



Related MLN Matters® Article #: MM5597 **Revised**

Date Posted: July 5, 2007

Related CR #: 5597

Revision to Medicare Publication 100-09, Chapter 3 – Provider Inquiries and Chapter 6 - Provider Customer Service Program Updates – JA5597

Note: This job aid was revised to remove a Web link at the end of page 1 that is no longer available. All other information is the same.

Key Words

MM5597, CR5597, R20COM, Inquiries, Customer

Provider Types Affected

All physicians, suppliers, and providers who submit written inquiries to, or contact the toll-free lines at, their Medicare Carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and/or Regional Home Health Intermediaries (RHHIs)

Key Points

- The effective date of the instruction is May 23, 2007.
- The implementation date is July 30, 2007.
- Change Request (CR) 5597 contains a number of revisions to the *Medicare Contractor Beneficiary and Provider Communications Manual*, including changes for authenticating providers who make inquiries to Medicare contractors.
- Due to the Medicare fee-for-service contingency plan for the National Provider Identifier (NPI), the NPI will not be a required authentication element for general provider telephone and written inquiries until the date that the Centers for Medicare & Medicaid Services (CMS) requires it to be on all claim transactions.
- In this contingency environment, the provider transaction access number (PTAN) is the provider's current legacy provider identification number. The provider's PTAN, which may be referred to as their legacy number by some Medicare fee-for-service provider contact centers, will be the required authentication element for all inquiries to Interactive Voice Response (IVR) systems, customer service representatives (CSRs), and written inquiry units.

Highlights of Changes Announced in CR5597

- CR5597 modifies *Medicare Contractor Beneficiary and Provider Communications Manual*, Publication 100-09. These changes are summarized as follows:

Overlapping Claims—New Rules

- Medicare often receives multiple claims for the same beneficiary with the same or similar dates of service. An overlap occurs when the date of service or billing period of one claim seems to conflict with the date on another claim, indicating that one of the claims may be incorrect.
- When an inquiry regarding an overlapping claim is received, only the Medicare contractor initially contacted by the provider can authenticate the provider. The provider will be authenticated by verifying the name, PTAN/ legacy number or NPI, beneficiary name, Health Insurance Claim Number, and date of service for post-claim information, or date of birth for pre-claim information. Authentication does not need to be repeated when the second contractor is contacted.
- Contractors will release overlapping claim information when a provider inquires about a claim that was rejected for overlapping information, or if the provider found overlapping information when checking eligibility for a new admittance.
- For specific information regarding the resolution of claims rejected by Medicare's Common Working File system, providers should refer to the *Medicare Claims Processing Manual*, Chapter 27, §50 at <http://www.cms.hhs.gov/manuals/downloads/clm104c27.pdf> on the CMS website.

Information Available on the IVR

- **Providers should use the IVR whenever possible.** Providers should be aware that if a request for claim status or eligibility is received by a CSR or written inquiry correspondent and the requested information is available on the IVR, the CSR/correspondent will probably encourage providers to use the self-service options that are available.
- If at any time during a telephone inquiry, a provider requests information that can be found on the IVR the CSR will most likely refer the provider back to the IVR.

Information Available on the Remittance Advice (RA)

- **Providers should use the RA whenever possible.** If a CSR or written inquiry correspondent receives an inquiry about information that is available on an RA, the CSR/correspondent will discuss with the inquirer how to read the RA in order to independently find the needed information. The CSR/correspondent will inform the inquirer that the RA is necessary in order to answer any specific questions for which the answers are available on the RA. Providers should also be aware that any billing staff or representatives that make inquiries on his/her behalf will need to have a copy of the RA.
- To make the provider's job easier, they may use the Medicare Remit Easy Print (MREP) software. Information about MREP is available at http://www.cms.hhs.gov/AccessToDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website.
- Providers may also take advantage of national training materials available to educate themselves and their representatives about reading an RA. The national training materials include the MLN product, *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians,*

Suppliers, and Billers, which is available at

http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

- A website that allows providers to check the definitions of Claim Adjustment Reason Codes and Remittance Advice Remark Codes is available at <http://www.wpc-edi.com/products/codelists/alertservice> on the Washington Publishing Company website.
- There is a web-based training course, *Understanding the Remittance Advice for Professional Providers*, which is available at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website.
- This course provides continuing education credits and contains general information about RAs, instructions to help interpret the RA received from Medicare and reconcile it against submitted claims, instructions for reading Electronic Remittance Advices (ERAs) and Standard Paper Remittance Advices, and an overview of the MREP software that Medicare provides free to providers for viewing ERAs.

Authentication of Beneficiary Elements — Additions to Current Rules

- The attachments to CR5597 contain a detailed table that shows the data elements that are released in response to provider inquiries for beneficiary information. A key new provision allows Medicare contractors to release abdominal aortic aneurysm screening information to providers. CR5597 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf> on the CMS website.

Additional Key Points of CR5597

- Medicare's CSRs have the discretion to end a provider telephone inquiry if the caller places them on hold for two minutes or longer. Where possible, the CSR will give prior notice that a disconnection may occur.
- If a provider requests a copy of the Report of Contact made during a telephone response to a written inquiry, Medicare contractors will send the provider a letter detailing the discussion. At the provider's request, this letter may be sent to the provider by e-mail or fax, unless the details include specific beneficiary or claim related information.
- When the provider's Medicare contractor schedules a training event for which there is a charge for attendance and the provider registers and pays, but is unable to attend, the provider may be entitled to a refund of some or all of their payment. To receive such a refund, the provider **must notify the contractor before the event**.

Important Links

The related MLN Matters® article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5597.pdf> on the CMS website.

The official instruction (CR5597) regarding this change may be viewed at

<http://www.cms.gov/Transmittals/downloads/R20COM.pdf> on the CMS website.