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PALMETTO GBA®

A CELERIAN GROUP COMPANY



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

The RRB-Contracted Specialty Medicare Administrative Contractor (RRB SMAC)
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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 Retirement Board Specialty Medicare Administrative Contractor (RRB SMAC) and processes Part B claims for Railroad Retirement beneficiaries nationwide. All RRB SMAC Part B 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.

How Can I Tell if a Patient Has Railroad Medicare?

The Medicare Beneficiary Identifier (MBI) numbers assigned to people with Railroad Medicare are not distinguishable from other MBIs. The Medicare card of a person with Railroad Medicare is unique, as seen below, with the RRB logo in the upper left corner and “Railroad Retirement Board” at the bottom.



If you verify a patient’s eligibility electronically, CMS will return a message on the eligibility transaction response for a fee-for-service (FFS) Railroad Medicare patient’s MBI inquiry that will read “Railroad Retirement Medicare Beneficiary” in 271 Loop 2110C, Segment MSG.

If you verify a patient’s eligibility using an MBI in the Palmetto GBA eService’s online provider portal, the portal will return the “Railroad Retirement Medicare Beneficiary” message in the Additional Information field of the Eligibility subtab. See page 27 of this guide for more information about eServices.

Where Do I File Other Types of Claims for Railroad Medicare Patients?

- Part A Hospital and Skilled Nursing Facility Claims — The jurisdictional A/B MACs process hospital and SNF facility claims for both Medicare and Railroad Medicare beneficiaries.
- Home Health and Hospice Claims — The jurisdictional Home Health and Hospice (HHH) MACs process home health and hospice claims for both Medicare and Railroad Medicare beneficiaries.
- Durable Medical Equipment Claims — The jurisdictional DME MACs process claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items for both Medicare and Railroad Medicare beneficiaries. See the CMS annual DMEPOS Jurisdiction Lists at <https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center>. Bill items listed as under DME MAC jurisdiction to your local DME MAC. Bill items listed as under Part B MAC jurisdiction to Palmetto GBA Railroad Medicare for Railroad Medicare beneficiaries.

You can use the CMS MAC website List to find website and contact information for the jurisdictional MACs: <https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List>.

PROVIDER ENROLLMENT

Providers must be enrolled with their local Part B Medicare Administrative Contractors (MACs) before requesting a Railroad Medicare Provider Transaction Access Number (PTAN). If you are a Medicare-enrolled provider, you are eligible to render services for a Railroad Medicare beneficiary, but you must be assigned a Railroad Medicare PTAN before Railroad Medicare can process your claims.

Once you are enrolled with your local MAC, you can request a Railroad Medicare PTAN in one of the following ways:

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. You must have a Railroad Medicare PTAN before you can submit claims electronically to Railroad Medicare. Please do not submit any electronic claims or a Railroad Medicare Electronic Data Interchange (EDI) Enrollment form until you have received your Railroad Medicare PTAN.

Once you have a pending claim for a Railroad Medicare patient, you may request a Railroad Medicare PTAN using our Railroad Medicare PTAN Lookup and Request Tool at www.PalmettoGBA.com/RR/PTAN. Provider Enrollment will not accept telephone requests or written requests to enroll a provider.

PTAN Lookup and Request Tool

The PTAN Lookup and Request Tool first validates the provider identification information you enter — local Part B MAC PTAN, National Provider Identifier (NPI) and Tax Identification Number (TIN) — against enrollment information in our files. If a match is found, the tool retrieves and releases the Railroad Medicare PTAN. If a match is not found, the tool gives providers the option to request a new Railroad Medicare PTAN. If you choose to request a new PTAN, the tool will then validate the provider identification information you entered against your enrollment record with your local Part B Medicare Administrative Contractor (MAC). Because Railroad Medicare's enrollment records will match what your local MAC has on file, please make sure your enrollment information is current with your MAC before requesting a Railroad Medicare PTAN.

If a match can be found, the PTAN assignment process begins. The PTAN Tool will assign and release most new PTANs the day they are requested. Some requests may require research and you will be advised to return to the tool after 30 days to retrieve the new PTAN. Do not submit additional requests for the same provider. The tool will provide you with a reference number and a pdf of your request for your records. Please note, you are not required to enter the reference number when you return to the PTAN Tool to check the status of your request.

After we assign a new PTAN, we will also send you a letter detailing your Railroad Medicare PTAN data. The letter will be sent to the pay-to address that is on the provider's Part B MAC enrollment record.

NOTE: If the provider information entered on the PTAN Tool does not match your local Part B MAC's files, you will receive a message informing you that the request cannot be completed.

PROVIDER ENROLLMENT, CONTINUED

PTAN Lookup and Request Tool Quick Reference

What do you want to do?	Enter the following provider identification elements
<p>Look up an existing Railroad Medicare PTAN for an individual provider or supplier (physician, nonphysician practitioner, ambulance, laboratory, ambulatory surgical center, etc.)</p>	<ul style="list-style-type: none"> • PTAN assigned to the individual provider by the local Part B MAC • Individual NPI • Last 5 digits of Tax Identification Number (TIN)* <p>* If the provider is enrolled with their Part B MAC under a Social Security Number (SSN), please contact the RRB SMAC PCC for assistance</p> <p>If you are employed by a clearinghouse or third-party biller, you must contact the provider to obtain the Railroad Medicare PTAN.</p>
<p>Look up an existing Railroad Medicare PTAN for a group/practice</p>	<ul style="list-style-type: none"> • PTAN assigned to the group/practice by the local Part B MAC • Group/practice NPI • Last 5 digits of Tax Identification Number (TIN) <p>If you are employed by a clearinghouse or third-party biller, you must contact the provider to obtain the Railroad Medicare PTAN.</p>
<p>Request a new Railroad Medicare PTAN for an individual provider (physician, non-physician practitioner, ambulance, laboratory, ambulatory surgical center, etc.)</p>	<ul style="list-style-type: none"> • PTAN assigned to the individual provider by the local Part B MAC • Individual NPI* • Last 5 digits of Tax Identification Number (TIN)** <p>* If the provider’s Part B MAC PTAN is linked to multiple NPIs, please contact the RRB SMAC PCC for assistance</p> <p>**If the provider is enrolled with their Part B MAC under a Social Security Number (SSN), please contact the RRB SMAC PCC for assistance.</p>
<p>Request a new Railroad Medicare PTAN for a group</p>	<p>Please do not attempt to request a new Railroad Medicare PTAN for a group/practice. A group PTAN will be created when a PTAN is assigned to the first group member.</p>

If you need assistance using the PTAN Lookup and Request Tool, please call our Provider Contact Center at 888–355–9165 for assistance. Choose option 3 for Provider Enrollment and then choose option 0 to speak with a Provider Enrollment Specialist.

For Paper Submitters

Providers that meet the CMS requirements to be waived from filing electronically have the option to submit their initial CMS-1500 (02/12) claim form to Railroad Medicare to obtain a PTAN. Once a claim has been received, we will obtain your enrollment information from your local Part B MAC and issue a Railroad Medicare PTAN if the provider information on the claim can be verified. Before submitting a claim to Railroad Medicare, please make sure that the provider information submitted on the claim matches the enrollment information on file with your local MAC. This includes the 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 the request cannot be completed.

PROVIDER ENROLLMENT, CONTINUED

Making Changes to an Existing Railroad Medicare PTAN

- Please complete all changes with your local MAC first. Once you have received confirmation that the provider's record has been updated by your MAC, please allow seven to 14 business days before sending notification to Railroad Medicare.
- Submit changes in writing on your provider/practice letterhead to our Provider Enrollment unit. Provider Enrollment will not accept telephone requests to update a record.
- Please include the following information:
 - Provider's name
 - Railroad Medicare PTAN
 - NPI
 - Tax Identification Number
 - Contact information
 - Explanation of the change
 - Billing address – Include new billing address
 - Practice address – Include new practice address
 - Practice name – Include new practice name
 - Provider's name – Include provider's new name
 - Provider retired – Include date provider retired
 - Provider left group – Include date provider left group
 - Copy of Part B MAC notice confirming change has been completed
- Fax the request to (803) 382–2415 or mail the request to:

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

NOTE: If at any time your enrollment status with your local Part B MAC changes (such as failure to revalidate, provider revocations, provider suspensions, etc.), the same activity will occur with your Railroad Medicare PTAN.

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

Palmetto GBA's Electronic Data Interchange (EDI) encourages providers to submit their claims electronically and to utilize certain electronic features we offer. These electronic services allow providers to submit claims using a computer and software instead of paper. You can also access certain claim and patient eligibility records and retrieve your remittance notices electronically.

The Administrative Simplification Compliance Act (ASCA) prohibits Medicare coverage of claims submitted to Medicare on paper, except in limited situations. All initial claims for reimbursement from Medicare must be submitted electronically with limited exceptions. For more information about ASCA requirements, please see the CMS website at www.cms.gov.

The Centers for Medicare & Medicaid Services (CMS) has approved version 5010 Base and Errata as the exclusive version for all ASC X12N electronic transaction sets used by Medicare. ASC X12 TR3 Implementation Guides for v5010 transactions are available through the ASC X12 Store at <http://store.x12.org/store/>. New submitters will need to complete the online EDI Enrollment Forms to request a Submitter ID. Vendors/Trading Partners will need to complete an online EDI Application form to request a Vendor Submitter ID prior to testing. Submitters who use approved vendor-supported systems are not required to submit test claims with Palmetto GBA. If you use PC-ACE Pro32 software, please ensure you are using the most current version of the Palmetto GBA-issued software. The GPNNet Communications Manual includes information about GPNNet, Palmetto GBA's EDI Gateway.

About Railroad Medicare EDI Web Pages

EDI enrollment forms can be found on the Enrollment web page. The Software & Technical Specifications web page includes user manuals and software download information including Companion documents and other materials in support of the approved ASC transaction sets. The RR EDI FAQ page includes answers to frequently asked EDI questions. Links to the Palmetto GBA EDI web pages, EDI resources and EDI forms referenced above can be found at www.PalmettoGBA.com/RR/EDI.

How to Submit Claims Electronically

Submitter Options	
Clearinghouse/Billing Service	A clearinghouse or billing service acts as an intermediary who submits claim files and/or retrieves reports and remittances between a provider and Palmetto GBA.
Direct Submitter	Electronic claims submission and remittances through PC ACE Pro32 or a vendor software. 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 software, it is important to consider whether you plan on using the software for billing only or if you intend to use for both billing and office accounting functions. A Part B Approved 5010 Errata Vendor list is available on our EDI Enrollment web page.

SUBMITTING CLAIMS ELECTRONICALLY, CONTINUED

How Do I Enroll?

The EDI Online Enrollment Tool allows you to submit the EDI enrollment forms electronically online. Once the forms have been processed, an email which includes the status will be sent to the email address listed on the forms.

You can also enroll by submitting the Railroad Medicare EDI Enrollment packet via fax or email. The EDI Enrollment Instructions Guide module has been created to help you determine which forms are required based on your submitter type and how to complete each form. You can find a link to the module on our EDI Enrollment web page. We ask that you please review the instruction guide before completing any forms. Once the forms have been processed, an email which includes the status will be sent to the email address listed on the forms.

All submitters must use a Network Service Vendor (NSV) to connect to Palmetto GBA. An NSV provides a secure connection to the Palmetto GBA front-end gateway. An approved network service vendors list is available on our EDI Enrollment web page to assist you with finding an NSV best suited for your needs.

Additional electronic submission information can be downloaded from the Palmetto GBA website at www.PalmettoGBA.com/RR/EDI. Our representatives are available to eChat on the EDI web pages or by phone by contacting the Palmetto GBA EDI Help Desk at 888-355-9165. You may also email us at rb.edi@palmettogba.com with general EDI questions. Palmetto GBA cannot respond to emails that contain Protected Health Information (PHI).

Get EDI Updates

Register on the Palmetto GBA website to receive EDI news electronically. By selecting Email Updates at the top of our web page www.PalmettoGBA.com/RR and completing a user profile, you will be notified via email when new or important EDI information is added to our website. If you have already subscribed, please ensure your selected topics includes the Electronic Data Interchange (EDI) topic located under the Railroad Medicare category. See Page 47 of this guide for more information.

Electronic Remittance Advice

An Electronic Remittance Advice (ERA) is an electronic version of a Standard Paper Remittance (SPR). It includes an explanation of claim payment information, claim adjustments, and claim denials.

In an effort to advance toward an electronic environment, CMS Change Request 4376 mandated that Part B MACs and Durable Medical Equipment (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

SUBMITTING CLAIMS ELECTRONICALLY, CONTINUED

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 Topics, EDI, and Software & Technical Specifications.

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.

SUBMITTING CLAIMS ELECTRONICALLY, CONTINUED

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 an 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

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 returned as unprocessable. Paper claims must be submitted on original red and white CMS-1500 (02/12) forms which include the printed information on the back on the form. Photocopies of claims are not accepted.

Paper claims are scanned into the claims processing system. Here are some tips to keep in mind when completing the CMS-1500 (02/12) claim form to accommodate our scanning process:

- Print claims using 10-, 11- or 12-point Courier or Arial font.
- Use capital letters. Mixed case can throw off character recognition (example: “5” can become “S”).
- Use black ink. Red ink and highlighting cannot be read by the scanning equipment.
- 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
- 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) Claim 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 Tools tab 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 patient’s Medicare ID number. Enter the number exactly as it appears on the patient’s Railroad Medicare card.
- **Items 2 and 5** are specifically for the patient information. In Item 2, enter the name of the person who received the services 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 enter 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.

- **SUBMITTING PAPER CLAIMS – TIPS AND REMINDERS. CONTINUED**
 - Enter the provider’s complete name spelled as it appears on the CMS Order and Referring File at <https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment>.
 - Include a hyphen in the last name only if the last name is hyphenated on the CMS file.
 - Do not enter middle initials or suffixes such as MD, DO, Jr, etc.
 - Do not enter Dr. before the name.
- **Item 17a** — Leave blank.
- **Item 17b** — Enter the ordering/referring/supervising provider’s NPI.
- **Item 21** is for the diagnosis code(s) and the ICD indicator.
 - In the ICD Indicator field, enter 0 (zero) for ICD-10 codes. Claims submitted without a valid ICD indicator will be rejected as unprocessable.
 - 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.
 - Do not duplicate diagnosis codes. Claims submitted with duplicate diagnosis will be rejected as unprocessable.
- **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 letter per line item. If multiple services are performed, enter the primary reference number for each service.
- **Item 24J** is for the rendering provider’s NPI number. Leave the shaded portion blank.
- **Item 24d** requires a valid five (5) character HCPCS or CPT-4 procedure code plus modifier(s), if applicable. 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.
 - Leave the shaded memo fields of the 24 A–J service area blank. Exception: 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 where the services were rendered. Cannot be a PO Box.
- **Item 32b** — Leave blank.
- **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** — Leave blank.
- 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 Code 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, while not all-inclusive, provides a brief description of common Medicare modifiers and some tips for their use. Railroad Medicare only recognizes national modifiers. Local MAC assigned modifiers will cause rejections. 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 tool on our website for additional modifiers and/or more information. A link to the Modifier Lookup tool can be found on our Tools tab.

- Up to four modifiers can be submitted on a single claim line. If more than four modifiers are needed to describe the service on that line, submit modifier 99 on the claim line, and list each modifier on the claim in Item 19 of the CMS-1500 (02/12) form or in 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 an 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	Intermediate stop at a physician’s office en route to the hospital (includes HMO non-hospital facility, clinic, etc.). Destination code only.
U	Urgent Care Facility — Destination code only for Emergency Triage, Treat, and Transport (ET3) Model claims
O	Physician’s Office — Destination code only for ET3 Model claims
F	Federally Qualified Health Center — Destination code only for ET3 Model claims
C	Community Mental Health Center — Destination code only for ET3 Model claims
W	Treatment in Place or via Telehealth Service — Destination code only for ET3 Model claims
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.

NATIONALLY ACCEPTED MEDICARE MODIFIERS, CONTINUED

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)
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	Qualified nonphysician anesthesiologist services with medical direction by a physician
QY	Medical direction of one qualified nonphysician anesthesiologist 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 physician in a non-teaching facility
82	Assistant surgeon (when qualified resident surgeon not available) ▪ Used for MD and/or DO only

NATIONALLY ACCEPTED MEDICARE MODIFIERS, CONTINUED

CATASTROPHE / DISASTER

HCPCS Modifier	Description
CR	Catastrophe / Disaster Related
CS	Cost-Sharing is Waived (COVID-19) <ul style="list-style-type: none"> ▪ Effective for dates of service from March 18, 2020, through the end of the COVID-19 Public Health Emergency (PHE) ▪ Use when physician and practitioner visit services lead to the administration of or an order for a COVID-19 lab test ▪ Coinsurance and deductible will not apply.

CHIROPRACTOR

HCPCS Modifier	Description
AT	Acute treatment <ul style="list-style-type: none"> ▪ 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
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 <ul style="list-style-type: none"> ▪ 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 ▪ 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. <p>* See the new distinct procedural service modifiers XE, XS, XP and XU that CMS created as specific subsets of modifier 59</p> <p>* 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.</p>
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service <ul style="list-style-type: none"> ▪ 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

NATIONALLY ACCEPTED MEDICARE MODIFIERS, CONTINUED

CORRECT CODING (NATIONAL CORRECT CODING INITIATIVE), CONT.

HCPCS Modifier	Description
XE	<p>Separate encounter, a service that is distinct because it occurred during a separate encounter</p> <ul style="list-style-type: none"> ▪ 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	<p>Separate structure, a service that is distinct because it was performed on a separate organ/structure</p> <ul style="list-style-type: none"> ▪ 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	<p>Separate practitioner, a service that is distinct because it was performed by a different practitioner</p> <ul style="list-style-type: none"> ▪ 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
XU	<p>Unusual Non-Overlapping Service, The Use of a Service That Is Distinct Because It Does Not Overlap Usual Components of The Main Service</p> <ul style="list-style-type: none"> ▪ 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)

DRUGS AND BIOLOGICALS

HCPCS Modifier	Description
JW	<p>Drug amount discarded/not administered to any patient</p> <ul style="list-style-type: none"> ▪ Use for claims for unused drugs or biologicals from single use vials or single use packages that are appropriately discarded ▪ Use on separate claim line for the amount of drug or biological discarded ▪ Document the discarded drug or biological in the patient’s medical record ▪ Do not use for drugs provided under the Competitive Acquisition Program (CAP) ▪ Do not use for discarded drugs or biologicals from multi-use vials
JZ	<p>Zero drug amount discarded/not administered to any patient</p> <ul style="list-style-type: none"> ▪ Use only for claims that bill for single-dose container drugs that are separately payable under Medicare Part B when there are no discarded amounts. ▪ Required on applicable claims effective July 1, 2023

NATIONALLY ACCEPTED MEDICARE MODIFIERS, CONTINUED

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, infliximab.
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

ERYTHROPOETIC STIMULATING AGENT (ESA)

HCPCS Modifier	Description
EA	Erythropoetic stimulating agent (ESA) administered to treat anemia due to anti-cancer chemotherapy
EB	Erythropoetic stimulating agent (ESA) administered to treat anemia due to radiotherapy
EC	Erythropoetic 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 Darbepoetin 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
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
AI	Principal Physician of Record ▪ 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. ▪ Use on CPT® codes 99221–99223 and 99304–99306.

NATIONALLY ACCEPTED MEDICARE MODIFIERS, CONTINUED

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 <ul style="list-style-type: none"> ▪ 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) <ul style="list-style-type: none"> ▪ Used only for professional services rendered by a physician.
AZ	Dental HPSA

LABORATORY

HCPCS Modifier	Description
LR	Laboratory round trip <ul style="list-style-type: none"> ▪ Used only with travel fees
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
CPT® Modifier	Description
90	Reference (outside) laboratory <ul style="list-style-type: none"> ▪ 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

NATIONALLY ACCEPTED MEDICARE MODIFIERS, CONTINUED

MISCELLANEOUS

HCPCS Modifier	Description
AP	Determination of refractive state was not performed in the course of diagnostic ophthalmological examination
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
JC	Skin substitute used as a graft
JD	Skin substitute not used as a graft
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 <ul style="list-style-type: none"> ▪ 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 <i>locum tenens</i> physician
RT	Right side (Informational only)
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). Examples: <ul style="list-style-type: none"> ▪ Separately payable anesthesia service in conjunction with a screening colonoscopy (CPT® code 00810) ▪ Advanced Care Planning (ACP) furnished as part of an Annual Wellness Visit ▪ Services billed with modifier 33 qualify for waiver of coinsurance and deductible if all other requirements are met ▪ Do not use on separately reported services specifically identified as preventive
76	Repeat procedure by the same physician
77	Repeat procedure by a different physician
99	Multiple modifiers Use only when more than four modifiers are necessary per line item <ul style="list-style-type: none"> ▪ 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

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

NATIONALLY ACCEPTED MEDICARE MODIFIERS, CONTINUED

MUSCULOSKELETAL, CONT.

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)

PROVIDER TYPE

HCPCS Modifier	Description
AE	Registered Dietician
AH	Clinical Psychologist
AJ	Clinical Social Worker

RADIOLOGY

CPT[®] Modifier	Description
CT	Computed tomography services furnished using equipment that does not meet each of the attributes of the national electrical manufacturers association (NEMA) XR-29-2013 standard
FX	X-ray taken using film
FY	X-ray taken using computed radiography technology/cassette-based imaging
HCPCS Modifier	Description
PI	Initial Anti-tumor Treatment Strategy
PS	Subsequent Treatment Strategy

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 met the KX modifier threshold for PT/SLP or OT, and the service qualifies as a medical necessary exception to be reimbursed over and above the threshold

NATIONALLY ACCEPTED MEDICARE MODIFIERS, CONTINUED

PHYSICAL THERAPY/OCCUPATIONAL THERAPY/SPEECH LANGUAGE PATHOLOGY, CONT.

CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant

SURGERY

CPT[®] Modifier	Description
22	Unusual procedural services <ul style="list-style-type: none"> ▪ Use only in conjunction with surgical procedure codes ▪ Submit operative report and/or a written detailed description with the initial claim
50	Bilateral procedure <ul style="list-style-type: none"> ▪ Refer to the Medicare Physician Fee Schedule Database (MPFSDB) bilateral indicator to determine if modifier is applicable to a particular procedure code ▪ Used on codes with bilateral indicators 1 or 3 when service is performed bilaterally. ▪ Should be used for some ophthalmology diagnostic tests
51	Multiple procedures <ul style="list-style-type: none"> ▪ Refer to the “Mult Surg” indicator in the Medicare Physician Fee Schedule database (MPFSDB) to determine if CPT[®] modifier 51 is applicable to a particular procedure code ▪ We strongly recommend that you do not submit this modifier to Palmetto GBA. Palmetto GBA will apply this modifier to indicate when multiple procedure pricing rules have been used to calculate the reimbursement
52	Reduced services <ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> ▪ Attach operative notes to the initial claim ▪ Claims without the proper documentation will be denied and must be resubmitted for payment
54	Surgical care only <ul style="list-style-type: none"> ▪ Use with surgery code to indicate postoperative care was done in part or whole by another provider ▪ Includes coverage for the surgical procedure and the preoperative care
55	Postoperative management only <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> ▪ Is a staged procedure ▪ Is a more extensive procedure than the original ▪ Involves therapy following a diagnostic surgical procedure
62	Two surgeons <ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> ▪ 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

NATIONALLY ACCEPTED MEDICARE MODIFIERS, CONTINUED

SURGERY, CONT.

CPT® Modifier	Description
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
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

TELEHEALTH

HCPCS Modifier	Description
G0	Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke
GQ	Via asynchronous telecommunications systems ▪ Use only for federal telemedicine demonstrations conducted in Alaska or Hawaii
FQ	The service was furnished using audio-only communication technology
CPT® Modifier	Description
95	Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System ▪ Use only on approved telehealth codes appearing on the current CMS listing located at: https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes .

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 current CMS ABN form, available on the CMS website at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html>. The ABN form and instructions for completing the form can be found under Downloads.

Notices placed on the CMS site can be downloaded and should be used as is because the ABN is a standardized OMB-approved notice. However, you may customize some fields of the ABN to integrate the ABN into other automated business. ABNs must be reproduced on a single page.

- It is not appropriate to ask patients to sign an ABN for every service
- The ABN form must be:
 - 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

Claims that are submitted with missing, incomplete or invalid information may be rejected as unprocessable. A claim that has been rejected may be identified by the following remittance advice message:

- 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.*

Rejected claims do not have appeal rights and should be resubmitted as new claims with the correct information. If you are required to submit electronic claims, do not resubmit a rejected claim on paper.

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 remittance advice to find out the specific reason for rejection so you can make the necessary corrections and submit a new claim. In addition to message MA130, your remittance advice should contain specific remittance advice remark codes that explain the reason for rejection.

The following chart contains some of the most common rejections and their solutions.

REJECTION	DESCRIPTION	PROBLEM	SOLUTION
N382	<i>Missing/incomplete/invalid patient identifier.</i>	The Medicare Beneficiary Identifier is missing or invalid. Claim was submitted on or after 1/1/2020 with a HICN.	Enter the correct Medicare Beneficiary Identifier in Block 1a.
MA83	<i>Did not indicate whether we are the primary or secondary payer.</i>	Paper claims only. Item 11 is blank.	If Railroad Medicare is primary insurance for the beneficiary, enter “ NONE ” in Item 11.
MA04	<i>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.</i>	Paper claims: There is a policy number and/or insurance name in Item 11, but no EOB attached, wrong EOB attached, or EOB is illegible. Electronic claims: Incorrect or missing MSP type code.	Paper claims: Attach the EOB from the primary insurer. EOB must be legible and complete. Electronic claims: Complete the primary insurance fields with correct MSP type.
N265 N276	<i>Missing/incomplete/invalid ordering provider primary identifier.</i> <i>Missing/incomplete/invalid other payer referring provider identifier.</i>	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.

REJECTION	DESCRIPTION	PROBLEM	SOLUTION
MA120	<i>Missing/incomplete/invalid CLIA certification number.</i>	<ul style="list-style-type: none"> ▪ The CLIA # is not in Item 23 of the claim ▪ The CLIA # has too few or too many characters ▪ The CLIA # is not legible 	<ul style="list-style-type: none"> ▪ Enter your correct CLIA # in Item 23 ▪ Enter the CLIA # using the correct format
N657	<i>This should be billed with the appropriate code for these services.</i>	<ul style="list-style-type: none"> ▪ Item 21 — Invalid/missing or truncated diagnosis. 	<ul style="list-style-type: none"> ▪ Refer to the most recent ICD-CM coding for correct/most specific diagnosis for your date of service
CO-11	<i>The diagnosis is inconsistent with the procedure.</i>	<ul style="list-style-type: none"> ▪ Item 21 — Invalid or missing ICD Indicator (9 for ICD-9, or 0 for ICD-10) 	<ul style="list-style-type: none"> ▪ In item 21, do not list the same diagnosis more than once
M76	<i>Missing/incomplete/invalid diagnosis or condition.</i>	<ul style="list-style-type: none"> ▪ Item 24e — Missing or invalid diagnosis pointer ▪ Item 21 — Duplicate diagnosis 	<ul style="list-style-type: none"> ▪ Enter the correct ICD indicator ▪ 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	<i>Incomplete/invalid “from” date(s) of service.</i>	Item 24A is blank or contains an invalid date of service.	Enter complete and valid “from” and “to” dates of service.
M77	<i>Missing/incomplete/invalid/inappropriate place of service.</i>	Item 24B — Missing/incorrect/invalid two-digit place of service code.	Make sure you are using the correct two-digit place of service code for the services you are billing.
M51	<i>Missing/incomplete/invalid procedure code(s).</i>	Item 24D — Incorrect/invalid procedure code.	Make sure the procedure code is valid for the DOS and has been keyed/printed correctly.
N198	<i>Rendering provider must be affiliated with the pay-to provider.</i>	<p>Item 24J — Rendering provider NPI</p> <p>Most commonly means the rendering provider either does not have a Railroad Medicare PTAN under the TIN submitted or the rendering provider does not have a Railroad Medicare PTAN linked to the billing provider group/organization NPI on the claim.</p>	<p>Verify the rendering provider has a Railroad Medicare PTAN for the TIN before submitting an electronic claim.</p> <p>Verify the rendering provider has a Railroad Medicare PTAN linked to the Group PTAN/NPI for the billing provider NPI submitted on your claim</p>

REJECTION	DESCRIPTION	PROBLEM	SOLUTION
MA81	<i>Missing/incomplete/invalid provider/supplier signature.</i>	Item 31 is blank and/or has an unacceptable entry. The name of a facility or supplier is not acceptable (example: ambulance company name, laboratory name, ASC name).	Enter an acceptable signature. Acceptable claim signatures include handwritten, pre-printed, computer generated, or typed name of provider or authorized employee/billing agent, and/or signature on file.
MA114	<i>Missing/incomplete/invalid information on where services were furnished.</i>	Item 32 is blank and/or has an unacceptable entry (P.O. 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 online, provider self- service portal. The eServices portal provides information access over the internet for the following online services:

- Patient Eligibility, including whether a patient has Railroad Medicare
- Medicare Beneficiary Identifier (MBI) Lookup Tool
- Claims Status
- Pending Medical Review Additional Documentation Requests (ADRs)
- Remittances Online
- eClaim Submissions
- Financial Tools — Payment Floor Status, Last 3 Checks, Overpayment Details
- Financial Forms — eOffset request and eCheck payments
- Appeals Forms — Redetermination: First Level Appeal, Redetermination: Overpayment Appeal, Redetermination: CERT Appeal, Reopening: Simple Claim Correction
- Other Secure Forms — Medical Review ADR Response Form, General Written Inquiry Request Form, Prior Authorization-Ambulance Form, Benefit Integrity Record Request Response Form
- eDelivery of Medical Review and Claims ADR letters, Targeted Probe and Educate ADRs and letters, Medicare Redetermination Notices, Overpayment Demand Letters, General Correspondence Responses, and Prior Authorization-Ambulance Decision letters via your eDelivery inbox
- eReview – eCBR, eUtilization, and eAudit

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 can grant permissions to additional users and administrators 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 PTAN, NPI, tax ID number and either the amount of the last Railroad Medicare payment you received for the PTAN/NPI combination or an EDI access code, if you recently set up your EDI Enrollment Agreement. You must register for each PTAN/NPI combination separately. Each combination will be assigned a unique User ID.

To register on our website:

- Go to www.PalmettoGBA.com/eServices
- Click on “Create Your Account”
- Complete the online form (Choose Railroad Medicare Part B — All States under Line of Business)
- Click “Submit”
- Make a note of your User ID
- Choose your security questions and answers and your password
- Verify your email address by accessing the link in your verification email
- Login as a Returning User

If you have any problems registering or have questions, please view our eServices User Manual at <https://www.palmettogba.com/eServicesuserguide>. You will find eServices FAQs under eServices Portal Resources at www.PalmettoGBA.com/RR.

eSERVICES. CONTINUED

Multi-Factor Authentication (MFA)

Due to increased CMS security requirements, all eServices portal users must use MFA when accessing an eServices account. Effective July 1, 2017, all eServices user accounts that had not already signed up for MFA were automatically set to MFA with the email address associated with the user ID. Users may choose to add a mobile phone number or set up the Google Authenticator app on their eServices My Account tab as an optional method of MFA verification.

How It Works

MFA adds an extra layer of security to your eServices account. You must receive and enter an MFA verification code each time you log into the portal.

1. You will enter your User ID and account password.
2. Then, you will select your preferred method of MFA code delivery: email, text or Google Authenticator. The delivery method will default to email for all users. Users who have added a mobile phone number or set up Google Authenticator on their profile page will also be able to select one or both of those options.
3. Once you receive your verification code by email, text or on the Google authenticator app, you will enter it in the verification box, hit Submit, and you're in.

You will be able to use your MFA code received by email or text for up to 12 hours. An MFA code will expire 12 hours from the time it was requested or when a new MFA code is generated. If you have opted to use Google Authenticator, the MFA code in the app will change every 30 seconds. Simply open the app for the most recent code to use.

Note: MFA is separate process from profile verification. You will be prompted to complete profile verification during initial account setup, any time you update your eServices user profile, and when it has been 250 days since your last profile verification.

To add a mobile phone number to your account:

1. After logging into eServices, you will go to the MyAccount tab.
2. You will then enter your mobile phone number and carrier name in the fields at the bottom of the screen. As you type in the Carrier field, a list of carrier options will display in a list. You must select the carrier that is associated with your mobile number. Failure to select the appropriate carrier will result in undeliverable MFA codes messages. If your carrier is not listed, you will not be eligible to receive the MFA code via test message.

To add Google Authenticator to your account:

1. Begin by clicking the “Authenticator Setup” button under the MFA Setup section of your My Account tab.
2. Follow the instructions for your mobile device type (iPhone or Android) or for the desktop browser option. Once you have completed this setup, you will be able to access the MFA code for the associated user ID from the Google Authenticator app going forward. You will not be required to perform the setup steps at each log in.

Note: Providers who have linked their accounts will only need to add a mobile phone number or set up Google Authenticator for their default account.

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 a.m. to 11 p.m. Eastern Time.
- General Medicare information is available 24 hours a day, seven days a week.
- Our peak calling times are between 12 p.m. to 3 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 27 of this guide 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.
 - Hospice
 - Skilled nursing
 - Pneumonia vaccination
- **Benefits** — Gives Medicare Secondary Payer (MSP), Managed Care, Medicare Advantage Plan, 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.
- **Redetermination/Reopening Status** — Gives status of redetermination or reopening request (upheld, reversed, not found, dismissed, or pending) when caller enters the 13-digit claim Internal Control Number.
- **Redeterminations** — Gives redetermination guidelines only.
- **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.

USING THE INTERACTIVE VOICE RESPONSE (IVR) SYSTEM, CONTINUED

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

Initial IVR Menu Options	
Claim Status, Eligibility, Duplicate Remittance, Redetermination Status, Request a Reopening or General Information	Press or say 1
Verify if your NPI is on file with Railroad Medicare	Press or say 2
Provider Enrollment, Reopenings, or EDI Telephone Numbers	Press or say 3
Our Mailing Address and Hours of Operation	Press or say 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 or say **1** or **Claims**
- To receive payment information, press or say **2** or **Financials**
- To check Medicare eligibility, benefits, and deductible information, press or say **3** or **Eligibility**
- To request a copy of your Medicare remittance notice, press or say **4** or **Dup Remit**
- To receive instructions on how Medicare pays and the redetermination process, press or say **6** or **Redetermination Process**
- For a list of website addresses, provider workshops, or claim errors, press or say **7**
- For the Ambulance Prior Authorization Tool, press or say **8**

Provider and Beneficiary Authentication: Provider and beneficiary authentication elements will be requested before you will be able to access provider and patient specific information from our Medicare files.

Provider authentication by Provider Transaction Access Number (PTAN), National Provider Identifier (NPI) and Tax Identification Number (TIN) is required before the Palmetto GBA IVR Unit is authorized to release Railroad Medicare claim status information, financial information, patient eligibility information, or to order a copy of a remittance advice.

ePass for the Railroad Medicare IVR

An “ePass” is an eight-digit code you will be prompted to receive or enter each time you choose the IVR options for claims, finance, eligibility or duplicate remittance advice. When you choose option 2 to receive an ePass, you will be assigned an ePass code for the provider’s PTAN/NPI/TIN combination you enter. You can then enter that ePass in the IVR for the rest of the day in order to authenticate that provider. This eliminates the need to repeatedly enter the same PTAN, NPI and TIN into the IVR.

USING THE INTERACTIVE VOICE RESPONSE (IVR) SYSTEM, CONTINUED

The tables below explain how to enter the required provider and beneficiary information into the IVR. **We encourage you to use the IVR Conversion Tool found under 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 Railroad Medicare PTAN

Use the following table to enter alphabetic characters of the provider’s Railroad Medicare PTAN. For example: If the PTAN begins with the letter P, enter *71 followed by the numeric characters in the PTAN and the # sign. If the PTAN starts with the letters CM, enter *23*61 followed by the numeric characters in the PTAN and the # sign. Please note that the provider’s PTAN, NPI and Tax ID must correspond. This means if you enter an individual PTAN, you must enter the individual NPI for that provider. If you enter a group PTAN, then you must enter the group NPI for that provider.

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

***NOTE:** The provider’s NPI and Tax identification number will be entered corresponding to the keypad on the telephone.*

How to Enter the Letters in a Patient’s Medicare Number

Use the following table to enter each letter in a patient’s Medicare number. For example: If the Medicare ID number contains a letter A, enter *21 to represent the “A”. The numbers in a Medicare ID Number should be entered using the corresponding number keys on your telephone keypad.

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 for a last name with less than six letters, you must enter all the letters followed by the (#) sign. If the last name has less than six letters followed by suffix of “Jr.” or “Sr.”, enter the last name followed by the first letter of the suffix. For example, if the beneficiary’s name shows in HIMR as John Kneer Sr., enter the numbers that correspond with the letters K-N-E-E-R-S- # followed by “J” for John.

For last names with more than six letters (such as Brad Johnson Jr.), enter only the first six letters of the last name. If the last name and the suffix are less than six letters combined, do not enter any additional characters or numbers; simply press the pound key.

Use the following table to enter the first characters of the beneficiary’s last name & the initial of their first name. For example, if the beneficiary’s name is Mary Smith, enter 76484 for Smith and 6 for Mary. For a beneficiary with the name of Steve McDonald, enter 623662 for McDonald and 7 for Steve.

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

USING THE INTERACTIVE VOICE RESPONSE (IVR) SYSTEM, CONTINUED

***NOTE:** The patient's date of birth must be entered in the format of MMDDYYYY and will correspond with the telephone keypad 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.

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."

After Using the IVR

If after using the IVR you discover that your claim has rejected or denied, or if you have other 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.

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 a.m. to 4 p.m. PT.

Please note: CMS requires providers to use the IVR to access claim status and beneficiary eligibility.

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

	Key to Press
Claim Status, Eligibility, or a Duplicate Remittance Advice Please note: Claim status, beneficiary eligibility and duplicate remittance advice should be requested through our Interactive Voice Response (IVR) unit at 877-288-7600 or through our secure internet portal, eServices. at www.palmettogba.com/eServices	Press 1
Technical Support Regarding 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

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 by a Medicare Contractor

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 (01/20) Medicare Redetermination Request — 1st Level of Appeal Form; available at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List>,
- 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 27 of this guide 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, please use the Railroad Medicare Redetermination Overpayment Appeal Request Form, which is found on our website under Forms, or the Overpayment Appeal eForm in eServices.

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
- Beneficiary Medicare ID number
- Date(s) of service for which the initial determination was issued
- The service/item that are at issue in the appeal
- The name of the party or the representative of the party who is requesting the appeal

Important Redetermination Information

1. Some denials can be adjusted via telephone reopening. See the Appeals page of 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.

RAILROAD MEDICARE APPEALS AND REOPENINGS PROCESSES, CONTINUED

4. Services that are rejected with Remittance Advice Remark Code (RARC) MA130 do not have appeal rights. These claims should be resubmitted as new claims with the correct information. To determine what is missing or invalid on these rejections, refer to the RARC and Claim Adjustment Reason Code (CARC) in the MOA, REM and Glossary sections of your remittance advice. For help reading your remittance advice, see our Interactive Remittance Advice Tool under Tools on our website home page. Also see the RETURN REJECT TROUBLESHOOTER on page 24-26 of this guide.

Railroad Medicare Redetermination Status Tool

To find the status of your redetermination request, use the Redetermination Status Tool found in the Tools section of our home page. 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: Hearing by an Administrative Law Judge (ALJ)

For hearing requests filed on or before December 31, 2023, if at least \$180 remains in controversy following the QIC's decision, a party to the reconsideration may request an ALJ hearing. This amount will remain \$180 for ALJ Hearing requests filed on or after January 1, 2024.

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: Review by the Medicare Appeals Council / 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 or findings being contested.
2. Refer to the ALJ decision for details regarding the procedures to follow when filing a request for Appeals Council review.

RAILROAD MEDICARE APPEALS AND REOPENINGS PROCESSES, CONTINUED

Fifth Level of Appeal: Judicial Review in Federal District Court

For hearing requests filed on or before December 31, 2023, if \$1,850 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. This amount will decrease to \$1,840 for appeals to Federal District Court filed on or after January 1, 2024.

Important Judicial Review in Federal 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

The Reopenings process allows for the correction of minor errors and omissions on 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 a.m. to 4 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
- Railroad Medicare 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.

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 eServices portal using eCheck. Please reference page 27 of this guide for more information on eServices. 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 our 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.

Immediate Offset

As an alternative to refunding Railroad Medicare by check or eCheck, you may request an immediate offset (recoupment) once an overpayment has been established and a demand letter has been sent.

You may request an immediate offset each time you receive a demanded overpayment, or you can make a permanent request for all future demanded overpayments. Recoupments that are associated with an immediate offset are considered a voluntary repayment of a debt.

Electing the immediate offset process may avoid the assessment of interest if the immediate offset satisfies the overpayment in full before aging 31 days from the date of the initial demand letter. While an immediate offset request will be processed as soon as possible, the request does not guarantee that

OVERPAYMENT REFUND INFORMATION. CONTINUED

interest will not accrue on the overpayment. To eliminate the risk of interest accruing, your request should be submitted as soon as possible after being notified of the debt.

Please note that immediate offset requests can only be honored if there are pending payments in the Railroad Medicare claims processing system from which to offset. If there is an insufficient amount of pending payments to satisfy the overpayment, interest may accrue.

You may request an immediate offset by one of the following methods:

- Submit an eServices eOffset Form
- Fax a request to (803) 382-2418
- Mail a request to:
Palmetto GBA Railroad Medicare
PO Box 10066
Augusta, GA 30999

Faxed and mailed requests should be submitted using the Immediate Offset Request form found on our Forms page under Finance/Overpayments. If the form is not used, fax or mail a copy of the first page of the overpayment demand letter and a copy of the overpayment detail listing specifying the account receivable number(s) to be placed in immediate offset status. Indicate “IMMEDIATE OFFSET” either on the demand letter and/or on the fax cover sheet.

To request immediate offset for all existing and future accounts receivable, complete and sign the Immediate Offset Request form indicating all eligible ARs. The form must be signed by a provider representative authorized to make the financial decisions for the provider.

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.

Researching an Overpayment

eServices users can research the status of an overpayment on the Financial Tools Overpayment Data subtab. Enter either the Accounts Receivable (AR) Transaction Number or the Demand Letter Number to see overpayment details including the overpayment balances (principal AR balance, the interest AR balance, and the total AR balance) and overpayment activity (recoupment, adjustments, collections). Please reference page 27 of this guide for more information on eServices.

MEDICARE SECONDARY PAYER (MSP)

Medicare generally uses the term Medicare Secondary Payer or "MSP" when the Medicare program is not responsible for paying a claim first. The Centers for Medicare & Medicaid Services (CMS) MSP Contractor consolidates the coordination of benefit activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries, as well as all insurance coverage obligated to pay primary to Medicare. The MSP Contractor was formerly known as the Benefits Coordination & Recovery Center (BCRC) or the Coordination of Benefits Contractor.

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 MSP Contractor. 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 MSP Contractor 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 MSP Contractor contact information can be found on page 39 of this guide.

Information Gathering

The MSP 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
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.

MEDICARE SECONDARY PAYER (MSP), CONTINUED

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 MSP Contractor. 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 MSP Contractor. 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 MSP 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 MSP Contractor 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 MSP Contractor. 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 MSP Contractor for investigation and deletion.

Contacting the MSP Contractor

For MSP inquiries, including the reporting of potential MSP situations, invalid MSP auxiliary files and general MSP questions/ concerns, contact the MSP Contractor. Continue to call Railroad Medicare regarding claims-related and recovery questions. The MSP Contractor Customer Call Center toll free number is 855-798-2627 (TTY/TDD 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 MSP Contractor 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. 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. An Additional Documentation Request (ADR) letter will be generated for each claim selected for prepayment or postpayment Targeted Probe and Educate (TPE) review or service-specific review.

Registered eServices users can receive MR prepayment ADR letters electronically through the eServices portal by choosing the eDelivery preference. You can also choose to receive an email to let you know a new ADR is available in eServices. Providers with active eServices accounts will automatically receive Targeted Probe and Educate (TPE) Initial Notification Letters, TPE ADR letters and TPE Results letters via eDelivery. See page 27 of this guide for information about the eServices portal.

Responding to a Medical Review Records Request

If you receive a Medical Review ADR letter, it is important that you comply with the following instructions within 45 days:

1. Provide the documents listed on the ADR and any related physician's orders. Make sure the signature is legible or includes an attestation of signature.
2. Include a copy of the ADR letter with your documents. If you do not have a copy of the ADR letter, include a completed 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 you are responding to.
3. When returning ADR responses for **multiple** letters, be sure to pair each ADR letter or Medical Review ADR Response Cover Sheet with the corresponding documentation. Pairing these documents ensures the documentation you return for each request letter is correct for each date of service requested.
4. 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 the eServices internet portal. eServices lets you upload your ADR response electronically, eliminating the need to fax or mail documents and packages. When you upload a document, you will receive a message when the form is submitted and another message with the Document Control Number (DCN) when the form has started processing. You can use the DCN to look up form processing status and view your submitted forms. See page 27 of this guide for more information on eServices.
 - 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 below:
Palmetto GBA Railroad Medicare
Medical Review
PO Box 10066
Augusta, GA 30999
5. 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.

MEDICAL REVIEW. CONTINUED

6. Do not submit replacement/duplicate claims for the ones pending in medical review. The submission of replacement/duplicate claims can result in claim denial and will prolong the medical review process.

Prepayment Reviews

For prepayment reviews, Palmetto GBA has 30 days from the date the documentation is received to review the documentation to make a payment decision.

When the claim is finalized, it will receive a status of paid in full, paid in part, denied or rejected.

- If you disagree with a denial or payment, you can request a redetermination within 120 days from the receipt of the initial determination (date on the Remittance Advice). The notice of initial determination is presumed to be received five days from the date of the notice. See page 33 of this guide for information on requesting an appeal.
- If the claim was rejected as unprocessable with remittance message MA130, you must submit a new corrected claim.

Postpayment Reviews

For postpayment reviews, Palmetto GBA has 60 days from the date the documentation is received to review the documentation to make a payment decision.

Upon review of the documentation, Railroad Medicare Medical Review clinicians will make a determination that either affirms the original payment or denies the payment (in part or in full). If any part of the claim is denied, an overpayment is assessed, and funds are recouped from the provider.

If you disagree with a denial or payment, you can request a redetermination within 120 days from the receipt of the initial determination (date on the Remittance Advice). The notice of initial determination is presumed to be received five days from the date of the notice. See page 33 of this guide for information on requesting an appeal.

For more information about the Medical Review process, visit our Medical Review web page by using the link on our homepage www.palmettogba.com/RR or by choosing the Topics tab and then choosing Medical Review.

COMPREHENSIVE ERROR RATE (CERT) PROGRAM

The Centers for Medicare & Medicaid Services (CMS) established the Comprehensive Error Rate Testing (CERT) program to monitor and report the accuracy of Medicare fee-for-service (FFS) payments. The CERT program measures the error rate for claims submitted to Medicare contractors.

To meet this objective, CERT selects a random sample of Medicare FFS claims for review; requests supporting documentation from the provider or supplier who submitted the claim for payment; and reviews the documentation to determine if the claim was paid properly under Medicare coverage, coding, and billing guidelines.

For information on where and how to submit records to CERT and answers to Frequently Asked Questions about the CERT program, visit the CERT C3HUB website at <https://c3hub.certrc.cms.gov/>.

If you have questions about a request for medical records:

- Email a request to CERTprovider@nciinc.com or
- Call CERT Customer Service toll free at 888-779-7477

If documentation is not received by CERT, the claim will be considered paid in error. CERT then notifies Railroad Medicare of the payment in error, which is subject to the normal overpayment recovery process.

When documentation is received by CERT, a review is conducted. Upon completion, if the documentation does not support that Medicare guidelines or coverage were met, the claim is counted as either a total or partial improper payment. CERT then notifies Railroad Medicare of the improper payments which are subject to the normal overpayment recovery process.

If the documentation supports that the claim should have been paid at a higher level of reimbursement, CERT will notify Railroad Medicare of the improper payment and the claim will be adjusted to issue additional payment to the provider as necessary.

For the current status or outcome of a CERT review, you can visit the C3Hub at <https://c3hub.certrc.cms.gov/> and look under the Claim Status Search feature or call our Provider Contact Center (PCC) at 888-355-9165. For more information about the CERT program, visit the CERT Contractor website at <https://c3hub.certrc.cms.gov/> and the CERT page of our website, www.PalmettoGBA.com/RR.

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 copayments
- 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.

BENEFIT INTEGRITY, CONTINUED

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

Interactive Voice Response 877-288-7600

The Interactive Voice Response Unit (IVR) is available 7 a.m. to 11 p.m., ET, for general information. Claim status and beneficiary eligibility are available 7 a.m. to 11 p.m. Monday through Friday.

Please refer to page 29 of this guide for IVR instructions.

**Electronic Data Interchange and eServices..... 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 a.m. to 4 p.m.

Please refer to page 7 of this guide for additional information on submitting claims electronically.

**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 a.m. to 4 p.m.

Please refer to page 3 of this guide for information on the Provider Enrollment process.

**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 a.m. to 4 p.m.

Prior to requesting a redetermination, please refer to page 33 of this guide for additional information.

**Provider Contact Center (PCC) 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 a.m. to 4 p.m. For dates and times our PCC will be closed, please view our holiday and training schedule on our Customer Service web page. From our homepage, www.palmettogba.com/RR, choose the Topics tab and then choose Customer Service.

Claim Status and beneficiary eligibility inquiries should be handled through the Interactive Voice Response system. Please refer to page 30 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, beneficiary's Medicare 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
Appeals
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 (when returning 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. Please do not send Protected Health Information (PHI) in an email.

RAILROAD MEDICARE EMAIL UPDATES

The Railroad Medicare email updates are an important communication tool that offers providers 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 email address

How to register to receive the Palmetto GBA Medicare email updates

Use the **Email Updates** link in the top toolbar on any Palmetto GBA Railroad Medicare website page to access the Subscribe to Email Updates page. Enter your email address and select the topics that interest you. Complete the CAPTCHA equation and submit the online form. Once you submit the form, we will send a confirmation email within 10 minutes to the email address you registered. Please use the link provided in the email to confirm your registration.

CONNECTING WITH RAILROAD MEDICARE

We invite you to stay connected with us on social media.

<p>Facebook</p> <p>Follow us on Facebook to receive updates, learn about upcoming events and ask us general questions</p>  <p>https://www.facebook.com/PalmettoGBA/</p>	
<p>X (previously known as Twitter)</p> <p>#StayConnected on X for quick access to news and information</p> 	
<p>You Tube</p> <p>Go to YouTube for educational videos, tips and strategies</p> 	
<p>LinkedIn</p> <p>LinkedIn is your source for the latest Palmetto GBA news</p> 	

IMPROVE YOUR EXPERIENCE

Tell Us What You Think of Our Service

If your experience with Railroad Medicare was awesome or not, we'd like to hear from you! Telling us what we do well lets us know what we should keep doing, and telling us how we can improve gives us room to grow.

All Railroad Medicare Providers and their staff can give immediate feedback about their customer experience by completing the MAC Customer Experience (MCE) surveys.

To provide feedback for the Palmetto GBA Railroad Medicare website and the Palmetto GBA eServices portal, complete the online experience MCE survey by using the blue FEEDBACK button that appears on the right side of each web page and portal screen, or accept the pop-up invitation when it presents itself.

You can also provide feedback for your experience with selected areas by selecting the green "Your Opinion Matters / Share Your Feedback" button on the right side of select topic website pages or select one of the survey links below:

- Appeals experience (Redetermination — 1st level appeals - <https://tinyurl.com/MCEAppeals>)
- Electronic Data Interchange (EDI) experience - <https://tinyurl.com/MCEEDI>
- Medical Review Targeted Probe and Educate (TPE) experience - <https://tinyurl.com/MCEMRTPE>
- Prior Authorization experience - <https://tinyurl.com/MCEPriorAuth>
- Provider Outreach and Education (POE) experience - <https://tinyurl.com/MCEProvOutreachEduc>
- Written General Correspondence experience - <https://tinyurl.com/MCEWrittenCorr>
- Additional surveys will be added in the future

When completing an MCE survey, please be sure to add details about your experience so we know exactly what you liked or what we could do better. We also encourage you to leave your contact information so we can reach out to you if we have questions about your feedback.

We value your comments and opinions, and we look forward to a culture of continuous improvement in the way we conduct business and serve our providers.

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 an individual who is eligible for Medicare benefits.

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.

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

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.

GLOSSARY, CONTINUED

Health Insurance Claim Number (HICN) — A Railroad Medicare HIC number consisted of a one to three letter alpha prefix followed by six or nine numbers. HICNs have been replaced with 11-character Medicare Beneficiary Identifiers (MBIs). Effective January 1, 2020, MBIs must be used for Medicare transactions including claim submission, eligibility status and claim status.

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) System — The computerized telephone answering service allowing a provider to check claim status and eligibility using a touch-tone telephone.

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 Administrative Contractor (MAC) — A private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare fee-for-service (FFS) beneficiaries. Railroad Medicare Part B claims are processed by the Railroad Retirement Board Specialty MAC (RRB SMAC).

Medicare Beneficiary Identifier (MBI) — Randomly generated 11-character MBIs have replaced Social Security Number (SSN)-based HICNs on Medicare cards. MBIs replaced HICNs for Medicare transactions including billing, eligibility status and claim status.

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.

Provider Transaction Access Number (PTAN) — A Medicare identification number issued to providers by MACs upon Medicare enrollment.

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

GLOSSARY, CONTINUED

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.

REVISION HISTORY

Date	Description
12/3/2018	Added 2019 dollar amount in controversy required to sustain Appeal rights for an Administrative Law Judge (ALJ) hearing or Federal District Court review.
1/23/2019	Removed embedded links. Page 2: Updated completion date of CMS New Medicare card mailings. Page 9: Removed MSP Type 42. Page 11: Removed ICD-9 information for CMS-1500 (02/12) Item 21. Page 17: Added Modifier G0. Page 19: Revised modifier KX for CR 11055. Page 46: Removed Palmetto GBA_RRB from Twitter instructions.
7/22/2019	Page 2: Replaced "New Medicare Card Project" with "How Can I Tell if a Patient Has Railroad Medicare?" Pages 14 and 15: Revised modifiers 59, XE, XS, XP and XU for CR 11168. Page 26: Removed outdated verbiage referencing 2/1/18 start of 8-hr MFAs. Page 31: Removed signature requirement for Redeterminations. Page 40: Updated CERT Contractor website URL to https://certprovider.admedcorp.com/
10/23/2019	Page 32: Updated amounts in controversy for ALJ hearing requests to include requests filed on and after 1/1/2020. Page 33: Updated amounts in controversy Federal District Court appeals to include requests filed on and after 1/1/2020.
1/8/2020	Page 48: Updated glossary terms for HICN and MBI.
1/23/2020	Page 7: Added EDI representatives are available for eChat. Page 26: Updated eServices MFA codes now valid for 12 hours. Page 29: Added IVR press or say options. Added ePass for Railroad Medicare IVR. Nationally Accepted Medicare Modifiers — added new ambulance destination modifiers C, F, O, U, W and new therapy modifiers CQ and CO.
7/22/2020	Nationally Accepted Medicare Modifiers — Added modifiers CS and 95. Added Telehealth section. Removed modifier GT. Page 2: Removed new Medicare card mailing information and resource links. Page 27: Added Google Authenticator option to Multifactor Authentication instructions. Page 39: Expanded instructions for responding to a prepayment ADR letter. Page 41: Updated CERT email address for submitting passwords associated with medical records. Added CERT email and phone numbers for questions about medical record requests. Added PCC phone number for questions about the current status or outcome of a CERT review.
10/5/2020	Pages 33 and 34: Added 2021 Amounts in Controversy.
1/7/2021	Page 31: Updated prompts.
1/22/2021	Page 2: Added where to file Part A, HHH and DMEPOS claims for Railroad Medicare patients. Page 3: Expanded PTAN Lookup and Request Tool information. Page 27: Added eServices registration option of entering EDI access code instead of last Railroad Medicare payment received. Page 42: Updated CERT contractor website.

6/24/2021	Page 42: Updated CERT contractor information and referred providers to CERT C3HUB website for information on where and how to submit records to the CERT Review Contractor.
7/23/2021	Page 3: Updated verbiage to explain the PTAN Tool will assign and release most new PTANs the day they are requested. Pages 7 and 8: Added information about online EDI enrollment. Updated EDI email update registration information. Page 27: Added eServices Financial Tools — Payment Floor Status, Last 3 Checks, Overpayment Data. Page 30: Updated Initial IVR Menu Options Table. Page 37: Added researching overpayments in eServices information. Page 42: Added option to check the status of outcome of a CERT review on the C3HUB website Claim Status Search.
10/27/2021	Page 34 and 35: Added 2022 Amounts in Controversy for ALJ and Federal District Court hearing requests.
1/21/2022	Page 3: Added users are not required to enter the reference number when returning to the PTAN Tool to check the status of a request. Page 10: Item 17, updated URL for CMS Order and Referring File. Page 21: Removed Therapy Functional Reporting HCPCS modifiers CH-CN. Page 28: Changed profile verification reminder timeline to 250 days. Page 30: Removed “For hours of operation, press/say 8” under Main Menu. Page 40 and 41: Combined responding to pre-payment and postpayment ADR requests. Added Providers with active eServices accounts will automatically receive Targeted Probe and Educate (TPE) Initial Notification Letters, TPE ADR letters and TPE Results letters via eDelivery.
7/21/2022	Page 8: EDI — Added email with status will be sent after enrollment forms are processed. Page 27: eServices — Added Prior Authorization-Ambulance Forms and Prior Authorization-Ambulance Decision Letters. Page 30: IVR — Added option to press 0 to be connected to an agent.
10/6/2022	Page 39 and 40: Changed BCRC references to MSP Contractor Page 35 and 36: Added 2023 amounts in controversy for or ALJ and Federal District Court hearing requests.
1/17/2023	Page 26: Added N198 Page 28: Added Pending Medical Review Additional Documentation Requests (ADRs) and Benefit Integrity Record Request Response Form to list of forms available in the eServices portal
7/19/2023	Page 18: Added modifier JZ Page 30: Updated IVR prompts Page 48: Updated social media channels Page 50: Added Improve Your Experience content
10/6/2023	Page 34-35: Added 2024 amounts in controversy for or ALJ and Federal District Court hearing requests. Page 48: Changed Twitter to X.