



To: PMHS Providers
From: MAPS-MD
Date: January 23, 2008
Re: Medicare Retractions: Clarification

If a consumer's eligibility changes due to retroactive Medicare Part A, Part B or a combination of Part A and B coverage for the dates of service listed on a previously paid claim, the claim will be retracted and the provider must submit a claim to Medicare.

If a claim is denied by Medicare, the provider must resubmit the claim, on paper, to MAPS-MD, within 120 days from the date on Medicare's Explanation of Benefits, in order to meet timely filing requirements.

EXCEPTIONS: Claims will not be retracted if the following applies:

UB claims:

- ▶ The retroactive Medicare *only* covers the part A (inpatient) portion of benefits for that eligibility span, outpatient claims will not be retracted.
- ▶ An outpatient claim has only one line item and the revenue code on the line is 910 or 911
- ▶ Any of the occurrence codes listed on the claim are "A3", indicating that Medicare benefits have exhausted
- ▶ The claim's first date of service is more than two years in the pas

CMS 1500 (HCFA) claims:

- ▶ A HCFA claim's pay-to-provider type is: Mobile Treatment, Case Management, CPC (licensed only), Psychiatric Rehabilitation or Head Injury Waiver

January 22, 2008

- ▶ The line item procedure code is G9010, G9011, H0032, H0035, H0045, H0046, H1011, H2027, S0201, S9480, T1005, 96101, 96102, 96151 or 96152
- ▶ The line item procedure code is 90801 with a modifier 22
- ▶ The claim's first date of service is more than two years in the past

If you have questions, please contact Brian Johnson at Bjohnson@apshealtcare.com