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Medicare Part B Top Claim Denials

10/16/2024

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NGSMU
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Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Objective

By utilizing internal claim reporting information, we'll help identify the top ten Part B claim denials and provide solutions to prevent them in the future.

Today's Presenters

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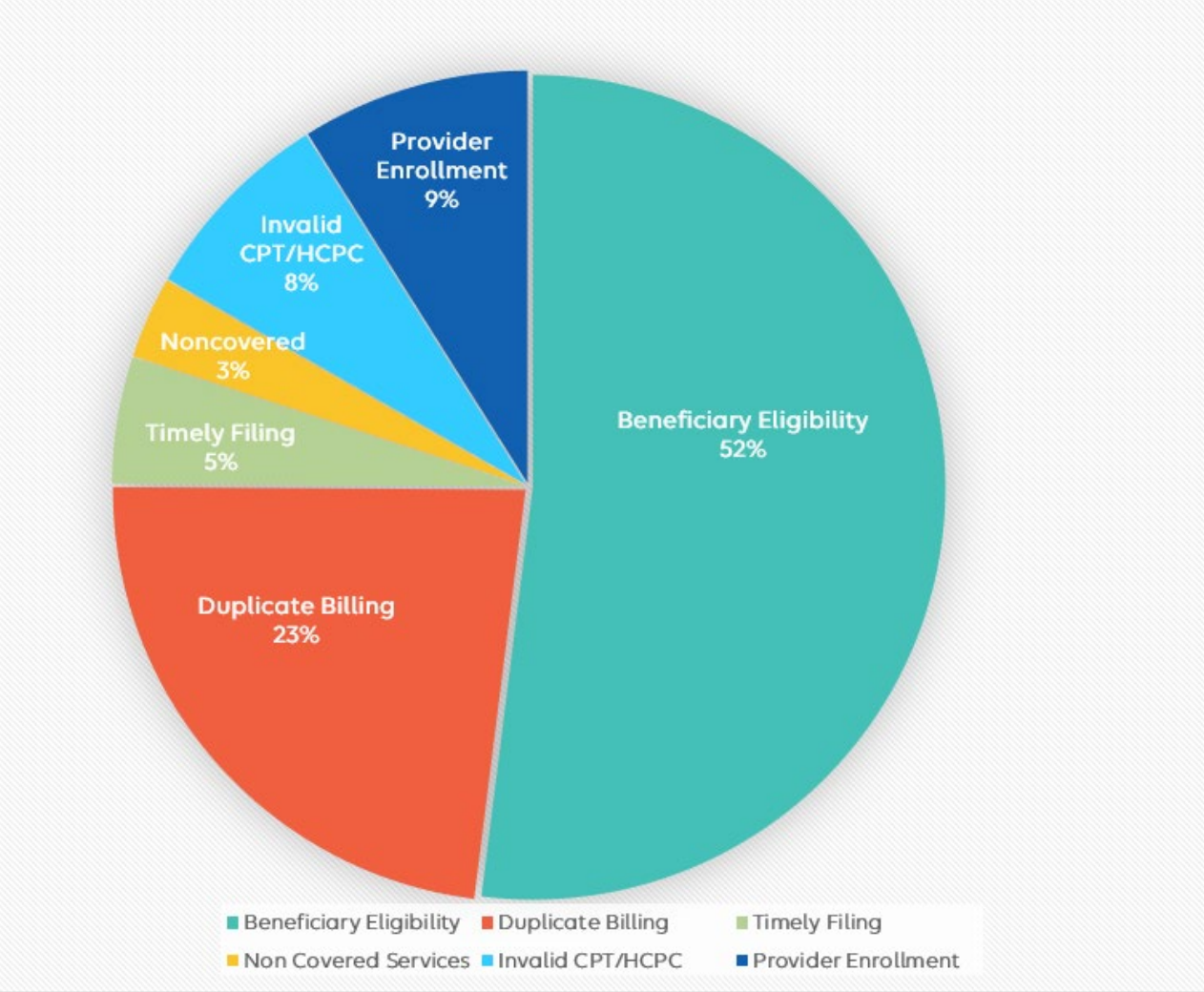
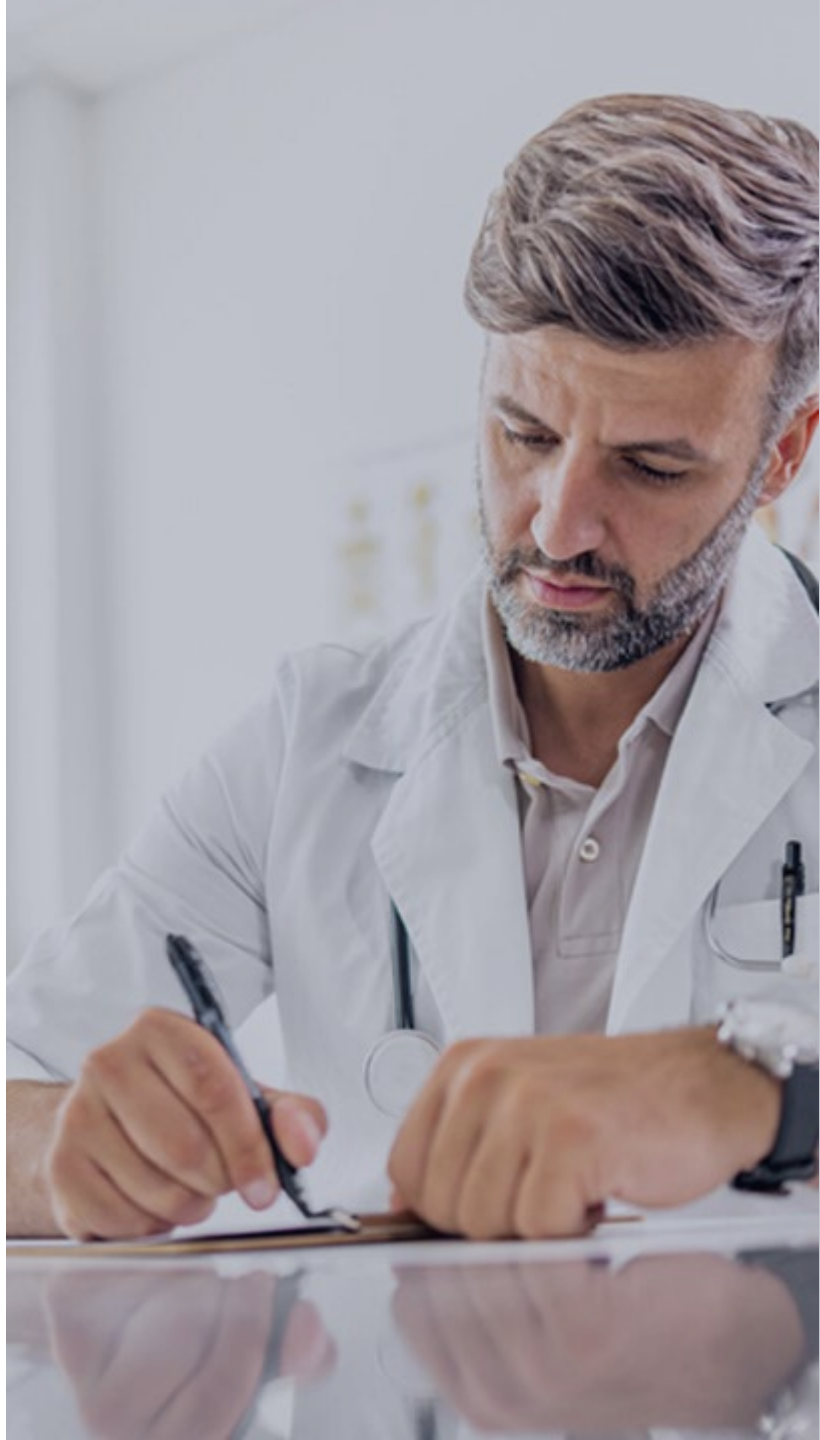
Agenda

- Q3 2024 Claim Denial Data
- Duplicate Billing
- Beneficiary Eligibility
- Invalid CPT/HCPC
- Noncovered Service
- Timely Filing
- Provider Enrollment
- Reopening versus Redetermination
- Reopening
- Appeals

Q3 2024 Claim Denial Data

Q3 2024 Claims Denial Chart





Duplicate Billing

Duplicate Billing

- Message Code OA-18
  - Exact duplicate claim/service
- Issues caused by duplicate billing
  - May delay payment
  - Increases administrative costs to the Medicare Program
  - Could be identified as an abusive biller; or
  - May result in an investigation for fraud if a pattern of duplicate billing is identified

Duplicate Elements

- Patient's Medicare number
- PTAN/NPI
- From and through date of service
- Type of service
- Place of service
- Procedure codes
- Billed amount

Tips to Avoid Duplicate Claims

- Use NGSConnex or the IVR to verify the status of the original claim
  - Denied/rejected
  - Pending
  - Approved to pay
- Electronic claim submitters
  - Check your EDI validation report to verify claims were received and accepted
  - Check your software system to verify claims are not set up for automatic rebill every 30 days
  - Review your remittances
- Review your remittance advice for denial/rejection reason
- Do not resubmit a claim to correct an original denial
  - May need to submit a reopening or appeal
- Tips for Avoiding Duplicate Billing Denials

EDI - Duplicate Claims

- Electronic claims that are duplicates to already received electronic claims will not be accepted into the Part B claims processing system
  - Will not appear on the remittance advice
- 277 CA report rejection codes
  - CSCC: A3 – Return as unprocessable
  - CSC: 78 – Duplicate of an existing claim/line

Beneficiary Eligibility

Beneficiary Eligibility

- Message code PR-31
  - Patient cannot be identified as our insured
  - Common reasons for denial
    - MBI invalid/incorrect
    - No Part B entitlement on date of service
- Resolution
  - Ensure MBI is valid, submit claim again
  - Verify eligibility in self-service tools, if no entitlement, check with patient

Medicare Advantage Plan

- Message code OA-109
  - Claim/service not covered by this payer/contractor, you must send the claim/service to the correct payer/contractor
  - Most commonly identifies that the patient is an MA plan enrollee
- Resolution
  - Check eligibility file for MA plan information
  - Submit claim to MA plan

Hospice

- Message code PR-B9
  - Patient is enrolled in a hospice
  - Covered only when performed by the attending physician
- Remark code N90
  - Covered only when performed by the attending physician
- Resolution
  - Services provided by attending physician?
    - GV modifier
  - Services provided are not related to terminal condition?
    - GW modifier
  - Reopen - To add the appropriate modifier
  - If related to hospice, work directly with hospice program for reimbursement
- The Medicare Hospice Benefit: Effects on Other Provider Types

Medicare Secondary Payer

- Message code CO-22
  - This care may be covered by another payer per COB
  - The patient has insurance that is primary to Medicare
- Resolution
  - Check eligibility file for the primary insurer
  - Submit claim to primary payer
  - You may submit an MSP claim once the primary has finalized the claim
- Medicare Secondary Payer (MSP)
- Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P

Therapy Cap

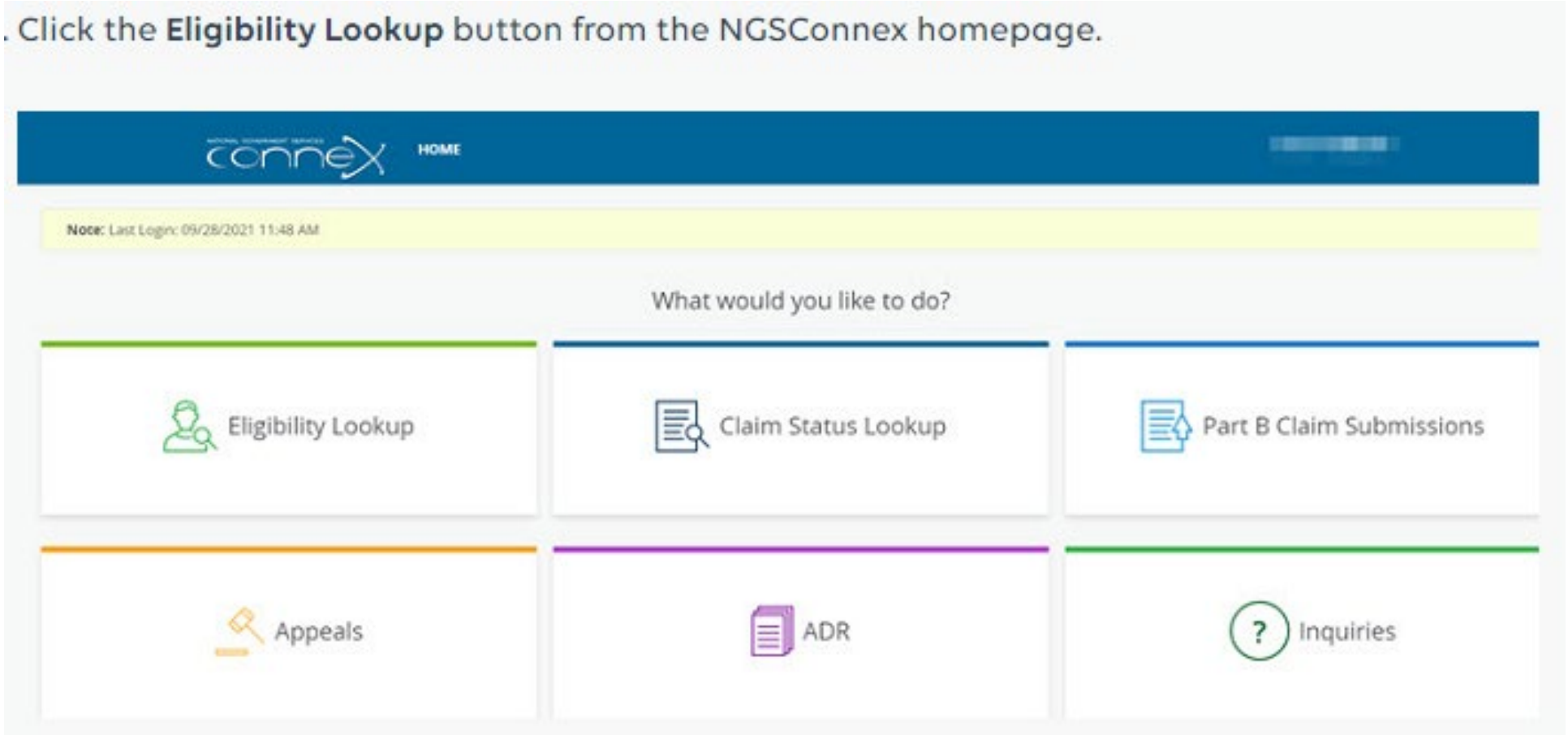
- Message code CO-19
  - Benefit maximum for this time period or occurrence has been reached
- Resolution
  - The beneficiary has reached their therapy cap limit for the year
  - The Bipartisan Budget Act of 2018 repealed application of the Medicare outpatient therapy caps but retains the former cap amounts as a threshold above which claims must include the KX modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record
  - For CY 2024, the limit on incurred expenses is $2,330 for PT and SLP services combined. There's another limit of $2,330 for OT services
  - For CY 2023, the limit on incurred expenses is $2,230 for PT and SLP services combined. There's another limit of $2,230 for OT services
- Annual Therapy Update

Beneficiary Eligibility Verification

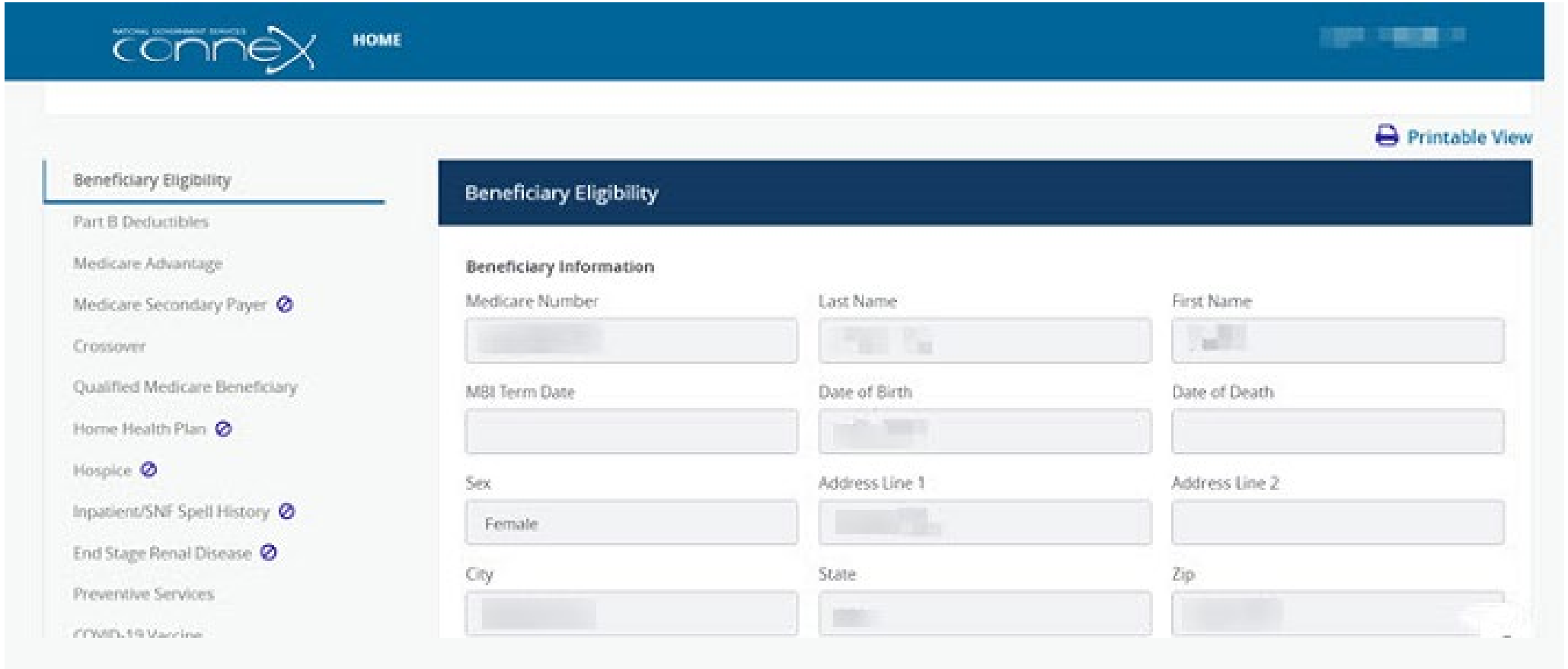
- Prior to claim submission, verify your patient's eligibility using
  - NGSConnex

NGSConnex Eligibility Verification

. Click the **Eligibility Lookup** button from the NGSConnex homepage.



NGSConnex Eligibility Verification



Eligibility Resources

- Checking Eligibility and Knowing your Point of Contact
- CMS IOM Publication 100-09, *Medicare Administrative Contractor (MAC) Beneficiary and Provider Communications Manual,* Chapter 6, Section 50.1
- *NGSConnex User Guide*
- Change Request 13371: 2024 Annual Update of Per-Beneficiary Threshold Amounts
- Annual Therapy Update
- Change Request 12923: 2023 Annual Update of Per-Beneficiary Threshold Amounts

Invalid CPT/HCPC

Invalid CPT/HCPC

- Message Code CO-16
  - Claim/service lacks information or has submission/billing error(s)
- Remark Code M51
  - Missing/incomplete/invalid procedure code(s)
- Resolution
  - Utilize the following resources, as well as the most current CPT/HCPCS coding books, to verify if the code you want to bill to Medicare is a covered service
    - Medicare Physician Fee Schedule Database
    - CMS Internet Only Manuals
    - Medicare Coverage Data Base

Noncovered Service

Noncovered Service

- Message Code PR 50
  - These are noncovered services because this is not deemed a ‘medical necessity’ by the payer
- Remark Code N180
  - This item or service does not meet the criteria for the category under which it was billed
- Resolution
  - The CPT/HCPCS code reported is not covered for the beneficiary, and the beneficiary is liable for these charges. If you have reported an incorrect code, or forgot a modifier, the claim will need to be reviewed as a reopening or a redetermination

Timely Filing

Timely Filing

- Message code CO-29/PR 29 (unassigned claims)
  - The time limit for filing has expired
- Remark code N211
  - You may not appeal this decision
  - The time limit for filing has expired
- All claims must be submitted within one year from the date of service
  - Span date claims use the “To” date

Timely Filing Exceptions

- CMS indicates Medicare contractors may determine certain situations allowing extension of the time limit
  - Administrative error
  - Retroactive Medicare entitlement
  - Retroactive MA plan disenrollment
  - Retroactive entitlement involving Medicaid
- Exceptions may be mailed to NGS before or after the claim is submitted
  - Preclaim: Completed 1500 claim form, a letter explaining reason claim is being filed late, documentation
  - Postclaim: Part B Reopening form with documentation
- Requesting an Exception to Timely Filing

Provider Enrollment

Provider Enrollment

- Message code CO-B7
  - This provider was not certified/eligible to be paid for this procedure/service on this date of service
- Resolution
  - The billing or rendering provider NPI is not actively enrolled with Medicare on the date(s) of service billed on the claim. Please verify the provider's Medicare effective date in PECOS
    - If the provider shows active now, the claim may be resubmitted
    - If the provider is not active, please contact our Provider Enrollment Contact Center to discuss what actions are needed to ensure the provider is properly enrolled in Medicare Part B

Reopening versus Redetermination

Reopening Versus Redetermination

- Reopening
  - To correct a claim(s) determination resulting from minor errors
  - Mathematical or computational mistake
  - Inaccurate data entry
  - Computer errors
  - Incorrect data items
  - Transposed procedure or diagnostic codes
- Redetermination
  - First level of the Medicare appeal process
  - For partially paid or denied claim(s) resulting from more complex issues that require analysis of documentation
  - Coverage of furnished items and service
  - Overpayment determinations
  - Medical necessity claim denials
  - Determination on limitation of liability provision

Reopening

Methods to Initiate a Reopening

- NGSConnex
  - Preferred method
    - NGSConnex Part B User Guide
- Telephone Reopening Unit
  - JK: 888-812-8905
  - J6: 877-867-3418
- Written Reopening
  - J6
    - National Government Services, Inc.
    - P.O. Box 6475
    - Indianapolis, IN 46206-6475
  - JK
    - National Government Services, Inc.
    - P.O. Box 7111
    - Indianapolis, IN 46207-7111
  - Reopenings for Minor Errors and Omissions

Large Various Adjustment Macro

- The Large Various Adjustment Macro (LVAM) form is an excel spreadsheet and shall be typed entirely to include an internal claim number (ICN)
  - If you cannot type the request, please make sure your handwriting is legible
  - Any incomplete LVAM request may be sent back to the provider as an incomplete submission
- The LVAM form includes
  - Patient's name
  - Patient's HIC/MBI
  - Date of service
  - ICN
  - Procedure code
  - Explain correction needed
- Examples of services that can be corrected through our LVAM process
  - Changing modifiers
  - Procedure codes
  - Adding diagnosis codes
  - Increasing billed amount
  - Changing the quantity billed

Reopenings Handled by Telephone Reopening Unit or Written Reopening

- Assignment of claims (carrier errors only)
- CLIA certification denials
- Adding or changing order/referring/supervising physician
- Duplicate denials
- MA plan denials (clinical trial or hospice related only)
- Modifier GV and GW
- Updated fee schedule allowance
- HIC/MBI corrections (carrier error only)
- MSP – Medicare now primary
- Patient paid amount (carrier error only)
- Add/change rendering provider
- Place of Service Changes

Appeals

Methods to Initiate a First Level Appeal

- NGSConnex
  - Preferred method
    - NGSConnex Part B User Guide
- Electronic Submission of Medical Documentation (EsMD)
    - Submit an Appeal Electronically via esMD
- Written Appeal
  - JK
    - National Government Services, Inc.
    - P.O. Box 7111 Indianapolis, IN 46207-7111
  - J6
    - National Government Services, Inc.
    - P.O. Box 6475 Indianapolis, IN 46206-6475
- Part B Redetermination Request Form

The Five Levels of Appeal

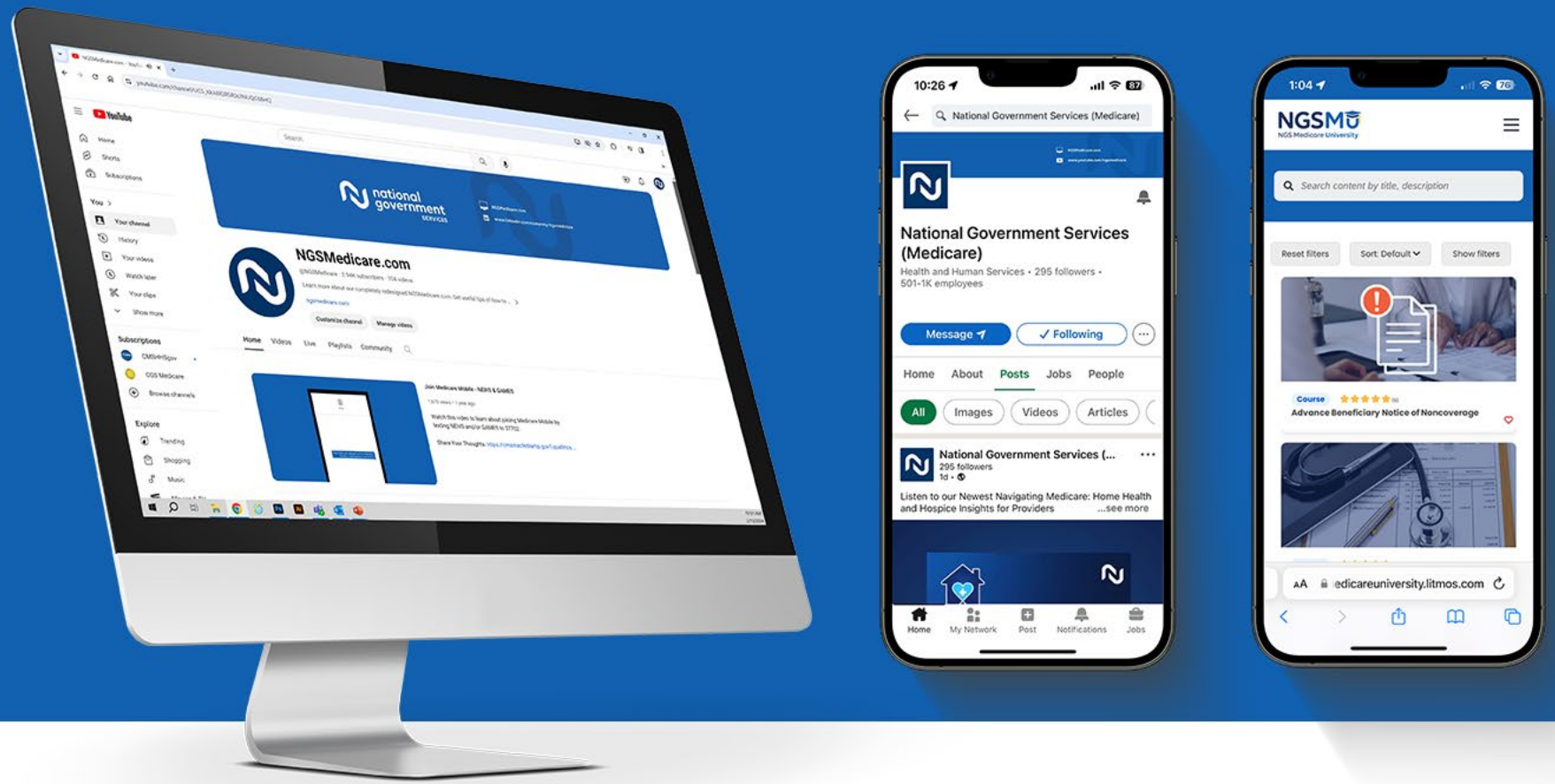
- Level One – Redetermination
  - 120 days from date of receipt of the initial determination notice
  - No minimum
- Level Two – Reconsideration (QIC)
  - 180 days from date of receipt of the redetermination decision
  - No minimum
- Level Three – Administrative Law Judge (ALJ)
  - 60 days from the date of receipt of the reconsideration (QIC decision)
  - For requests filed on or after 1/1/2024, at least $180 remains in controversy
- Level Four – Medicare Appeals Council (MAC)
  - 60 days from date of receipt of the ALJ decision
  - No minimum (none)
- Level Five – Federal Court Review
  - 60 days from date of receipt of the MAC decision
  - For requests filed on or after 1/1/2024, at least $1,840 remains in controversy.
  - For requests filed on or after 1/1/2023, at least $1,850 remains in controversy
- How to Avoid Costly Appeals

Appeal Documentation

- Include appropriate documentation for service
  - Provide at the time of the initial appeal request
  - Additional information/documentation will not be requested
  - The medical documentation must be signed and dated by the physician
  - Only you can decide which documentation best supports your claim
- A guide to assist your office with the documentation required
  - Medical Records to Support an Appeal

Questions?

Thank you!



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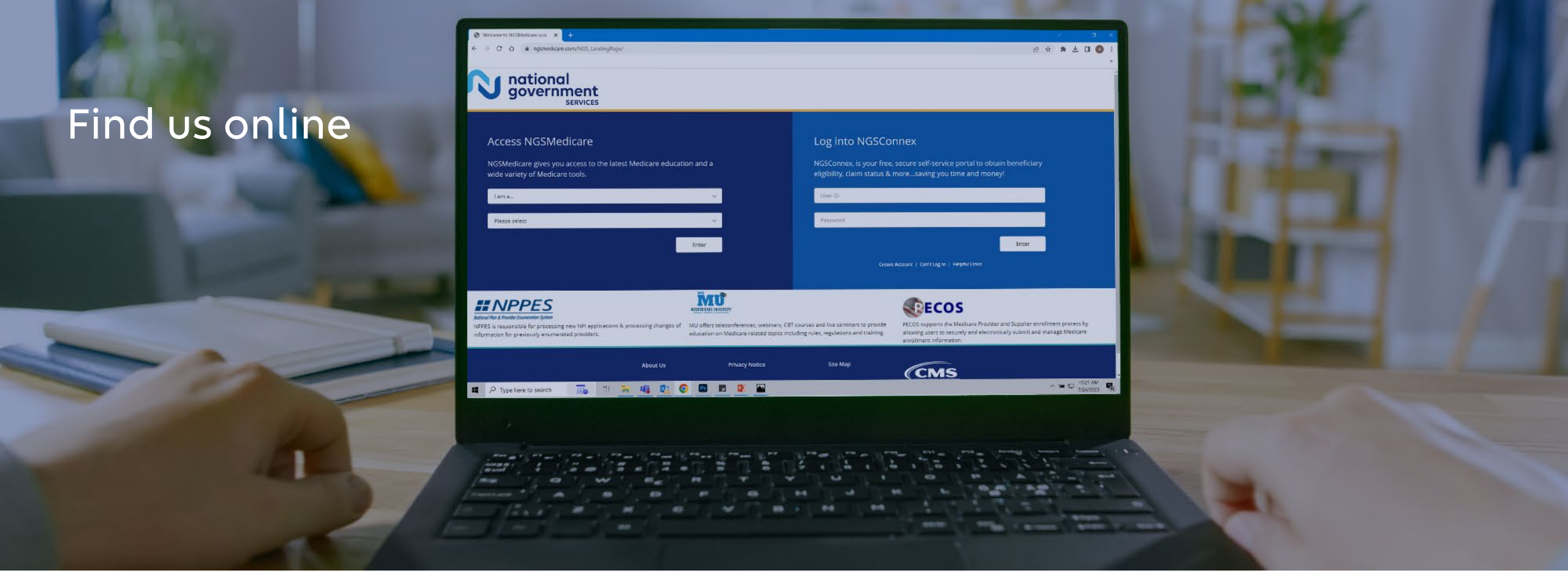

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