

Critical Access Hospital

Updates and Changes

Published Month Year

The information contained in this presentation was current as of **April 2011** and can be found in the ***Critical Access Manual***. All manuals can be downloaded from:

<http://www.trailblazerhealth.com/Publications/Manuals/>

Providers are encouraged to subscribe to a variety of available listservs to receive e-mail updates with important Medicare changes, time-sensitive alerts, educational events and links to newly published documents posted on the TrailBlazer Health Enterprises® Web site.

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Contact Information

- Web site:
<http://www.trailblazerhealth.com>
- Part A Provider Contact Center:
(866) 640-9202
- E-mail:
parta.j4@trailblazerhealth.com

Part A deductible:

- Applied to inpatient claims.
- 2011 deductible is \$1,132.
- 2010 deductible is \$1,100.

Part B deductible:

- Applied to outpatient claims.
- 2011 deductible is \$162.
- 2010 deductible is \$155.

Coinsurance

If the item or service is covered as a Critical Access Hospital (CAH) outpatient service, the clinic may not charge the beneficiary more than 20 percent of the charges plus the deductible.

The facility may charge the beneficiary for items and services that are not Medicare-covered services.

Pulmonary Rehabilitation

Pulmonary rehabilitation programs must include:

- Physician-prescribed exercise.
- Education or training closely and clearly related to the individual's care and treatment that is tailored to the individual's needs.
- Psychosocial assessment.
- Outcomes assessment.
- An individualized treatment plan detailing how components are utilized for each patient.

Pulmonary Rehabilitation (Cont.)

Pulmonary rehabilitation billing:

- TOB 851.
- Revenue code 0948.
- Modifier KX.
 - Used when sessions exceed 36.

Method II Selection:

- Must be selected on an annual basis, 30 days prior to cost reporting period.
- Effective for the entire cost reporting period to which it applies.
- Under this election, a CAH will receive payment from its Medicare contractor for professional services furnished in that CAH's outpatient department.
- Billing the professional services on the CMS-1450 (UB-04) claim form.

ANSI Version 5010

New Health Insurance Portability and Accountability Act (HIPAA)-mandated electronic format:

- Base version is ANSI 5010.
- Errata version is ANSI 5010A1.

Compliance date established by Final Rule is January 1, 2012:

- ANSI 5010 testing commenced January 4, 2011.
- No providers will be placed in production with ANSI 5010 until:
 - After 5010A1 is loaded on April 4, 2011.

Watch 5010 Web page for details.

<http://www.trailblazerhealth.com/Electronic Data Interchange/5010.aspx>

Version 5010A1 is essential for use of ICD-10.

ANSI Version 5010 (Cont.)

5010 HIPAA Implementation Guides:

- Institutional (Part A) Electronic Claim (837I).
- Professional (Part B) Electronic Claim (837P).
- Electronic Remittance Advice (835).
- Claim Status and Response (276/277).
- Eligibility Inquiry and Response (270/271).

Side-by-side comparisons (4010A1 → 5010):

http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp

ANSI Version 5010 (Cont.)

The HIPAA-compliant version of PC-ACE Pro32 will be rolled out soon. Watch for a listserv announcement!

Consult your software vendor, clearinghouse or billing service to ensure they have tested and your software version is compliant.

You do not have to test if your vendor has tested and is compliant.

If you have any questions, please call the EDI Technology Support Center at (866) 749-4302.

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E-mail Page

Notices

Medicare Home Page » Notices

CMS and TrailBlazer Are Official Sources for Medicare Information

All TrailBlazer Part A and Part B notices will be posted to this site. Users are able to view the latest information from TrailBlazer and CMS, such as CR or JSM instructions, or easily retrieve the most up-to-date information without searching the entire site. The CMS mandated notices will include a link to the CMS Web site where providers may view the transmittals in their entirety. For your convenience, notices are listed in date order with the most current being shown first. This page is updated daily.

[Search other Notices](#)

SE1106 – Important Reminders About HIPAA 5010 and D.0 Implementation

(3/11/2011)

The implementation of the Health Insurance Portability and Accountability Act (HIPAA) 5010 and D.0 presents substantial changes in the content of the data that providers submit with their claims as well as the data available to them in response to electronic inquiries. The implementation requires changes to the software, systems and perhaps procedures that providers use for billing Medicare and other payers. It is important for new providers enrolling in Medicare to know that Electronic Data Interchange (EDI) transactions are the normal mode of business for Medicare claims, claim status and the remittance advice.

Medicare requires the use of electronic claims (except for certain rare exceptions) for providers to receive Medicare payment. Effective January 1, 2012, providers **must** be ready to submit claims electronically using the Accredited Standards Committee (ASC) X12 Version 5010 and National Council for Prescription Drug Programs (NCPDP) Version D.0 standards. This also is a prerequisite for implementing the new ICD-10 codes.

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ICD-10 Implementation

Medicare Home Page » Claims » ICD-10 Implementation

What's New?

SE1106 - Important Reminders About HIPAA 5010 and ...	(Notice) 3/11/11	
Have You Started External Testing of Version 5010?	(Notice) 2/7/11	
New ICD-10 Implementation Web Page	(Notice) 1/26/11	
SE1033 - Partial Code Freeze Prior to ICD-10 Imple...	(Notice) 11/15/10	
ICD-10 Implementation Information - CMS SE 1019	(Notice) 6/24/10	
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TrailBlazer has created this ICD-10 information Web page to ensure providers receive the latest information and important updates throughout the ICD-10 implementation. This site will be updated with pertinent information as soon as it becomes available.

[CMS ICD-10 Overview Page](#)

[CMS ICD-10 and Version 5010 Compliance Timelines](#)

Providers are also encouraged to refer to the [5010 Information page](#) for news and information related to the ANSI Version 5010 implementation.

CMS Resources

- [Medicare Fee-for-Service Provider Resources \(Includes link to ICD-10 FAQs\)](#)
- [CMS Sponsored ICD-10 Teleconferences](#)

Notices

- [SE1106 - Important Reminders About HIPAA 5010...](#)
Date Posted: 3/11/2011
- [Have You Started External Testing of Version...](#)
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Date Posted: 11/15/2010
- [ICD-10 Implementation Information - CMS SE 1019](#)
Date Posted: 6/24/2010

Publications

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Claim Filing Time

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which amended the time period for filing Medicare Fee-for-Service (FFS) claims as one of many provisions aimed at curbing fraud, waste and abuse in the Medicare program.

Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service.

PEPPER Training for CAHs

Beginning in April 2011, CMS will make available free hospital-specific comparative data reports for Critical Access Hospitals (CAHs) nationwide. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) provides hospital-specific data statistics for Medicare discharges at risk for improper payments.

PEPPER (Cont.)

Hospitals can use the data to support internal auditing and monitoring activities. PEPPER is the only free report comparing a CAHs Medicare billing practices with other CAHs by state, Medicare Administrative Contractor (MAC)/Fiscal Intermediary (FI) jurisdiction and the nation. CMS has contracted with TMF Health Quality Institute to develop and distribute the reports.

- Effective October 1, 2010, providers are no longer required to submit any of the value codes when billing for therapy services.
 - 50 – Physical therapy.
 - 51 – Occupational therapy.
 - 52 – Speech therapy.
 - 53 – Pulmonary rehabilitation.

Psychiatric Coverage

Effective January 1, 2010, the limitation will be phased out according to CR 6686:

- January 1, 2010 – December 31, 2011:
 - The limitation percentage is 68.75 percent.
 - Medicare pays 55 percent and the patient pays 45 percent.
- January 1, 2012 – December 31, 2012:
 - The limitation percentage is 75 percent.
 - Medicare pays 60 percent and the patient pays 40 percent.
- January 1, 2013 – December 31, 2013:
 - The limitation percentage is 81.25 percent.
 - Medicare pays 65 percent and the patient pays 35 percent.
- January 1, 2014:
 - The limitation percentage is 100 percent.
 - Medicare pays 80 percent and the patient pays 20 percent.

CMS Resources

- <http://www.cms.gov/PrevntionGenInfo/>.
- http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf.
- http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf.
- <http://www.cms.gov/MLNMattersArticles/downloads/MM7012.pdf>.

Effective for dates of service on or after January 1, 2011, per Change Request (CR) 7012, coinsurance and deductible are waived for most preventive services as enacted in Section 4104 of the Affordable Care Act.



PREVENTIVE SERVICES







Quick Reference Information: Preventive Services



This educational tool provides information on Medicare preventive services. Information provided includes Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes; International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes; coverage requirements; frequency requirements; and beneficiary liability for each Medicare preventive service.

SERVICE	HCPCS/CPT CODES	ICD-9-CM CODES	WHO IS COVERED	FREQUENCY	BENEFICIARY PAYS
Initial Preventive Physical Examination (IPPE) Also known as the "Welcome to Medicare Visit"	G0402 – IPPE G0403 – ECG for IPPE G0404 – ECG tracing for IPPE G0405 – ECG interpret & report Important – The screening EKG is an optional service that may be performed as a result of a referral from an IPPE	No specific diagnosis code Contact the local Medicare Contractor for guidance	All Medicare beneficiaries whose first Part B coverage began on or after 01/01/05	Once in a lifetime benefit per beneficiary Must be furnished no later than 12 months after the effective date of the first Medicare Part B coverage	G0402 prior to 01/01/11: - Copayment/coinsurance applies - Deductible waived G0402 on or after 01/01/11: - Copayment/coinsurance waived - Deductible waived G0403, G0404, G0405: - Copayment/coinsurance applies - Deductible applies
Annual Wellness Visit (AWV) This is a new benefit beginning for dates of service on and after 01/01/11	G0438 – First visit G0439 – Subsequent visit	No specific diagnosis code Contact the local Medicare Contractor for guidance	All Medicare beneficiaries who are no longer within 12 months after the effective date of their first Medicare Part B coverage period and who have not received an IPPE or AWV within the past 12 months	- Once in a lifetime for G0438 - Annually for G0439	Prior to 01/01/11: - N/A On or after 01/01/11: - Copayment/coinsurance waived - Deductible waived
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	G0389 – Ultrasound exam AAA screen	No specific diagnosis code Contact the local Medicare Contractor for guidance	Medicare beneficiaries with certain risk factors for abdominal aortic aneurysm Important – Eligible beneficiaries must receive a referral for an AAA ultrasound screening as a result of an IPPE	Once in a lifetime benefit per eligible beneficiary	Prior to 01/01/11: - Copayment/coinsurance applies - Deductible waived On or after 01/01/11: - Copayment/coinsurance waived - Deductible waived
Cardiovascular Disease Screenings	80081 – Lipid Panel 82465 – Cholesterol 83718 – Lipoprotein 84478 – Triglycerides	Report one or more of the following codes: V81.0, V81.1, V81.2	All Medicare beneficiaries without apparent signs or symptoms of cardiovascular disease 12-hour fast is required prior to testing	Every 5 years	- Copayment/coinsurance waived - Deductible waived
Diabetes Screening Tests	82947 – Glucose, quantitative, blood (except reagent strip) 82950 – Glucose, post-glucose dose (includes glucose) 82951 – Glucose Tolerance Test (GTT), three specimens (includes glucose)	V77.1	Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes Beneficiaries previously diagnosed with diabetes are not eligible for this benefit	- 2 screening tests per year for beneficiaries diagnosed with pre-diabetes - 1 screening per year if previously tested, but not diagnosed with pre-diabetes, or if never tested	- Copayment/coinsurance waived - Deductible waived
Diabetes Self-Management Training (DSMT)	G0108 – DSMT, individual session, per 30 minutes G0109 – DSMT, group session (2 or more), per 30 minutes	No specific diagnosis code Contact the local Medicare Contractor for guidance	Medicare beneficiaries diagnosed with diabetes Must be ordered by the physician or qualified non-physician practitioner treating the beneficiary's diabetes	- Up to 10 hours of initial training within a continuous 12-month period - Subsequent years: Up to 2 hours of follow-up training each year after the initial year	- Copayment/coinsurance applies - Deductible applies
Medical Nutrition Therapy (MNT)	97802, 97803, 97804, G0270, G0271 Services must be provided by a registered dietitian or nutrition professional	No specific diagnosis code Contact the local Medicare Contractor for guidance	Certain Medicare beneficiaries diagnosed with diabetes, renal disease, or who have received a kidney transplant within the last three years	- 1st year: 3 hours of one-on-one counseling - Subsequent years: 2 hours	Prior to 01/01/11: - Copayment/coinsurance applies - Deductible applies On or after 01/01/11: - Copayment/coinsurance waived - Deductible waived
	G0123, G0124, G0141, G0143, G0144,	Report one of the following codes:		- Annually if at high-risk for developing cervical or vaginal cancer, or childbearing age with	G0124, G0141, P3001, Q0091 prior to 01/01/11: - Copayment/coinsurance applies - Deductible waived All other codes prior to 01/01/11:


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Important Information for Institutional Providers Regarding Billing Codes for Preventive Services


(4/11/2011)

CMS has identified a Medicare claims processing system issue that is causing certain preventive services rendered in an institutional setting to be processed incorrectly. The following information provides the actions that will be taken by Medicare claims administration contractors:

- Preventive service codes listed in Change Request (CR) 7012 and surgical procedure codes 10000-69999 furnished on the same date and in the same encounter as a colonoscopy, flexible sigmoidoscopy or barium enema that was initiated as colorectal cancer screening services with dates of service on or after January 1, 2011, were suspended due to deductible and coinsurance being erroneously applied. A partial correction for this problem was implemented April 4, 2011. **TrailBlazer is suspending affected claims in location SMAP42 with reason code WW042.**
- Outpatient claims containing hepatitis B vaccines codes 90740-90747 submitted on Type of Bill (TOB) 13X with dates of service on or after January 1, 2011, are suspending if they are the only service on the claim. Also, claims containing hepatitis B vaccine services are not being paid when other services are billed on the same claim. Medicare contractors have been instructed to hold claims impacted by this problem until a correction is implemented. Medicare providers will be notified of this correction via listserv message. **TrailBlazer is suspending affected claims in location SMFHL8 with reason code 39910.**
- Outpatient Prospective Payment System (OPPS) claims containing codes G0402, G0389, Q0091, G0101, G0130, 77078, 77079, 77080, 77081, 77083, 76977, G0104, G0105, G0106, G0120, G0121, G0008, G9141, G0009, G0436 and G0437 submitted on TOB 13X with dates of service on or after January 1, 2011, are erroneously applying deductible and coinsurance. Medicare contractors have been instructed to hold claims impacted by this problem. A software correction is scheduled for May 9, 2011. **TrailBlazer is suspending affected claims in location SMAP40 with reason codes WW040 and WW041.**

As the software corrections are made, Medicare contractors will release any suspended claims and automatically reprocess claims for preventive services and claims for surgical services billed with a PT modifier (bullet 1) that have been paid incorrectly or erroneously applied deductible or coinsurance. Most reprocessing will be completed by May 31, 2011.

However, claims being suspended for surgical services billed with a PT modifier (bullet 1) reimbursed under OPPS will be released with the implementation of the Integrated Outpatient Code Editor (I/OCE) software in July 2011. Reprocessing of claims that have been paid incorrectly for this issue will be completed by July 31, 2011.

For further information, please see MLN Matters® article [MM7012](#) , issued March 2, 2011.

TrailBlazer Instructions

Please refer to the Part A Claims Processing/Payment Issues on the [Reports Web page](#) for updates to these processing issues.

(CMS Learn Resource 201104-17, dated April 7, 2011, and Joint Signature Memorandum (JSM) 11267, dated April 1, 2011)

This content pertains to...

Programs: Part A

Topics: Claims, Education, Facility Types, Specialty Services

Subtopics: CAH, OPPS, Preventive Services

Primary Care Incentive Program (PCIP)

For dates of service beginning on or after January 1, 2011, and before January 1, 2016, a 10 percent incentive payment will be provided to primary care practitioners. If a claim for primary services is submitted by a CAH reimbursed under the optional method for an eligible primary care physician's or non-physician practitioner's professional services, the Other Provider field on the claim must be populated by the eligible primary care practitioner's NPI in order for the primary care service to qualify for the incentive payment.

Primary Care Incentive Program (PCIP) (Cont.)







The former Quarterly HPSA and Scarcity Report for CAHs is now known as the Special Incentive Remittance for CAHs. This change is necessary because PCIP payments are made for all primary care services furnished by eligible primary care practitioners, regardless of the geographic location where the primary care services are furnished.

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- [Cardiac Rehabilitation and Intensive Cardiac Rehab...](#) (J4) (Draft Comment Ended) **RB**
- [Ambulance Services \(Ground Ambulance\) \(J4\) \(Active\)](#) **RB**
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- [5010.](#)
- [CMS Medicare Advantage \(MA\) Claims Processing Contacts](#) . (This link to the CMS Web site lists MA contract numbers and claims processing contact information.)
- [Important CMS Information.](#)
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Part B Virginia Transition

Part B Virginia Transition Resources



Making Sense of Medicare

For the latest educational tips and information, please click the links below.

- [Emergency Department Evaluation/Management Services.](#)
- [Medicare Incentive Payments Are Not Just for Physicians Anymore.](#)
- [Incorrect Billing of Dual-Chamber Pacemakers.](#)
- [Outpatient Diagnostic Testing for Ordering Physicians and Clinical Laboratories.](#)

Need help understanding an acronym or term used on our Web site? Try the [Acronyms/Glossary of Terms](#)

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Self-Service Tools

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The TrailBlazer Web site was designed as a topic-driven self-service tool. Self-service technology is an efficient, cost-effective method of disseminating Medicare provider information, education and assistance. Use of self-service technology enables providers to access certain information without direct personal assistance from the Customer Service Provider Contact Center (PCC).

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PCIP Eligibility NPI Tool

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A 10 percent incentive payment is available to primary care practitioners for primary care services furnished on or after January 1, 2011, and before January 1, 2016 through the Primary Care Incentive Payment Program (PCIP). CMS has provided all contractors with a list of National Provider Identifiers (NPIs) of the primary care practitioners eligible to receive the incentive payments. This tool may be used to search your NPI to determine if you are eligible for the incentive. Results will indicate the incentive payment year and the qualifying year.


The 10 percent PCIP payment is payable to a Critical Access Hospital (CAH) billing under the optional method for the primary care professional services of eligible primary care physicians and non-physician practitioners who have reassigned their billing rights to the CAH.


Please reference MLN Matters® Articles [MM7060](#) and [MM7115](#) for additional information.

PCIP Eligibility Search

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Primary Care Incentive Program (PCIP) (Cont.)

More information concerning the PCIP can be found in MLN Matters[®] article MM7115:

<http://www.cms.gov/MLNMArticles/downloads/MM7115.pdf>

HPSA Surgical Incentive Payment Program (HSIP)

For major surgical services furnished on or after January 1, 2011, and before January 1, 2016, CAHs paid under the optional method will be paid an additional 10 percent incentive based on the amount actually paid for those services when furnished by general surgeons in HPSAs. Quarterly incentive payments will be made to CAHs paid under the optional method on behalf of physicians.

HPSA Surgical Incentive Payment Program (HSIP) (Cont.)

More information concerning the PCIP can be found in MLN Matters[®] article MM7146:

<http://www.cms.gov/MLNMArticles/downloads/MM7146.pdf>

Change Request 7172 requires CAHs to submit informational only claims to their Medicare Contractor for Medicare Advantage plan beneficiaries they treat.

- Effective for discharges on or after October 1, 2010
- Submit on TOB 11X along with condition code 04

<http://www.cms.gov/MLNMArticles/downloads/MM7172.pdf>

Medicare contractors will expand claims editing to verify that the attending, operating or other physician or non-physician practitioner on a Critical Access Hospital (CAH) claim is eligible and active in the Medicare program's Provider Enrollment, Chain and Ownership System (PECOS).

MM7046, titled “Expansion of the Current Scope of Editing for Attending, Operating or Other Physician or Non-Physician Practitioner Providers for Critical Access Hospital (CAH) Claims Processed by Medicare Fiscal Intermediaries (FIs) and Part A Medicare Administrative Contractors (A/B MACs),” is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLNMArticles/downloads/MM7046.pdf>

Payment is currently being calculated for **non-medically directed** CRNA services in a Method II CAH without a CRNA pass-through exemption based on a 20 percent reduction of the fee schedule amount before deductible and coinsurance are calculated.

CR 7207 clarifies the following:

- CRNA Anesthesia Services (00100-01999).
- Submitted by a Method II CAH (without the pass-through exemption).
- For dates of services on or after July 1, 2007
- Billed on TOB 85X
- With revenue code 0964 and QZ modifier

Medicare Secondary Payer Questionnaire (MSPQ):

- Every inpatient admission.
- Quarterly for outpatient admission.
- Hard copy or online.
- No signature is needed.
- Retained for 10 years from date of service.

Welcome, Jeremy.

LOGOUT » EDIT PROFILE »

Search

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Medicare Secondary Payer Questionnaire Interactive Decision Tree

[Medicare Home Page](#) » [Customer Service](#) » [Self-Service Tools](#)

Please answer the following questions to determine:

- When a non-group plan is primary to Medicare.
- When a group plan is primary to Medicare.
- When Medicare is the appropriate primary payer.

Please remember that a completed MSPQ should be held on file for a minimum of 10 years.

Reference: [CMS Pub. 100-05, Chapter 3](#) 

Is the patient enrolled in a Medicare Advantage plan?

- Yes.
- No.

Answer Summary:

Restart

Hide Answer Summary

Print

Tips

- Select the answer that applies to the service in question.
- Either a new question or instructions will automatically display based on the answer to the question.
- The "Answer Summary" column will display each question with the answer. To change an answer, click on the question and re-answer the question. The Answer Summary may be hidden by clicking the Hide Answer Summary button.
- The "Previous" and "Restart" buttons may also be used to either view the previous question or go back to the first question.
- Click Print to open a new window with printable view.

Return to Provider Errors

Top RTPs

Reason Code 39012

Description:

- The justification for timeliness (reason code 39011) is either missing or not formatted correctly.

Resolution:

- Include one of the following justification statements (if applicable):
 - Justify: MSP involvement.
 - Justify: SSA involvement.
 - Justify: PRO review involvement.
 - Justify: Other involvement.

Reason Code 32400

Description:

- A HCPCS code is required for one of the line items but a HCPCS code is not present.

Resolution:

- Verify the revenue code billed is correct.
- Add a valid HCPCS code for the service provided (if applicable).

Reason Code 19301

Description:

- A principal procedure code or a surgical CPT/HCPCS code is present but the operating physician's National Provider Identifier (NPI), last name and/or first initial is missing.

Resolution:

- Report the operating physician's NPI, last name and first initial in the operating physician fields.

Reason Code T5052

Description:

- The beneficiary identification submitted on the claim is incorrect. Medicare records do not exist for this beneficiary.

Resolution:

- Ensure the Health Insurance Claim (HIC) number submitted on the claim matches the HIC number on the beneficiary's Medicare card.

Reason Code U5233

Description:

- The admission date falls within a risk Group Health Organization (GHO) paid period; however, there is no GHO paid code or condition code 69 indicated on the claim.

Resolution:




- Verify the patient's managed care eligibility.
- If the claim is an acute inpatient claim, resubmit with condition code 04 for benefit period purposes.
- If the patient is under a managed care plan, submit the claim to the managed care plan for reimbursement.


Welcome, Jeremy.

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New and revised publications ...

- [Ambulance Manual](#) 
- [IHS Adjustments in DDE](#) 
- [Overpayment Unsolicited Voluntary Refunds](#) 
- [Surgery Manual](#) 
- [Ambulance Documentation](#) 



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Medicare Home Page

Searching For?

Use the following quick links to access frequently searched information:

- [Modifiers.](#)
- [Home Health.](#)
- [Hospice](#) (Part B billing, GW and GV modifiers).
- [ABN Form and Instructions](#) .
- [5010](#)
- [CMS Medicare Advantage \(MA\) Claims Processing Contacts](#) . (This link to the CMS Web site lists MA contract numbers and claims processing contact information.)
- [Important CMS Information.](#)
- [Reason Code/Denial Message Search.](#)
- [Claim Status and Eligibility.](#)
- [Procedure Codes.](#)

Provider Enrollment

Making Sense of Medicare



For the latest educational tips and information, please click the links below.

- [Emergency Department Evaluation/Management Services.](#)
- [Medicare Incentive Payments Are Not Just for Physicians Anymore.](#)
- [Incorrect Billing of Dual-Chamber Pacemakers.](#)
- [Outpatient Diagnostic Testing for Ordering Physicians and Clinical Laboratories.](#)

Need help understanding an acronym or term used on our Web site? Try the [Acronyms/Glossary of Terms](#)

Medicare Advantage/Part D Contract and Enrollment Data

- » Overview
- » Monthly Contract and Enrollment Summary Report
- » Monthly Enrollment by Contract
- » Monthly Enrollment by Contract/Plan/State/County
- » Monthly Enrollment by Plan
- » Monthly MA Enrollment by State/County/Contract
- » Monthly PDP Enrollment by State/County/Contract
- » MA State/County Penetration
- » PDP State/County Penetration
- » MA Contract Service Area by State/County
- » PDP Contract Service Area by State/County
- » State Service Area
- » Enforcement Letters
- » Corrective Action Plans
- » Special Needs Plan (SNP) Data
- » HEDIS Public Use Files
- » MA Plan Directory

MA Claims Processing Contacts



MA Claims Processing Contacts

Select From The Following Options:

Show all items

Show only (select one or more options):

Show only items whose last modified date is within the past

Show only items containing the following word

Show Items

There is **1** item in this list.

Sort by:

[View Results in Excel](#)

[Title](#) ▲ ▼

[Report](#) ▲ ▼

[MA Claims Processing Contacts](#)

2011-04

View Items Per Page:

Data Last Updated : 04/15/2011

[Help with File Formats and Plug-Ins](#)



Medicare Advantage Claims Processing Contacts

Sorted by Contract Number

Self-Service Tools

Medicare Home Page » Customer Service » Self-Service Tools

The TrailBlazer Web site was designed as a topic-driven self-service tool. Self-service technology is an efficient, cost-effective method of disseminating Medicare provider information, education and assistance. Use of self-service technology enables providers to access certain information without direct personal assistance from the Customer Service Provider Contact Center (PCC).

Show Options For:

Part A&B

Part A

Part A Tools

- [Acronyms/Glossary](#)
- [ESRD Separately Billable Drugs](#)
- [IRF Compliance Review Time Period Determination](#)
- [IVR Name to Number/PTAN Conversion Tools](#)
- [Modifier Code Search](#)
- [OPPS Addendum B Search](#)
- [Primary Care Incentive Payment Program \(PCIP\) Eligibility](#)
- [Reason Code Search](#)

Part A Calculators

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- [MSP Inpatient Payment Calculator](#)
- [OPPS APC Calculator](#)
- [Redetermination Filing Calculator](#)
- [SNF Payments Calculator](#)
- [Timely Filing Calculator](#)

Part A Guides

Part B

Part B Tools

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Part B Calculators

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- [ESRD Coordination Period Calculator](#)
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- [Global Period Calculator](#)
- [Redetermination Filing Calculator](#)
- [Timely Filing Calculator](#)

Part B Guides

- [Advance Beneficiary Notice \(ABN\) of Non-Coverage Completion Guide](#)

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can be accessed on the CMS Medicare Coverage Database (MCD) Web site by keying in the EOB ID identified in the narrative of the reason code. Select "Search" from the left navigation menu. When the narrative displays, scroll down to the bottom of the document to view the attachments (limited coverage, etc.).

Part B users enter a reason/remark code from their Medicare Remittance Advice (MRA), and a description of the code with an associated solution (in red text) is returned. The example provided may or may not be an all-inclusive example listing. If your claim denied/rejected and the example provided does not assist with the claim, please contact the Provider Contact Center for one-on-one assistance with the remittance advice message.

A complete list of ANSI Claim Adjustment Reason Codes and Remittance Advice Remark Codes is available on the [WPC Web site](#).

Search Reason Codes	
Search Term	<input style="width: 150px;" type="text"/> match these words close together ▾
The phrase 'advance notice' would match 'advance beneficiary notice'.	
Program	Return content for <input checked="" type="checkbox"/> Part A <input type="checkbox"/> Part B Search

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Total: 441 Rows: [Show All](#)

Reason Code	Description	Description
10415		ALL BILL TYPES EXCEPT TOB FREQ CODE G UNSOLICITED ADJUSTMENTS. THIS IS A CLAIM LEVEL REJECT REASON CODE FOR CLAIMS THAT HAVE ALL LINE ITEMS REJECTED BY C7251, C7252, C7253, C7254, C7255, C7256 OR C7257 RECEIVED FROM CWF.
10416		ONLY BILL TYPES WITH TOB FREQ CODE G UNSOLICITED ADJUSTMENTS. THIS IS A CLAIM LEVEL REJECT REASON CODE FOR CLAIMS THAT HAVE ALL LINE ITEMS REJECTED BY C7251, C7252, C7253, C7254, C7255, C7256 OR C7257 RECEIVED FROM CWF.
10417		THERAPY EXPENSE LIMIT EXCEEDED. NO MEDICARE REIMBURSEMENT WILL BE MADE.
11503		The qualifying hospital stay (occurrence span code 70 "through" date) is more than 30 days prior to the Skilled Nursing Facility (SNF) admission date.
Resolution		
If the qualifying hospital stay dates are correct and one of the following conditions applies, add the appropriate condition code.		
<ul style="list-style-type: none"> Condition code 55 -The patient's SNF admission was delayed more than 30 days after discharge from the hospital because an SNF bed was not available. Condition code 56 -The patient's SNF admission was delayed more than 30 days after discharge from the hospital because the patient's condition made it inappropriate to begin active care within that period. Condition code 57 - The patient previously received Medicare-covered SNF care within 30 days of the current SNF admission. 		
11801		The point of origin for admission or visit code (Form Locator (FL) 15) is missing or invalid.
Resolution		

TrailBlazer offers an Interactive Voice Response (IVR) system, which is a self-service tool that allows providers to quickly and easily access most Medicare information.

A summary of information that is available to providers on the IVR is listed below.

Claim Information

- Pending and processed claim information.
- Coinsurance amount (Part A only).
- Amount paid.
- Order a duplicate remittance notice (Part B paid remittances only).

Eligibility and Benefits Information

- Part A and Part B effective and termination dates.
- Amount of Part B deductible remaining to be met for the current year.
- Amount of Part B deductible remaining to be met for the prior year.
- Amount of physical and speech-language pathology cap remaining to be met for current year.
- Amount of occupational therapy cap remaining to be met for the current year.
- Medicare Advantage Plans.
- Medicare Secondary Payer (MSP) information.
- Benefits under a different Medicare number.
- Hospice enrollment.
- Home health enrollment.
- Capability of verifying preventive services available for patient.

Provider Enrollment

- PECOS status (Part B only).
- Application status (Part B only).

Financial Information

- Information on the last three checks (up to 24), which includes the issue date, check number, check amount and status of the check (Part A).
- Information on the last five checks (up to 25), which includes the issue date, check number, check amount and status of the check (Part B).
- The number of claims approved to pay and the approved-to-pay amount (Part B only).
- Check status by check number (Part B only).
- Number of pending claims and the pending claims amount (Part B only).

Redetermination Status

- Pending and processed redetermination information (Part A only).

Duplicate Remittance

- Request a duplicate copy of a remittance (Part B paid remittances only).

General Information (Available 24 hours a day)

- Important notices.
- Important telephone numbers.
- Important addresses.
- Look up a remittance code.
- Explanation of the five levels of appeals.

Reference Documents

- | | | |
|-----|---|----|
| REV | Medicare Advantage (MA) Plans | B |
| REV | IVR Trifold - Part B | B |
| REV | IVR Operating Guide | B |
| REV | J4 A/B MAC Provider Problem-Solving Guide | FB |
| | IVR Operating Guide | B |

Contacts

Resources

- [IVR Hours](#)
- [IVR Name Conversion Tool](#)
- [IVR PTAN Conversion Tool](#)

Notices

[MORE](#)

- [May TrailBlazer A/B Call Center Closures](#) Date Posted: 4/13/2011
- [How to Research Part B Claims That Deny as...](#) Date Posted: 4/6/2011
- [IVR/CSR Satisfaction Surveys Discontinued](#) Date Posted: 3/31/2011
- [Part B IVR Financial Section Enhanced](#) Date Posted: 3/24/2011
- [IVR Hours](#) Date Posted: 3/18/2011

FAQs

[MORE](#)

- [How can a provider verify if the claim payment calculation...](#)
- [What information must the provider furnish when contacting...](#)
- [My claim is denying stating "Claim not covered by this..."](#)
- [Why can't providers speak to a Customer Service Representative...](#)
- [How can I verify a patient's eligibility?](#)

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Critical Access Hospital Updates and Changes

Thank you for attending.