT Modifier	**Description**
23	Unusual anesthesia
47	Anesthesia by surgeon

ASSISTANT AT SURGERY

HCPCS Modifier	Description
AS	Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant at surgery
CPT Modifier	**Description**
80	Assistant surgeon - Use for assistant surgeon services rendered by a qualified physician in a non-teaching facility - Allowable for MDs and/or DOs only - The same doctor cannot bill as the surgeon and as the assistant surgeon
81	Minimum assistant surgeon - Not to be used for services performed by PAs or RNs - Use for minimal assistant surgeon services rendered by a qualified phy sician in a non-teaching facility
82	Assistant surgeon (when qualified resident surgeon not available) - Used for MD and/or DO only

CATASTROPHE / DISASTER

HCPCS Modifier	Description
CR	Catastrophe / Disaster Related
CS	Item or service related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico, including but not limited to subsequent clean-up activities.

CHIROPRACTOR

HCPCS Modifier	Description
AT	Acute treatment - Use when providing active/corrective treatment for acute or chronic subluxation - Do not use when providing maintenance therapy - Documentation in the patient's medical record must support the active nature of the treatment

CLINICAL TRIALS

HCPCS Modifier	Description
Q1	Item or service provided as routine care in a Medicare qualifying clinical trial. Q1 replaced HCPCS modifier QV for dates of service on or after January 1, 2008.
Q0	Item or service provided as non-routine care in a Medicare qualifying clinical trial. Investigational clinical service provided in a clinical research study that is in an approved clinical research study.

CORONARY ARTERIES

HCPCS Modifier	Description
LC	Left circumflex coronary artery
LD	Left anterior descending coronary artery
LM	Left main coronary artery
RC	Right coronary artery
RI	Ramus intermedius coronary artery

CORRECT CODING (NATIONAL CORRECT CODING INITIATIVE)

CPT Modifier	Description
59	Distinct procedural service - Use when documentation indicates the service rendered was distinct or separate from other services performed on the same day. Examples: service was performed in a different session or patient encounter; performed on a different site or organ system, separate incision or excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same physician - In Correct Coding situations, use on the NCCI column II code - Use of this modifier does not guarantee a service will be paid separately - For NCCI purposes, modifier 59 should <u>only</u> be used when NO other more specific NCCI-associated modifier* is appropriate and the use of modifier 59 best explains the clinical circumstances. * See the new distinct procedural service modifiers XE, XS, XP and XU that CMS created as specific subsets of modifier 59 * See also E1, E2, E3, E4, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, LC, LD, LM, RC, RI, LT, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, 25, 27, 58, 78, 79, and 91.
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service - May be used to signify that the E/M service was performed for a reason unrelated to the other procedure in the NCCI code pair - Use of this modifier does not guarantee a service will be paid separately

HCPCS Modifier	Description
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter - Use on the NCCI column II code - Use only when another valid NCCI-associated modifier does not describe the separate service - Do not use on the same line with modifier 59 or on E/M codes - Documentation in the patient's record must clearly support the use of modifier XE - Use of this modifier does not guarantee a service will be paid separately
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure - Use on the NCCI column II code - Use only when another valid NCCI-associated modifier does not describe the separate service - Do not use on the same line with modifier 59 or on E/M codes - Documentation in the patient's record must clearly support the use of modifier XS - Use of this modifier does not guarantee a service will be paid separately
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner - Use on the NCCI column II code - Use only when another valid NCCI-associated modifier does not describe the separate service - Do not use on the same line with modifier 59 or on E/M codes - Documentation in the patient's record must clearly support the use of modifier XP - Use of this modifier does not guarantee a service will be paid separately

CORRECT CODING, CONT.

XU	Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service - Use on the NCCI column II code - Use only when another valid NCCI-associated modifier does not describe the separate service - Do not use on the same line with modifier 59 or on E/M codes - Documentation in the patient's record must clearly support the use of modifier XU - Use of this modifier does not guarantee a service will be paid separately

DIAGNOSTIC TESTS

HCPCS Modifier	Description
TC	Technical component (Must be submitted in the first modifier field)

CPT Modifier	Description
26	Professional component (Must be submitted in the first modifier field)

END STAGE RENAL DISEASE (ESRD)/CHRONIC RENAL DISEASE (CRD)

HCPCS Modifier	Description
CB	Service ordered by a renal dialysis facility (RDF) physician as part of the ESRD beneficiary's dialysis benefit - Not part of the composite rate; separately reimbursable
EJ	Subsequent claims for a defined course of therapy, e.g., EOP, Sodium Hyaluronate, infiximab.
Q3	Live kidney donor: services associated with postoperative medical complications directly related to the donation
AY	Item or service furnished to an ESRD patient that is not for the treatment of ESRD.

ERYTHRYOPOETIC STIMULATING AGENT (ESA)

HCPCS Modifier	Description
EA	Erythryopoetic stimulating agent (ESA) administered to treat anemia due to anti-cancer chemotherapy
EB	Erythryopoetic stimulating agent (ESA) administered to treat anemia due to radiotherapy
EC	Erythryopoetic stimulating agent (ESA) administered to treat anemia not due to anti-cancer radiotherapy or anti-cancer chemotherapy
ED	Hematocrit level has exceeded 39 percent (or hemoglobin level has exceeded 13.0 g/dl) for three or more consecutive billing cycles immediately prior to and including the current cycle
EE	Hematocrit level has not exceeded 39 percent (or hemoglobin level has not exceeded 13.0 g/dl) for three or more consecutive billing cycles immediately prior to and including the current cycle
GS	Dosage of EPO or Darbepoeitin Alfa has been reduced and maintained in response to hematocrit or hemoglobin level
JA	Administered intravenously - All providers that submit claims for injections of ESA for ESRD beneficiaries are encouraged to include HCPCS modifier JA or JB on their claims to the route of administration
JB	Administered subcutaneously - All providers that submit claims for injections of ESA for ESRD beneficiaries are encouraged to include HCPCS modifier JA or JB on their claims to the route of administration

EVALUATION AND MANAGEMENT

CPT Modifier	Description
21	Prolonged Evaluation and Management (E&M) services
24	Unrelated Evaluation and Management service by the same physician during a postoperative period - Should only be used by the surgeon for an E&M service rendered during the postoperative period that is totally unrelated to the procedure previously performed - Use only with E&M and eye exam codes - Supporting documentation in the form of a clearly unrelated diagnosis code and/or additional documentation must be submitted with the claim

EVALUATION AND MANAGEMENT, CONT.

25	Significant, separately identifiable Evaluation and Management service by the same physician on the same day as a surgical procedure - Used by the surgeon on an E&M code performed on the same day as a minor surgical procedure (000 or 010 global days) when the E&M service is significant and separately identifiable from the usual work associated with the surgery - Use only with E&M and eye exam codes - Documentation in the patient's medical record must support the use of this modifier
57	Decision for surgery - Should only be used when an E&M service performed by the surgeon the day before or the same day as a major surgical procedure (090 global days) resulted in the decision to perform the procedure - Use only with E&M and eye exam codes - Documentation in the patient's medical record must support the use of this modifier

EYE   (These modifiers are informational only. The use of an additional modifier may be required for claim payment)

HCPCS Modifier	Description
E1	Upper left eyelid
E2	Lower left eyelid
E3	Upper right eyelid
E4	Lower right eyelid

HOSPICE

HCPCS Modifier	Description
Q5	Service furnished by a substitute physician under a reciprocal billing arrangement - Should be submitted with the GV modifier - Claim should be billed under the attending physician's provider number, not the substituting physician's
GW	Service not related to the hospice patient's terminal condition
GV	Attending physician not employed or paid under agreement by the patient's hospice provider

HPSA

HCPCS Modifier	Description
AQ	Physician providing service in a Health Professional Shortage Area (HPSA) - Used only for professional services rendered by a physician.
AZ	Dental HPSA

LABORATORY

HCPCS Modifier	Description
LR	Laboratory round trip - Used only with travel fees - Not to be used on lab codes
QP	Documentation is on file showing that the laboratory test(s) was ordered individually or ordered as a CPT-recognized panel other than automated profile codes 80002-80019, G0058, G0059, and G0060
QW	CLIA waived test
Q4	Service for ordering/referring physician qualifies as a service exemption
TS	Follow up diabetes screening test performed on individual diagnosed with pre-diabetes (effective October 1, 2005).

CPT Modifier	Description
90	Reference (outside) laboratory - Item 20 of the CMS-1500 (02/12) claim form or the Purchased Service Charges field of the ANSI 5010 EMC claim (Loop 2400, PS1, 02) should be checked "yes" and the purchase price of the test must be indicated - The NPI number of the referring lab must appear in item 32A the CMS-1500 (02/12) claim form or in the Facility NPI number field of the ANSI 5010 EMC claim (Loop 2310C, NM1/77, 09)
91	Repeat clinical diagnostic lab test

LIMITATION OF LIABILITY

HCPCS Modifier	Description
GA	Waiver of liability statement issued as required by paper policy individual case (also known as Advance Beneficiary Notice)
GU	Waiver of liability statement issued as required by payer policy, routine notice.
GY	Non-covered item or service that does not have Medicare benefits
GX	Voluntarily obtained a valid Advance Beneficiary Notice of Noncoverage (ABN). This includes ABNs obtained for services that are 'statutorily denied,' such as physical therapy services provided by chiropractors. You may, but are not required to, ask patients to sign ABNs for services that are 'statutorily denied.'
GZ	Item or service expected to be denied as not reasonable and necessary and an Advanced Beneficiary Notice has not been signed by the beneficiary

MISCELLANEOUS

HCPCS Modifier	Description
AP	Determination of refractive state was not performed in the course of diagnostic ophthalmological examination
AO	Alternate payment method declined by provider of service
CG	Policy criteria applied
GG	A screening test was changed to a diagnostic test on the same day
GH	Screening mammogram converted to a diagnostic mammogram on the same day
GT	Via interactive audio and video telecommunication systems
GQ	Via asynchronous telecommunications systems - Use only for federal telemedicine demonstrations conducted in Alaska or Hawaii
JC	Skin substitute used as a graft - HCPCS codes Q4100 through Q4121, Q4131-Q4136, G0440 or G0441 must be submitted with either HCPCS modifier JC or JD
JD	Skin substitute not used as a graft - HCPCS codes Q4100 through Q4121, Q4131-Q4136, G0440 or G0441 must be submitted with either HCPCS modifier JC or JD
KZ	New coverage not implemented by managed care
LT	Left side (Informational only)
PT	Colorectal cancer screening test; converted to diagnostic test or other procedure - Use with the appropriate CPT code for colonoscopy, flexible sigmoidoscopy or barium enema when the service is initiated as a colorectal cancer screening service but becomes a diagnostic service - Use with CPT codes 10000 through 69999
QJ	Service to a prisoner in state or local custody
Q5	Service furnished by a substitute physician under a reciprocal billing arrangement
Q6	Service furnished by a *locum tenens* physician
RT	Right side (Informational only)
V6	Arteriovenous graft or other vascular access not including a vascular catheter
V7	Arteriovenous Fistula only (in use with two needles).

CPT Modifier	Description
32	Mandated services
33	Preventive Services: when the primary purpose of the service is the delivery of an evidence based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory) - Do not use on separately reported services specifically identified as preventive - Effective January 1, 2015, anesthesia professionals who furnish a separately payable anesthesia service in conjunction with a screening colonoscopy shall include modifier 33 on the anesthesia services. The services will qualify for waiver of coinsurance and deductible.
99	Multiple modifiers - Use only when more than four modifiers are necessary per line item - Use Item 19 of the CMS-1500 (02/12) claim form to enter all of the applicable modifiers for paper claims - Use the Documentation Record to enter all of the applicable modifiers for electronic claims

NATIONALLY ACCEPTED MEDICARE MODIFIERS, CONTINUED

MUSCULOSKELETAL (These modifiers are informational only. An additional modifier may be required for claim payment)

HCPCS Modifier	Description
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit

OPT OUT PROVIDERS

HCPCS Modifier	Description
GJ	Opt out physician or practitioner emergency or urgent service

PODIATRY

HCPCS Modifier	Description
Q7	One class A finding
Q8	Two class B findings
Q9	One class B and two class C findings

PORTABLE XRAY

HCPCS Modifier	Description
UN	Two patients served (used with procedure R0075)
UP	Three patients served (used with procedure R0075)
UQ	Four patients served (used with procedure R0075)
UR	Five patients served (used with procedure R0075)
US	Six or more patients served (used with procedure R0075)

POSITION EMISSION TOMOGRAPHY (PET) SCAN

HCPCS Modifier	Description
PI	Initial Anti-tumor Treatment Strategy
PS	Subsequent Treatment Strategy

PROSTHETICS

HCPCS Modifier	Description
LS	FDA monitored Intraocular Lens Implant

PROVIDER TYPE

HCPCS Modifier	Description
AE	Registered Dietician
AI	Identifies the physician that oversees the patient's care from all other physicians who may be furnishing specialty care. Only the principal physician of record may submit this modifier.

PSYCHOLOGICAL

HCPCS Modifier	Description
AH	Clinical Psychologist
AJ	Clinical Social Worker

REPEAT PROCEDURES

CPT Modifier	Description
76	Repeat procedure by the same physician
77	Repeat procedure by a different physician

PHYSICAL THERAPY/OCCUPATIONAL THERAPY/SPEECH LANGUAGE PATHOLOGY

HCPCS Modifier	Description
GN	Service delivered personally by a speech-language pathologist or under an outpatient speech-language pathology plan of care
GO	Service delivered personally by an occupational therapist or under an outpatient occupational therapy plan of care
GP	Service delivered personally by a physical therapist or under an outpatient physical therapy plan of care
KX	Patient has already met the financial cap for PT/SLP or OT, and the service qualifies as an 'exception' to be reimbursed over and above the cap
CH	0% impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted

SURGERY

CPT Modifier	Description
22	Unusual procedural services - Use only in conjunction with surgical procedure codes - Submit operative report and/or a written detailed description with the initial claim
50	Bilateral procedure - Use only with surgery codes identified by CMS as bilateral procedures - Bill on one line (i.e., 15822-50) instead of two lines (i.e., 15822, 15822-50) - Should be used for some ophthalmology diagnostic tests - The number of services should be one (1)
51	Multiple procedures - Use when more than one surgical procedure is performed - Use on the secondary procedure.
52	Reduced services - Use when less than the full service is performed (the submitted amount should be reduced accordingly) - Should be supported by documentation and a brief statement of explanation to clarify the reduction
53	Discontinued procedure - Attach operative notes to the initial claim - Claims without the proper documentation will be denied and must be resubmitted for payment

SURGERY, CONT.

54	Surgical care only - Use with surgery code to indicate postoperative care was done in part or whole by another provider - Appropriate for surgery codes only - Includes coverage for the surgical procedure and the preoperative care
55	Postoperative management only - Use with the surgery code - The date of service should always be the same as the date of the surgery - The date the provider assumed and relinquished care should be indicated in Item 19 of the CMS-1500 (02/12) claim form. On an ANSI 5010 EMC claim, the dates can be entered into either the narrative section (Loop 2300 or 2400, NTE, 02) or in the Assumed & Relinquished Care Dates section (Loop 2300, DTP/90 or 91, 03) - The total number of post-operative days the provider was responsible for should be indicated in Item 24G of the CMS-1500 (02/12) claim form or the equivalent days or units of service field on the ANSI 5010 EMC claim - Billing for the number of times the provider saw the patient during the post-operative period, rather than the number of post-operative days the provider was responsible for, will result in an underpayment.
58	Staged or related procedure or service by the same physician during the postoperative period If the surgeon performs a subsequent surgery related to the original surgery, the surgery may be paid separately if it: - Is a staged procedure - Is a more extensive procedure than the original - Involves therapy following a diagnostic surgical procedure
62	Two surgeons - The surgeons must have different specialties or documentation must be available to verify the necessity for two surgeons of the same specialty - An assistant at surgery may not be billed when co-surgeons are billed
66	Surgical team
78	Return to the operating room for a related procedure during the postoperative period - Use only if the procedure is related to complications of the previous procedure - Use only when procedures are performed in an operating room, cardiac catheterization suite, laser suite, or endoscopy suite - Use on surgical procedures only - Does not start a new global period
79	Unrelated procedure or service by the same physician during the postoperative period - Use only when the procedure performed is unrelated to the previous procedure - Use on surgical procedures only - Starts a new global period

HCPCS Modifier	Description
PA	Surgery wrong body part
PB	Surgery wrong patient
PC	Surgery wrong patient

TEACHING PHYSICIAN

HCPCS Modifier	Description
GC	This service has been performed in part by a resident under the direction of a teaching physician.
GE	This service has been performed by a resident without the presence of a teaching physician under the primary care exception

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

The ABN is a notice given to beneficiaries to convey that Medicare is not likely to provide coverage in a specific case because it is not considered medically reasonable and necessary by Medicare. Providers must complete the ABN per CMS requirements and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice.

ABN Requirements:

- All providers are required to use the CMS ABN form, available on the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html

- Notices placed on the CMS site can be downloaded and should be used as is because the ABN is a standardized OMB-approved notice

- It is not appropriate to ask patients to sign an ABN for every service

- The ABN form must be:
    - Reproduced as a single page (you may customize some fields of the ABN to integrate the ABN into other automated business processes)
    - Presented to the patient before the service or procedure is initiated
    - Verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed
    - Delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice

- Maintain a signed copy of the form in the patient's medical record.

RETURN REJECT TROUBLESHOOTER

A claim that has been rejected may have the following message codes on your remittance notice:

CO-16 – *Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.*
MA130 - *Your claim contains incomplete and/or invalid information, and not appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.*

If your claim is rejected for an administrative reason, the claim must be submitted as a **new claim with the correct information.** If you are required to submit electronic claims, do not resubmit a rejected claim on paper.

An MA130 rejection is a contractual obligation and <u>has no appeal rights</u>. It is classified as a Return Reject. If you request an appeal on a claim rejected with MA130, your request will be dismissed. This will further delay the adjudication process of your claim.

Read your remit to find out the specific reason for rejection so you can make the necessary corrections and submit a new claim.

Your remittance advice also contains specific reasons for nonpayment. You will find some of the most common rejections, and their solutions, in the following chart.

REJECTION	DESCRIPTION	PROBLEM	SOLUTION
N34	*Incorrect claim form/format for this service.*	Paper claim was submitted on old CMS-1500 (08-05) version form	Use only the new CMS-1500 (02/12) version form
MA83	*Did not indicate whether we are the primary or secondary payer.*	Item 11 is blank	If Railroad Medicare is primary insurance for the beneficiary, enter "**NONE**" in Item 11
MA04	*Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.*	There is a policy number and/or insurance name in Item 11 but no EOB attached	An EOB from the primary insurer needs to be attached to paper the claim.
N265 **N276**	*Missing/incomplete/invalid ordering provider primary identifier.* *Missing/incomplete/invalid other payer referring provider identifier.*	Item 17b - The referring/ordering provider NPI is blank or invalid	Enter a valid NPI for the referring/ordering provider's name listed in Item 17 along with the correct qualifier
MA120	*Missing/incomplete/invalid CLIA certification number.*	▪ The **CLIA #** is not in Item 23 of the claim ▪ The **CLIA #** has too few or too many characters ▪ The **CLIA #** is not legible	▪ Put your correct **CLIA #** in Item 23 ▪ Enter the **CLIA #** using the correct format

N657 **11**	*This should be billed with the appropriate code for these services.* *The diagnosis is inconsistent with the procedure.*	Item 21 - Invalid/ missing or truncated diagnosis. Item 21 - Invalid or missing ICD Indicator (9 for ICD-9, or 0 for ICD-10) Item 24e - Missing or invalid diagnosis pointer	Refer to the most recent ICD-CM coding for correct/most specific diagnosis for your date of service. Enter the correct ICD indicator for the type of ICD-CM code billed In Item 24e, enter one letter (A-L) from Item 21 to indicate the corresponding primary diagnosis code for the date of service and procedure performed.
M52	*Incomplete/invalid "from" date(s) of service.*	Item 24A is blank or contains an invalid date of service.	Enter complete and valid "from" and "to" dates of service.
M77	*Missing/incomplete/invalid/ inappropriate place of service.*	Item 24B - Missing/ incorrect/invalid 2-digit place of service code	Make sure you are using the correct 2 digit place of service code for the services you are billing
M51	*Missing/incomplete/invalid procedure code(s).*	Item 24D - Incorrect/ invalid procedure code.	▪ Make sure the procedure code is valid for the DOS ▪ Make sure the procedure code has been keyed/printed correctly
M52	*This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.*	Item 24B - Missing or invalid reporting codes and the associated modifiers	The appropriate reporting codes and associated modifiers should be submitted with this procedure code.
MA81	*Missing/incomplete/invalid provider/supplier signature.*	Item 31 is blank and/or has an unacceptable entry. The name of a facility or supplier is not acceptable (ex. ambulance company name, laboratory name, ASC name)	Enter an acceptable signature. Acceptable claim signatures include: stamped, handwritten, pre-printed, computer generated, or typed name of provider or authorized employee/billing agent, and/or signature on file.
MA114	*Missing/incomplete/invalid information on where services were furnished.*	Item 32 is blank and/or has an unacceptable entry (PO Boxes are unacceptable).	The complete name, street address, city, state and zip code of the facility where services were rendered must be entered in Item 32

eSERVICES

Palmetto GBA is pleased to offer eServices, our free, secure Internet-based, provider self- service portal. The eServices application provides information access over the Web for the following online services:

- Beneficiary Eligibility
- Claims Status
- eClaim Submissions
- Remittances Online
- Financial Information - Payment Floor, Last Three Checks Paid, eOffset requests, and eCheck payments
- Appeals Submissions - Reopenings and Redeterminations
- Medical Review ADR Response Form
- General Inquiry Request Form
- eDelivery of Medical Review and Claims ADR letters, Medicare Redetermination Notices, Overpayment Demand Letters and General Correspondence Responses

All forms currently have a file size limitation of 40 MB per attachment. Users may attach an unlimited number of attachments as long as individual files do not exceed 40 MB and the total size of all attachments does not exceed 150 MB.

You can participate in eServices if you have a signed electronic data interchange (EDI) Enrollment Agreement on file with Palmetto GBA Railroad Medicare. If you are already submitting claims electronically to Railroad Medicare, you do not have to submit a new EDI Enrollment Agreement.

Note: Only one provider administrator per PTAN/NPI combination performs the registration process. The provider administrator grants permissions to additional users related to that PTAN/NPI combination. Billing services and clearing houses should contact their provider clients to gain access to the system.

Registration and Login
To register, you will need your Railroad Medicare Provider Number (PTAN), NPI, tax ID number and the amount of the last Railroad Medicare payment you received. You must register for each PTAN/NPI combination separately. Each combination will be assigned a unique User ID.

Use the following instructions to register for and access the portal. If you are having problems registering or have questions, please view our eServices User Manual and eServices FAQs under eServices, at www.PalmettoGBA.com/RR.

To register on our website:

- Go to www.palmettogba.com/eServices
- Click on the Register Now button in the New User Box
- Complete the online form (Choose Railroad Specialty Medicare Administrative Contractor under Line of Business)
- Click 'Submit'
- Make a note of your User ID
- Choose your security questions and answers
- Choose your password
- Verify your email address by accessing the link in your verification email
- Login as a Returning User

USING THE INTERACTIVE VOICE RESPONSE (IVR) SYSTEM

Claim status, beneficiary eligibility and duplicate remittance notices should be requested by calling our Railroad Medicare Interactive Voice Response (IVR) System.

- The IVR line is available Monday through Friday, from 7:00 a.m. to 11:00 p.m. Eastern Time.

- General Medicare information is available 24 hours a day, seven days a week.

- Our peak calling times are between 12:00 p.m. to 3:00 p.m. Eastern Time.

CMS mandates that claim status and beneficiary eligibility must be obtained through the IVR system.

As an alternative to the IVR, use our eServices internet portal. See page 25 for details.

Railroad Medicare's Interactive Voice Response (IVR) system allows providers access to:

- **Eligibility** – Gives Part B benefits such as entitlement dates, termination dates, date of death (voiced as a termination date), deductible, physical and occupational therapy.
- **Eligibility for a Specific Date of Service** - Gives the following eligibility data for a specific date of service entered in MMDDYYYY format. The DOS can be up to 27 months in the past and up to four months in the future.
    - Crossover
    - Hospice
    - Skill Nursing
    - Pneumonia Vaccination
- **Benefits** –Gives Medicare Secondary Payer (MSP), Managed Care, Medicare Advantage Plan, Crossover, Hospice, Skilled Nursing, Home Health (only states if currently enrolled) and Pneumonia benefits.
- **Claim Status** –Gives the following status information for a date of service entered in MMDDYYYY format:
    - Claim is pending, processed, paid, rejected or denied
    - The payment details for paid claims
    - The Internal Control Number (ICN) for the claim (all claims types except rejections)
    - No claim on file for the date of service
- **Payment Information** – Payment Floor gives pending count as of year to date. Last Three Checks gives information on the last three checks issued.
- **Remittance Advice** – Gives option to request a duplicate remittance by check number or by patient Medicare number.
- **Redeterminations** – Gives redetermination guidelines only.   Use the Railroad Medicare Redetermination Status Tool on our website to check the status of an appeal.
- **General Information** – Gives eligibility, managed care, multiple surgery guidelines. Educates on Advance Beneficiary Notices and gives the hours of operation.
- **Website Address** – Gives address for CMS and Palmetto GBA.
- **NPI verification** – Callers must enter their NPI, PTAN, and last five digits of the Tax ID. The IVR will check a crosswalk table for Railroad Medicare and state if the NPI is on file.

To access the IVR system, call 877- 288-7600.

Initial IVR Menu Options	
Claim Status, Eligibility Information, Duplicate Remittance or General Information	Press **1**
NPI Verification	Press **2**
Customer Service, Provider Enrollment, Reopenings, or EDI Telephone Numbers	Press **3**
Our Mailing Address and Hours of Operation	Press **4**

Main Menu

After the pressing 1 on the initial menu, you will be offered the following options:

- To receive information on a specific claim or inquiry of a claim (requires ICN number), press 1.
- To receive payment information, press 2.
- To check Medicare eligibility, benefits and deductible information, press 3.
- To request a copy of your Medicare remittance notice, press 4.
- To receive instructions on how Medicare pays and the redetermination process, press 6.
- For a list of website addresses about new legislation, other provider issues, provider workshops, and the top ten claim submission errors, press 7.
- To receive general information or hours of operation, press 8.
- To end the call, press 9.

Provider and beneficiary authentication elements will be requested before you will be able to access provider and patient specific information from our Medicare files. The tables below explain how to enter the required provider and beneficiary information into the IVR. **You can also use the IVR Conversion Tool located under Self-Service Tools on our website's homepage to convert the provider's PTAN and the beneficiary's Medicare Number and name.**

How to enter the provider's PTAN:

The following table should be utilized to enter alphabetic characters of the provider's PTAN. For example: If the PTAN is the individual number of P, then enter *7. If the PTAN is the group number listed contains the letters CM, then enter *23 followed by the other numeric characters. Please note that the provider's PTAN, NPI and Tax ID must correspond. This means if the provider enters their individual PTAN, then the individual NPI for that provider must be entered. If the provider enters their group PTAN, then the group NPI for that provider must be entered.

NOTE: The provider's NPI and Tax identification number will be entered corresponding to the key pad on the telephone.

A	B	C	D	E	F	G	H	I	J	K	L	M
*21	*22	*23	*31	*32	*33	*41	*42	*43	*51	*52	*53	*61

N	O	P	Q	R	S	T	U	V	W	X	Y	Z
*62	*63	*71	*72	*73	*74	*81	*82	*83	*91	*92	*93	*94

How to enter the Health Insurance Claim (HIC) number:

The following table should be utilized to enter the alphabetic portion of a Medicare number. For example: If the Medicare number begins with an A, enter *21 to represent the "A" followed by the numeric portion of the Railroad Medicare number.

A	B	C	D	E	F	G	H	I	J	K	L	M
*21	*22	*23	*31	*32	*33	*41	*42	*43	*51	*52	*53	*61
N	O	P	Q	R	S	T	U	V	W	X	Y	Z
*62	*63	*71	*72	*73	*74	*81	*82	*83	*91	*92	*93	*94

How to enter the beneficiary's last name and first initial:

When checking eligibility, if the last name is less than six letters, all alpha characters must be entered followed by the (#) sign along with the patient's initial of the first name. If the last name has less than six letters followed by suffix of "Jr." or "Sr." then the last name would need to be entered followed by the first initial of the suffix. For example, if the beneficiary's name shows in HIMR as John Kneer Sr., the provider will enter the numbers that correspond with the letters K-N-E-E-R-S- # followed by "J" for John.

If the last name has more than six letters (such as Brad Johnson Jr.), you will only use the first six letters of the last name Johnson. If the last name and the suffix are less than six letters combined, the provider will not add any additional characters or numbers; they will simply press the pound key.

The following table should be utilized to enter the first characters of the beneficiary's last name & first initial. For example: If the beneficiary's name is Mary Smith, you would enter 76484 for Smith and 6 for Mary. For a beneficiary with the name of Steve McDonald, you would enter 623662 for McDonald and 7 for Steve.

ABC	DEF	GHI	JKL
2	3	4	5
MNO	PQRS	TUV	WXYZ
6	7	8	9

NOTE: _The patient's date of birth must be entered in the format of MMDDYYYY and will correspond with the telephone key pad on the telephone._

NPI Verification Option

NPI verification is Option 2 on the Initial IVR menu. On this option, you will be prompted to enter the provider's NPI, PTAN, and last five digits of the tax id. The IVR will check a crosswalk table for Railroad Medicare and state if the NPI is on file. PTANS are entered the same as they are in the IVR.

The IVR currently voices the following:

- If the caller enters an NPI and PTAN that match but the Tax ID does not, the IVR voices "The tax identification number entered is not valid."

- If the caller enters an NPI that is on file, but the PTAN does not match the NPI, the IVR voices "We do not have…in our records. Please verify the PTAN."

- If the caller enters an NPI that is not on file, the IVR voices "The NPI, PTAN, and Tax ID combination that you entered is not on file with Railroad Medicare."

If after using the IVR you discover that your claim has rejected or denied, or if you have any additional questions regarding your claim, you may call Customer Service toll-free by dialing 888-355-9165. Press 5 for Customer Service, and then to speak with a Customer Service Advocate, press 0.

PLEASE NOTE: Customer Service Advocates are available from 8:30 a.m. to 4:30 p.m. for all time zones with the exception of Pacific Time (PT) which receives service from 8:00 a.m. to 4:00 p.m. PT.

CMS requires providers to use the IVR to access claim status and beneficiary eligibility information.

When you call the toll-free 888-355-9165 line, the system provides the following options:

To Access:	Key to Press
Claim Status or Eligibility Information	Press 1
EDI or eServices	Press 2
Provider Enrollment	Press 3
Telephone Reopening	Press 4
Customer Service	Press 5
Our Mailing Address and Hours of Operation	Press 6
To repeat this menu	Press 9

After choosing Option 5 for Customer Service, the system provides the following options:

Option	Key to Press
For information on pre-authorization guidelines for items or services	Press 1
To speak with a Customer Service Representative	Press 0
To return to the Main Menu	Press 8
To repeat these options	Press 9

RAILROAD MEDICARE APPEALS AND REOPENINGS PROCESSES

Medicare offers five levels in the Part B appeals process. The levels, listed in order are:

1. Redetermination by the Medicare Administrative Contractor (MAC/SMAC)
2. Reconsideration by a Qualified Independent Contractor (QIC)
3. Hearing by an Administrative Law Judge (ALJ)
4. Review by the Medicare Appeals Council within the Departmental Appeals Board (DAB)
5. Judicial review in the U.S. Federal District Court

First Level of Appeal: Redetermination

If you are dissatisfied with the initial determination of your claim, you may file a request for redetermination by one of the following methods:

- On a CMS-20027 (12/10) Medicare Redetermination Request-1st Level of Appeal Form, available at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html,
- On a Railroad Medicare Redetermination Request form from our website at www.palmettogba.com/RR/Forms,
- On an eServices First Level Appeal eForm (see page 25 for more information), or
- Via the esMD (Electronic Submission of Medical Documentation) mechanism. For more information about esMD, please see the CMS website at www.cms.gov/esmd

If you are requesting an appeal of an overpayment, you may use the Railroad Medicare Redetermination Overpayment Appeal Request Form, which is located on our website under Forms, or the eServices Overpayment Appeal eForm.

Appeals requests can be faxed to 803-462-2218.

If you do not wish to use a form to file a redetermination or an overpayment appeal, you can send in a written and signed request expressing disagreement with the initial determination. Your request must contain the following information:

- Beneficiary name
- Medicare health insurance claim (HIC) number
- Date(s) of service for which the initial determination was issued
- The service/item that are at issue in the appeal
- The name and signature of the party or the representative of the party. A signature must be handwritten; electronic signatures suffice for appeals submitted through the eServices portal.

Important Redetermination Information:

1. Some denials can be adjusted via telephone reopening. See our website at www.PalmettoGBA.com/RR for more details about the Reopenings process
2. Timeframe: 120 days from the receipt of the initial determination. The notice of initial determination is presumed to be received 5 days from the date of the notice.
3. When submitting medical documentation such as operative notes, ambulance trip reports, radiology reports, etc, a valid signature must be present to signify knowledge, approval, acceptance or obligation. See CMS IOM Pub. 100-08, Chapter 3, Section 3.3.2.4 - Signature Requirements for details.

4. Services that are rejected with remittance advice remark code MA130 do not have appeal rights. These claims should be resubmitted as new claims with the correct information. If you are required to submit claims electronically, do not resubmit a rejected claim on paper. To determine what is missing or invalid on these rejections, please refer to the Claim Adjustment Reason Code (CARC) and the Remittance Advice Remark Code (RARC) in the MOA, REM and Glossary sections of your remittance advice. For help reading your remittance advice, see our Interactive Remittance Advice Tool under Self-Service Tools on our website home page. Also see the RETURN REJECT TROUBLESHOOTER on page 23-24 of this guide.

Railroad Medicare Redetermination Status Tool

To find the status of your redetermination request, use the Redetermination Status Tool found in the "Self Service Tools" sections of our home page or follow this link:
http://www4.palmettogba.com/pgx_rrbredeterminations/

Enter the Internal Control Number (ICN) of the claim in question and click "**Search Now**". The ICN for the claim is located on your remittance notice on the same line as the patient's name. If you submitted more than one appeal for the same claim, the tool will display the results from your first level of appeal.

Second Level of Appeal: Reconsideration by a Qualified Independent Contractor (QIC)

A party to the redetermination may request a reconsideration if dissatisfied with the redetermination. A QIC will conduct the reconsideration. The introduction of QICs allows for an independent review of medical necessity issues by a panel of physicians or other health care professionals.

Important Reconsideration Information:

1. A written reconsideration request must be filed within **180 days of receipt of the redetermination decision.**
2. To request a reconsideration, follow the instructions on your Medicare Redetermination Notice (MRN).

Third Level of Appeal: Administrative Law Judge (ALJ) Hearing

For hearing requests filed on or after January 1, 2015, if at least $150 remains in controversy following the QIC's decision, a party to the reconsideration may request an ALJ hearing.

Important ALJ Information:

1. An ALJ hearing request must be filed within **60 days of receipt of the reconsideration decision.**
2. Refer to the reconsideration decision letter for details regarding the procedures for requesting an ALJ hearing.

Fourth Level of Appeal: Appeals Council Review/Departmental Appeals Board (DAB)

If a party to the ALJ hearing is dissatisfied with the ALJ's decision, the party may request a review by the Medicare Appeals Council/Departmental Appeals Board (DAB).

Important DAB Information:

1. The request for 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.

2. Refer to the ALJ decision for details regarding the procedures to follow when filing a request for Appeals Council review.

Fifth Level of Appeal: Judicial Review in U.S. District Court

For hearing requests filed on or after January 1, 2015 through December 31, 2015, if $1,460 or more is still in controversy following the Appeals Council's decision, a party to the decision may request judicial review before a U. S. District Court judge (DAB). For hearing requests filed on and after January 1, 2016, the amount in controversy will increase to $1,500.

Important Judicial Review in U.S. District Court Information:

1. The appellant must file the request for review within **60 days of receipt of the DAB's decision**.

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

CLERICAL ERROR CORRECTIONS – BY TELEPHONE

Section 937 of the Medicare Prescription Drug, Improvements and Modernization Act of 2003 (MMA) established a process for the correction of minor errors and omissions in claims without pursuing the formal appeals process. Requests to reopen an initial claim to correct minor errors or omissions can be made in writing or by phone on our toll-free Reopenings line at 888-355-9165. The Reopenings line is available Monday through Friday from 8:30 a.m. to 4:30 p.m. in all time zones with the exception of PT, which receives service from 8:00 a.m. to 4:00 p.m. Press 4 for Telephone Reopenings. A total of three qualifying requests will be accepted per phone call.

When calling to request a claim correction, please be prepared to provide the following information (*items must match exactly):

-   Your name with business telephone number
-   Provider Transaction Access Number (PTAN)*
-   Provider NPI Number*
-   Last 5 digits of the provider Tax Identification Number (TIN)*
-   Beneficiary's Medicare number*
-   Beneficiary's last name and first initial*
-   Date of service
-   Reason for the request including new or corrected information

Claim corrections can include:

-   Number of services/units
-   Add, change or delete certain modifiers
-   Transposed procedure or diagnostic codes
-   Erroneous denials (such as duplicates)
-   Place of service; or
-   Date of service (excluding a change in the year)

NOTE: The addition/correction of any of this information that results in a medical necessity decision will not be eligible for a telephone reopening. Also, if your claim was rejected as unprocessable (MA130), a new corrected claim must be submitted. Corrections will not be made on this phone line.

RAILROAD MEDICARE APPEALS AND REOPENINGS PROCESSES, CONTINUED

The following issues are redeterminations and must be submitted in writing:

- Limitation of liability
- Medical necessity denials and reductions; or
- Analysis of documents such as operative reports, clinical summaries, etc.

OVERPAYMENT REFUND INFORMATION

Overpayments are Medicare funds that a provider has received which are over and above what is due and payable to them. Any overpayment is a debt owed to the United States government and must be recovered. Some examples of overpayments are:

- Payment based on a charge that exceeds the reasonable charge
- Duplicate processing of charges/claims
- Payment made to wrong payee
- Payment for non-covered items and services, including medically unnecessary services
- Incorrect application of the deductible or coinsurance
- Payment for items or services rendered during a period of non-entitlement
- Primary payment for items or services for which another entity is the primary payer

By refunding voluntarily, your office may avoid being assessed interest and being offset from funds that are due to you on pending claims (see the following paragraph on how to avoid interest and claim offset). Checks should be made payable to Palmetto GBA Railroad Medicare. You may also make payment electronically via the sServices portal using eCheck. Please reference page 25 of this guide for more information. A copy of the remittance notice should be returned with the refund check and the Railroad Medicare Voluntary Refund Overpayment – Check Enclosed form on our website. These can be attached when using eCheck as well.

NOTE: Only use the "Voluntary Refund Overpayment-Check Enclosed" form when sending in payment (either with a check or when paying via eCheck on eServices.) If you want a claim adjusted and require a demand letter to be sent prior to sending payment, use the "Reopening: Simple Claim Correction" form found on the website.

Completed forms and checks can be returned to:

Palmetto GBA - Railroad Medicare
Medicare Part B - Finance & Accounting
P.O. Box 367
Augusta, GA 30999-0001

Once an overpayment notice has been received, you have 30 days from the date of the letter to refund before interest begins to accrue and 40 days from the date of the letter before offset begins. If a refund check is not received, payment on future claims will be offset. Offset information can be found on the last page of the remittance notice. Offsets are taken from the entire payment due to the provider, not an individual beneficiary/account.

For Medicare Secondary Payer claims:

Once Medicare has identified a claim (or a number of claims) that you have received primary payment from Medicare and primary payment from another insurance, you are required to repay Medicare within 60 days from the date that the other insurance paid as primary. Please send a check for the full amount to Palmetto GBA Railroad Medicare. Do not submit an adjusted claim. If you do not repay the amount within the time frame specified above, we will collect against future Medicare payments to you. The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

BENEFITS COORDINATION & RECOVERY CENTER (BCRC)

The Centers for Medicare & Medicaid Services (CMS) consolidates the coordination of benefit activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries into the Benefits Coordination & Recovery Center (BCRC).

Consolidation of the coordination of benefits activities provides many benefits for employers, providers, suppliers, third party payers, attorneys, beneficiaries, and Federal and State insurance programs. All Medicare Secondary Payer (MSP) claims investigations are initiated from, and researched at the BCRC. This single-source development approach reduces the amount of duplicate MSP investigations. It also offers a centralized, one-stop customer service approach for all MSP-related inquiries, including those seeking general MSP information but not those related to specific claims or recoveries that serve to protect the Medicare Trust Fund. The BCRC provides customer service to all callers from any source, including but not limited to beneficiaries, attorneys/other beneficiary representatives, employers, insurers, providers and suppliers. The BCRC contact information can be found on page 35 of this guide.

Information Gathering

Medicare generally uses the term Medicare Secondary Payer or "MSP" when the Medicare program is not responsible for paying a claim first. The BCRC contractor will use a variety of methods and programs to identify situations in which Medicare beneficiaries have other health insurance that is primary to Medicare. In such situations, the other health plan has the legal obligation to meet the beneficiary's health care expenses first before Medicare. The following table describes a few of these methods and programs.

Method/Program	Description
Initial Enrollment Questionnaire (IEQ)	Beneficiaries are sent a questionnaire about other insurance coverage approximately three (3) months before they are entitled to Medicare.
IRS/SSA/CMS Data Match	Under the Omnibus Budget Reconciliation Act of 1989, employers are required to complete a questionnaire that requests Group Health Plan (GHP) information on identified workers who are either entitled to Medicare or married to a Medicare beneficiary.
MSP Claims Investigation	This activity involves the collection of data on other health insurance that may be primary to Medicare based on information submitted on a medical claim or from other sources.
Voluntary MSP Data Match Agreements	Voluntary Agreements allow for the electronic data exchange of GHP eligibility and Medicare information between CMS and employers or various insurers.

Provider Requests and Questions Regarding Claims Payment

Medicare Administrative Contractors (MACs) will continue to process claims submitted for primary or secondary payment. Claims processing is not a function of the BCRC. Questions concerning how to bill for payment should be directed to Railroad Medicare, and you should continue to return inappropriate Medicare payments to our office. Checks should not be sent to the BCRC. Questions regarding Railroad Medicare claim or service denials and adjustments should continue to be directed to our office. If a provider submits a claim on behalf of a beneficiary and there is an indication of MSP, but not sufficient information to disprove the existence of MSP, the claim will be investigated by the BCRC Contractor. This investigation will be performed with the provider or supplier that submitted the claim. The goal of MSP information gathering and investigation is to identify MSP situations quickly and accurately, thus ensuring correct primary and secondary payments by the responsible party. Providers, physicians, and other suppliers benefit not only from lower administrative claims costs, but also through enhanced customer service to their Medicare patients.

Medicare Secondary Payer Auxiliary Records in CMS' Database

The BCRC is the sole authority to ensure the accuracy and integrity of the MSP information contained in CMS' database (i.e., Common Working File - CWF). Information received as a result of MSP gathering and investigation is stored on the CWF in an MSP auxiliary file. The MSP auxiliary file allows for the entry of several auxiliary records, where necessary. MSP data may be updated, based on additional information received from external parties (e.g., beneficiaries, providers, attorneys, third party payers). Beneficiary, spouse and/or family member changes in employment, reporting of an accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information should be reported directly to the BCRC. CMS also relies on providers and suppliers to ask their Medicare patients about the presence of other primary health care coverage, and to report this information when filing claims with the Medicare program.

Termination and Deletion of MSP Auxiliary Records in CMS' Database

MACs will continue to terminate records on the CWF where the provider has received information that MSP no longer applies (e.g. succession of employment, exhaustion of benefits). Termination requests should continue to be directed to Railroad Medicare. MSP records on the CWF that you identify as invalid should be reported to the BCRC for investigation and deletion.

Contacting the BCRC

For MSP inquiries, including the reporting of potential MSP situations, invalid MSP auxiliary files and general MSP questions/ concerns to the BCRC. Continue to call Railroad Medicare regarding claims-related and recovery questions. The BCRC Customer Call Center toll free number is 1-855-798-2627 (TTY/TDD 1-855-797-2627). Customer service representatives are available to assist you from 8 a.m. to 8 p.m., Monday through Friday, Eastern Time, except holidays. The BCRC mailing address is:

Medicare – MSP General Correspondence
P.O. Box 138897
Oklahoma City, OK   73113-8897

MEDICAL REVIEW

The Medical Review (MR) program is designed to prevent improper payments. MR automates this process to the extent possible. There are times when review of medical records and related documents are needed to determine whether claims were billed in compliance with Medicare coverage, coding, payment and billing policies. When medical records are needed, a request will be sent via the Additional Documentation Request (ADR) process.

Registered eServices users can receive MR ADRs electronically through eServices by choosing the eDelivery preference. You can also choose to receive an email to let you know an ADR is available in eServices for you. See page 25 for details.

If you receive an ADR letter, it is important that you comply with the following instructions:

1. Provide the documents listed on the ADR and any related physician's orders. Make sure the signature is legible or include an attestation of signature.

2. Include a copy of the ADR with your documents

3. When returning ADR responses for multiple claims, be sure to pair each ADR letter with the corresponding documentation. Pairing these documents ensures the documentation for each request letter is correct for each date of service requested.

4. Return your ADR responses to Palmetto GBA Medical Review with a completed Railroad Medicare Medical Review ADR Response Cover Sheet, which can be found in the Forms section of our website. Use one ADR Response Cover Sheet for each ADR letter/claim.

5. Return your ADR responses by one of the following methods. Do not submit by more than one method as a duplicate response slows down the documentation review process.

   - Upload through our eServices internet portal. See page 25 for details.
   - Submit via the Electronic Submission of Documentation (esMD) mechanism. For more information about esMD, please visit www.cms.gov/esmd.
   - Fax to 803-264-8832
   - Mail to the address shown at the end of this list

6. Return your ADR response to Palmetto GBA promptly within 45 days of the date on the ADR letter. The claim will automatically deny on the 46th day if a response has not been received.

7. Once ADR responses are received, CMS requires Palmetto GBA to complete medical review of the documentation within 30 days. Do not resubmit ADR responses to Palmetto GBA.

8. Do not submit replacement/duplicate claims for the ones pending in medical review. The submission of replacement/duplicate claims will result in claim denial, rejection or recoupment and will prolong the medical review process. When the claim is finalized, the claim will have been paid in full or in part, or denied. If you disagree with the decision, you can request a redetermination within 120 days of the determination (date on the Remittance Advice).

Mail ADR responses to:

Palmetto GBA Railroad Medicare
Medical Review
PO Box 10066
Augusta, GA 30999

BENEFIT INTEGRITY

The primary function of Benefit Integrity is to identify and investigate cases of suspected fraud or abuse, and to take actions to ensure the Medicare Trust Fund is protected from inappropriate payments.

What is Fraud and Abuse?

Fraud is an intentional representation that an individual makes, or attempts to make, which he/she knows to be false, or does not believe to be true, and knows that such misrepresentation could result in some unauthorized benefit to themselves or another person(s).

Examples of fraud may include:

- Billing for services not rendered
- Misrepresentation of services
- Bribes, rebates and other kickbacks
- Falsified medical records
- Misrepresentation of diagnosis reported on claims
- Causing payment to be generated to someone other than the provider of services or beneficiary who incurred expenses
- Beneficiaries, providers, or employees altering claims in any way to generate payments that would otherwise not be payable

Abuse describes incidents or practices of providers, which are inconsistent with accepted sound medical and business practices or the intentional over utilization of a service, that are contrary to customary standards, and ethics of medical practice.

Examples of abuse may include:

- Services not medically necessary
- Up coding
- Screening services
- Violation of assignment agreement
- Waiver of co-payments
- Billing for a non-covered service
- Misusing codes on the claim (i.e. the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered)

An abusive situation can turn into fraud, when, after being brought to the provider's or beneficiary's attention through educational contacts, the abuse continues to occur.

The above lists are in no way intended to address every potentially fraudulent or abusive situation. Providers with questions about the appropriateness of particular situations should contact us for clarification.

Penalties for Committing Fraud and/or Abuse

Providers who commit fraud and/or abuse may be subject to both criminal and civil penalties. Civil penalties include payment recoveries, monetary fines, payment suspensions and exclusion from federal programs. Criminal penalties may include convictions for various violations such as mail fraud, wire fraud and healthcare fraud which may result in fines and/or imprisonment.

Routine Waiver of Deductible and/or Copayments

Medicare regulations require that all providers collect any applicable deductibles and/or copayments from ALL beneficiaries. Routine waiver of deductibles and copayments can be construed as program abuse, misrepresentation of the cost of a service, and a violation of federal anti-kickback laws. With the exception of financial hardship, providers who waive these fees may be offering incentives to patients to purchase services from them. In cases of financial hardship, providers are required to obtain a written statement from the patient as to their financial hardship. If you fail to obtain such a statement, Medicare requires you follow your standard practice for collecting fees from patients (i.e. written demands for payment).

Services Advertised as Free or Without Charge

When advertising a free or discounted service or a free initial visit, the beneficiary should be made aware of just what the free service or visit entails. This will help to ensure that he or she is making an informed decision about whether to continue treatment after the free service has been provided. This is especially important since an advertisement that the service is being performed without charge may have been an enticement for the beneficiary to schedule an appointment with that physician, provider or supplier. Failure to make this information available to the beneficiary may be interpreted as misleading and/or misrepresentation.

Penalties for Assignment Violations

The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (PL 95-142) strengthen the Government's capability to detect and prosecute cases of Medicare and Medicaid fraud. We are notifying all physicians, providers, and suppliers of the penalties that are provided by this law for repeated violations of the assignment agreement.

When a physician, provider, or supplier accepts assignment, he/she agrees that the reasonable charge, determined by the Medicare Administrative Contractor (MAC), shall be his/her full charge for the service. He/she violates the assignment agreement if he/she collects, or attempts to collect, from the beneficiary or other person an amount that, when added to the benefit payment, exceeds the reasonable charge.

Prior to the passage of the amendments, the only action that would be initiated against a physician, provider, or supplier who repeatedly violated the assignment agreement was revocation of assignment privileges under Medicare.

The law now provides that any person who knowingly, willingly, and repeatedly violates the assignment agreement shall be guilty of a misdemeanor and subject to a maximum fine of $2000 and/or six (6) months imprisonment.

This legislation also provides that when a physician/practitioner, provider or supplier has been convicted of a criminal offense related to his/her involvement in Medicare or Medicaid; he/she will be excluded from program participation and from any State health care programs as defined under Section 1128(h) of the Social Security Act.

In addition, the Omnibus Budget Reconciliation Act of 1981 provides authority for the imposition of civil monetary penalties of up to $2,000 per item or service claimed, for violations of an assignment agreement under Section 1842 (b)(3)(B)(ii) of the Social Security Act.

To report Fraud and Abuse, call us at: 888-355-9165
- Select option 5
- Press 0 to speak with a representative

PHONE DIRECTORY

Provider Enrollment **888-355-9165**
Option 3

The Provider Enrollment Department is available Monday through Friday, from 8:30 a.m. to 4:30 p.m.
for all time zones with the exception of PT, which receives service from 8:00 a.m. to 4:00 p.m.
Please refer to page 3 for information on the Provider Enrollment process.

Electronic Data Interchange **888-355-9165**
Option 2

The EDI team is available to assist you with problems and questions, Monday through Friday, from 8:30 a.m.
to 4:30 p.m. for all time zones with the exception of PT, which receives service from 8:00 a.m. to 4:00 p.m.
Please refer to page 5 for additional information on submitting claims electronically.

Reopenings **888-355-9165**
Option 4

The Reopenings department is available Monday through Friday, from 8:30 a.m. to 4:30 p.m. for all time
zones with the exception of PT, which receives service from 8:00 a.m. to 4:00 p.m.
Prior to requesting a redetermination, please refer to page 30 of this guide for additional information.

Interactive Voice Response **877-288-7600**

The Interactive Voice Response Unit (IVR) is available 7:00 a.m. to 11:00 p.m., ET, for general
information. Claim status and beneficiary eligibility are available 7:00 a.m. to 11:00 p.m. Monday
through Friday.
Please refer to page 26 of this guide for IVR instructions.

Provider Contact Center **888-355-9165**
Option 5

Customer Service Representatives are available Monday through Friday from 8:30 a.m. to 4:30 p.m. for
all time zones with the exception of PT, which receives service from 8:00 a.m. to 4:00 p.m. On
Thursdays the Service Center closes from 2:15 p.m. to 4:45 p.m. for Customer Service training.

Claim Status and beneficiary eligibility inquiries should be handled through the Interactive Voice
Response Unit.   Please refer to page 26 of this guide for additional information on IVR.

TTY/TDD Provider Contact Center.. **877-715-6397**

The Railroad Medicare provider call center has the capability for hearing impaired providers, or
their staff, to communicate by using Teletypewriter/Telecommunications device for the Deaf
(TTY/TDD) service.

MAIL DIRECTORY

Please use the **ATTENTION LINE** in conjunction with our address when sending correspondence. Always be sure to clearly explain your question or concern in writing. You should include the beneficiary's name, Medicare (HIC) Number and/or a copy of the remittance notice, along with a detailed description of the nature of your inquiry.

Attention Line Options:
Accounting and Finance
Medicare Secondary Payer Department
Redeterminations/Reopenings
General Inquiries

Use in conjunction with this address:

Palmetto GBA Railroad Medicare
P.O. Box 10066
Augusta, GA 30999

If you are sending information via private courier service (FedEx, UPS, etc.), send to:

Palmetto GBA Railroad Medicare
2743 Perimeter Parkway, Bldg. 200
Augusta, GA 30909

Other direct addresses for your use by unit:

Accounting and Finance (To report an overpayment):

Palmetto GBA Railroad Medicare
Attention: Accounting
PO Box 367
Augusta, GA 30999

Benefit Integrity
If you are sending information via U.S. Mail, please send to the following address:
Palmetto GBA Railroad Medicare
Attention: Benefit Integrity
PO Box 1956
Augusta, GA 30999

If you are sending information via private courier service (FedEx, UPS, etc.), send to:
Palmetto GBA Railroad Medicare
Attention: Benefit Integrity
2743 Perimeter Parkway, Bldg. 200
Augusta, GA 30909

To Contact Us by Email
Contact us via Email at medicare.railroad@palmettogba.com

RAILROAD MEDICARE E-MAIL UPDATES

The Railroad Medicare listserv is a wonderful communication tool that offers its members the opportunity to stay informed about:

- Medicare incentive programs
- Fee Schedule changes
- New legislation concerning Medicare
- And so much more!

What is needed to receive updates?

- Internet access and an e-mail address
- Completion of the form
- Railroad Medicare will enter the information you provide into the online registration
- This information will not be shared with any mailing list

Note: Once the registration information is entered, you will receive a confirmation/welcome message informing you that you've been successfully added to our List Serv. You must acknowledge this confirmation within 3 days of your registration.

Fax the completed form to 803-763-2280

User Name	(Email address cannot be used for user name or password)
Print First and Last Name	
Password	S3cret*1 (Your confirmation email will instruct you on how to change this password later.)
Your E-mail Address	

Topics (mark those you're interested in staying informed about):

Ambulance	Federally Qualified Health Center	Physical/Occupational Therapy
Ambulatory Surgical Center	General - Railroad Medicare	Physician
Anesthesia/Pain Management	Gynecology	Podiatry
Cardiovascular	Hematology/Oncology	Primary Care
Chiropractic	Independent/Clinical Diagnostic and Testing Facilities	Psychology/Psychiatry
Community Mental Health Center	Nephrology	Radiology
Diagnostic Tests	Non-Physician Practitioners	Surgery
Drugs/Biologicals	Ophthalmology/Optometry	
Electronic Data Interchange (EDI)	Pathology & Laboratory	

CONNECTING WITH RAILROAD MEDICARE

Twitter

Twitter is a real-time information network powered by people all around the world. It lets you share and discover what's happening now. Twitter asks 'what's happening' and makes the answer spread across the globe to millions, immediately. For Railroad Medicare, Twitter is an alternative for delivering listserv messages in a timely, concise, effective and repeatable manner. Each listserv message is condensed for Twitter delivery, and those smaller pieces of information can be resent by receiving/following individuals to others as needed. To register, please visit www.twitter.com and follow the simple steps to set up an account to receive Palmetto GBA_RRB messages.

Facebook

Facebook is a social utility that connects people with friends and others who work, study, and live around them. It allows a centralized location for receiving updates on a person or organization as well as sending messages. For Railroad Medicare, this is another means to stay connected and receive updates on Medicare and how it affects you. To view the Palmetto GBA Facebook page, go to https://www.facebook.com/PalmettoGBA/. If you are not a registered Facebook user, click on the Sign Up button and follow the simple steps to set up an account to exchange messages with "Palmetto GBA, LLC".

GLOSSARY

Adjudication – The process of deciding whether to pay, pend, or reject a claim based upon the information submitted, the eligibility of the recipients, and the available benefits.

Adjustment – Additional payment or correction of records on a previously processed claim

Ambulatory Surgical Center (ASC) – A free standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Amount in Controversy – The difference between the amount charged the beneficiary, less the amount allowed, less any remaining deductible and/or, if applicable, blood deductible, less 20 percent of remainder.

Appeal – Written or verbal statement from a provider that conveys an explicit request for redetermination of the initial decision of a claim, or dissatisfaction with the most recent determination.

Beneficiary – Term used to identify any individual eligible for Medicare benefits.

Bilateral Surgery – Procedures that are performed on both sides of the body, or organ site of a paired physiological pair, during the same operative session or on the same day.

Centers for Medicare & Medicaid Services (CMS) – The division of the Department of Health and Human Services responsible for administering the Medicare program

Coordination of Benefits (COB) – The determination of primary, secondary, and tertiary insurer responsibility for a patient's health claim and the passing of claim and payment information between insurers.

Coordination Period – Specified period of time when the employer plan is the primary payer to Medicare

CPT – Physicians' Current Procedural Terminology (procedure codes, used along with HCPCS codes).

CWF – Common Working File

DAB – Appeals Council Review/ Departmental Appeals Board

Diagnosis – Identifies the condition, cause or disease of the patient

Employer Group Health Plan (EGHP) – Group health plan provided by a single employer of 20 or more employees or provided by an employee organization associated with that employer.

End Stage Renal Disease (ESRD) – A person will be classified as having ESRD when there is permanent kidney failure, and dialysis or kidney transplant are the only two options for treatment.

Explanation of Benefits (EOB) – The explanation generated by an insurance that pays BEFORE Medicare pays, i.e., Employer Group Health Plan, workers compensation, etc.

HCPCS – Healthcare Common Procedure Coding System. HCPCS includes three levels of procedure codes as well as modifiers. Level I contains the AMA's CPT-4 codes. Level II contains alphanumeric codes maintained by CMS. Level III contains MAC-assigned local codes.

Health Insurance Claim Number (HIC) – A Railroad Medicare HIC number consists of one to three alpha prefix followed by six or nine numbers.

Health Professional Shortage Area (HPSAs) – Physicians, including psychiatrists, should note that if they furnish services in primary medical care Health Professional Shortage Areas, they are eligible to receive ten percent bonus payments.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for automated transfer of certain health care data between health care payers, billers, plans and providers. This will enable the entire health care industry to communicate electronic data using a single set of standards.

IOM – Internet Only Manual - This manual contains informational and procedural material that Medicare Administrative Contractors (MACs) use to adjudicate claims. It includes instructions dealing with coverage of services, bill review, reasonable charges and other pertinent claims procedures.

Interactive Voice Response (IVR) – The computerized telephone answering service allowing a provider to check claim status using a touch-tone telephone.

Julian Date – A three-digit number indicating the day of the year. January 1 is 001 and December 31 is 365 or 366.

Large Group Health Plan (LGHP) – A plan provided by an employer who employs 100 or more persons or a plan belonging to a multi-employer plan where at least one employer has 100 or more full or part time employees.

Medicare Secondary Payer (MSP) – There is another insurance company that is primary to Medicare; the primary insurance company pays first and Medicare would be secondary payer for the service(s).

Modifiers – Two-digit codes that indicate services or procedures have been altered by some specific circumstance. Modifiers do not change the definition of the reported procedure codes.

Office of the Inspector General (OIG) –A division of the U.S. Department of Health and Human Services tasked with investigating criminal and civil violations of federal laws relating to Medicare and other healthcare matters.

eServices – An secure internet-based, provider self-service portal that provides information over the Web for eligibility, claim status, remittances, financial information and more.

Optical Character Recognition (OCR) –Software used to translate images of scanned claims with handwritten, typewritten or printed text.

Qualified Independent Contractor (QIC) – The second level of appeal following the redetermination of a Part B claim.

Redetermination – The first formal level of appeal following the initial processing of a Part B claim. It is a second look at the claim and supporting documentation by a different employee.

Remittance Notice – A summarized statement for providers including payment information for one or more beneficiaries.

Returned/Rejected Claim – Process where a claim is returned/rejected because essential information is missing. Rejected claims can be identified by remittance remark code MA130. This action is not appealable. The claimant must resubmit the claim and may not bill the beneficiary until Medicare gives the claimant a decision.

Reopening – A re-evaluation of the claim determination. A reopening does not take your appeal rights. It is a discretionary action by the Medicare Administrative Contractor in response to the identification of an error, fraud, or the submittal of new information.

Third Party Liability (TPL) – When a Beneficiary sues another party due to an accident, such as a fall on someone's property.

Time Limit – The specified period of time during which a notice of claim or redetermination must be filed.

Unprocessable Claim – Process where a claim is returned/rejected because essential information is missing. This action is not appealable. The claimant must resubmit the claim and may not bill the beneficiary until Medicare gives the claimant a decision.

Waiver of Liability Provision – A provision which states that if the provider informed the beneficiary in writing before the item or service was furnished that Medicare is likely to deny payment for the item or service rendered as "not reasonable and necessary," and obtained his or her agreement to pay, the provider's liability is waived and payment is made to the provider by the beneficiary.

Working Aged – Employed individuals aged 65 or over and individuals aged 65 or over with employed spouses of any age.