

## APPENDIX F

### FAX/MAIL EMC DOCUMENTATION MEDICARE PART B

**The Fax/Mail EMC Documentation feature enables Medicare Part B providers to submit 100% of their claims electronically and to take advantage of the 14 day payment floor for electronic media claims.**

Attached are the MEDICARE PART B DOCUMENTATION GUIDELINES. Claims can be filed electronically which include these services and the required documentation faxed or mailed. The specific documentation requirements are listed for each specified service.

If you wish to take advantage of this feature, complete the following steps:

- 1.) Electronic claims which require additional documentation must indicate the method of submission of the documentation (i.e., faxed or mailed) and the postmark or fax transmission date. Submit this information in the following fields in your software. If you are not sure where this should be entered in your system, please contact your software support personnel.

**National Standard Format (320 byte) - HA0 record, field 05.0**

**American National Standards Institute ASC-X12 837 - 2-485-NTE02**

ENTER: **FAX DOC: MM-DD-YY - if you are faxing the documentation**  
**MAIL DOC: MM-DD-YY - if you are mailing the documentation**

- 2.) Complete a **MEDICARE PART B FAX/MAIL EMC DOCUMENTATION** cover sheet (copy enclosed) for each electronic claim for which you are submitting additional documentation. The cover sheet and the documentation must be faxed to the appropriate numbers as indicated on the attachments.

Documentation is expected to be received within 2 days of the electronic claims submission if faxed or 5 days if mailed. If an electronic claim is received which requires documentation but the documentation is not received within the designated time frames, the claim will be processed with the information at hand and developed/denied based on claims processing guidelines. If documentation is faxed or mailed but the electronic claim does not reflect the required information or the documentation was not submitted in the method indicated on the electronic claim, the claim will be processed with the information on the EMC claim only and developed/denied based on claims processing guidelines.

If you have any questions, please contact the EDI Helpline at:

(972) 766-5480      or      (410) 527-5654 in Baltimore.

## MEDICARE PART B DOCUMENTATION GUIDELINES

The following procedures require additional documentation for Medicare Part B claims processing. The precise documentation requirements have been specified. Fax or mail only the specified documents. Other documentation, if required, will be requested.

- **MULTIPLE SURGERIES:**

An operative report is required when more than five procedures are performed.

- **NOT OTHERWISE CLASSIFIED CODES (NOC):**

Only when sufficient documentation cannot be supplied in the narrative record.

- **MODIFIER 22 - UNUSUAL SERVICES:**

When the service(s) provided is **greater than** that usually required for the listed procedure, these claims will suspend for pricing. An operative report must be with the claim. This modifier should only be reported with procedure codes that have a global period of 0, 10, or 90 days. Field HA0-05.0 may be used to provide a concise statement about how the service differs from the usual and provide the date and mode of submission of the operative report. Claims received with the -22 modifier and without the additional information will be processed as though the -22 modifier were not present.

- **MODIFIER 52 - UNUSUAL SERVICES:**

Surgeries for which services performed are significantly **less than** usually required may be billed with the -52 modifier. The following information must accompany the claim:

- There must be a concise statement about how the service differs from the usual (this should be submitted in HA0-05.0);
- An operative report must be with the claim.

Modifier -52 can be reported with any surgical procedure. Assigned claims received with the -52 modifier and no additional information will be denied; non-assigned claims will be delayed while the additional information is requested

- **PROCEDURE CODES REQUIRING ADDITIONAL DOCUMENTATION:**

The following procedures require an invoice:

A4300	L8620-L8629
A4301	L8640
A4641	L8655-L8657
A4644-A4646	L8690
E0751	V2630
E0753	V2631
E0782	V2632
E0783	V2785
E1340	L7500 - L7520 (Repair of implanted prosthesis)
E1399	L8499 - Implanted prosthesis
L8605	V2799 (Scleral tissue or pericardium tissue graft)
L8611	79900 (Provision of therapeutic redionuclide(s))
L8615-L8618	

- **RADIOPHARMACEUTICALS:**

**Texas and Maryland** providers must submit an invoice for radiopharmaceuticals if it is not on the pricing list.

**DCMA/DE** providers must submit an invoice with all claims for radiopharmaceuticals.

- **MAJOR JOINT AND/OR ALLOGRAFTS:**

Documentation regarding graft acquiral required.

- **ELECTRICAL NERVE STIMULATOR SERVICES:**

Require the following:

- Type of implantation
- Statement indicating late/last resort
- Statement indicating other treatment modalities have been tried and results
- Statement concerning patient evaluation
- Documentation of availability of treatment facilities, equipment and personnel
- Documentation of pain relief by temporary implanted electrode prior to permanent implantation
- Invoice

- **COCHLEAR DEVICE IMPLANTATION (69930):**

Adults

- Total sensorineural deafness that cannot be mitigated by use of a hearing aid in patients whose auditory cranial nerves are stimulable;
- Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation;
- Post-lingual deafness;
- Adulthood (at least 18 years of age);
- Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system; and
- No contraindications to surgery.

Children

- No contraindications to the implant, including those described in the product's FDA-approved package insert;
- Diagnosis of bilateral profound sensorineural deafness with little or no benefit from a hearing (or vibrotactile) aid, as demonstrated by the inability to improve on age appropriate closed-set word identification tasks;
- Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system; and,
- The device must be used in accordance with the FDA approved labeling.

- **AIR AMBULANCE - TEXAS ONLY:**

Due to the circumstances surrounding air ambulance transports and the severity of the patient's condition, the ambulance run sheet often provides pertinent information to support the coverage of these transports. Attached is an "Air Ambulance Fax Sheet" by which you may submit this or any pertinent documentation relating to AIR AMBULANCE transport claims.

NOTE: You must use the fax number on the Air Ambulance cover sheet.

- **GROUND AMBULANCE:**

Electronic Ground Ambulance claims that include NOC codes A0999 or J3490 may utilize the Ground Ambulance Fax Sheet (attached) to provide a complete description and charge. (The only information that can be faxed are the explanations for codes A0999 or J3490. Diagnosis information and origin and destination information must be included on the claim. **Do not submit claims for review by fax.**)

NOTE: You must use the fax number and mailing address indicated on the Ground Ambulance cover sheet.

**TEXAS - MEDICARE PART B  
FAX/MAIL EMC DOCUMENTATION  
COVER SHEET**

<b>Batch ICN:</b> _____
<b>Claim ICN:</b> _____

**Do Not Write in This Box**

**To: Document Preparation  
EMC Medical Documentation  
P.O. Box 660595  
Dallas, TX 75265-0595**

**Fax: 972/766-7909  
Fax line available 24 hours a day.**

**Date:** \_\_\_\_\_

**From:** \_\_\_\_\_  
**Physician/Provider Name**

\_\_\_\_\_  
**Provider Number**

**Contact:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Patient's HIC:** \_\_\_\_\_

**Patient's Last Name:** \_\_\_\_\_

**Patient's First Name:** \_\_\_\_\_

**Patient's Middle Initial:** \_\_\_\_\_

**Date of Service on Claim:** \_\_\_\_\_  
(First From & To Dates of Service on Claim)

**Total Charge of Claim:** \_\_\_\_\_

**Total Number of Documentation Pages:** \_\_\_\_\_  
(Include this cover sheet in count)

**MARYLAND / DC/ DELAWARE  
MEDICARE PART B  
FAX/MAIL EMC DOCUMENTATION  
COVER SHEET**

<b>Batch ICN:</b> _____
<b>Claim ICN:</b> _____

**Do Not Write in This Box**

**To: Document Preparation  
EMC Medical Documentation  
P.O. Box 5798  
Timmonium, MD 21094-5798**

**Fax: 410/527-5652  
Fax line available 24 hours a day.**

**Date:** \_\_\_\_\_

**From:** \_\_\_\_\_  
**Physician/Provider Name**

\_\_\_\_\_  
**Provider Number**

**Contact:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Patient's HIC:** \_\_\_\_\_

**Patient's Last Name:** \_\_\_\_\_

**Patient's First Name:** \_\_\_\_\_

**Patient's Middle Initial:** \_\_\_\_\_

**Date of Service on Claim:** \_\_\_\_\_  
**(First From & To Dates of Service on Claim)**

**Total Charge of Claim:** \_\_\_\_\_

**Total Number of Documentation Pages:** \_\_\_\_\_  
**(Include this cover sheet in count)**

ALL STATES  
MEDICARE PART B - GROUND AMBULANCE



FAX TO: GROUND AMBULANCE UNIT OR MAIL TO:  
FAX NUMBER: 410/527-5652

MEDICARE PART B  
EMC MEDICAL DOC.  
P.O. BOX 5798  
TIMONIUM, MD21094-5798

FROM:

Provider Name

Provider Number

Contact Person: \_\_\_\_\_

Contact's Phone: \_\_\_\_\_

Claim Identification Information: \_\_\_\_\_

Patient: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Last Name First Name M. I.

HIC/Medicare ID Number: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Total Charge of claim: \_\_\_\_\_

Total Number of pages (including this cover sheet) for this patient: \_\_\_\_\_

If there is a problem with this fax, we will contact the person identified above. Please do not phone Medicare for confirmation of receipt of these documents. Please do not send fax until after 10:00 A.M. each day.



TEXAS

