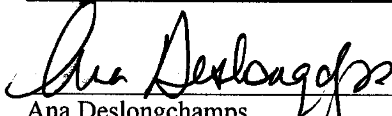
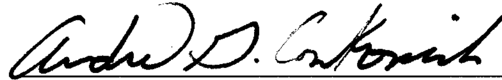
TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
MEDICAL PRACTICE INCOME PLAN POLICY AND PROCEDURE

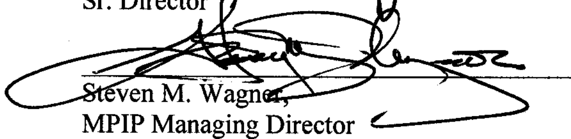
Revised Date: Effective Date: 09/01/2015



Ana Deslongchamps
Sr. Director



Andrew Conkovich
Asst VP, Compliance Office PLFSOM



Steven M. Wagner,
MPIP Managing Director

Department: **BAC-Billing and Collections**

TITLE: **Billing Compliance Refunds - Government Programs**

Policy#: BAC 18

Policy: The purpose of this policy is to outline the procedure for processing billing compliance refunds and identified under payments for government programs. The billing compliance director works directly with department billing supervisors to ensure compliance audits are conducted regularly and timely. Medical charts are selected for audit by MD Audit and are assigned to the coders for audit by the department billing supervisors. Charge correction of invoices and refund of overpayment is required within 60 days when a billing discrepancy is identified. Government programs include Medicaid, Medicare, and Railroad Medicare.

Procedures:

1) Charts selected for audit are routed to the department billing supervisor for distribution to coders. Upon finding errors, coders submit charge corrections within 10 days of discovery to the Medical Plan Income Practice Plan (MPIP) business office using the MPIP SharePoint website located at https://sharepoint.elpaso.ttuhsc.edu/support/mpip/Lists/Charge%20Correction%20Request/Active%20only.aspx.

2) Medicaid charge corrections completed within the 120-day appeal deadline are submitted to the Medicaid plan by the department for reprocessing as corrected claims within 15 days of notification. The payer reprocesses the charge and recoups the difference between the initial claim and the corrected claim allowed amount. Medicaid charge corrections completed after the 120-day appeal deadline are not eligible for reprocessing as corrected claims and require a refund to the Medicaid payer for the difference between the initial claim and corrected claim allowed amount. Departments complete and submit the Texas Medicaid Refund Information Form and the Medicaid remittance advice to the MPIP accounting unit for processing.

3) Medicare charge corrections completed within the 365-day claim filing deadline are completed by MPIP using the Novitasphere online portal within 15 days of notification. Medicare reprocesses the charge and recoups the difference between the initial claim and the corrected claim allowed amount. Medicare charge corrections completed after the 365-day filing deadline are not eligible for reprocessing as corrected claims and require a refund to Medicare for the difference between the initial claim and corrected claim allowed amount. Departments complete

and submit the Return of Monies to Medicare refund form to the MPIP accounting unit for processing.

4) Railroad Medicare charge corrections completed within the 365-day claim filing deadline are completed by MPIP by using the Palmetto GBA Reopening: Simple Claim Correction form within 15 days of notification. Railroad Medicare reprocesses the charge and recoups the difference between the initial claim and the corrected claim allowed amount. Charge corrections completed after the 365-day filing deadline are not eligible for reprocessing as corrected claims and require a refund to Railroad Medicare for the difference between the initial claim and corrected claim allowed amount. Departments complete and submit the Voluntary Refund Overpayment refund form to the MPIP accounting unit for processing

5) All refund forms specify the refund amount and the reason for the refund. The reasons for the refund indicate 'service was not rendered as billed' and 'per quarterly progress note, audit level of service 992XX was billed in error and should have been level of service 992XX; refund is enclosed for $X'. MPIP processes the refund check and mails it to the appropriate plan with the documentation submitted by the department.

RESPONSIBILITIES

1) Compliance Department: MDAudit application.

2) Department Coding Supervisors: distribute charts selected for audit.

3) Department Coders: audit charts, submit charge corrections, prepare refund documentation

4) MPIP: process charge corrections and refunds.

Texas Medicaid Refund Information Form

To refund a Texas Medicaid payment to TMHP, complete this form and attach the refund check. Make the refund check payable to TMHP, and include a copy of the corresponding Texas Medicaid Remittance and Status (R&S) report that shows the remitted payment. Mail the completed form, the refund check, and the R&S report to the TMHP-Financial Department at the following address:

Texas Medicaid & Healthcare Partnership Financial Department
12357-B Riata Trace Parkway Suite 150
Austin, TX 78727

A. Provider Information		
Provider Name (*please print*):		
TPI:	NPI:	Taxonomy:
Contact Name (*please print*):		
Telephone Number with Extension:		
E-mail Address:		

B. Claim Information	
Apply refund to claim ICN number (from Texas Medicaid R&S report):	
Patient's Name:	Patient's Medicaid Number (ICN):
Date(s) of Service (DOS):	

C. Reason for the Refund (Choose One)	
☐ TMHP audit identified overpayment	☐ Other Insurance paid $ ______ on this claim.
☐ Duplicate Medicaid payment	**Instructions:** *If the submitted refund is because of another insurance payment, attach the other insurance Explanation of Benefits (EOB) document that shows the payment. If no EOB is available, complete the following:*
☐ Claim paid on wrong provider's Medicaid TPI/NPI/API	
☐ Billing error	
☐ Late credit for blood or pharmacy	
☐ Patient' Medicare eligibility	• Insurance Co. Name:
☐ Credit balance refund	• Address:
☐ Claim paid on wrong patient's Medicaid ID number	• Telephone Number:
☐ Above named person is not our patient	• Policy Number:
☐ Service was not rendered as billed	• Group Number:
☐ Other refund reason (*describe in detail*):	

Provider Signature (*stamped signatures not accepted*)	Date

NOVITAS SOLUTIONS - Part B
RETURN OF MONIES TO MEDICARE

Medicare
Part B

Date form is being completed: ______

MAIL TO: Novitas Solutions - CASHIER. Please select the address according to the state you rendered services:
AR - PO Box 890091, Camp Hill, PA 17089-0091 **PA** - PO Box 890304, Camp Hill, PA 17089-0304 **DCMA/DE** - PO Box 890405, Camp Hill, PA 17089-0405
LA - PO Box 890090, Camp Hill, PA 17089-0090 **MD** - PO Box 890404, Camp Hill, PA 17089-0404 **NJ** - PO Box 890034, Camp Hill, PA 17089-0034
MS - PO Box 890128, Camp Hill, PA 17089-0128 **TX** - PO Box 890106, Camp Hill, PA 170890106 **CO/NM/OK** - PO Box 890105, Camp Hill, PA 17089-0105

Please select one provider: ☐ AR ☐ CO ☐ DCMA ☐ DE ☐ LA ☐ MD ☐ MS ☐ NJ ☐ NM ☐ OK ☐ PA ☐ TX

This form, or a similar document containing the following information , should be completed fully and accompany each unsolicited/ voluntary refund check so that your refund can be properly recorded and applied. In addition:

- **Multiple Claims being refunded:** If refunding multiple claims, list all claim numbers and the required data on a separate sheet if necessary.
- **Medicare Secondary Payment (MSP) Refunds:** Include a copy of the primary insurer's explanation of benefit (EOB) & indicate the MSP reason (see below).
- **Statistical Sampling:** If specific Beneficiary/HIC/Claims data is not available, indicate the methodology and formula used to determine the refund amount and explain the reason for the refund.
- **OIG Self Disclosure:** Providers/Physicians/Suppliers and other entities submitting a refund under the OIG's Self Disclosure Protocols are not provided appeals rights as stated in the signed agreement presented by the OIG.
- **OIG Reporting Requirements:** Do you have a Corporate Integrity Agreement (CIA) with the OIG? ☐ Yes ☐ No
  Are you participating in the OIG Self-Disclosure Protocol? ☐ Yes ☐ No

For each claim the required fields to be completed are noted with *. If the required fields for specific Patient/HIC & Claim Numbers are not completed, NO appeal rights can be provided for this voluntary refund.

BILLING PROVIDER / PHYSICIAN / SUPPLIER NUMBER	*BENEFICIARY MEDICARE HEALTH INSURANCE NUMBER / HIC
NPI NUMBER	*BENEFICIARY NAME (Patient)
PROVIDER / PHYSICIAN / SUPPLIER NAME	BENEFICIARY ADDRESS
PROVIDER / PHYSICIAN / SUPPLIER ADDRESS (Street, City, State, Zip Code)	PROVIDER / PHYSICIAN / SUPPLIER REFUND CHECK NUMBER
PROVIDER OFFICE CONTACT TELEPHONE NUMBER	PROVIDER / PHYSICIAN / SUPPLIER REFUND CHECK DATE
BILLING OFFICE CONTACT NAME & TELEPHONE NUMBER	PROVIDER / PHYSICIAN / SUPPLIER TAX ID NUMBER

*CLAIM NUMBER/ICN	CLAIM BILLED AMOUNT	DATES OF SERVICE(s)	CLAIM AMOUNT BEING RETURNED (check amount)

***REASON CODES FOR EACH CLAIM INCORRECT PAYMENT (Required to check one reason code per refunded claim):**

***Billing/Clerical**
- ☐ 01-Corrected Date of Service
- ☐ 02-Duplicate - Indicate Both Claim Number/ICN's
- ☐ 03-Corrected CPT Code
- ☐ 04-Not Our Patient
- ☐ 05-Mod. Add/Remove
- ☐ 06-Billed in Error

***MSP/Other Payer Involvement**
- ☐ 07-MSP Group Health Plan Insurance
- ☐ 08-MSP No Fault Insurance, Date of Incident: ______
- ☐ 09-MSP Liability Insurance, Date of Incident: ______
- ☐ 10-MSP, Workers Comp, Date of Incident: ______
- ☐ 11-Veterans Administration

***Miscellaneous**
- ☐ 12-Insufficient Doc
- ☐ 13-Patient Enroll HMO
- ☐ 14-Svcs Not Rendered
- ☐ 15-Medical Necessity
- ☐ 16-Other-Please Specify: ______

OTHER INSURER INFORMATION (MSP):

Name: ______
Address: ______
City/State/Zip: ______
Telephone # (if available): ______

EMPLOYER INFORMATION (MSP):

Name: ______
Address: ______
City/State/Zip: ______
Telephone # (if available): ______
Subscriber/Member/Policy #: ______

Please return this completed form with your remittance.

Novitas Solutions, Inc.
A CMS CONTRACTOR
Camp Hill, PA 17089 • www.novitas-solutions.com

8322 (R11-12) Reset Form Print Form

PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

PALMETTO GBA.
A CELERIAN GROUP COMPANY

Reopening: Simple Claim Correction

ALL fields are REQUIRED.

Provider Information

Provider Name:

Provider Address:

Provider Telephone Number:
( ) -

National Provider Identifier (NPI):

Provider Number (PTAN):

Tax ID:

Requestor Information (if different)

Requestor Name:

Requestor Address:

Requestor Telephone Number:
( ) -

Patient & Claim Information

Patient Name:

Health Insurance Claim (HIC) Number:

Claim Number (ICN):

Claim Date(s) of Service:

CPT Code(s):

ICD-9 Code(s):

Reason for Reopening (What Corrections Need to be Made?):

Name (Please Print):

Signature:

Date:

PLEASE ATTACH:

1. Please attach this form completed in its entirety.
2. Please include Remittance Advice (RA).
3. If you have multiple claims for the same issue, only one form is needed provided you attach Remittance Advice (RA) forms and clearly indicate (circle or asterisk) which claims need to be changed.

AP-RRB-B-1020

Revised 01/2014

Please mail this form and all additional documentation to:
Palmetto GBA - Railroad Medicare
P.O. Box 10066
Augusta, GA 30999
Fax: (803) 462-2218

PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

Voluntary Refund Overpayment — Check Enclosed

ALL fields are REQUIRED.

For your convenience, submit this form and your payment electronically via the Online Provider Services (OPS) portal located at www.PalmettoGBA.com/Medicare or complete this form and mail to the address at the bottom of this form.

Provider Information	Patient & Claim Information	Enclosed Check Information
Provider Name:	Patient Name:	Enclosed Check Number:
Provider Address:	Health Insurance Claim (HIC) Number:	Enclosed Check Amount:
Contact Name:	Claim Number (ICN):	Enclosed Check Date: __/__/__
Contact Direct Telephone & Extension ( ) - x	Claim Date(s) of Service:	
National Provider Identifier (NPI):	CPT Code(s):	
Provider Number (PTAN):	ICD-9 Code(s):	
Tax ID:	Overpaid Amount:	

☐ Yes, we have a corporate Integrity Agreement with OIG

Reason(s) for Overpayment (Please select from the list below)

☐ Billed in Error	☐ Service Not Rendered
☐ Incorrect Service Date (Please provide correct date of service): __/__/__	☐ Modifier Added or Removed (Please provide correction you wish to make):
☐ Duplicate Payment (Please provide correct payment date): __/__/__	☐ Medical Necessity Not Met (Please explain. Attach additional sheet if necessary):
☐ Incorrect CPT Code (Please provide correct CPT code):	☐ Patient Enrolled in HMO (Please indicate which HMO):
☐ Not Our Patient(s) (Please explain circumstances):	☐ Other (Please explain):

PLEASE ATTACH:

- Please complete this form and include it with your submission.
- Please attached detailed information. For overpayments that involve multiple patients, please submit detailed information for each.
- Please enclose the check made payable to Palmetto GBA or Medicare, otherwise the check cannot be accepted for deposit.

FN-RRB-B-2010

Revised [illegible]/2015

Please send this form and all additional documentation to
Palmetto GBA - Railroad Medicare
Medicare Part B - Finance & Accounting
P.O. Box 367
Augusta, GA 30999-0001