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800.277.0080

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**MAULDIN
& JENKINS**
CERTIFIED PUBLIC ACCOUNTANTS, LLC

Mauldin & Jenkins, Certified Public Accountants, LLC

The Healthcare Bulletin

Credit Balance Reports

Credit Balance Reports must be submitted hardcopy. Fax reports will no longer be accepted. A faxed or photocopied signature is not considered valid. Some fiscal intermediaries (FIs) will not accept reports received with a postmark prior to the end of the quarter. Adjustment claims should be submitted to the FI as soon as a credit balance is recognized.

PPS Assessments and Claims

The Centers for Medicare and Medicaid Services (CMS) edits and validates the RUG-III codes of transmitted MDS assessments. Facilities cannot submit Medicare Part A claims until the assessment has been accepted into the CMS data base. Billers must use the RUG-III code as validated by CMS when claims are filed. (Source: *MDS 2.0 User's Manual, pages 6-4*)

Denial Letters and Expedited Review Process

The Denial Letter and the Expedited Review process are two separate CMS requirements. The Expedited Review process does not replace or eliminate the requirement for SNFs to issue either Denial Letters or the SNF ABN. (Source: *CMS Expedited Review Q&A March 2006*)

New Waived Tests

Transmittal 947 dated May 12, 2006 lists the latest tests approved by the Food and Drug Administration as waived tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The transmittal with the tests and instructions can be accessed at :

<http://www.cms.hhs.gov/transmittals/downloads/R947CP.pdf>

Benefits Exhaust and No Payment Billing

On April 28, 2006, CMS issued Transmittal 930 for fiscal intermediaries and skilled nursing facilities with instructions for benefits exhaust and no payment billing. The effective date is October 1, 2006. The transmittal may be accessed at [Transmittal 930, CR4292](#).

Therapy Cap Automatic Exception Process

Providers are not required to submit any documentation to their intermediary if the beneficiary qualifies for the automatic cap exception for a current condition when documentation **justifies medically necessary** services above the caps. However, providers are required to maintain documentation of medical necessity in the beneficiary's clinical records and justify the clinician's decision that the beneficiary qualified for the automatic cap exception for **medically necessary** services. Use the KX modifier on each line of the claim for the excepted medically necessary services. Use the KX modifier only in cases where the condition of the individual patient supports the services and that those services are appropriately provided.

Revised Medicare Enrollment Applications

On May 1, 2006, the Centers for Medicare & Medicaid Services issued revised CMS-855 Medicare Enrollment applications. Providers and suppliers should begin to use the new Medicare enrollment application immediately. The applicant's National Provider Identifier (NPI) and Authorization Agreement for Electronic Funds Transfer information must be included. For more details see MLN Matters Number SE0634 or contact your contractor.

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