

1st Quarter FY08 Written Correspondence FAQs

Q1. Is it a requirement to issue an Advance Beneficiary Notice (ABN) to patients who qualified for the therapy cap exception but are no longer meeting the medical necessity requirement?

A1. No. An ABN is not required for patients who qualified for the therapy cap exception but no longer meet the medical necessity requirement.

Q2. Does Medicare pay for blood transfusions when the patient is an inpatient of an Acute facility?

A2. Yes. A medically necessary transfusion of blood, regardless of the type, may generally be a covered service under both Part A and Part B of Medicare.

Go to <http://www.cms.hhs.gov/>

Click on "Regulations and Guidance"

Under "Guidance" click on "Manuals"

Under "Manuals" on the left side, click on "Internet Online Manuals"

Click on *100-3 Medicare NCD Manual*

Click on Chapter 1, Part 2

Click on section 110.7

Q3. We require that patients having an Aortic Valve Replacement have a Partial Thromboplastin Time (PTT) laboratory test performed prior to surgery. Is this service covered by Medicare?

A3. Testing prior to any medical intervention associated with a risk of bleeding and thrombosis (other than thrombolytic therapy) will generally be considered medically necessary only where there are signs or symptoms of a bleeding or thrombotic abnormality or a personal history of bleeding, thrombosis or a condition associated with a coagulopathy.

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Click on Chapter 1, Part 3

Click on section 190.16

Q4. Does Medicare pay for two screening fecal occult tests (FOBT) performed within a 12 month period?

A4. No. Medicare covers one FOBT annually for beneficiaries 50 and older. A written order from the beneficiary's attending physician is required.

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Click on *100-4 Medicare Claims Processing Manual*

Click on Chapter 18

Click on section 60.2

Q5. We are a certified Outpatient Dialysis center within an Acute hospital. How do we bill for Epoetin Alfa (EPO) given to dialysis patients?

A5. For instructions on how to bill Medicare for the administration of Epoetin in a Certified Outpatient Dialysis Center refer to the *Medicare Claims Processing Manual* 100-4, Chapter 8, Section 60.4.1.

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Click on 100-4 *Medicare Claims Processing Manual*

Click on Chapter 8

Click on section 60.4.1

Q6. How many specimen collections are allowed to be billed if multiple specimens are drawn?

A6. Only one collection fee is allowed for each type of specimen for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter.

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Click on Chapter 16

Click on section 60.1

Q7. I have a claim that denied for reason code U5211 stating that the billing dates exceed the beneficiary's date of death. Common Working File is showing the incorrect date of death. How can I get this corrected?

A7. The representative for the beneficiary must contact the Social Security Administration (SSA) to have this corrected as these cases cannot be corrected through the Fiscal Intermediary.

Q8. What type of documentation is accepted from Medicare as proof of timely filing?

A8. For information regarding specific documentation required for proof of Timely Filing please see the *Medicare Claims Processing Manual* (100-4), Chapter 1, Section 70.7 & 70.7.1.

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Click on 100-4 *Medicare Claims Processing Manual*

Click on Chapter 1

Click on section 70.7 & 70.7.1

Q9. What process should I follow to obtain the date that Medicare benefits exhausted for a beneficiary?

A9. If the benefits exhausted in your facility you can obtain the exhaust information from your Remittance Advice.

If you have reviewed all of your Remittance Advices and have not found the exhaust information, you can contact our Customer Service area to further research.

Q10. I have a claim that is editing for reason code 31715 stating that the units of service are exceeding the medically reasonable daily allowance. Do we need to appeal this claim or is there another process to correct this claim?

A10. No an appeal would not be appropriate. CMS established units of service edits referred to as Medically Unlikely Edits (MUEs). An MUE is defined as an edit that tests claim lines for the same beneficiary, HCPCS code, date of service, and billing provider against a criteria number of units of service. Providers should determine why the claim was returned, correct the error, and resubmit the corrected claim if appropriate.

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Under "MLN" click on "MLN Matters Articles"

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Go to "MLN 5603"

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