MedHelp, Inc.'s Third-Party-Payor News

MedHelp brings you a dynamic news outlet designed to break the barriers between Third-Party-Payors and the Facilities and Practices!

Breaking News from the Source to You…

CMS'—Recovery Audit Contractor FAQs (Information Provided by CMS)

Question

If a demand letter from a Recovery Audit Contractor (RAC) is received because a service didn't meet Medicare's medical necessity criteria for an inpatient level of service, can we re-bill all the services on an outpatient claim?

Answer

Providers can re-bill for Inpatient Part B services, also known as ancillary services, but only for the services on the list in the Benefit Policy Manual. That list can be found in Ch. 6, Section 10: http://www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf.

Rebilling for any service will only be allowed if all claim processing rules and claim timeliness rules are met. There are no exceptions to the rules in the national program. The time limit for re-billing claims is 15-27 months from the date of service. These normal timely filing rules can be found in the Claims Processing Manual, Chapter 1; Section 70.

Question

Will providers be required to submit a UB-92 with medical records to the Recovery Audit Contractors (RACs)?

Answer

The decision to request a UB-92 will be up to the individual RAC. If this information is needed it will be notated on the medical record request letter.

Question

Will the RACs receive a full contingency fee for claims in which they utilize the extrapolation procedure outlined in the SOW?

Answer

Yes, RACs will receive their full contingency fee for extrapolated claims.

At a Glance

Who Are We—

Specializing in the areas of Medical Billing and Denial Management services, MedHelp, Inc. is the leading provider of Medical Management solutions to Facilities and Specialty Physician Practices

Services—

Medical Billing

Medicaid Qualification

Emergency Department Leveling Services

MedHelp, Inc. Benefits—

Reduced Claims Denials

Optimized Revenue

Lost Revenue Recovery

Free EMR Software

Contact Us—

sales@medhelpinc.com

Toll Free: 800 275-6011

Direct: 443 524-4455

MedHelp, Inc.'s Third-Party–Payor News

Breaking News from the Source to You…

CMS'—Recovery Audit Contractor FAQs (Information Provided by CMS)

Question

If a provider has performed a self-audit prior to RAC review and want to extrapolate these findings, will all these claims included in a self-audit be excluded from RAC review?

Answer

If a provider self-discloses a payment error and the Claims Processing Contractor confirms that a payment error exists and the sampling/extrapolation methodology used was correct, then these claims will not be reviewed by the RAC. The claims processing contractor will exclude the self-disclosed claims in the RAC data warehouse.

Question

How will the Recovery Audit Contractors (RAC) determine which claims to review?

Answer

The RACs will use their own proprietary software and systems as well as their knowledge of Medicare rules and regulations to determine what areas to review.

Question

Under what circumstances will a Recovery Audit Contractors (RAC) request medical records in order to determine if an overpayment exists.

Answer

RACs must use complex review (where medical records ARE involved in the review) in situations where there is a high probability (but not certainty) that the claim contains an overpayment.

At a Glance

Who Are We—

Specializing in the areas of Medical Billing and Denial Management services, MedHelp, Inc. is the leading provider of Medical Management solutions to Facilities and Specialty Physician Practices

Services—

Medical Billing

Medicaid Qualification

Emergency Department Leveling Services

MedHelp, Inc. Benefits—

Reduced Claims Denials

Optimized Revenue

Lost Revenue Recovery

Free EMR Software

Contact Us—

sales@medhelpinc.com

Toll Free: 800 275-6011

Direct: 443 524-4455

MedHelp, Inc.'s Third-Party-Payor News

Breaking News—From the Source to You…

CMS'—Recovery Audit Contractor FAQs (Information Provided by CMS)

Question

How are the Recovery Audit Contractors (RAC) paid for finding and recovering overpayments?

Answer

RACs are paid on a contingency basis (i.e., they retain a portion of the monies recovered) for all accurately identified overpayments.

Question

Will Critical Access Hospitals (CAH) be subject to Recovery Audit Contractors (RAC) review? If so, how will the funds be recouped?

Answer

Yes, Critical Access Hospitals are subject to RAC review. Any adjustments will be reflected on the final PS&R. If the cost report has already had a final settlement, the amount will be demanded and then offset against future claims if not paid in full by the provider.

Question

Who should providers contact with questions concerning Recovery Audit Contractors (RAC) communications?

Answer

Providers should first attempt to contact the Recovery Audit Contractors (RAC) through the customer service line. If that does not answer the provider's questions and/or concerns, then the provider can contact CMS. CMS has set up a special email address for the provider community to use. It is CMS RAC@cms.hhs.gov.

Question

Will the timing for appeals by the Medicare contractors be the same for the Recovery Audit Contractors?

Answer

Yes. The timeframe for filing an appeal remains the same.

MEDHELP INC.
MEDICAL MANAGEMENT SPECIALISTS

At a Glance

Who Are We—

Specializing in the areas of Medical Billing and Denial Management services, MedHelp, Inc. is the leading provider of Medical Management solutions to Facilities and Specialty Physician Practices

Services—

Medical Billing

Medicaid Qualification

Emergency Department Leveling Services

MedHelp, Inc. Benefits—

Reduced Claims Denials

Optimized Revenue

Lost Revenue Recovery

Free EMR Software

Contact Us—

sales@medhelpinc.com

Toll Free: 800 275-6011

Direct: 443 524-4455

MedHelp, Inc.'s Third-Party–Payor News

Breaking News—From the Source to You…

CMS'—Recovery Audit Contractor FAQs (Information Provided by CMS)

Question

Will the Recovery Audit Contractors (RAC) review evaluation and management (E&M) services on outpatient hospital claims?

Answer

Yes.

Question

If a provider repays or Medicare recoups an alleged overpayment identified by the Recovery Audit Contractors (RAC) and the provider later wins an appeal, will CMS reimburse the provider with interest?

Answer

CMS is required to pay interest when an appeal decision is favorable to the provider. The payment of interest in response to a favorable provider appeal decision is determined by CMS' interpretations of the appeal regulations. These regulations determine the process for all overpayments, not just RAC identified overpayments.

Question

Does the Recovery Audit Contractors (RAC) look for underpayments? What happens if they find an underpaid claim?

Answer

Yes, Recovery Audit Contractors (RAC) will identify underpayments as well as overpayments. In situations where a RAC identifies both overpayments and underpayments for a provider, the RACs offset the underpayment from the overpayment. In situations where a RAC identifies an underpayment for which there is no overpayment from which to offset, the RACs will inform the carrier or intermediary who will proceed with the claim adjustment and payment to the provider.

Contact Us—

sales@medhelpinc.com

Toll Free: 800 275-6011

Direct: 443 524-4455

MedHelp, Inc.'s Third-Party-Payor News

Breaking News—From the Source to You…

CMS'—Recovery Audit Contractor FAQs (Information Provided by CMS)

Question

Will the Recovery Audit Contractors (RAC) replace all current review entities?

Answer

No, the RACs will not review a claim that has previously been reviewed by another entity. Other entities such as Medicare contractors (Carriers, Durable Medical Equipment Regional Carriers, and Fiscal Intermediaries), Program Safeguard Contractors, Office of Inspector General or Quality Improvement Organizations (QIO) could still review a provider's claims.

Contact Us—

sales@medhelpinc.com

Toll Free: 800 275-6011

Direct: 443 524-4455

MEDHELP, INC. 'S THIRD-PARTY–PAYOR NEWS

Breaking News—From the Source to You…

CMS'— Healthcare Eligibility Transaction System (HETS) FAQs (Information Provided by CMS)

Question

What is HETS? How do I get connected to use this system?

Answer

The Healthcare Eligibility Transaction System (HETS) system is intended to allow release of eligibility data to Medicare providers or their authorized billing agents for the purpose of preparing an accurate Medicare claim, determining beneficiary liability, or determining eligibility for specific services. Such information may not be disclosed to anyone other than the provider, supplier, or beneficiary for whom a claim is filed.

The system provides access to Medicare beneficiary eligibility data in a real-time environment. In this environment, the submitter transmits a 270 eligibility request file (either directly or through a switch, i.e. a clearinghouse) and remains connected while Medicare processes the transaction. Medicare then returns a response (typically, a 271 eligibility response) file via the same network connection. HETS 270/271 is an extranet-based eligibility system for high volume providers who frequently check Medicare eligibility. The HETS 270/271 system allows providers or clearinghouses to submit HIPAA compliant 270 eligibility request files over a secure connection.

All extranet submitters must obtain a secure connection to the Medicare Data Communication Network (MDCN). Extranet submitters must also develop or acquire a mechanism to construct and send 270 eligibility request files and receive and deconstruct 271 eligibility response files in a real-time environment. The extranet system supports real-time transactions only; the system does not accept batch transactions.

If you are interested in the HETS 270/271 system, your organization must obtain an AT&T Global Network Service (AGNS) connection to the MDCN network. AT&T Resellers: AAMVA, IVANS or McKesson can facilitate this connection to your organization. More information on how to register is available here.
CMS is currently pilot testing an internet-based 270/271 User Interface (HETS UI) for providers who check Medicare eligibility infrequently. The HETS UI is a simple, low cost option for Medicare providers.

The only technical requirement is a secure computer with internet access. After completing registration and validation, each user is given a User ID and password. The user simply types Medicare beneficiary information into a secure, direct data entry website and clicks 'submit.' If the beneficiary information is entered properly, Medicare eligibility data displays on the computer screen and can be printed as necessary. The HETS UI does not accept FTP files or batch requests; screen scraping is not permitted.

CONTACT US—

sales@medhelpinc.com

Toll Free: 800 275-6011

Direct: 443 524-4455

MEDHELP, INC. 'S THIRD-PARTY–PAYOR NEWS

Breaking News—From the Source to You…

CMS'— Healthcare Eligibility Transaction System (HETS) FAQs (Information Provided by CMS)

Question

Who can use the HETS system?

Answer

All current submitters of Medicare claims to a local Carrier/FI/DMERC are entitled to utilize the HETS system. All potential submitters are validated and authenticated before being allowed to submit eligibility requests. All submitters must agree to CMS' Eligibility Rules of Behavior before submitting eligibility requests. If submitters do not comply with the CMS Eligibility Rules of Behavior, this could result in revoked access and other penalties.

Question

How do I sign up for HETS?

Answer

The HETS 270/271 system is intended to allow release of eligibility data to Medicare providers or their authorized billing agents for the purpose of preparing an accurate Medicare claim, determining beneficiary liability or determining eligibility for specific services. Such information may not be disclosed to anyone other than the provider, supplier, or beneficiary for whom a claim is filed.

If you are interested in the HETS 270/271 system, your organization must obtain an AT&T Global Network Service (AGNS) connection to the Medicare Data Communication Network (MDCN). AT&T Resellers: AAMVA, IVANS or McKesson can facilitate this connection to your organization. More information on how to register is available at www.cms.hhs.gov/HETSHelp/02_SignUpNow.asp

CONTACT US—

sales@medhelpinc.com

Toll Free: 800 275-6011

Direct: 443 524-4455

MEDHELP, INC.'S THIRD-PARTY–PAYOR NEWS

Breaking News—From the Source to You…

CMS'— Healthcare Eligibility Transaction System (HETS) FAQs (Information Provided by CMS)

Question

What is a Submitter ID number? How do I get this? Why does the Help Desk ask for this when I call?

Answer

The Submitter ID number is the value that identifies your organization to the HETS 270/271 system. The Submitter ID should appear in two places in the 270 eligibility request file -- the ISA06 and GS02 elements. To determine your Submitter ID number, check these values in your 270-eligibility request. The Help Desk will provide you with your organization's Submitter ID number when you have established connectivity and are ready to test. If your organization has not received its Submitter ID number but has established an AT&T Global Network Service (AGNS) connection to the Medicare Data Connectivity Network (MDCN) network and is ready to test, contact the Help Desk to receive your Submitter ID number. The Help Desk documents all telephone calls that are received. Your organization's Submitter ID number is used to cross-reference the record of all telephone calls from your organization.

Question

Why is the HETS system giving me the response that the patient is not found?

Answer

Verify that the information being submitted exactly matches the beneficiary's Medicare card. Information should be entered as it appears on the Medicare card, including any suffixes (Jr, III, etc.) that may appear.

Question

I verified the patient's card and the information matches. Why am I still not able to locate them in the system?

Answer

The system obtains basic beneficiary information (name, date of birth, etc.) directly from the Social Security Administration (SSA) or Railroad Retirement Board (RRB) databases. The beneficiary may want to contact the SSA or RRB to verify their information is correct.

sales@medhelpinc.com

Toll Free: 800 275-6011

Direct: 443 524-4455

MEDHELP, INC.'S THIRD-PARTY–PAYOR NEWS

Breaking News—From the Source to You…

CMS'— Healthcare Eligibility Transaction System (HETS) FAQs (Information Provided by CMS)

Question

Why does the 271 response not match what I receive from the IVR/DDE/other Medicare eligibility system? Which one is right?

Answer

CMS designed the HETS 270/271 system with the provider's beneficiary eligibility data needs in mind. The HETS 270/271I application obtains the response data for the transaction from the CMS beneficiary eligibility databases. The beneficiary eligibility databases are considered the authoritative source for beneficiary Part A and B effective and termination, demographic, managed care organization (MCO), and end stage renal disease (ESRD) data. When we say authoritative source, this means for CMS' purposes, the data originates here and is shared with other systems. The Common Working File (CWF), which is a Medicare claims processing system, shares other data, such as Medicare Secondary Payer (MSP), home health, hospice, skilled nursing facility (SNF) and hospital data, with the HETS 270/271 system through a nightly data exchange with the eligibility databases. CWF is considered the authoritative source for this data.

The MCARE help desk is responsible for investigating issues where the 271 response is different from the source database where the Medicare beneficiary eligibility data originates. For Medicare Secondary Payer (MSP) issues, if the 271 response matches the response from the Common Working File (CWF) provider queries (HUQA, HIQH, HIQA, ELGH, ELGB, ELGA) or the Provider Contact Center interactive voice response (IVRs) units response which utilizes CWF for eligibility inquiries, then the 271 response is returning what is sent from the source database. Please go to the following link to resolve MSP issues if you still feel the 271, CWF, and Provider Contact Center IVR provider eligibility query responses is incorrect: http://www.cms.hhs.gov/ProviderServices/01_overview.asp Other eligibility queries, such as the provider call center Interactive Voice Response (IVR) units and the CWF provider inquiry transactions, receive data directly from the CWF. As stated above, the CWF is considered the authoritative source for MSP, home health, hospice, SNF and hospital data. CWF receives eligibility data, such as Part A and B effective and termination, demographic, MCO, and ESRD data, through a nightly data exchange with the CMS eligibility databases.

As an eligibility requestor, you may see differences in Medicare eligibility responses based on the source (provider IVR, CWF inquiry, HETS 270/271) of your query due to the exchange of information between the sources. Typically these differences are due to a delay, up to 24 hours, in sharing information on nightly exchanges between the sources. It is CMS's vision that the HETS 270/271 system's data source will be used for all eligibility transaction responses in the future. Thus, no matter which eligibility transaction is being performed by the user, there will be a consistent response. The data returned on any eligibility inquiry that is claims related is only as good as the claims that have been processed by CWF. Thus, provider timely submittal of claims directly impacts the data returned on an eligibility inquiry. An eligibility response does not guarantee payment for a claim.

AT A GLANCE

WHO ARE WE—

Specializing in the areas of Medical Billing and Denial Management services, MedHelp, Inc. is the leading provider of Medical Management solutions to Facilities and Specialty Physician Practices

SERVICES—

Medical Billing

Medicaid Qualification

Emergency Department Leveling Services

MEDHELP, INC. BENEFITS—

Reduced Claims Denials

Optimized Revenue

Lost Revenue Recovery

Free EMR Software

CONTACT US—

sales@medhelpinc.com

Toll Free: 800 275-6011

Direct: 443 524-4455

MEDHELP, INC.'S THIRD-PARTY–PAYOR NEWS

Breaking News—From the Source to You…

CMS'— Healthcare Eligibility Transaction System (HETS) FAQs (Information Provided by CMS)

Question

How do I build the transaction for the HETS system?

Answer

Your organization will use the 270/271 Implementation Guide (IG) and the Medicare 270/271 Companion Guide to construct a transaction for the HETS 270/271 system.

Question

Where can I find an example of how to build the envelope?

Answer

Refer to section 4.1 of the HETS 270/271 Companion Guide for a detailed example.

Question

Where can I find the HETS Companion Guide?

Answer

The current version of the HETS 270/271 Companion Guide is available for download at: http://www.cms.hhs.gov/HETSHelp/Downloads/HETS%20270-271%20User%20Companion%20Guide.pdf

Question

Where can I find the 270/271 Implementation Guide?

Answer

The 270/271 Implementation Guide can be purchased from Washington Publishing Company. For more Information, call 1-800-972-4334 or visit http://www.wpc-edi.com/ Note: please look for the 004010X092A1 Combined Implementation Guide.

MEDHELP INC. MEDICAL MANAGEMENT SPECIALISTS

AT A GLANCE

WHO ARE WE—

Specializing in the areas of Medical Billing and Denial Management services, MedHelp, Inc. is the leading provider of Medical Management solutions to Facilities and Specialty Physician Practices

SERVICES—

Medical Billing

Medicaid Qualification

Emergency Department Leveling Services

MEDHELP, INC. BENEFITS—

Reduced Claims Denials

Optimized Revenue

Lost Revenue Recovery

Free EMR Software

CONTACT US—

sales@medhelpinc.com

Toll Free: 800 275-6011

Direct: 443 524-4455