national government SERVICES

NGS PROVIDER EXPERIENCE
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Quarterly Review of Top Part A Claim Errors

2/19/2025

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.*

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Objective

After this session, attendees will know what the top J6 and JK Part A claim errors are based on recent data analysis, how to utilize reason codes to understand why a claim denied, rejected or RTP'd, how to prevent the most common errors and what resources to use for more information.

Today's Presenters

- Provider Outreach and Education Consultants
  - Andrea Freibauer
  - Jean Roberts, RN, BSN, CPC

Agenda

Understanding and Locating Claim Errors

Top Denial Reason Codes

Top Rejection Reason Codes

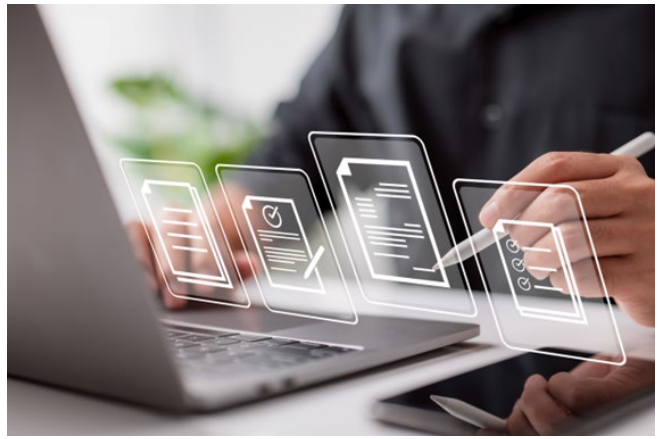
Top Return to Provider (RTP) Reason Codes

Stay in the Know With NGS!

Questions?

Understanding and Locating Claim Errors

Benefits of Preventing Claim Errors



Financial

Increase Medicare cash flow by correctly submitting claims the first time

Avoid the expense of resubmitting, adjusting, or appealing incorrect claims

Time

Utilize staff time more efficiently by avoiding the "claim error rollercoaster" – researching and fixing errors

Ensure claims are submitted timely

Compliance

Avoid being investigated for Medicare program integrity (fraud and abuse) by submitting Medicare-compliant claims

Claims Adjudication Process

- Once submitted, claims process through FISS
- Follows specific path based on type; subject to various edits
  - Status/location – where claim is in processing
  - Reason codes – indicate status of claim
- When transaction/claim passes FISS edits, subject to various CWF edits
  - Nationwide repository for Medicare patient and claim information
  - If claim passes CWF edits, returns to FISS for finalization/adjudication
- Identify claim payments, rejections and denials and determine if next steps needed for rejections and denials
  - Utilize FISS DDE, remittance advice, or other methods

FISS Status/Locations

- S XXXXX – Claim suspended (processing)
- P B9997 – Claim finalized/adjudicated
  - Doesn't always mean paid
- T B9997 – Claim returned to provider (RTP)
  - Claim has error(s) that need to be corrected and sent back to MAC via FISS (PF9)
  - Providers must check RTP bucket often as these claims not considered received by Medicare
- R B9997 – Claim rejected
  - No action may be needed, determined by reason code
  - May have to resubmit (or adjust) claim, if appropriate
- D B9997 – Claim denied
  - Determine if appeal needed
  - Documentation must support services rendered

What are FISS Reason Codes?

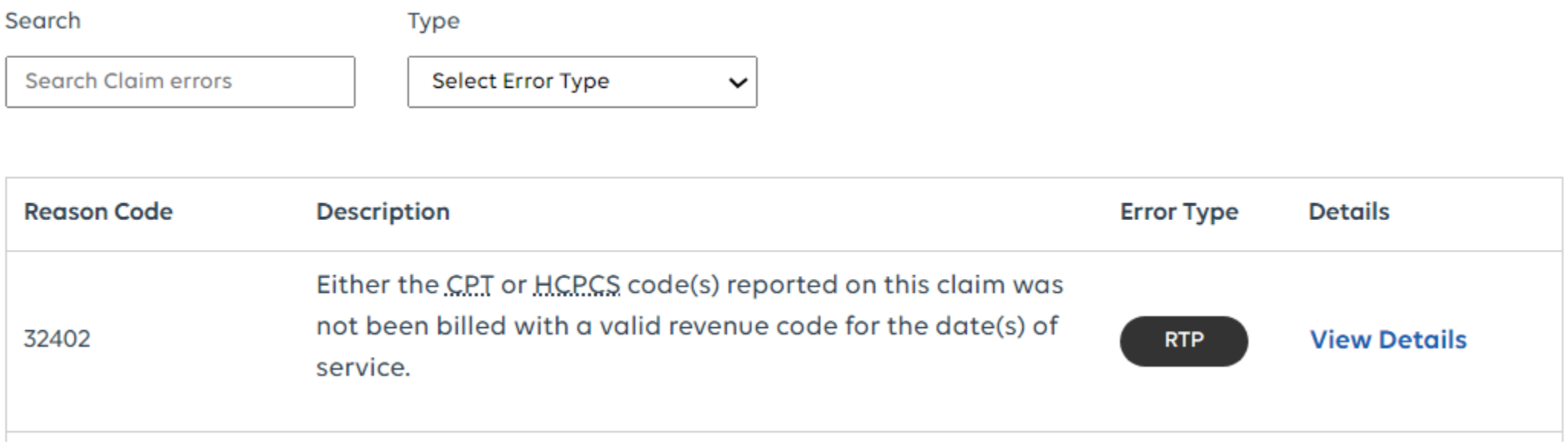
- Five-digit codes that direct outcome of claim edit or process
- Review reason code to determine next steps
  - Correct claim online and resubmit
  - Appeal claim
  - Adjust claim
  - Submit new claim
  - No action may be needed

Locating Reason Codes in FISS DDE

- Reason code file
  - Inqiuires (Main Menu Selection 01)
  - Reason Codes (Menu Selection 17)
- Finalized claims (Processed/Rejected/Denied)
  - Inquiries (Main Menu Selection 01)
  - Claim Summary (Menu Selection 12)
- RTP claims
  - Claims Correction (Main Menu Selection 03)
  - Then appropriate selection for type of claim
    - Inpatient (Menu Selection 21)
    - Outpatient (Menu Selection 23)
    - SNF (Menu Selection 25)

Tips on Avoiding/Correcting Claim Errors

- Research reason codes on our website
  - Part A and your state > Resources > Claims and Appeals > Top Claim Errors



Top Denial Reason Codes

Denials: October – December 2024

Jurisdiction K

CAH	CMHC	CORF/ ORF	ESRD	FQHC	IP Hospital	OP/ OPPS	RHC	SNF IP	SNF OP	Swing Bed
39928	-	39928	-	5WEXC	5ND07	39928	5WEXC	56900	39928	-
5WEXC	-	-	-	-	59301	5WEXC	39928	55S29	54NCD	-
52MUE	-	-	-	-	59118	54NCD	55B31	55S33	-	-

Jurisdiction 6

CAH	CMHC	CORF/ ORF	ESRD	FQHC	IP Hospital	OP/ OPPS	RHC	SNF IP	SNF OP	Swing Bed
39928	-	39928	-	5WEXC	59118	39928	39928	56900	39928	-
5WEXC	-	-	-	56900	59091	5WEXC	5WEXC	55S08	5WEXC	-
56900	-	-	-	55B00	59144	54NCD	59132	55S25	54NCD-	-

Denial Reason Code 39928

- Each line of charges on this claim has been denied by medical review
- Avoiding/Correcting this error
  - Determine line level denial codes for each line of claim
    - Claim page 2 (MAP 1712) and F11 to MAP171D
  - Ensure all Medicare coverage, documentation and medical necessity requirements met before billing claim
    - Review current National Government Services LCDs and Billing and Coding Articles
  - If you disagree with denial, you have the right to appeal

Denial Reason Code 5WEXC

- Claim does not qualify for Medicare payment due to principal diagnosis code billed
- Avoiding/Correcting this error
  - Ensure all Medicare coverage, documentation and medical necessity requirements met before billing claim
    - Review current National Government Services LCDs and Billing and Coding Articles
    - Look for typos and transposed numbers
  - If additional medical circumstances exist or more specific diagnosis code appropriate, indicate when submitting appeal

Denial Reason Code 56900

- Requested medical records not received within 45-day time limit; therefore, unable to determine medical necessity of services billed
  - Automatic denial – documentation not received within 45 days of date on ADR
- Avoiding/Correcting this error
  - Respond to ADR letters promptly – if sending close to due date, FISS may not be updated in time to avoid denial
  - Utilize NGSConnex
    - Review list of incoming/current ADRs and note due dates
    - Easily upload documentation for ADRs instead of mailing
  - View ADRs online in FISS DDE
    - Hard-copy ADRs not sent for claims pending in status locations SB6099 or SB6098
    - Providers who cannot submit electronic attachments will see all claims requiring medical documentation in status/location SB6001

Denial Reason Code 54NCD

- Line level reason code indicates that none of the diagnosis codes on claim support medical necessity of the services
- Avoiding/Correcting this error
  - Review coverage guidelines for service being denied to ensure medical necessity of services being provided to beneficiary
  - Review Submit an Adjustment to Correct Claims Partially Denied by Automated LCD-NCD Denials article on our website under Appeals tab

Denial Reason Code 52MUE

- All line items on claim have units of service exceeding medically reasonable daily allowable frequency
  - Excess charges due to units of service greater than maximum allowable may not be billed to beneficiary
  - This provision cannot be waived nor subject to ABN
- Avoiding/Correcting this error
  - When you believe medical records support that denied services were reasonable and medically necessary, you have right to submit appeal
  - Review CMS MUE file prior to claim submission
    - MUE files updated on quarterly basis – ensure referencing appliable file for DOS
    - If units rendered exceed allowed units for that service, determine whether excess units rendered and billed correctly

Denial Reason Code 55B00

- Claim denied after review because plan of treatment missing evidence of physician supervision/evaluation not documented
- Avoiding/Correcting this error
  - Always ensure complete documentation submitted and documentation supports services billed
  - Review appropriate chapter(s) of CMS IOM Publication 100-02, *Medicare Benefit Policy Manual* for your facility type for coverage and documentation requirements

Denial Reason Code 55B31

- Medical review denial for services not documented in medical records (incomplete/insufficient information)
- Avoiding/Correcting this error
  - Always ensure complete documentation submitted and documentation supports services billed
  - Review appropriate chapter(s) of CMS IOM Publication 100-02, *Medicare Benefit Policy Manual* for your facility type for coverage and documentation requirements

Denial Reason Code 55S08

- Insufficient documentation to support that beneficiary had three-day qualifying inpatient hospital stay prior to admission to SNF and no waiver indicated
- Avoiding/Correcting this error
  - No action necessary if denial was desired outcome
  - Three-day qualifying hospital stay billed with OSC 70 and inpatient hospital stay dates
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 8, Section 20.1
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 6, Section 30

Denial Reason Code 55S25

- SNF claim denied for no MDS found in repository
- Avoiding/Correcting this error
  - Ensure staff properly completes and submits MDS
  - Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual
  - CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 6, Section 6.1.4
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 8, Section 30

Denial Reason Code 55S29

- Documentation missing for services billed
- Avoiding/Correcting this error
  - Always respond to ADRs with proper and thorough documentation to support services billed
  - Review appropriate chapter(s) of CMS IOM Publication 100-02, *Medicare Benefit Policy Manual* for your facility type for coverage and documentation requirements

Denial Reason Code 55S33

- Documentation submitted did not include required certifications and recertifications for SNF stay
- Avoiding/Correcting this error
  - Ensure familiarity and compliance with Medicare coverage requirements
    - CMS IOM Publication 100-01, Medicare General Information, Eligibility and Entitlement, Chapter 4, Section 40
    - CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 8, Section 40
    - 42 CFR § 424.20 - Requirements for post-hospital SNF care

Denial Reason Code 59091

- TOB 11X claim billed with procedure code 5A05121 but missing appropriate diagnosis code for hyperbaric oxygen therapy
- Avoiding/Correcting This Error
  - Ensure all Medicare coverage, documentation and medical necessity requirements met before billing claim
    - NCD – Hyperbaric Oxygen Therapy (20.29)
    - CMS IOM Publication 100-03, *Medicare National Coverage Determinations Manual*, Part 1, Section 20.29
  - If you disagree with denial, you have the right to appeal

Denial Reason Code 59118

- TOB 11X claim denied for one of the following reasons:
  - Claim contains valid ICD-10 procedure code but no valid ICD-10 diagnosis code for PTA of carotid artery
  - One of the valid ICD-10 procedure codes present and ICD-10 diagnosis code I672 and one code from the ICD-10 diagnosis code list for PTA and stenting not all present on/after ICD-10 effective date
- Avoiding/Correcting This Error
  - Ensure all Medicare coverage, documentation and medical necessity requirements met before billing claim
    - *CMS National Coverage Determination (NCD)* 20.7 Percutaneous Transluminal Angioplasty (PTA)
    - CMS IOM Publication 100-03, *Medicare National Coverage Determinations* Manual, Chapter 1, Part 1, Section 20.7
  - If you disagree with denial, you have the right to appeal

Denial Reason Code 59132

- HCPCS G0108 OR G0109 billed on 71X TOB (RHC)
- Avoiding/Correcting This Error
  - Medicare does not cover DSMT services in RHCs
  - NCD – Diabetes Outpatient Self-Management Training (40.1)
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 70.5

Denial Reason Code 59144

- TOB 11X with discharge date on/after 03/06/24
  - Claim contains clinical trial ICD-10 procedure code and diagnosis code but does not contain
    - Condition Code 30
    - Value Code D4 with valid eight-digit Clinical Trial Number
    - Clinical Trial Diagnosis Code Z006
- Avoiding/Correcting this error
  - Make sure to review Clinical Trials information and prepare claims correctly

Denial Reason Code 59301

- TOB 11X with discharge date on/after 10/1/23
  - Claim contains one of the payable procedure codes but does not meet diagnosis code criteria
- Avoiding/Correcting this error
  - Ensure all Medicare coverage, documentation and medical necessity requirements met before billing claim
    - NCD - Implantable Cardioverter Defibrillators (ICDs) (20.4)

Denial Reason Code 5ND07

- Procedure and/or diagnoses requirements not met for *National Coverage Determination (NCD) 100.1 Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity*
- Avoiding/Correcting this error
  - Ensure all Medicare coverage and medical necessity requirements met prior to billing
    - CMS IOM Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 2, Section 100.1 "Bariatric Surgery for Treatment of Co-morbid Conditions Related to Morbid Obesity"
    - MLN Matters® *MM10086: ICD-10 Coding Revisions to National Coverage Determinations (NCDs)*
      - Contains spreadsheet link with coding updates for NCD 100.1

Resources & References

- LCDs, Billing and Coding Articles and NCDs
  - National Government Services Medical Policies/LCDs
  - CMS Medicare Coverage Database
  - CMS IOM Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*
- Appeals
  - Appeals section
  - Original Medicare (Fee-for-service) Appeals
- Correct Coding
  - Medicare National Correct Coding Initiative (NCCI) Edits
  - Medically Unlikely Edits

Top Rejection Reason Codes

Rejections: October – December 2024

Jurisdiction K

CAH	CMHC	CORF/ ORF	ESRD	FQHC	IP Hospital	OP/ OPPS	RHC	SNF IP	SNF OP	Swing Bed
38105	39929	39929	U5233	U5233	38005	38200	38200	38200	U5233	19904
39929	W7027	C7010	U5210	39721	38200	39929	38031	U5607	39929	38001
38200	-	38200	U538Q	38312	U5233	U5233	U5233	19904	38200	11313

Jurisdiction 6

CAH	CMHC	CORF/ ORF	ESRD	FQHC	IP Hospital	OP/ OPPS	RHC	SNF IP	SNF OP	Swing Bed
38105	-	39929	U5233	U5233	38200	39929	38200	7B908	U5233	19904
39929	-	U5233	10418	38312	38005	U5233	U5233	U5607	39929	38200
U5233	-	38200	U5210	U5210	38017	34538	C7010	C7010	C7010	38001

Rejection Reason Code U5233

- Services on claim fall within or overlap MA HMO enrollment period
  - For inpatient PPS claims, admission date falls within MA HMO enrollment period
- Avoiding/Correcting this error
  - Verify admission date, from, and through dates on claim
  - Compare admission date, from, and through dates on claim to MA HMO entitlement dates
  - Determine if billed correctly for your facility type and take appropriate action

Rejection Reason Code U5233 – Facility Actions

- Outpatient facilities and inpatient/non-inpatient PPS and IRF hospitals or LTCH
  - Services within HMO enrollment period must be submitted directly to HMO
- Non-PPS inpatient hospital or inpatient SNF
  - Claims overlap effective or termination date of HMO period must be split and services billed to HMO and Medicare according to coverage dates
- Non-teaching IPPS hospitals, IRFs and LTCHs
  - Required to submit informational no-pay bills with covered charges and CC 04
  - IRF providers use appropriate HIPPS code based on PAI assessment accompanied by OC 50 and corresponding assessment date when submitting no-pay claims

Rejection Reason Code U5233 – Facility Actions (cont.)

- IPPS, IRF, and LTCH and SNF (covered services)
  - Services during HMO enrollment period submitted to MAC as informational no-pay encounter claim for benefit period purposes
  - IPPS acute care teaching hospitals billing for IME payment must bill with both CC 04 and CC 69 and with covered charges
  - SNF-covered services during HMO enrollment period billed using CC 04 with covered charges

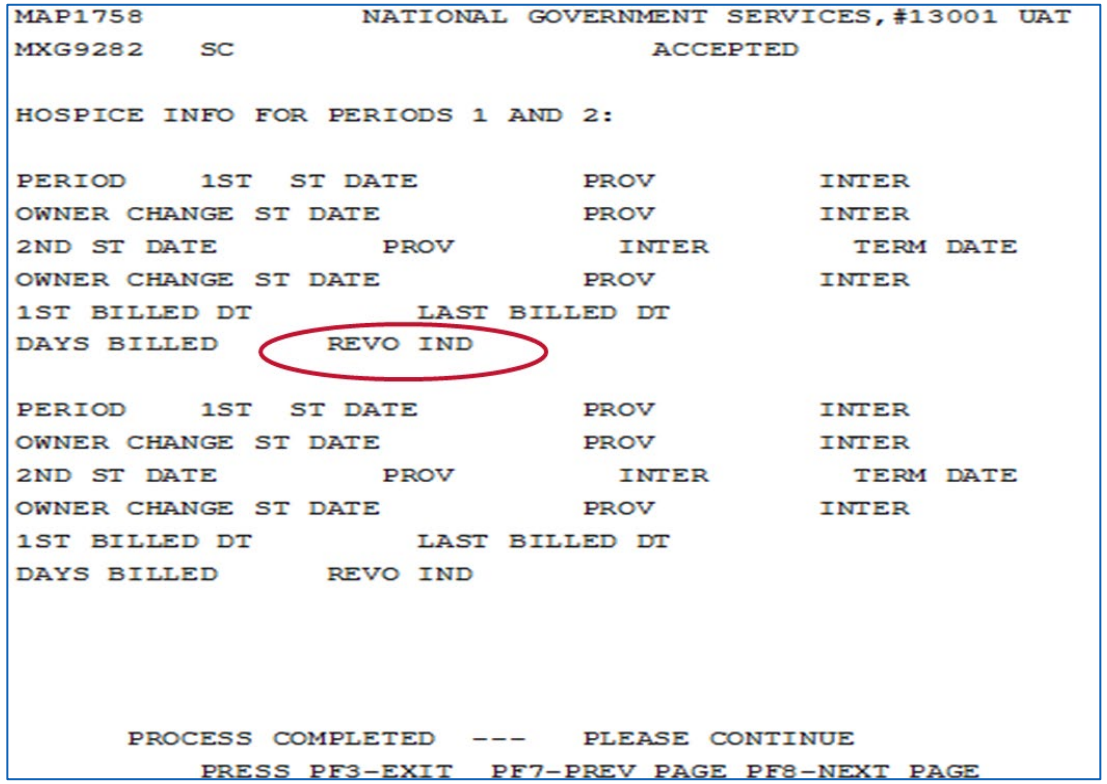
Rejection Reason Code 39929

- Each line of charges on this claim rejected and/or rejected and denied
- Avoiding/Correcting this error
  - Verify line level rejection information to determine rejection for each claim line and resubmit as appropriate
    - Line level reason code(s) appear on the right view (PF11) of claim page 2 (MAP171D)

Rejection Reason Code C7010

- Service dates on claim overlap hospice election period and CC 07 not present
- Avoiding/correcting this error
  - Verify if beneficiary elected Medicare hospice benefit via FISS, NGSConnex, or IVR
  - Determine if services rendered related to terminal illness
    - If related, bill hospice agency
      - May not pay if services weren't coordinated with agency, beneficiary not liable!
    - If not related, bill traditional Medicare and place CC 07 on claim
  - Special rules for certain situations
    - Beneficiary elects or revokes Medicare hospice benefit during inpatient stay
    - Hospice beneficiary also enrolled in MAO plan

CWF Hospice Election Period MAP 1758



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MAP1758              NATIONAL GOVERNMENT SERVICES,#13001 UAT
MXG9282   SC                          ACCEPTED

HOSPICE INFO FOR PERIODS 1 AND 2:

PERIOD    1ST  ST DATE          PROV          INTER
OWNER CHANGE ST DATE           PROV          INTER
2ND ST DATE          PROV          INTER          TERM DATE
OWNER CHANGE ST DATE           PROV          INTER
1ST BILLED DT          LAST BILLED DT
DAYS BILLED      REVO IND

PERIOD    1ST  ST DATE          PROV          INTER
OWNER CHANGE ST DATE           PROV          INTER
2ND ST DATE          PROV          INTER          TERM DATE
OWNER CHANGE ST DATE           PROV          INTER
1ST BILLED DT          LAST BILLED DT
DAYS BILLED      REVO IND



      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
```

- Review hospice election period information
  - Start Date
  - Billed Date(s)
  - Provider number
  - Revocation indicator code
    - Blank/0 = No revocation on file
    - Code 1 = Revoked by beneficiary
    - Code 2 = Revoked by MAC

Rejection Reason Code C7010 - Resources

- CMS Hospice page
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 9, Section 40.1
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 11, Section 30.4
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 100.5

Rejection Reason Code U5210

- Beneficiary's entitlement for Medicare coverage terminated prior to DOS
- Avoiding/Correcting This Error
  - Verify eligibility using self-service tools before submitting claim
  - Determine effective dates of Medicare coverage – can be different for Part A and Part B
    - Part A coverage for inpatient services
    - Part B coverage for outpatient services (may have multiple effective dates)

Rejection Reason Code 13313

- One of the following applies:
  - Three-day qualifying stay requirement not met (OSC 70 thru date not three or more days later than from date)
  - Subsequent 183, 184, 213 and 214 TOB when initial 182/212 or 180/210 TOB rejected with reason code 13303
- Avoiding/Correcting this error
  - Verify information billed
  - If appropriate, make corrections and submit new claim

Rejection Reason Code 19904

- Claim does not indicate that beneficiary had three-day qualifying hospital stay (QHS) prior to admission to SNF/swing bed or hospital stay prior to beneficiary's Part A effective date
- Avoiding/Correcting this error
  - Verify claim TOB
  - Verify if beneficiary had three-day QHS and if yes:
    - First claim in continuing stay - submit cancel adjustment and once finalized submit new claim with OSC 70 and dates
    - Claims without patient status 30 - submit adjustment (217 TOB) to add OSC 70 and dates

Rejection Reason Code 34538

- Claim submitted as Medicare primary but open MSP Working Aged record (VC = 12; Payer Code = A) in CWF and claim did not contain reason Medicare primary
- Avoiding/Correcting This Error
  - Do not resubmit claims as they will be rejected as duplicates
  - If MSP record correct, submit claim to primary EGHP
    - Once you receive payment, submit adjustment (TOB XX7) to this claim to change it to MSP claim
  - If MSP record is incorrect because beneficiary and/or spouse retired
    - Submit adjustment to this claim to change it to Medicare primary (as originally billed) and code beneficiary's retirement date with OC 18 and/or spouse's retirement date with OC 19

MSP Resources and References

- Collect and Report Retirement Dates on Medicare Claims
- Correct or Adjust a Claim Due to an MSP-Related Issue
- Prevent an MSP Rejection on a Medicare Primary Claim

Rejection Reason Code 39721

- Requested non-medical information not received timely
- Avoiding/Correcting This Error
  - To have claim considered for payment, submit new electronic billing with requested information
  - Ensure your facility has processes in place for timely responses to medical and non-medical ADRs

Rejection Reason Code 7B908

- No Medicare payment can be made since Medicare beneficiary's benefits were exhausted relative to this SNF claim
- Avoiding/correcting this error
  - If claim rejection was not desired outcome, submit adjustment to correct

Rejection Reason Code U538Q

- Services billed while beneficiary unlawfully present in US
- Avoiding/Correcting this error
  - Verify eligibility using self-service tools before submitting claim
  - If appropriate, make corrections and submit claim adjustment

Rejection Reason Code U5607

- Admit date less than from date and no previously processed history claims present with same admit date, same provider number and patient status 30
- Avoiding/Correcting this error
  - Verify MBI, provider number, admit date, DOS and patient status on this claim and previously processed claim(s) for this admission
  - If this claim is in error, correct and resubmit.
  - If previously processed claim(s) incorrect, submit cancel for claim(s) in error
    - Resubmit claim(s) for stay in sequential order after receiving RA for each claim as submitted

Avoiding/Correcting Duplicates & Overlaps

- Before submitting claims
  - Verify DOS and ensure not previously submitted
    - Review RA and/or use self-service tools
  - Ensure all charges from coordinating departments listed on claim
- When duplicate or overlap rejection received
  - Verify information billed on your claim
  - Determine whether previously processed claims needs to be adjusted, cancelled or appealed
    - Your facility or may need to contact overlapping facility
- All additions and/or corrections to processed claims must be adjustment claims, not new claims

Rejection Reason Code 38200

- Claim exact duplicate of previously submitted claim
  - MBI number
  - TOB (all three positions of any TOB)
  - Provider number
  - DOS
  - Total charges (0001 revenue line)
  - Revenue code, HCPCS and modifiers (if required by revenue code file)

Rejection Reason Codes – Inpatient

- Reason code 38001
  - IP claim contains DOS equal to or overlapping denied IP claim
- Reason code 38005
  - Duplicate of previously submitted IP claim where TOB equals 11X, 18X OR 41X and the following same on both claims:
    - MBI
    - Provider number
    - Statement from and thru DOS
    - Revenue code
    - HCPCS and modifiers (if required by revenue code file)
- Reason code 38017
  - IP claim contains service dates that overlap previously processed IP claim (TOB 11X, 18X OR 41X)

Rejection Reason Code 10418

- Claim-level reject code, all revenue lines rejected by one of the following CWF line-item reject code(s)
  - C729A - LIDOS equals LIDOS with same revenue code(s) HCPCS code(s), modifier code(s) of an ESRD claim (72x)
  - C729B - Revenue code 0821, 0831, 0841, and/or 0851 present and LIDOS equals LIDOS of an OP claim (13X or 85X) with HCPCS code G0257
  - C729C - For RDF claim ESRD (72X) LIDOS within admission and discharge date of inpatient claim (11X)
  - C729I - For RDF claim ESRD (72X) LIDOS within from and thru date of IP Part B claim (12X)

Rejection Reason Code 38312

- FQHC PPS claim with LIDOS matching another LIDOS on previously submitted claim and all of the following match:
  - MBI
  - PTAN
  - LIDOS

Rejection Reason Code 38031

- OP claim possible duplicate to previously submitted OP claim for same provider number
  - Statement from and thru dates overlap
  - At least one revenue code line matches
  - Same diagnosis code(s)

Rejection Reason Code 38031 - FQHC

- 73X/77X claims
  - Diagnosis codes same or different
  - HCPCS code matches but different revenue code
  - HCPCS code modifier LT, RT, E1-E4, FA, F1-F9, TA or T1-T9 and either claim contains one of these modifiers (or blank), same HCPCS code and same DOS
  - Other HCPCS code modifiers, at least one HCPCS code same (or blank)
- History claim 71X and incoming claim (71x/73x/77x)
  - Same diagnosis, beneficiary, DOS, and provider
  - Even if revenue code line matching history claim missing LIDOS or HCPCS code on either claim

Rejection Reason Code 38105

- Outpatient claims cannot overlap dates of another claim with different TOBs but same provider number, regardless if same revenue code line(s)
  - TOBs 13X, 14X, 83X, 85X
  - Exceptions:
    - One claim only for pap smear or mammography screening
    - One claim has OSC 74 and other claim within those OSC dates
    - One claim for repetitive Part B services only (CAH 85X TOB)

Top RTP Reason Codes

RTPs: October – December 2024

Jurisdiction K

CAH	CMHC	CORF/ ORF	ESRD	FQHC	IP Hospital	OP/ OPPS	RHC	SNF IP	SNF OP	Swing Bed
34963	31576	34963	U5065	34963	38119	34977	34963	38119	U5065	38119
32402	W7191	U5065	36618	W7088	U5065	34963	E0401	38117	31255	38117
32391	W7118	31408	34942	31836	38117	38038	32019	U5606	31413	32242

Jurisdiction 6

CAH	CMHC	CORF/ ORF	ESRD	FQHC	IP Hospital	OP/ OPPS	RHC	SNF IP	SNF OP	Swing Bed
34963	-	34963	U5065	34963	U5065	34977	39910	38119	34963	32242
32402	-	U5065	32418	31836	32242	34963	W7072	38117	U5065	12302
32372	-	30993	36220	37098	30993	38038	32402	12302	32415	13314

RTP Tips

- Check RTPs routinely
  - Daily, every other day or weekly, based on claim volume
- RTPs not considered "received" by Medicare
  - Must be resubmitted before passes timely filing period
- Review and correct RTPs in FISS DDE Claims Correction submenu
  - Option 03 from FISS DDE Main Menu

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MAP1704          NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 12/18/19
MXG9282          CLAIM AND ATTACHMENTS CORRECTION MENU     A20201AF 11:58:07

                          CLAIMS CORRECTION
                  INPATIENT                21
                  OUTPATIENT               23
                  SNF                      25
                  HOME HEALTH              27
                  HOSPICE                  29
                         CLAIM ADJUSTMENTS    CANCELS
                  INPATIENT                30       50
                  OUTPATIENT               31       51
                  SNF                      32       52
                  HOME HEALTH              33       53
                  HOSPICE                  35       55
                         ATTACHMENTS
                  PACEMAKER                42
                  AMBULANCE                43
                  HOME HEALTH              45


   ENTER MENU SELECTION:
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RTP Reason Code 34963

- One of the following applies:
  - Attending physician on claim page 05 invalid or not present in PECOS Enrolled Physicians file (Type C Records)
  - Attending physician NPI present on PECOS Enrolled Physicians file but first four digits of last name do not match
  - Through DOS on claim equal or greater than Termination Date on PECOS Enrolled Physician Inquiry screen
- Avoiding/Correcting this error
  - Review PECOS to ensure information correct, update if necessary
  - Verify billing
    - Note – For therapy claims, MD signing treatment plan can be used as attending
  - If appropriate, correct attending physician information on claim and resubmit (PF9)

RTP Reason Code U5065

- Claim from date prior to MBI effective date on CWF crosswalk file
- Avoiding/Correcting this error
  - Check/verify beneficiary's entitlement dates in CWF
  - Verify MBI number
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 38117 & 38119

- Claim DOS part of continuing stay and claim immediately preceding DOS on claim not processed
- Avoiding/Correcting this error
  - All inpatient SNF and non-PPS claims must be submitted one month at a time, in sequential order
  - Subsequent claims in stay should not be submitted until prior month's claim processed and finalized (appears on remittance advice)
  - Before submitting next claim in sequence, verify status of prior month's claim
    - FISS Inquiry Claim Summary option - FISS DDE Provider Online Guide
    - IVR
    - *NGSConnex User Guide*
  - Once prior claim shown on remittance advice, resubmit RTP claim (PF9)

RTP Reason Code 32402

- CPT or HCPCS code reported on claim not billed with valid revenue code for claim DOS
- Avoiding/Correcting This Error
  - Verify whether CPT/HCPCS code and revenue code combination valid
  - From FISS DDE Main Menu, select 01 (Inquiries) and then 14 (HCPCS Code)/1E (New HCPCS Screen)
    - Revenue code(s) must be reported with CPT/HCPCS code displayed
    - If several revenue codes displayed, choose most appropriate one
    - If revenue code field blank, any revenue code may be used
  - If appropriate, correct claim to report appropriate HCPCS/CPT code and resubmit (PF9)

RTP Reason Code 12302

- Sum of covered and non-covered days must equal total number of days in statement covers period (DOS)
- Avoiding/Correcting this error
  - Verify patient status
    - Status 30 (still patient), count through date in day calculation
    - Same day transfers (same admission, from and through date, CC 40 present and patient status of 02, 03, 05, 50, 51, 61, 62, 63, 65, 66, 71, 72, 82, 83, 85, 89, 90, 91, 93 or 94) - claim must show one non-covered day
    - If not same day transfer, but same from and through dates, then claim must show one covered day
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 13314

- One of the following applies
  - OSC 70 from date greater than claim admission from date
  - OSC 80 (prior same-SNF stay) from date greater than claim admission from date and PPS indicator equal to N
- Avoiding/Correcting this error
  - Review OSC and dates entered on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 30993

- Claim submitted with MBI and MBI/HIC combination not found in MBI cache or CWF MBI Crosswalk
- Avoiding/Correcting this error
  - Review MBI entered on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 31255

- TOB 12X, 13X, 22X, 23X, 34X, 74X, or 75X
- Claim contains revenue code 42X and OC 29 missing or claim contains OC 29 and revenue code 42X missing
- Avoiding/Correcting this error
  - Review revenue codes and OCs entered on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 31408

- Claim contains revenue code series 42X and OC 35 missing, or OC 35 present and no billing line in revenue code series 42X
- Avoiding/Correcting this error
  - When billing for PT services (revenue code series 42X), OC 35 required to indicate date treatment started
  - Review revenue codes and OCs entered on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 31413

- Claim contains revenue code series 44X and OC 45 missing, or OC 45 present and no billing line in revenue code series 44X
- Avoiding/Correcting this error
  - When billing for speech/language pathology services (revenue code series 44X), OC 45 required to indicate date treatment started
  - Review revenue codes and OCs entered on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 31576

- CMHC TOB 76X required to bill valid community mental health revenue code
  - 001, 250, 430-439, 78X, 900, 904, 914-916, 918 or 942
- Avoiding/Correcting this error
  - Review TOB and revenue code(s) entered on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 31836

- HCPCS code on revenue code line has status code of 'M', but one of the following applies
  - TOB not equal to 85X
  - TOB equals 85X but revenue code not equal to 96X, 97X or 98X
- Avoiding/Correcting this error
  - Review TOB entered on claim
  - Review billing claim line(s) for appropriate revenue code(s)
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 32019

- One of the following applies:
  - Statement covers through date on claim greater than provider's Medicare termination date
  - For TOB 11X, 18X, 21X, 81X, or 82X, statement covers through date on claim greater than termination date plus 30 days for provider
- Avoiding/Correcting this error
  - Review DOS entered on claim
  - Review provider file for termination date
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 32242

- Revenue code non-billable for this TOB and covered charges on claim greater than zero (0)
- Avoiding/Correcting this error
  - Review revenue codes entered on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 32372

- One of the following applies:
  - ZIP code in offsite ZIPCD field page 3 (MAP1713) does not match any valid ZIP codes in our files for off-site clinics
  - Required HPSA/PSA modifier (QB, QU, AQ or AR) not present on claim
- Avoiding/Correcting this error
  - For ZIP code, correct or remove offsite zip code and enter main office ZIP code in facility ZIP code field and resubmit (PF9)
  - Review billing and if appropriate, correct and resubmit (PF9)

RTP Reason Code 32391

- Method II CAH provider (XX1300-XX1399) billing professional services revenue code 96X, 97X, 98X, but not 964
  - Claim contains valid HCPCS code and DOS, but no PC/TC indicator present for HCPCS code billed
- Avoiding/Correcting this error
  - Review revenue code(s) and HCPCS code(s) entered on claim
    - If claim contains unlisted HCPCS code(s), update claim with more specific HCPCS code for services rendered
    - If a more specific HCPCS code cannot be identified, contact the American Medical Association to request valid code be assigned for such services
    - For HCPCS identified as restricted or carrier priced under the MPFSDB, contact PCC for coverage
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 32415

- CC A6 required when billing for vaccines and/or their administration
- Avoiding/Correcting this error
  - Review coding on claim
  - If appropriate, correct and resubmit (PF9)
  - Additional resources:
    - MLN006559 – Medicare Preventive Services
    - Vaccine Pricing
    - Flu Shot
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 10

RTP Reason Code 32418

- Units more than one for automated profile test, hematology profile test or organ and disease panel HCPCS code
  - Certain laboratory HCPCS codes subject to bundling rules for chemistries
- Avoiding/Correcting this error
  - Review coding on claim and determine if bundled code should be billed instead of individual codes
    - NCCI for Medicare
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 34942

- 72X TOB (ESRD) and one of the following applies
  - Latest LIDOS billing revenue code 0821 does not contain modifier V5, V6 or V7
  - Incorrect or missing CC, HCPCS code(s) and diagnosis code for acute kidney injury (AKI) dialysis claim
- Avoiding/Correcting this error
  - Review coding on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 34977

- TOB 13X or 14X and practice address on claim does not exactly match address on Provider Practice Address Query screen (MAP1AB2) in FISS DDE or PECOS
- Avoiding/Correcting this error
  - Verify address billed and ensure address matches exactly
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 36220

- Diagnosis N186 required unless influenza vaccine, PPV, or hepatitis B only services billed
- Avoiding/Correcting this error
  - Review diagnosis coding and services billed on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 36618

- ESRD Pricer return code equal to 71, height for VC A9 exceeds 300 cm
- Avoiding/Correcting this error
  - Review amount entered in VC A9
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 37098

- FQHC PPS claim (TOB 77X) supplemental rate not present for MA plan
- Avoiding/Correcting This Error
  - Verify billing
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 38038

- OPPS TOB (12x, 13x, 14x, 76x, 75x, 34x) or any claim containing CC 07 cannot have overlapping dates when provider numbers same unless CC G0, 20 or 21 present
- Avoiding/Correcting This Error
  - Submit adjustment claim to add any charges to first claim processed
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 38136

- Statement DOS either equal or overlap previously processed claim from same provider with revenue code 300-319
  - Both claims contain same HCPCS code and same LIDOS
    - 80054, 80058, 82040, 82247, 82248, 82250, 82251, 82374, 84075, 84450, or 84460
- Avoiding/Correcting this error
  - Review previously processed claim
  - Verify DOS and HCPCS code(s) billed
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 39910

- RTP for one or more of the following reasons:
  - TOB must be 72X if modifier CD, CE or CF on claim
  - Revenue code 881 does not require HCPCS code
  - Modifier CG required on RHC (TOB 71X) claim on revenue code line 52X or 900
    - MLN Matters® SE1611: *Rural Health Clinics (RHCs) Healthcare Common Procedure Coding System (HCPCS) Reporting Requirement and Billing Updates*
  - Do not include charges for vaccines on RHC or FQHC claim (not visit if only service)
  - TOB 12X invalid for billing HCPCS G9141 for vaccines (H1N1) or any flu vaccine codes
  - Revenue code 651, 652, 655 or 656 required on TOB 81X and 82X
  - Claim for same-day transfer requires same admission, from and through dates, patient status 02, 03 or 04 and CC 40
  - SNF/SB PDPM claims following interrupted stay or non-skilled LOC stays greater than three days require new assessment and new admit date
- Avoiding/Correcting this error
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code E0401

- TOB either
  - Invalid
  - Inconsistent with provider number (PTAN)
  - Inappropriate when billing revenue code 403
- Avoiding/Correcting this error
  - Verify TOB, PTAN and revenue codes billed on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code U5606

- Admit date less than from date and no record of prior processed claim in CWF with through date one day prior to from date on this claim
- Avoiding/Correcting this error
  - Review previously processed claims for this beneficiary
    - Adjustments to previously processed claims may be required to allow this claim to process
  - Review DOS entered on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code W7072

- Service not billable to MAC
- Avoiding/Correcting this error
  - Review HCPCS code(s) entered on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code W7088

- TOB 77X (FQHC) submitted and at least one of the specific payment codes G0466 - G0470 not present
- Avoiding/Correcting this error
  - Review CPT/HCPCS coding on claim
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 60.2 for descriptions and billing requirements
    - Federally Qualified Health Centers (FQHC) Center
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code W7191

- PHP service reported without PHP primary service on same day of PHP claim
- Avoiding/Correcting this error
  - Review HCPCS code(s) entered on claim
    - Refer to “PH Primary” field in the Data_HCPCS file for applicable codes
      - I/OCE Quarterly Release Files
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code W7118

- Invalid bill type
- Avoiding/Correcting this error
  - Review TOB entered on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code W7218

- Invalid TOB for service(s) on claim
- Avoiding/Correcting this error
  - Ensure billing correct TOB, revenue code(s) and HCPCS/CPT code(s)
  - If appropriate, correct and resubmit (PF9)

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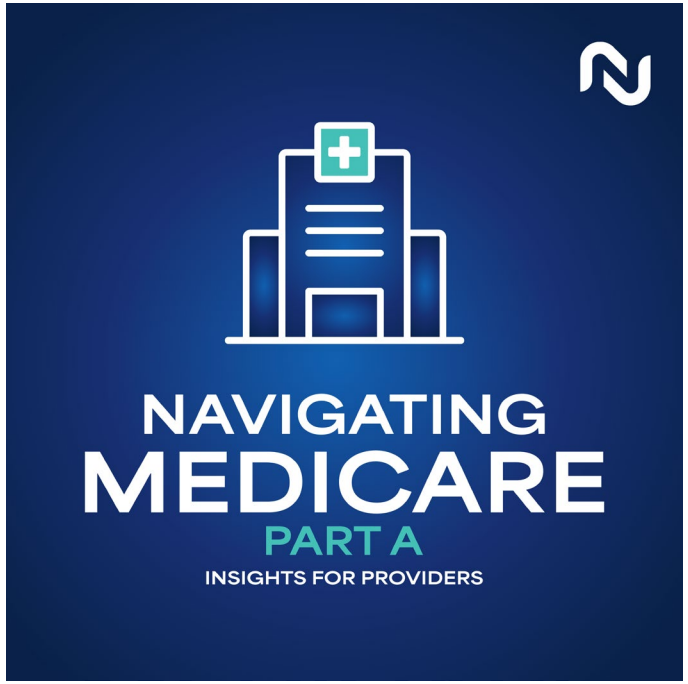

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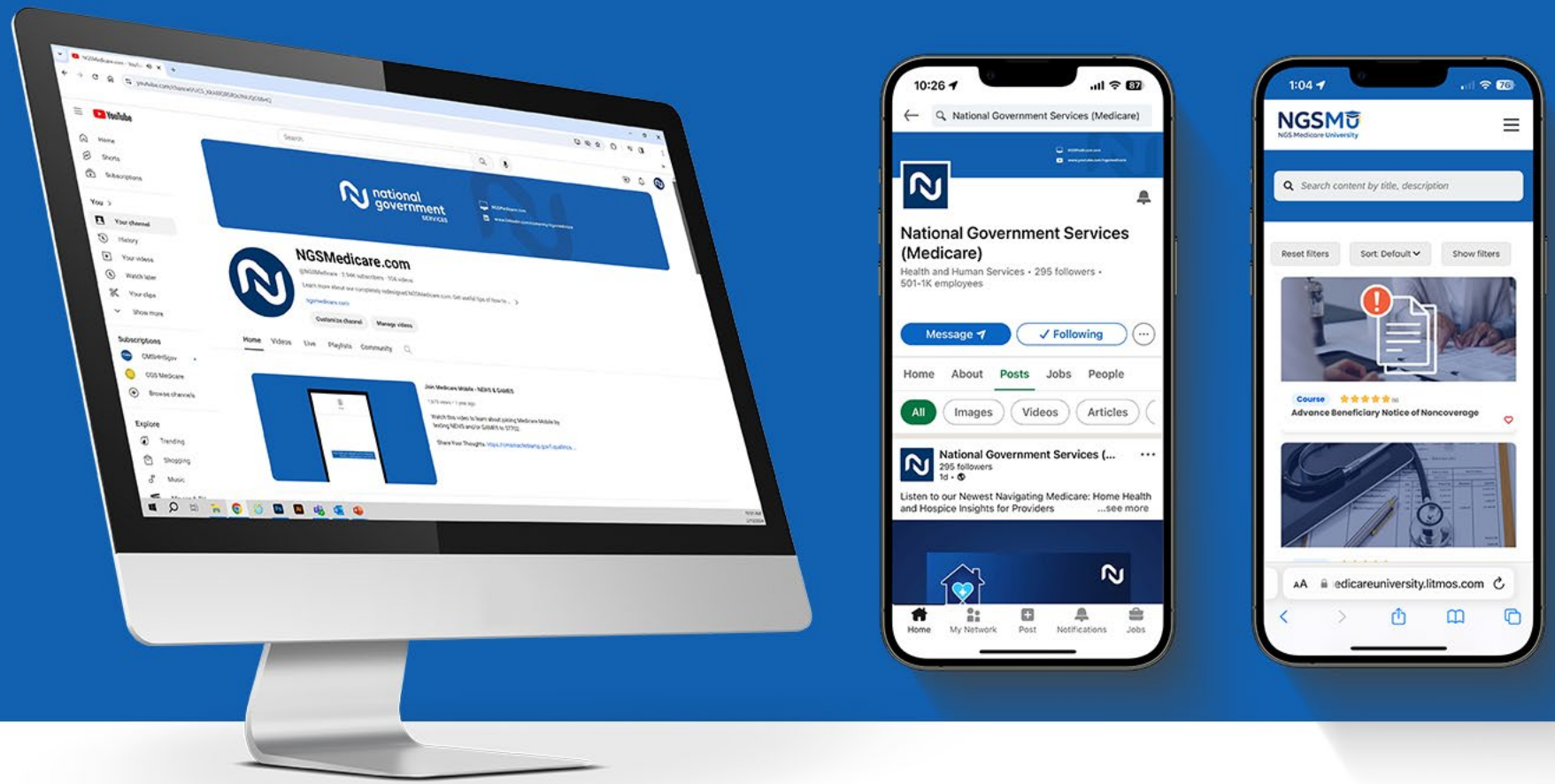

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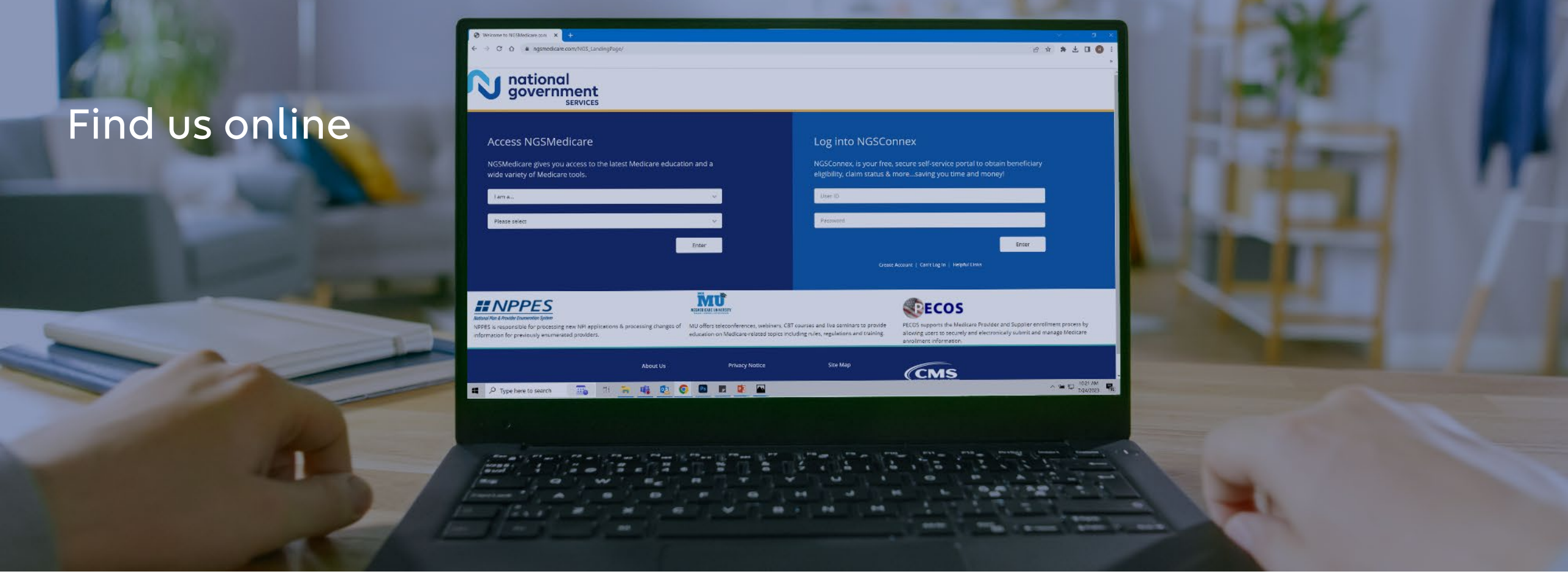

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