



# Reducing Unprocessable Claim Rejections

6/29/2021



# Today's Presenters

- JK Provider Outreach and Education Consultants
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# Objectives

- After today's session you will understand the importance of submitting a claim the first time with all the required facts for NGS to process a claim

# Agenda

- Reducing Claim Rejection
  - Claim Requirements
  - Remittance CARC and RARC
  - Beneficiary Eligibility
  - Provider Information
  - CPT and HCPCS
  - Modifiers

# Claim Requirements

- If claims do not conform to NGS specifications, they will be returned
- NGS' initiative is to reduce the number of unprocessable claims
- Goal is to get your claims accurately processed the first time

# Unprocessable

- Information is
  - Invalid
  - Missing
  - Insufficient
  - Incomplete
- Claims will be rejected
- Must submit a new claim
- No appeal rights granted



# Unprocessable

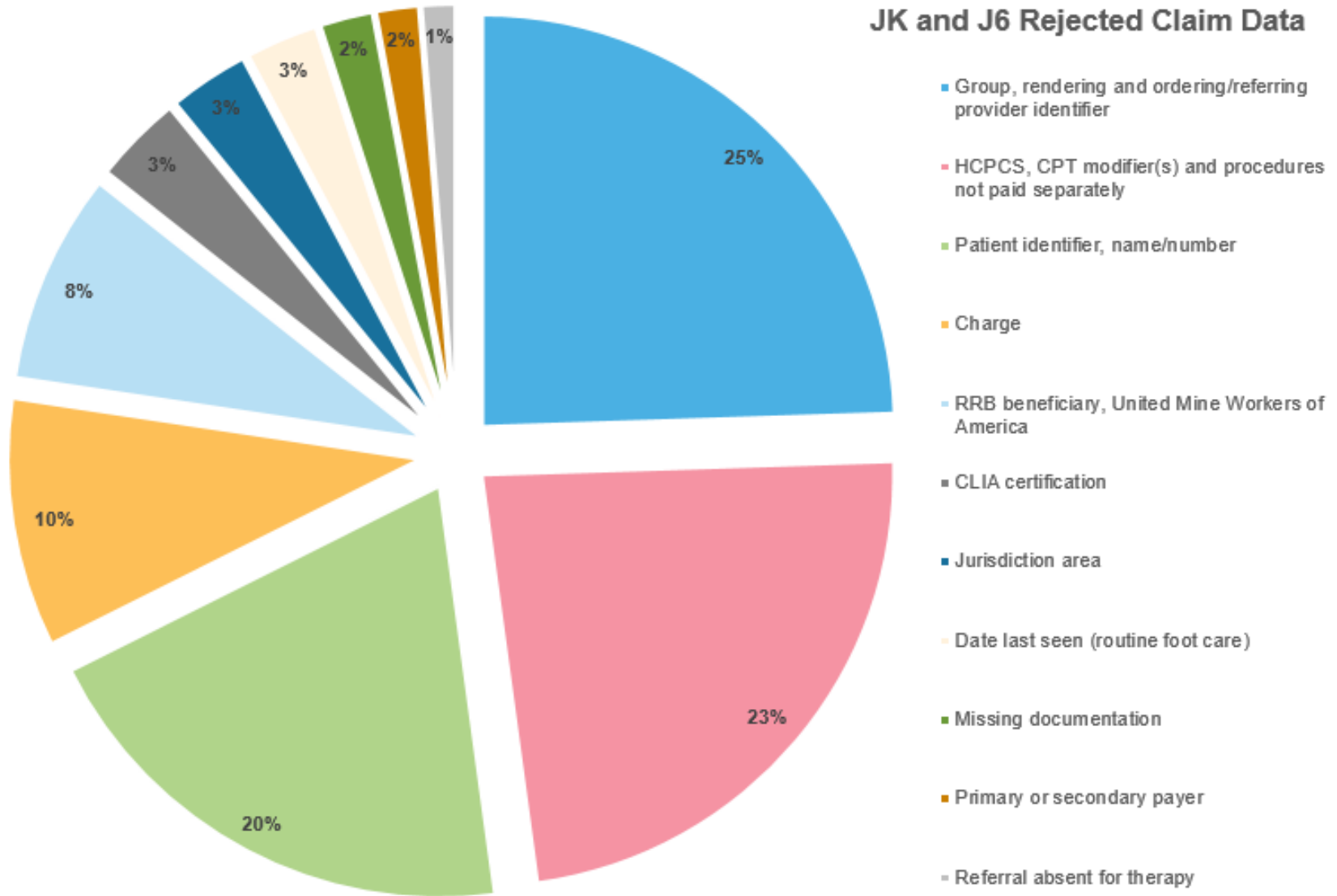
- Methods for rejection
  - Remittance advice shows an MA130
  - Additional remark codes used to identify the error
- Paper claims are screened
  - Form letter sent back indicating the error
- Electronic claims
  - Fail initial edits

# Remittance Example and References

Code	Description
CO-16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Additional information is supplied using remittance advice remarks codes. <b>Note:</b> Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF)
MOA Code MA27	Missing, incomplete or invalid entitlement number or name shown on the claim submitted

- WPC references
- Remittance Advice Remarks Code reference
- Claim Adjustment Reason Code reference

## 1st Quarter 2021 JK and J6 Rejected Claim Data

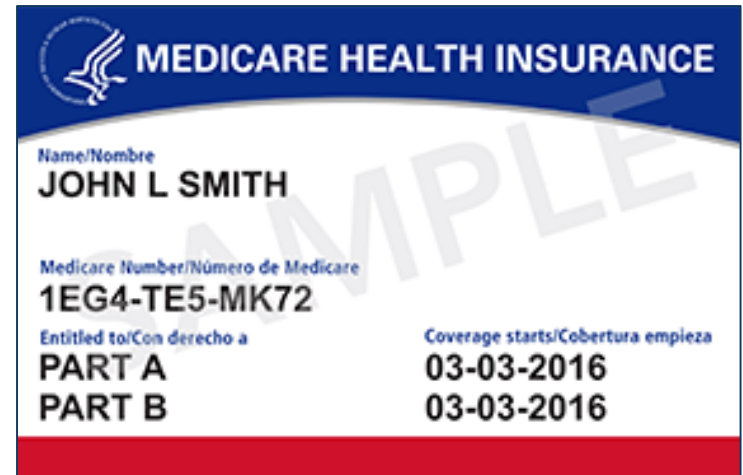


# Reducing Claim Rejections for Beneficiary Eligibility



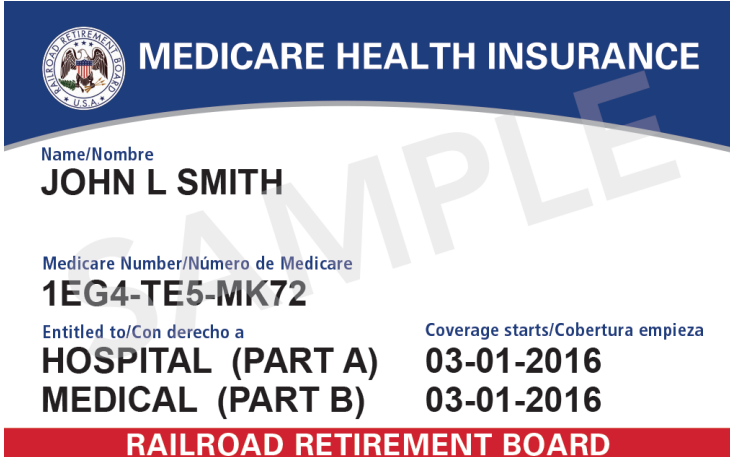
# Traditional Beneficiary Eligibility


- PR-31
  - Name or MBI was incorrect or missing
  - Date of death precedes date of service
  - Expenses incurred prior to coverage or after coverage terminated
  - Not covered by Medicare at time patient received services



# Railroad Retirement Board Eligibility

- N105
- Misdirected claim for RRB beneficiary
- Submit claims to the RRB carrier
  - Palmetto GBA  
P.O. Box 10066  
Augusta, GA 30999  
866-749-4301



 **MEDICARE HEALTH INSURANCE**

Name/Nombre  
**JOHN L SMITH**


Medicare Number/Número de Medicare  
**1EG4-TE5-MK72**


Entitled to/Con derecho a	Coverage starts/Cobertura empieza
<b>HOSPITAL (PART A)</b>	<b>03-01-2016</b>
<b>MEDICAL (PART B)</b>	<b>03-01-2016</b>

**RAILROAD RETIREMENT BOARD**

# Medicare Advantage Eligibility

- OA-109
  - Yearly open enrollment
    - Usually October 15th–December 7th
- Private health plans for members' health care and claims must be sent to MA plan
- Screen beneficiaries
- Provider self service
  - IVR or NGSConnex

<b>Anthem</b> 	<b>MEDICARE   PPO ADVANTAGE</b>
Member Name: Jane Doe	Anthem Medicare Preferred <b>Anthem Rx Network</b>
Subscriber Name: Jane Doe	PCP Office Visit \$20
Identification No: 123456789	Specialist Office Visit \$20
Group No: 0084567	Emergency room \$50
Plan No: 332	Urgent Care \$50
PCP not required. Begin Date: 01/01/2006	H5529-001

 <b>MEDICARE HEALTH INSURANCE</b>	
Name/Nombre <b>JOHN L SMITH</b>	
Medicare Number/Número de Medicare <b>1EG4-TE5-MK72</b>	
Entitled to/Con derecho a	Coverage starts/Cobertura empieza
<b>PART A</b>	<b>03-03-2016</b>
<b>PART B</b>	<b>03-03-2016</b>

# MSP

- When Medicare is Secondary
  - Enter insured's policy or group number (Item 11) and proceed to Items 11a through 11c, also complete Items 4, 6 and 7
- Electronic Data Interchange
  - [Medicare Secondary Payer ANSI Specifications for 837P](#)
    - Indication of MSP, insurance type, COB payer paid amount – claim level, COB allowed amount – claim level, contractual obligations (OTAF) – claim level, claim adjudication date – claim level, line adjudication information, line adjustments, line adjudication date



## Interactive Voice Response Touch-Tone Instructions

### Tips for Successful Touch Tone Use

- 1) You cannot combine speech and touch-tone when providing a single element (e.g., you cannot speak the numbers in a Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI) and then enter the alpha character(s) via touch-tone). However, you can switch between speech and touch-tone throughout the call (e.g., speech for beneficiary name and touch-tone for HICN/MBI).
- 2) There is no need to wait for a prompt to try touch-tone.
- 3) You are able to press "9" to move to the next topic.

Visit [www.NGSMedicare.com](http://www.NGSMedicare.com) for interactive voice response (IVR) telephone numbers and complete touch-tone instructions.

### Using The IVR Conversion Tool

Visit [www.NGSMedicare.com](http://www.NGSMedicare.com) > Provider Resources > Calculators & Tools > Interactive Voice Response Conversion Tools to easily convert the name, Provider Transaction Access Number (PTAN), Medicare numbers (HICN/MBI), etc. to touch tone for easy input into the IVR system.

### Alpha-Only Touch Tone Entries

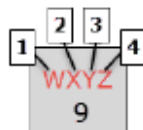
When speaking the beneficiary's name the IVR requires First Name, Last Name. However, when using touch-tone, the IVR requires Last Name, First Initial. For names, you only have to press the button on a telephone keypad that corresponds with the letter. Below are some examples:

Beneficiary Name	Converted Name	Touch Tone
John Doe	DOEJ	3 6 3 5
John St. Doe	STDOEJ	7 8 3 6 3 5
John Doe Jr.	DOEJRJ	3 6 3 5 7 5
John L. Doe Smith	DOESMITHJ	3 6 3 7 6 4 8 4 5

### Alpha-Numeric Touch Tone Entries

Use this function to enter elements that contain both alpha and numeric characters.

Each button on a telephone keypad has a corresponding set of letters. Each letter is identified as a 1, 2, 3 or 4 to indicate the position on that key.



To enter a letter, you will need to press a combination of buttons on your telephone keypad.

First, press the \* key. Then, press the key the letter appears on. Lastly, press the key corresponding to the position of the letter on that key. Below are some examples:

Alpha-Numeric Example	Touch Tone Entry
123456789B	1 2 3 4 5 6 7 8 9 *2 2
1EG4TE5MK72	1* 3 2* 4 1 4* 8 1* 3 2 5* 6 1* 5 2 7 2
Q5W5Z5	*1 1 5* 9 1 5* 1 2 5

### Touch Tone Combinations for Letters

Letter	Press	Letter	Press
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*72
E	*32	R	*73
F	*33	S	*74
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*94

### Medicare IVR Eligibility Check List

Please remember to have your NPI and PTAN and last five digits of your TIN available.

HICN/MBI:

Patient's First Name:  DOB:

Patient Last Name:

Part A: Effective:  Termed:

Part B: Effective:  Termed:

MSP Type:  Name:

Effective:  Termed:

Medicare Advantage (MA) Plan #:

Name:

Address:

Phone:

Effective:  Termed:

Last Billing Date:

Hospital Full Days:  Coinsurance Days:

SNF Full Days:  Coinsurance Days:

Lifetime Reserve Days:

Part B Deductible:

This year:  Last year:

Physical Therapy Limits:

This year:  Last year:

Occupational Therapy Limits:

This year:  Last year:

Home Health Name:

Address:

Effective:  Termed:

Hospice Name:

Address:

Effective:  Termed:

# NGSConnex Eligibility Data

**Beneficiary Eligibility Information** Search Printable View 1 of 1+ Show More

Beneficiary Medicare Number:	XXXXXXXXXXXX	Current Part A Entitlement:	5/1/2004	Current Part A Termination Date:	
Beneficiary Last Name:	XXXXXXXXXXXX	Prior Part A Entitlement:		Prior Part A Termination Date:	
Beneficiary First Name:	XXXXXXXXXXXX	Current Part B Entitlement:	5/1/2004	Current Part B Termination Date:	
Beneficiary Date of Birth:	XX/XX/XXXX	Prior Part B Entitlement:		Prior Part B Termination Date:	
Cross Reference HICN:		Medicare Inactive Begin Date:		Medicare Inactive End Date:	
Sex:	M	Beneficiary Address Line 1:	XXXXXXXXXXXX	Current Year Inpatient Deductible Amount:	\$0.00
Date of Death:		Beneficiary Address Line 2:	XXXXXXXXXXXX	Current Year Inpatient Blood Deductible:	3
MBI Term Date:		Beneficiary City:	XXXXXXXXXXXX		
		Beneficiary State:	NY		
		Beneficiary ZIP + ZIP Ext:	XXXXX-XXXX		
		Jurisdiction:	A		
		Pneumococcal Vaccine Date:	1/15/2015		

<b>Part B Deductible Years</b>		<b>Part B Initial Deductible Amounts</b>		<b>Part B Remaining Deductible Amounts</b>	
Year 1:	2018	Year 1 Amount:	\$183.00	Year 1 Amount:	\$0.00
<b>Therapy Services Years</b>		<b>Occupational Therapy Amount Used</b>		<b>Physical Therapy Amount Used</b>	
Year 1:	2018	Year 1 Amount:	\$0.00	Year 1 Amount:	\$5,346.56



**Note:** If a new Medicare card has been mailed, an informational message will display. If the beneficiary has coverage via Railroad Medicare, information will be provided.

CMS mailed a Medicare card with a new Medicare Beneficiary Number to this beneficiary. Medicare providers, please get the new Medicare Beneficiary Number from your patient and save it in your system(s).

# Reminder: Electronic Beneficiary Eligibility Verification Requirements

- Four beneficiary data elements required
  - Last name
  - First name or initial
  - HICN or MBI
  - Date of birth

# Steps to Successfully Check Eligibility

- Collect all insurance data from beneficiary
- Visit our [Interactive Voice Response System section](#)
- [NGSConnex](#)

State	IVR Number
Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont	877-869-6504
Illinois, Minnesota, Wisconsin	877-908-9499

# Reducing Claim Rejections for Provider Information and Data



# Ordering and Referring Provider Information

- N264, N265, N285, N286 provider name and NPI
  - Provider who orders item or services
  - Provider who requests an item or service
    - Clinical laboratories
    - Diagnostic imaging

# Ordering and Referring Provider Information

- Missing, incomplete or invalid provider identifier
  - Line items 17 and 17b or electronic equivalent
  - No nick names
  - First and last name as it appears in PECOS
    - Ordering = DK
    - Referring = DN
    - Supervising = DQ

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		
	←	
17a.	X	X
17b.	NPI	

# Rendering Provider Information

- Provider that actually rendered service
- Type I
  - Individual provider
- Line Item 33 or electronic equivalent
  - NPI of rendering provider



# Billing Provider Information

- Organization or individual billing provider data
  - Type 1 (Individual)
  - Type 2 (Organization)
- Medical group or other entity entitled to bill and receive payment for physician services
  - Each physician/NPP rendering services under the group will be identified in 24J
- Line Item 33 or electronic equivalent
  - Billing provider

# Reducing Claim Rejections for Clinical Laboratory Improvement Amendment

# Clinical Laboratory Improvement Amendments

- Quality standard for laboratory testing to ensure accuracy, reliability and timeliness of patient test results
- Different types of waivers are available
  - Effective for two years
- Some CLIA waived tests required modifier QW
  - Item 24D right of CPT/HCPCS code
- Enter ten-digit CLIA number for laboratory services billed by an entity performing CLIA-covered procedures
  - Item 23 or electronic equivalent

# Steps to Successfully Check CLIA Information

- [List of Waived Tests](#)
- [Clinical Laboratory Fee Schedule](#)
- [NGS Medical Policy Education Topics](#)
- [Clinical Laboratory Improvement Amendments \(CLIA\)](#)
- [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 16](#)
- [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 23](#)
- MLN Matters Article® [MM9956 Revised: New Waived Tests](#)

# Initial Treatment Date

- Certain services need the initial date of treatment
  - Six-digit or eight-digit date of current illness, injury, pregnancy or chiropractic services
- Qualifier space is not used

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)			
MM	DD	YY	QUAL

Item No.	Claim Description	Loop	Field	Status	Data Element Description	Requirements
14	Date if current illness, injury, pregnancy	2300	DTP03 (439)	S	Accident Date	Required if Related Cause code (CLM11-1, -2 or -3) = Auto Accident (AA) or Other (OA). Enter the date of current illness or injury.
		2300	DTP03 (431)	S	Onset of current illness or injury date	Required for the initial medical service or visit performed in response to a medical emergency when the date is available and is different than the date of service
		2300	DTP03 (454)	S	Initial treatment date	Required on all claims involving spinal manipulation.
		2400**	DTP03 (454)	S	Initial Treatment Date	Required when the Initial Treatment Date is known to impact adjudication for claims involving spinal manipulation, physical therapy, occupational therapy, or speech language pathology and when different from what is reported at the claim level

# Provider Place of Service Information

- Provide place where services are rendered
- Complete name, address, ZIP Code where services were furnished
  - Hospital
  - Clinic
  - Laboratory
  - Patient's home
  - Physician's office
  - Diagnostic tests subject to anti-markup
- Line Item 32 or electronic equivalent

# Steps to Successfully Check Provider Data

- [Data Files for Ordering and Referring](#)
- [National Plan & Provider Enumeration System](#)
- [Medicare Place of Service Codes and Descriptions](#)
- [CMS-1500 Claim Form Completion Instructions](#)

# Requested Information Not Provided/Not Provided Timely/Insufficient





# Additional Documentation Request

- NGS or other CMS contractors may need to analyze claims to determine provider compliance
- ADR letters will be generated for claims selected for review
  - NGS may require clarification
  - Claim submitted electronically for PWK segment
  - NGS TPE Review
  - CMS Audit Contractors
- ADR letter will indicate whether you have 30 days or 45 days to respond

# Steps to Successfully Check Additional Documentation Request

- [General Information](#)
- [Additional Development/Documentation Request Timeline Calculator](#)
- [Additional Development Request Letters Guide](#)
- [Responding to an ADR](#)
- [Methods for Submitting an ADR](#)


# Reducing Claim Rejections for CPT and HCPCS



# Have Current Code Books

- CPT
  - Numeric coding system that describes the services and procedures provided by a physician
- HCPCS
  - Alpha numeric coding system used by a physician to report services
- ICD-10-CM code books
  - Used to select appropriate diagnosis codes

# Medicare Physician Fee Schedule

 *JURISDICTION 6 - PART B*  
IN ILLINOIS

Enter keywords or phrases  Search >

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**WELCOME to**

*NGSMedicare.com for  
Part B providers and  
suppliers*

Medicare **Part B providers** administer medically-necessary and preventive services for beneficiaries by diagnosing and treating medical conditions or preventing illness or detecting it at an early stage.



Log in to NGSConnect	Use the IVR System	 <b>Fee Schedule Lookup</b>
Find an MU Course	Visit New Provider Center	 <b>LCD/Policy Search</b>
Take a Web Tour 	Learn About MBI	LCD or article <input type="text"/> Search



# FEE SCHEDULE LOOKUP


To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select **Search**.

**ENTER SEARCH CRITERIA**

\*Select a Fee Schedule: 
 -- Please Select --  
 ASC Fees  
 Ambulance  
 CP/CSW  
 Medicare Physician Fee Schedule Pricing  
 Molecular Pathology
 
(\* indicates a required field)

**CODE SEARCH RESULTS**

Please Enter Search Criteria



## *Admin for Flu/PPV/Hepatitis Fee Schedules*

Effective Date	J6: IL-MN-WI	JK: CT-NY	JK: MA-ME-NH-RI-VT
1/1/2020–12/31/2020	<ul style="list-style-type: none"> <li>• IL</li> <li>• MN</li> <li>• WI</li> </ul>	<ul style="list-style-type: none"> <li>• CT</li> <li>• NY</li> </ul>	<ul style="list-style-type: none"> <li>• MA</li> <li>• ME</li> <li>• NH</li> </ul>

# FEE SCHEDULE LOOKUP

To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select **Search**.

## ENTER SEARCH CRITERIA

\*Select a Fee Schedule: Medicare Physician Fee Schedule Pricing

\*Result Type:  Full Fee Schedule  Specific To Fee Code

\*Date of Service: 01/06/2021

\* Procedure Code: 76706

\*Region: Massachusetts (area 01)

Search

-- Please Select --

- Connecticut
- Illinois (area 12)
- Illinois (area 15)
- Illinois (area 16)
- Illinois (area 99)
- Maine (area 03)
- Maine (area 99)
- Massachusetts (area 01)**
- Massachusetts (area 99)
- Minnesota
- New Hampshire (area 40)
- New York (area 01)
- New York (area 02)
- New York (area 03)
- New York (area 04)
- New York (area 99)
- Rhode Island (area 01)
- Vermont (area 50)
- Wisconsin



## CODE SEARCH RESULTS

National Government Services, Inc. - Massachusetts (area 01)

Medicare Physician Fee Schedule Pricing Fee Schedule for 01/06/2021

Click on the [Details](#) links to view MPFS policy indicators.

Procedure Code ?	76706
Effective Date ?	01/01/2021
State/Territory ?	14212
Locality ?	01
Short Description ?	Us abdl aorta scree n aaa

### Non-OPPS Capped Payment Rates (NON-OPPS) ?

Modifier ?	NON FAC PAR ?	NON FAC NON PAR ?	NON FAC LC ?	FAC PAR ?	FAC NON PAR ?	FAC LC ?
(Details)	131.58	125.00	143.75	131.58	125.00	143.75
26 (Details)	29.70	28.22	32.45	29.70	28.22	32.45
TC (Details)	101.88	96.79	111.31	101.88	96.79	111.31



# Review Policy Indicators

Modifier Selected: (blank)			
Status ?		Global Surgery ?	
Conversion Factor ?		Facility Pricing ?	
Update Factor ?		PC/TC ?	
Work RVU ?		Preoperative Percentage ?	
FAC PE RVU ?		Interoperative Percentage ?	
NON FAC PE RVU ?		Postoperative Percentage ?	
Malpractice RVU ?		Multiple Surgery ?	
Work GPCI ?		Bilateral Surgery ?	
Practice GPCI ?		Assistant At Surgery ?	
Malpractice GPCI ?		Two Surgeons ?	
Reduced Therapy Amt ?		Team Surgery ?	
Endoscopic Base ?			

- Global surgery
- Facility pricing
- Professional/Technical Components
- Pre, inter and post operative
- Multiple surgery
- Bilateral surgery
- Assistant at surgery
- Two surgeons
- Team surgery



Policy Indicators tell you everything you need to know about a code

**Professional and Technical Component Indicator Example 76706**

Indicator	Description
0	Physician Service Codes
1	Diagnostic Tests for Radiology Services
2	Professional Component Only Codes
3	Technical Component Only Codes
4	Global Test Only Codes
5	Incident To Codes
6	Laboratory Physician Interpretation Codes
7	Physical Therapy service for which payment may not be made
8	Physician Interpretation Codes
9	Not Applicable

Modifier Selected: (blank)

Status	A	Global Surgery	XXX
Conversion Factor	3.6039	Facility Pricing	1
Update Factor	1	PC/TC	1
Work RVU	0.55	Preoperative Percentage	0%
FAC PE RVU	0.00	Interoperative Percentage	0%
NON FAC PE RVU	2.61	Postoperative Percentage	0%
Malpractice RVU	0.04	Multiple Surgery	0
Work GPCI	1.000	Bilateral Surgery	0
Practice GPCI	1.007	Assistant At Surgery	0
Malpractice GPCI	0.670	Two Surgeons	0
Reduced Therapy Amt	0.00	Team Surgery	0
Endoscopic Base			



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Modifier Selected: (blank)			
Status ?	A	Global Surgery ?	090
Conversion Factor ?	3.6039	Facility Pricing ?	1
Update Factor ?	1	PC/TC ?	0
Work RVU ?	13.25	Preoperative Percentage ?	9%
FAC PE RVU ?	0.00	Interoperative Percentage ?	81%
NON FAC PE RVU ?	9.08	Postoperative Percentage ?	10%
Malpractice RVU ?	3.09	Multiple Surgery ?	2
Work GPCI ?	1.000	Bilateral Surgery ?	0
Practice GPCI ?	1.007	Assistant At Surgery ?	2
Malpractice GPCI ?	0.670	Two Surgeons ?	1
Reduced Therapy Amt ?	0.00	Team Surgery ?	0
Endoscopic Base ?			

Policy Indicators tell you everything you need to know about a code

## Incision of gallbladder Example: 47480

What is the global timeframe?	090 day post op
What is the multiple surgery rule?	2= yes MSG 100/50/50/50
Can assistant at surgery be allowed?	2= yes
Can co-surgery be allowed?	1= w/doc to establish med nec
Can team surgery be allowed?	0= no



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**Modifier Selected: (blank)**

Status 	R	Global Surgery 	090
Conversion Factor 	3.6039	Facility Pricing 	1
Update Factor 	1	PC/TC 	0
Work RVU 	91.78	Preoperative Percentage 	9%
FAC PE RVU 	0.00	Interoperative Percentage 	84%
NON FAC PE RVU 	29.67	Postoperative Percentage 	7.0000000000000001%
Malpractice RVU 	22.45	Multiple Surgery 	2
Work GPCI 	1.033	Bilateral Surgery 	0
Practice GPCI 	1.179	Assistant At Surgery 	2
Malpractice GPCI 	1.061	Two Surgeons 	1
Reduced Therapy Amt 	0.00	Team Surgery 	2
Endoscopic Base 			

Policy Indicators tell you everything you need to know about a code

<b>Transplantation heart/lung</b>	
<b>Example: 33935</b>	
What does status code "R" mean?	R = Restricted coverage
What is the global timeframe?	090= Day post op
What is the multiple surgery rule?	2= Yes, MGS, 100/50/50/50
Can assistant at surgery be allowed?	2= Yes
Can co-surgery be allowed?	1= Yes, with doc to est. med necessity
Can team surgery be allowed?	2= Team surgeons permitted; pay by report.



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Modifier Selected: (blank)			
Status ?	N	Global Surgery ?	XXX
Conversion Factor ?	0.0000	Facility Pricing ?	9
Update Factor ?	0	PC/TC ?	9
Work RVU ?	0.00	Preoperative Percentage ?	0%
FAC PE RVU ?	0.00	Interoperative Percentage ?	0%
NON FAC PE RVU ?	0.00	Postoperative Percentage ?	0%
Malpractice RVU ?	0.00	Multiple Surgery ?	9
Work GPCI ?	1.000	Bilateral Surgery ?	9
Practice GPCI ?	1.007	Assistant At Surgery ?	9
Malpractice GPCI ?	0.670	Two Surgeons ?	9
Reduced Therapy Amt ?	0.00	Team Surgery ?	9
Endoscopic Base ?			

Policy Indicators tell you everything you need to know about a code

**Established patient preventive medicine 65+ years**  
**Example: 99397**

What does status code "N" mean?

# CPT/HCPCS Code Ranges

- Anesthesia: 00000–09999
- Surgery: 10000–69999
- Radiology: 70000–79999
- Pathology/laboratory: 80000–89999
- Medicine: 90000–99999
- Ambulance: A0000–A9999
- Drugs: J0000–J9999

# Not Otherwise Classified or Unlisted Codes

- An unlisted code represents an item, service, or procedure for which there is no specific CPT or Level II alphanumeric HCPCS code
- Unlisted codes should be reported only if no other specific codes adequately describe the procedure or service
- Consider finding a CPT code that best describes service/procedure using the reduced service modifier 52

# Documentation for NOC and Unlisted Codes

- Service/procedure(s) should be adequately documented in your medical record and submitted with each claim
  - Paper or electronic media claims
- Medicare allowable amounts are not established; therefore, allowance is based on the supporting documentation



# Steps to Successfully Check CPT/HCPCS

- MPFS available on our [Fee Schedule Lookup](#) page
- [Fee Schedule Assistance](#)
- MLN Booklet® [How To Use The Searchable Medicare Physician Fee Schedule \(MPFS\) \(ICN 901344\)](#)
- [Unprocessable Claim Rejections and Corrections](#)
- [Medically Unlikely Edits](#)
- [Instructions for Use of Not Otherwise Classified or Unlisted Codes](#)

# Reducing Claim Rejections for Modifiers



# Modifiers

- MCS allows up to four modifiers keyed per claim detail
- Two types of modifiers in MCS
  - Pricing modifiers
    - First field
  - Statistical/informational modifiers
    - Special coverage/informational
    - Second field
- Always enter pricing modifiers before statistical/informational modifiers

# Pricing Modifiers

- Anesthesia modifiers
  - AA, AD, QK, QW, QX, QY, QZ
- Assistant at surgery modifiers
  - AS, 80, 81, 82
- Diagnostic modifiers
  - CT, FX, TC, 26
- Evaluation and management
  - 24, 25, 57
- Surgery modifiers
  - 50, 62, 66, 73, 74, 78
- Shared care
  - 54, 55

# Steps to Successfully Submitting Modifiers

- [Policy Education Topics](#) – Medical Policy Education Modifier and Topics
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
  - [Chapter 17 “Drugs and Biologicals”](#)
  - [Chapter 23 “Fee Schedule Administration and Coding Requirements”](#)
  - [Chapter 26 “Completing and Processing Form CMS-1500 Data Set”](#)
- MLN Matters Article® [SE1314: Duplicate Claims–Outpatient](#)
- [Evaluation and Management Frequently Asked Questions](#)

# Claim Reminders

- Resubmit, redetermination or reopen
- Resubmit
  - MA130 denials
- Redetermination
  - Medical necessity claim denials
- Reopen
  - Minor clerical errors or omissions
- [Reopenings for Minor Errors and Omissions](#)

# Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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