

Reducing Unprocessable Claims

7/23/2024

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

Today's Presenters

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Objective

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



Agenda

- [Claim Requirements](#)
- [Reducing Claim Rejections for Beneficiary Eligibility](#)
- [Reducing Claim Rejections for Provider Information and Data](#)
- [Reducing Claim Rejections for MSP and Non-MSP Claims](#)
- [Reducing Claim Rejections for Absent Therapy Referral and Therapy Modifiers](#)
- [Reducing Rejected Claims for Laboratory Codes](#)
- [Reducing Claim Rejections for Date Last Seen by Attending Physician for Routine Foot Care](#)
- [Reducing Claim Rejections for Services Not Payable Under NGS Jurisdiction](#)
- [Reducing Claim Rejections for Missing Billed Charges](#)
- [Reducing Claim Rejections for CPT and HCPCS Codes and Modifiers](#)
- [Reducing Claim Rejections for Missing Documentation](#)

Claim Requirements

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



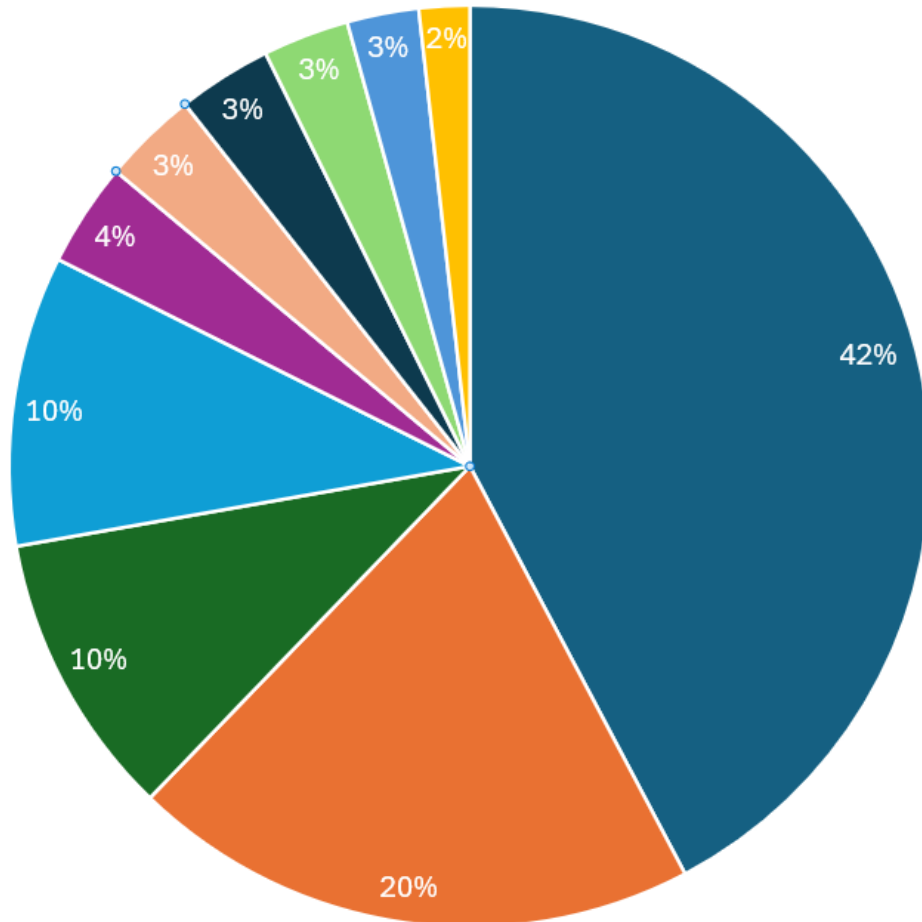
Unprocessable Claims

- Information is
 - Invalid
 - Missing
 - Insufficient
 - Incomplete
- Claims will be rejected
- Must submit a new claim
- No appeal rights granted
- Methods for rejection
 - Remittance advice shows an MA130
 - Additional remark code used to identify the error
- Paper claims are screened
 - Form letter sent back indicating the error
- Electronic claims
 - Fall 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. Note: 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	X12 Claim Adjustment Group Codes <ul style="list-style-type: none">• Remittance Advice Remark Codes Reference• Claim Adjustment Reason Code Reference

Q2 2024 J6 and JK Claim Rejection Data

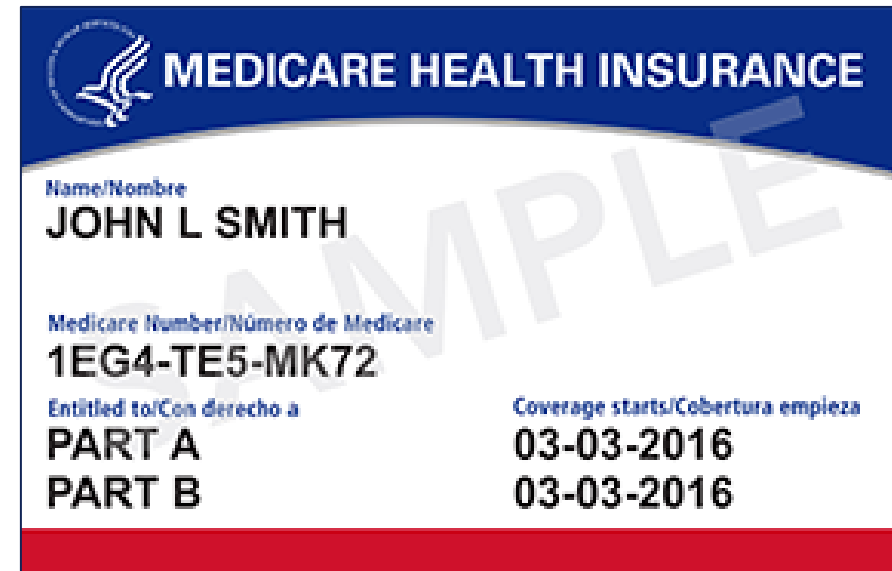


- 42% Patient identifier and RRB
- 20% Group and rendering and ordering provider
- 10% Indication of primary or secondary payer
- 10% Missing therapy modifier(s) GN, GO and referral for therapy
- 4% Lab codes billed individually
- 3% Missing date last seen and attending physician NPI for routine foot care
- 3% Not payable under NGS Jurisdiction
- 3% No charge indicated
- 3% Invalid or missing HCPCS/CPT and modifiers
- 2% Missing documentation

Reducing Claim Rejections for Beneficiary Eligibility

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



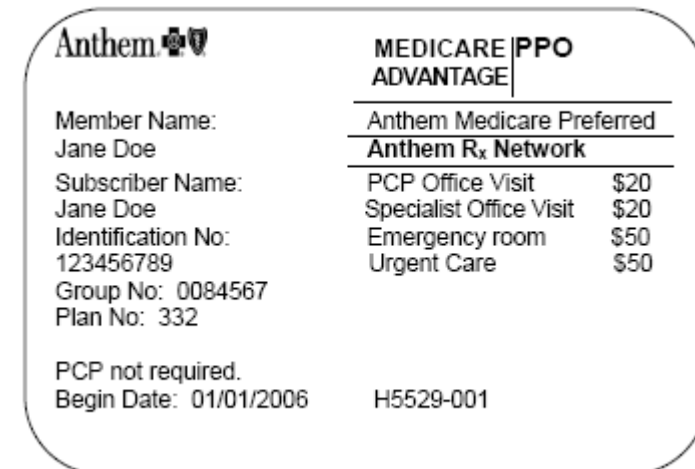
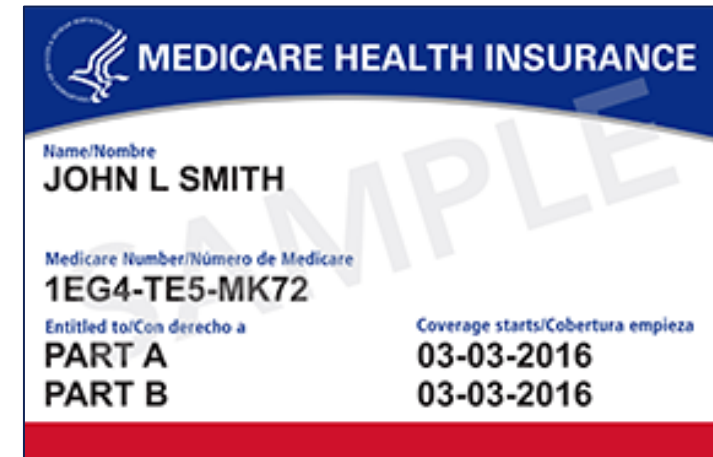
Railroad Retirement Board Eligibility



- 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 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



NGSConnex Beneficiary Eligibility Verification Requirements

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

The screenshot shows the NGSConnex web interface for beneficiary eligibility verification. The header includes the 'connex' logo and a 'HOME' link. A 'Printable View' button is highlighted in the top right corner. The main content area is titled 'Beneficiary Eligibility' and contains a 'Beneficiary Information' section with the following fields:

Beneficiary Information		
Medicare Number	Last Name	First Name
2DM		
MBI Term Date	Date of Birth	Date of Death
	12	
Sex	Address Line 1	Address Line 2
Female	PO BOX	
City	State	Zip
MINNEAPOLIS	MN	55405

Steps to Successfully Check Eligibility

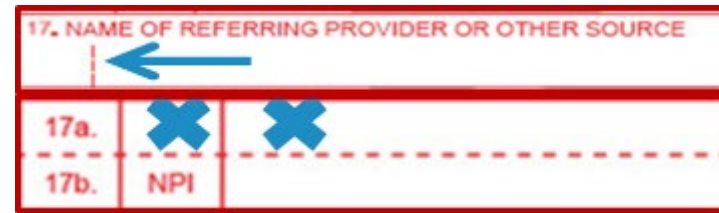
- Collect all insurance data from beneficiary
- Use our [Interactive Voice Response System](#)
- Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont
 - 877-869-6504
- Illinois, Minnesota, Wisconsin
 - 877-908-9499
- [NGSConnex](#)



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
- 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



Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
17	Name of Referring physician or other source	2310A	NM103 (DN)	Referring provider last name	Required if claim involved a referral or services were ordered. When reporting the provider who ordered services such as diagnostic and lab utilized the Referring Provider Name (Z310A) loop at the claim level. Required if a service or supply was ordered by a provider and that provider is a different entity than the rendering provider for this service line. When a claim involves multiple referring and/or ordering physicians, a separate claim must be billed for each ordering/referring physician.
			NM104	Referring provider first name	
			NM105	Referring provider middle name	
	Name of Ordering physician	2420E	NM103 (DN)	Referring provider last name	
			NM104	Referring provider first name	
			NM105	Referring provider middle name	
17a	Other ID number of Referring physician				
17b	NPI	2310A	REF02 (1C)	Referring provider primary ID	
			REF02 (1C)		Enter "XX" in the NM108 to indicate an NPI is present in the NM109. Enter the NPI of the referring/ordering physician listed in Item 17
			REF02 (1C)	Ordering provider primary ID	

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 36400 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GOVT HEALTH PLAN BC OR BC/LIBS OTHER
 (Medicare) (Medicaid) (TRICARE) (Champus) (Govt Health Plan) (BC or BC/LIBS) (Other)

2. PATIENT'S NAME (Last name, first name, middle initial)
 3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)
 4. INSURED'S NAME (Last name, first name, middle initial)
 5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (3 digit area code)
 6. PATIENT RELATIONSHIP TO INSURED (Self Spouse Child Other)
 7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (3 digit area code)
 8. RESERVED FOR NUCC USE
 9. OTHER INSURED'S NAME (Last name, first name, middle initial)
 10. IS PATIENT'S CONDITION RELATED TO:
 a. EMPLOYMENT (Current or Previous) YES NO
 b. AUTO ACCIDENT? YES NO PLACE (State)
 c. OTHER ACCIDENT? YES NO
 11. INSURED'S POLICY GROUP OR FCDA NUMBER
 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)
 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)
 14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM (MM DD YY)
 15. OTHER DATE (MM DD YY)
 16. DATE PAYMENT LABEL TO WORK IN CURRENT OCCUPATION (FROM TO MM DD YY)
 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (17a 17b IR)
 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO MM DD YY)
 19. OUTSIDE LAB YES NO \$ CHARGES
 20. PHYSICIAN OR SUPPLIER (ICD 9-CM) ORIGINAL REF. NO.
 21. PRIOR AUTHORIZATION NUMBER
 22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please fill in to the extent below ICD 9-CM)
 A. B. C. D. E. F. G. H. I. J.
 23. PROVIDER INFORMATION (Name, Address, City, State, ZIP, Phone, Fax, NPI, etc.)
 24. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials to certify that the statements on this form apply to this bill and are true to a good faith)
 25. SERVICE FACILITY LOCATION INFORMATION
 26. BILLING PROVIDER INFO & PAYER (NPI)
 27. FEDERAL TAX ID NUMBER
 28. PATIENT'S ACCOUNT NO.
 29. ACCEPT ASSIGNMENT? (YES NO)
 30. TOTAL CHARGE
 31. AMOUNT PAID
 32. RESERVED FOR NUCC USE
 33. BILLING PROVIDER INFO & PAYER (NPI)

Billing Provider Information

- Individual or Organization 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

Steps to Successfully Check Provider Data

- [Data Files for Ordering and Referring](#)
- [National Plan & Provider Enumeration System](#)
- [Medicare Place of Service Code Set and Descriptions](#)
- [CMS-1500 Claim Form](#)
- [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)



Reducing Claim Rejections for MSP or Non-MSP Claims

Medicare Secondary Payer (MSP)

- 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
 - 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

Non-MSP

- When Medicare is Primary
 - If there is NO insurance primary to Medicare, enter the word “NONE” and proceed to Item 12
- Only acceptable verbiage in Item 11 is “None” or the policy number of the insured when MSP
- Entering any other information in this field will cause the claim to reject

SURANCE CLAIM FORM

UNIVERSITY OF MICHIGAN HEALTH SYSTEM
UNIVERSITY OF MICHIGAN HEALTH SYSTEM CLAIM COMMITTEE (MUCO 0012)

MEDICAD		TR OFFE		CHAMPVA		GROUP HEALTH PLAN		DC OF (LIFE)		OTHER		16. INSURED'S I.D. NUMBER		(For Hosp)	
<input type="checkbox"/> (Individual) <input type="checkbox"/> (Group/DCO)		<input type="checkbox"/> (Individual) <input type="checkbox"/> (Group)		<input type="checkbox"/> (Individual) <input type="checkbox"/> (Group)		<input type="checkbox"/> (Individual) <input type="checkbox"/> (Group)		<input type="checkbox"/> (Individual) <input type="checkbox"/> (Group)		<input type="checkbox"/> (Individual) <input type="checkbox"/> (Group)					
PATIENT'S NAME, First Name, Middle Initial, Last Name				A. PATIENT'S BIRTH DATE (MM/DD/YY)				SEX (M/F)				4. INSURED'S NAME: Last Name, First Name, Middle Initial			
ESS (No. 3540)				B. PATIENT RELATIONSHIP TO INSURED (Mort, Spouse, Child, Other)								7. INSURED'S ADDRESS (incl. State)			
STATE				C. RESERVED FOR MUCO USE								ZIP CODE			
TELEPHONE (Include Area Code)												TELEPHONE (Include Area Code)			
8. NAME: Last Name, First Name, Middle Initial				10. IS PRESENT CONDITION RELATED TO:				NONE				12. INSURED'S DATE OF BIRTH (MM/DD/YY)			
9. POLICY OR GROUP NUMBER				a. EMPLOYMENT (Date of Pre-claim)				b. AUTO ADD'DENT?				D. OTHER CLAIM ID (Designated by MUCO)			
MUCO USE				c. OTHER ADD'DENT?				E. INSURANCE PLAN NAME OR PROGRAM NAME				6. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
SUCC USE				100. CLAIM CODES (Designated by MUCO)								15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (Must show the issue of any medical or other information necessary for the payment of proceeds or credits other than to the party who accepts assignment)			
9. NAME OR PROGRAM NAME												16. DATE (MM/DD/YY) TIME (AM/PM) CHARGE (ICD-9-CM)			
11. ILLNESS (ICD-9-CM), or PREGNANCY QUARTER				15. OTHER DATE (MM/DD/YY)				18. HOSPITALIZATION DATES RELATED TO CURRENT CLAIM (MM/DD/YY)				20. OUTSIDE LAB? (YES/NO)			
12. PROVIDER OF OTHER SOURCE				17. ICD-9-CM				21. PRESCRIPTION CODE (ORIGINAL REF NO)				23. PRIOR AUTHORIZATION NUMBER			
NATURE OF ILLNESS OR INJURY (Include ALL external and internal diagnoses)															
13. SERVICE TO (MM/DD/YY)				14. PROCEDURE, SERVICE, OR SUPPLIER (ICD-9-CM)				19. DIAGNOSIS (ICD-9-CM)				22. CHARGE (ICD-9-CM)			
14. NUMBER				15. PATIENT'S ACCOUNT NO.				16. ACCOUNT ASSIGNMENT? (YES/NO)				17. TOTAL CHARGE			
18. PHYSICIAN OR SUPPLIER (ICD-9-CM)				19. SERVICE FACILITY LOCATION INFORMATION				20. BILLING PROVIDER INFO & PAY #							

Steps to Successfully Submitting MSP and Non-MSP Claims

- [CMS-1500 Claim Form Completion Instructions](#)
- [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)
- [Medicare Secondary Payer ANSI Specifications for 837P](#)
- [NGS Website Medicare Secondary Payer \(MSP\)](#)



Reducing Claim Rejections for Absent Therapy Referral and Therapy Modifiers



Certifying Physician/NPP

- Outpatient Physical and Occupational Therapy Services
 - Patients must be under the care of a physician/NPP
 - Claims must list the name and NPI of the certifying physician/NPP

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN OTHER		2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		
3. PATIENT'S ADDRESS (No. & Street) CITY STATE ZIP CODE TELEPHONE (3rd or Area Code)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
5. PATIENT'S RELATIONSHIP TO INSURED		6. INSURED'S ADDRESS (No. & Street) CITY STATE ZIP CODE TELEPHONE (3rd or Area Code)		
7. EMPLOYMENT (Date of Pre-1980) YES NO		8. INSURED'S POLICY OR GROUP NUMBER		
8. OTHER ACCIDENT? YES NO		9. INSURED'S DATE OF BIRTH (MM DD YY) SEX M F		
9. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO		
11. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE		
13. NAME OF REFERRING PROVIDER OR OTHER SOURCE		14. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		
15. ADDITIONAL CLAIM INFORMATION		16. OUTSIDE LAB? YES NO		
17. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		18. PRESCRIPTION CODE ORIGINAL RFP NO		
19. A. DATE(s) OF SERVICE B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER		20. PRIOR AUTHORIZATION NUMBER		
21. FEDERAL TAX ID NUMBER		22. PATIENT'S ACCOUNT NO		
23. SIGNATURE OF PHYSICIAN OR SUPPLIER		24. SERVICE FACILITY LOCATION INFORMATION		

Order and Referring

- Claims must list the name and NPI of ordering and referring
 - Line item 17 (or electronic equivalent) – Provider's first name, last name as it appears in PECOS and one qualifier identifying the physician/NPP's role (DN, DK, DQ)
 - Line item 17b (or the electronic equivalent) – NPI
- Reminder
 - Include an appropriate modifier to indicate the patient was under a therapy plan of care
 - GO – Services delivered under an outpatient occupational therapy plan of care
 - GP – Services delivered under an outpatient physical therapy plan of care

Steps to Successfully Check Therapy Requirements

- Referral, DLS and NPI of attending physician requirements
 - [CMS-1500 Claim Form Completion Instructions](#)
- Physical therapy L33631/A56566
 - [Local Coverage Determinations](#)



Reducing Rejected Claims for Laboratory Codes

Laboratory Billing

- The term “profile” or “panel” means grouping of laboratory tests, which is usually performed automatically on single piece of testing equipment
- Providers are required to submit all individual automated multi-channel chemistry (AMCC) laboratory test codes for same beneficiary, performed on same date of service on same claim
- Submit complete organ disease panel; or
- Submit individual component tests of organ disease panel when all components of panel were not performed



Table of Chemistry Panels Example

		Hepatic Function Panel 80076	Basic Metabolic Panel (Calcium, ionized) 80047	Basic Metabolic Panel (Calcium, total) 80048	Comprehensive Metabolic Panel 80053	Renal Function Panel 80069	Lipid¹ Panel 80061	Electrolyte Panel 80051
Chemistry	CPT							
Albumin	82040	X			X	X		
Alkaline phosphatase	84075	X			X			
ALT (SGPT)	84460	X			X			
AST (SGOT)	84450	X			X			
Bilirubin, total	82247	X			X			
Bilirubin, direct	82248	X						
Calcium	82310			X	X	X		
Calcium ionized	82330		X					
Chloride	82435		X	X	X	X		X
Cholesterol	82465						X	
CK, CPK	82550							
CO2 (bicarbonate)	82374		X	X	X	X		X
Creatinine	82565		X	X	X	X		
GGT	82977							
Glucose	82947		X	X	X	X		
LDH	83615							
Phosphorus	84100					X		
Potassium	84132		X	X	X	X		X
Protein	84155	X			X			
Sodium	84295		X	X	X	X		X
Triglycerides	84478						X	
Urea nitrogen (BUN)	84520		X	X	X	X		
Uric Acid	84550							

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SCHIP/CHIP (LTD) OTHER % INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM, DD, YY) SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. & Street) 6. PATIENT RELATIONSHIP TO INSURED (Set Spouse Child Other) 7. INSURED'S ADDRESS (No. & Street)

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE

ZIP CODE TELEPHONE (3rd or Area Code) ZIP CODE TELEPHONE (3rd or Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PRESENT CONDITION RELATED TO: 11. INSURED'S POLICY OR GROUP OR FCDA NUMBER

12. OTHER INSURED'S POLICY OR GROUP NUMBER 13. EMPLOYMENT (Current or Previous) a. YES NO b. AUTO ACCIDENT? PLACE (State) c. OTHER ACCIDENT? YES NO 14. INSURED'S DATE OF BIRTH (MM, DD, YY) SEX 15. OTHER CLAIM BY (Designated by NUCC) 16. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (Specify complete form #, title, and no.)

17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment or government benefits other to myself or to the party who accepts assignment of benefits. 18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED DATE SIGNED

19. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM, DD, YY) QUAL. 20. OTHER DATE (MM, DD, YY) QUAL. 21. DATE PATIENT WANTED TO WORK (Month, Day, Year) OCCUPATION

22. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Last Name, First Name, Middle Initial) NPI 23. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM, DD, YY) TO (MM, DD, YY)

24. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 25. OUTSIDE LAR? YES NO 26. CHARACT? YES NO

27. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ICD-9-CM or ICD-10-CM code) 28. PRESCRIPTION CODE ORIGINAL RFP NO. 29. PRIOR AUTHORIZATION NUMBER

LINE	A. DATE OF SERVICE (From MM, DD, YY To MM, DD, YY)	B. PLACE OF SERVICE (ICD-9-CM)	C. PROCEDURE, SERVICE, OR SUPPLIER (ICD-9-CM or ICD-10-CM)	D. DIAGNOSIS (ICD-9-CM or ICD-10-CM)	E. CHARGE	F. UNITS	G. UNIT PRICE	H. TOTAL CHARGE	I. PROVIDING PROVIDER ID #
1									NPI
2									NPI
3									NPI
4									NPI
5									NPI
6									NPI

30. FEDERAL TAX ID NUMBER 31. PATIENT'S ACCOUNT NO. 32. SERVICE ASSIGNMENT? YES NO 33. TOTAL CHARGE 34. AMOUNT PAID 35. PROVIDER NUCC USE

36. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including address or credentials (I certify that the statements on this invoice apply to this bill and are true to the best of my knowledge)) 37. SERVICE FACILITY LOCATION INFORMATION 38. BILLING PROVIDER INFO & PAYER ()

Ordering and Referring

- Claims must list the name and NPI of ordering and referring
 - Line item 17 (or electronic equivalent) – Provider’s first name, last name as it appears in PECOS and one qualifier identifying the physician/NPP’s role (DN, DK, DQ)
 - Line item 17b (or the electronic equivalent) – NPI

Steps to Successfully Check Laboratory Billing

- Physician/NPP ordering and referring
 - [Order and Referring](#)
 - [CMS-1500 Claim Form Completion Instructions](#)
- Automated Multi-Channel Chemistry
 - [CMS IOM, Pub 100-04, Medicare Claims Processing Manual, Chapter 16, Laboratory Services](#)



Reducing Claim Rejections for Date Last Seen by Attending Physician for Routine Foot Care

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 3/8/00 0312

1. MEDICARE (Medicare) MEDICAID (Medicaid) TRICARE (TRICARE) CHIP/VA (Medicaid) GROUP HEALTH PLAN (Group Health Plan) DEER (DEER) OTHER (Other)	2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM, DD, YY) SEX (M, F)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (3rd or Area Code)			6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)		7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (3rd or Area Code)	
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			9. IS PATIENT'S CONDITION RELATED TO EMPLOYMENT (Current or Previous) YES NO		10. INSURED'S POLICY OR GROUP OR FIDA NUMBER	
11. IS THIS ANOTHER HEALTH BENEFIT PLAN? YES NO			12. IS THIS CLAIM DESIGNATED BY NUCC?		13. INSURED'S DATE OF BIRTH (MM, DD, YY) SEX (M, F)	
14. STATE OF CURRENT RESIDENCE (Include if pregnancy claim)			15. OTHER DATE (MM, DD, YY)		16. DATE OF LAST VISIT TO WORK IN CURRENT OCCUPATION (FROM, TO)	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM, TO)		19. OUTSIDE LAMP (YES, NO)	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. PHYSICIAN CODE ORIGINAL REF. NO.		21. PRIOR AUTHORIZATION NUMBER	
22. A. CARRIER OF SERVICE (From, To) B. PLACE OF SERVICE (EMS) C. PROVIDER, SERVICES, OR SUPPLIER (Diagnose Unless Otherwise Indicated) D. DIAGNOSIS (ICD-9-CM) E. CHARGE			23. DATE OF SERVICE (MM, DD, YY)		24. ICD-9-CM (Qual.) PROVIDING PROVIDER ID #	
25. FEDERAL TAX ID NUMBER			26. PATIENT'S ACCOUNT NO.		27. ACCOUNT ASSIGNMENT? (YES, NO)	
28. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including address or credentials if bills to the insurer or the insurer apply to this bill and set it with a post office)			29. SERVICE FACILITY LOCATION INFORMATION		30. BILLING PROVIDER INFO & PAF ()	
31. SIGNATURE OF AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government credits other to myself or to the party who accepts assignment below)			32. DATE		33. SIGNED	

Date Last Seen and Attending Physician

- Routine foot care
 - CPT/HCPCS G0127, 11055, 11056, 11057, 11719, 11720 and 11721
- Certain conditions require a patient to be under the care of a primary physician
 - Claims must indicate the date last seen and NPI of attending physician
 - Line item 19 or electronic equivalent
- Systemic condition modifiers: Q7, Q8 or Q9

Steps to Successfully Check LCDs

- Referral, DLS and NPI of attending physician requirements
 - [CMS-1500 Claim Form Completion Instructions](#)
- Routine foot care L33636/A57759
 - [Local Coverage Determinations](#)



Reducing Claim Rejections for Services Not Payable Under NGS Jurisdiction

Place Where Services are Rendered

- Line item 32
 - If services were furnished in hospital, clinic, laboratory, or any facility or physician's office, enter the name, address, and ZIP code where the patient received care
 - Only one name, address, and ZIP code may be entered in the block
 - PO Box is not acceptable
 - Do not include telephone numbers, commas, periods, or other punctuation in address
 - Enter a space between city and state postal code
 - Provider must be enrolled in MAC for location from which they perform service

HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/00 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DEER (LUMP) OTHER
 (Medicare) (Medicaid) (TRICARE) (Champion) (Group Health Plan) (Deer) (Other)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M, F, C) 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. & Street) 6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other) 7. INSURED'S ADDRESS (No. & Street)

CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PRESENT CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) b. AUTO ACCIDENT? c. OTHER ACCIDENT? 10. IS THERE ANOTHER HEALTH BENEFIT PLAN? 11. INSURED'S POLICY OR GROUP OR FICA NUMBER 12. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M, F) 13. OTHER CLAIM ID (Designated by NUCC) 14. INSURANCE PLAN NAME OR PROGRAM NAME 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Yes/No) 16. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party and accept assignment below.) 17. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)

18. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) QUAL. 19. OTHER DATE (MM DD YY) QUAL. 20. DATE (P) AND NUMBER TO WORK IN CURRENT OCCUPATION (MM DD YY) (P) (MM DD YY)

21. NAME OF REFERRING PROVIDER OR OTHER SOURCE (M, F, N) 22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY) 23. OUTSIDE LAB? (Yes/No) 24. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ICD-9-CM code in the block) (ICD NO.) 25. PHYSICIAN OR SUPPLIER (Name, Address, City, State, ZIP Code) (ORIGINAL REF. NO.) 26. PRIOR AUTHORIZATION NUMBER

27. A. DATE OF SERVICE (From MM DD YY To MM DD YY)	27. B. PLACE OF SERVICE (ICD-9-CM PROCEDURE CODE)	27. C. PROVIDER (Name, Address, City, State, ZIP Code)	27. D. DIAGNOSIS (ICD-9-CM CODE)	27. E. CHARGE	27. F. DAYS OF SERVICE	27. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.
1						
2						
3						
4						
5						
6						

28. FEDERAL TAX ID NUMBER (SSN) 29. PATIENT'S ACCOUNT NO. 30. ACCOUNT ASSIGNMENT? (Yes/No) 31. TOTAL CHARGE 32. AMOUNT PAID 33. FEE FOR SERVICE (FEE) 34. BILLING PROVIDER INFO & P.I.F. ()

35. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials to certify that the statements on this form apply to this bill and are made a part thereof.) 36. SERVICE FACILITY LOCATION INFORMATION 37. BILLING PROVIDER INFO & P.I.F. ()



Durable Medical Equipment MAC

- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)
 - HCPCS code and modifier combinations
 - Example HCPCS A, B, E, J, K, L, Q and V
 - Part B services processed by DME Regional Contractors
 - Item 24D on CMS-1500 or the electronic equivalent
- Do not send these claims to NGS Medicare

Steps to Successfully Check Jurisdictions

- Know what codes are billable to DME MAC
- [DME MAC Jurisdiction A](#)
 - CT-MA-ME-NH-NY-RI-VT
- [DME MAC Jurisdiction B](#)
 - IL-MN-WI
- [CMS IOM Pub 100-04, Medicare Claims Processing Manual, Chapter 12-Physicians/Nonphysician Practitioners](#)



Reducing Claim Rejections for Missing Billed Charges

Invalid Charges

- Each line submitted should have valid charge
- If there are no cents in charge amount, enter 00
- Codes with zero-charge used for reporting purposes may be billed with a 0.01
- Total charges in line Item 24F or electronic equivalent
- Multiple claim forms with “continued” or “see next page” or single total in Item 28 for multiple claim forms will be returned as unprocessable

HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN DEER RCV (LIFE) OTHER
 Medicare Medicaid Tricare Member ID (ID) (ID) (ID) (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F) 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other) 7. INSURED'S ADDRESS (No. Street)

CITY STATE ZIP CODE TELEPHONE (Include Area Code) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. RESERVED FOR NUCC USE 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: (a) EMPLOYMENT (Current or Previous) YES/NO (b) AUTO ACCIDENT? YES/NO (c) OTHER ACCIDENT? YES/NO 11. INSURED'S POLICY OR GROUP OR FICA NUMBER 12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F) 13. OTHER CLAIMS (Designated by NUCC) 14. INSURANCE PLAN NAME OR PROGRAM NAME 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES/NO (If yes, complete Item 9, 10, and 11)

16. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other than Social Security to the party who accepts assignment below.) SIGNED DATE 17. OTHER DATE (MM/DD/YY) 18. DATES OF WORK (Current Occupation) FROM TO 19. NAME OF REFERRING PROVIDER OR OTHER SOURCE (MD, DO, DPM, NP, PA) 20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO 21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 22. OUTSIDE LABOR CHARGES YES/NO 23. PHYSICIAN CODE ORIGINAL REF NO 24. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE (From To) B. PLACE OF SERVICE (ICD-9-CM) C. PROCEDURE, SERVICE, OR SUPPLY (ICD-9-CM) D. DIAGNOSIS (ICD-9-CM) E. F. G. H. I. J. K. L.

LINE	A	B	C	D	E	F. \$ CHARGES	G. ICD-9-CM	H. PROVIDING PHYSICIAN ID #
1							NP1	
2							NP1	
3							NP1	
4							NP1	
5							NP1	
6							NP1	

25. FEDERAL TAX ID NUMBER SSN ID# 26. PATIENT'S ACCOUNT NO 27. ACCOUNT ASSIGNMENT? YES/NO 28. TOTAL CHARGE \$ 29. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degree or Credentials (I certify that the statements of this claim apply to this bill and can't be a part thereof.) 30. SERVICE FACILITY LOCATION INFORMATION 31. AMOUNT PAID 32. RESERVED FOR NUCC USE

Steps to Successfully Check Billed Charges

- [CMS-1500 Claim Form Completion Instructions](#)
- [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)



Reducing Claim Rejections for CPT and HCPCS Codes and Modifiers



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

The screenshot shows the National Government Services website interface. At the top, there is a blue header with the logo and a search icon. Below the header, there are six white cards arranged in a 2x3 grid. The 'Fee Schedules' card is highlighted with a black border. Each card contains an icon, a title, and a brief description.

Category	Icon	Title	Description
Medical Policies	Open book	Medical Policies	Find LCDs and related billing and coding articles
Enrollment	Document with pencil	Enrollment	Getting started, after you enroll, and revalidating your enrollment
Fee Schedules	Document with \$\$\$	Fee Schedules	Code pricing search, payment systems, limits, and fee schedule lookup
Claims and Appeals	Document with magnifying glass	Claims and Appeals	Learn about claims, top errors, fees, MBI and appeals
Overpayments	Dollar sign in a circle	Overpayments	Repayment schedules, and post-pay adjustment
Medicare Compliance	Clipboard with checkmark	Medicare Compliance	Medical Review, Prior Authorization, Fraud & Abuse, CERT, and more

Fee Schedule Lookup – Types

NGSConnex | Subscribe for Email Updates | Part B Provider in Massachusetts (JK) ▾

national government SERVICES | HOME | EDUCATION ▾ | **RESOURCES ▾** | EVENTS | ENROLLMENT | APPS ▾

Resources > Tools & Calculators

FEE SCHEDULE LOOKUP

Fee Schedule Lookup



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

Select a Fee Schedule: ▾

- Select Fee Schedule--
- ASC Fees
- Ambulance
- Anesthesia Conversion Factor
- CP/CSW
- Flu/PPV/Hepatitis
- Home Infusion Therapy Services (HITS)
- Medicare Physician Fee Schedule Pricing
- Opioid Treatment Program (OTP)

Fee Schedule Lookup

NCSCConnex [Subscribe for Email Updates](#) [Part B Provider in Massachusetts \(JK \)](#) ▼

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[Resources](#) > [Tools & Calculators](#)


FEE SCHEDULE LOOKUP

Fee Schedule Lookup

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

Select a Fee Schedule: *

Result Type: * Full Fee Schedule
 Specific To Fee Code

Date of Service: * 

Procedure Code: *

Region: *

Fee Schedule Lookup – Regions

To initiate a search, select a fee schedule type from the drop-down

Select a Fee Schedule: *

Result Type: *

Date of Service: *

Procedure Code: *

Region: *

--Select Region--

- 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

--Select Region--

Search

Illinois Locality/Area and County Information

Locality/Area	Counties
12	Bond, Calhoun, Clinton, Jersey, Macoupin, Madison, Monroe, Montgomery, Randolph, St. Clair, Washington
15	DuPage, Kane, Lake, Will
16	Cook
99	All Other Counties

Maine and Massachusetts, Locality/Area and County Information

Locality/Area	State	Counties
01	MA	Middlesex, Norfolk and Suffolk
99	MA	All Other Counties
03	ME	York and Cumberland
99	ME	All Other Counties

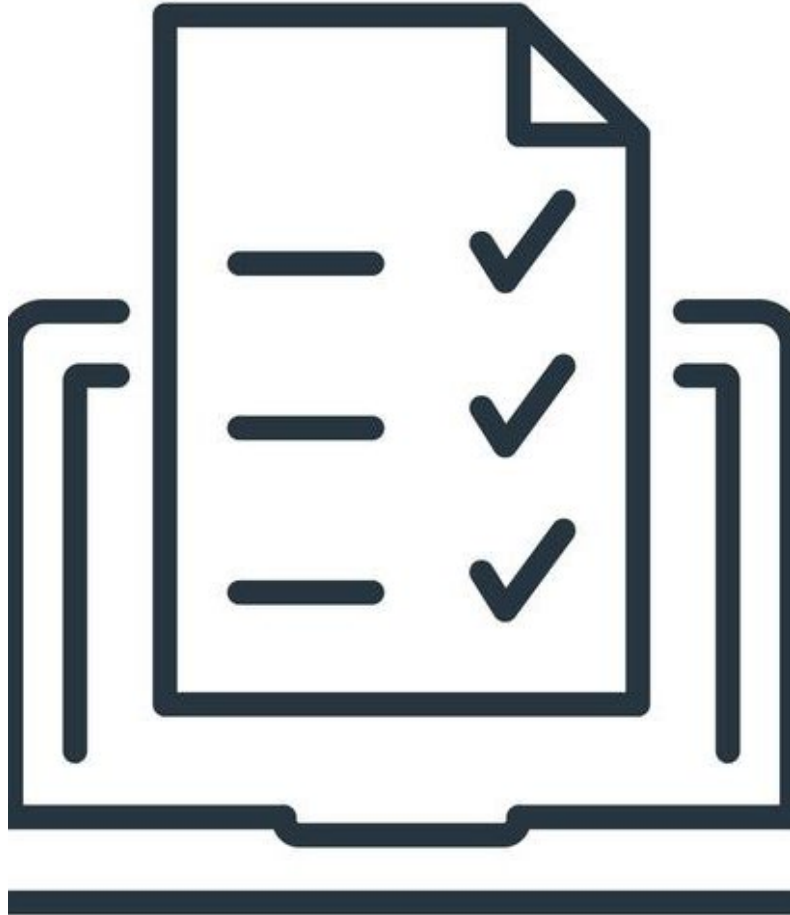
New York Locality/Area and County Information

Locality/Area	State
01	Manhattan
02	Bronx, Brooklyn, Nassau, Rockland, Staten Island, Suffolk, Westchester
03	Columbia, Delaware, Dutchess, Greene, Orange, Putnam, Sullivan, Ulster
04	Queens
99	All Other Counties



Policy Indicators

- Procedure status indicators
- Global surgery
- Facility pricing
- Preoperative
- Interoperative
- Postoperative
- Multiple surgery
- Bilateral surgery
- Assistant at surgery
- Two surgeons
- Team surgery
- Use References: [Fee Schedule Lookup Details](#)



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 and Documentation

- 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
- 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

Modifiers

- Two types of modifiers in MCS
 - CPT – numeric
 - HCPCS – letter and numeric
- Pricing modifiers
 - First field
- Statistical/informational modifiers
 - Second field
- Always enter pricing modifiers before statistical/informational modifiers

Modifiers – List Not All Inclusive

- 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
- Statistical/informational modifiers
 - Coronary artery modifiers
 - LC, LD, LM, RC, RI
 - Eye lid modifiers
 - E1, E2, E3, E4
 - Finger modifiers
 - FA, F1, F2, F3, F4, F5, F6, F7, F8, F9
 - Toe modifiers
 - TA, T1, T2, T3, T4, T5, T6, T7, T8, T9
 - Side of body modifiers
 - LT, RT

Steps to Successfully Check CPT/HCPCS

- [MPFS available on our Fee Schedule Lookup page](#)
- [Fee Schedule Assistance](#)
- [CMS IOM Publication 100-04, Medicare Claims Processing Manual](#)
 - [Chapter 23 “Fee Schedule Administration and Coding Requirements”](#)
 - [Chapter 26 “Completing and Processing Form CMS-1500 Data Set”](#)
- [Unlisted and Not Otherwise Classified Procedure Codes](#)
- [Education > Medicare Topics > Billing](#)
- [Education > Manuals and Guides > Medicare Part B 101 Manual](#)



Reducing Claim Rejections for Missing Documentation

Missing Documentation

- Examples of documentation that is required when submitting claims
- N706: Missing documentation
 - Information requested was not provided or not provided timely or was insufficient/incomplete
- Common error among providers is submitting claims without documentation
 - Modifiers: AS, 22, 52, 53, 62, 66, 80, NOC and unlisted codes





Additional Documentation Requests

- NGS may need to analyze claims to determine allowance
- ADR letters will be generated
 - NGS may require clarification or documentation
 - If documentation is not submitted, claim rejects as unprocessable
- Avoid this by utilizing ANSI electronic attachments program
- Data that comes together to process claim

Steps to Successfully Submit Claims with Required Documentation

- Additional Development Request Letters Guide
 - [Ways to Respond](#)
 - [Claim Additional Development Requests](#)
 - [MR TPE Additional Development Requests](#)
 - [Other Audit Contractor Additional Development Requests](#)
 - [Overpayments Due to Contractor Audit Reviews](#)
 - [EDI Solutions Benefits of Electronic Attachments ANSI 275](#)
 - [EDI Solutions Benefits of the 277 RFI ANSI 277](#)



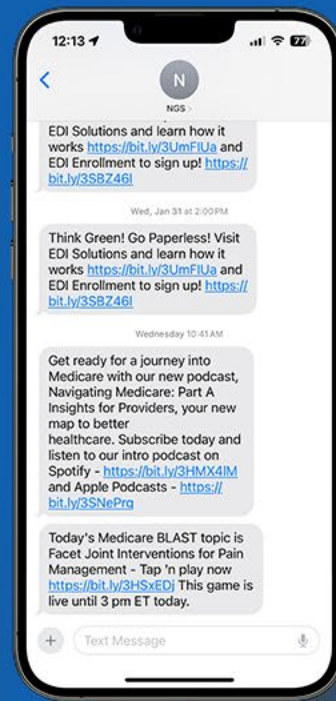
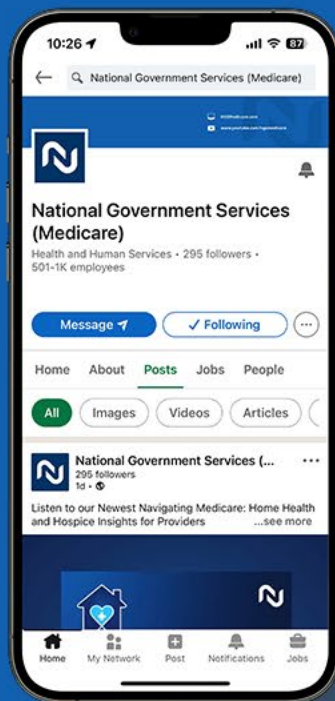
Claim Reminders

- Resubmit, redetermination or reopen
- Resubmit
 - Unprocessable denials
- Redetermination
 - Medical necessity claim denials
- Reopen
 - Minor clerical errors or omissions
- Reopenings for Minor Errors and Omissions



Questions?

Thank you!



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Educational Videos



www.MedicareUniversity.com
Self-paced online learning

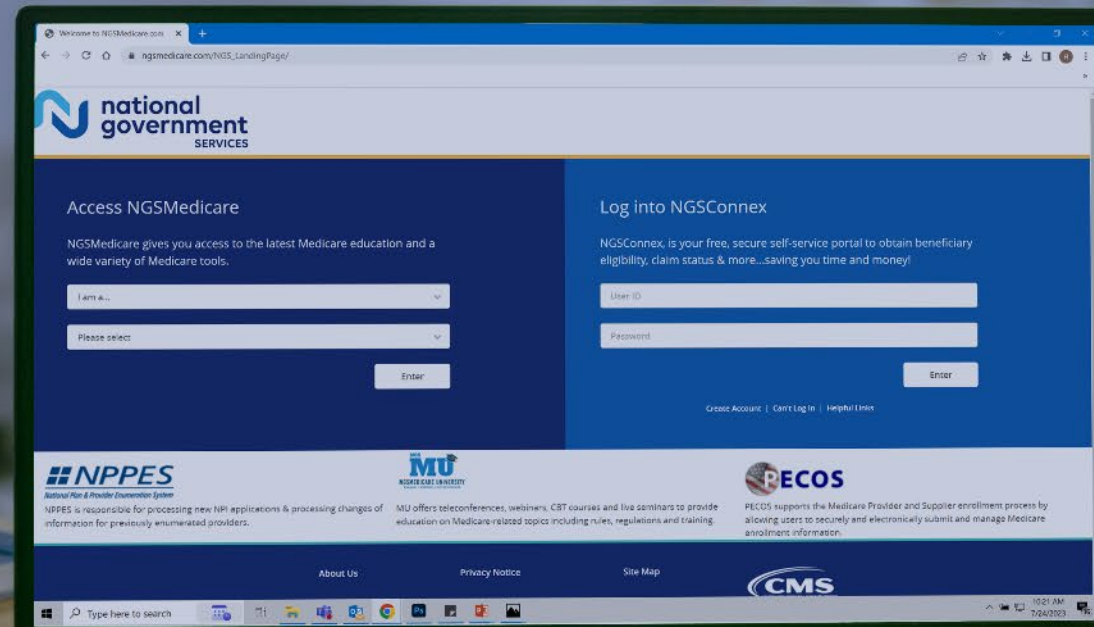
medicare **mobile**

Text NEWS to 37702; Text GAMES to 37702



[LinkedIn](#)
Educational Content

Find us online



www.NGS Medicare.com

Online resources, event calendar, LCD/NCD, and tools



IVR System

The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries



[NGSConnex](#)

Web portal for claim information



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