national government SERVICES

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Hospital, CMHC, CORF/ORF and ESRD Facilities Quarterly Top Claim Errors

4/30/2025

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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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

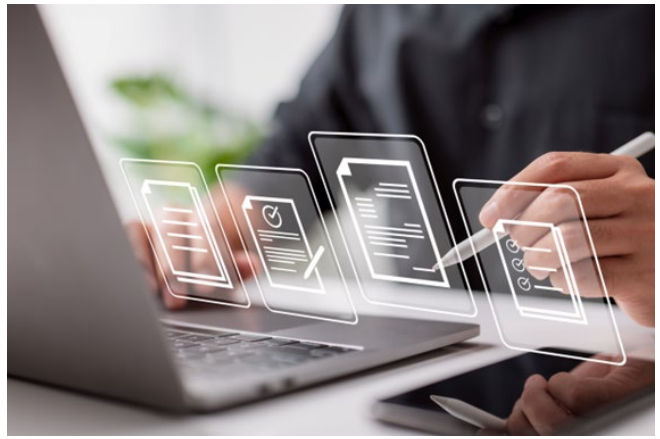
- Provider Outreach and Education Consultants
  - Andrea Freibauer
  - Jean Roberts, RN, BSN, CPC

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 first time

Avoid expense of resubmitting, adjusting, or appealing incorrect claims

Time

Utilize staff time more efficiently by avoiding “claim error rollercoaster” – researching and fixing errors

Ensure claims 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 located in processing
  - Reason codes – indicate status of claim
- When transaction/claim passes FISS edits, subject to CWF edits
  - Nationwide repository for Medicare beneficiary and claim information
  - If claim passes CWF edits, returns to FISS for finalization/adjudication
- After claims finalized/adjudicated, providers need to
  - Identify claim payments, rejections and denials
  - Determine if next steps needed for rejections and denials
    - Utilize FISS DDE, RA 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 returned to us in FISS (PF9)
  - Providers must check RTP claims often as we don't consider them received
- 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?

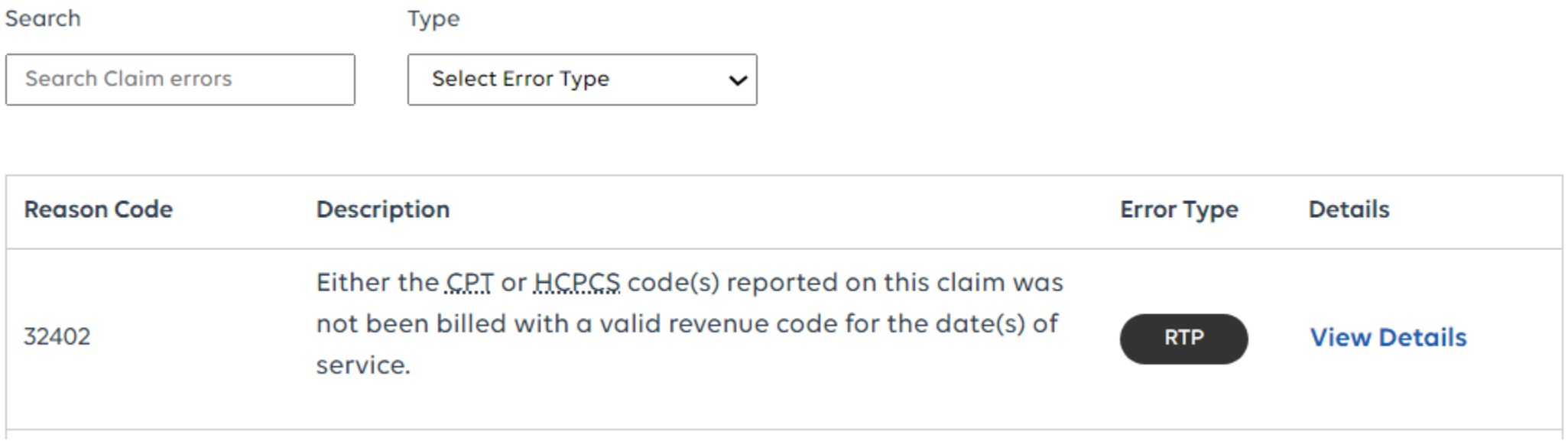
- Five-digit codes that direct outcome of claim edit or process
- Review reason code to determine next steps
  - Correct claim online and resubmit
  - Appeal claim
  - Adjust claim
  - Submit new claim
  - No action may be needed

Locating Reason Codes in FISS DDE

- Reason code file
  - Inquiries (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)

Tips For 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: January – March 2025

Jurisdiction K

CMHC	CORF/ ORF	ESRD	IP Hospital	OP/ OPPS
39928	39928	-	59118	39928
-	-	-	59301	5WEXC
-	-	-	59138	54NCD

Jurisdiction 6

CMHC	CORF/ ORF	ESRD	IP Hospital	OP/ OPPS
39928	39928	-	59118	39928
-	-	-	59138	5WEXC
-	-	-	59301	54NCD

Denial Reason Code 39928

- Each line of charges 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 our current LCDs and Billing and Coding Articles
  - If you disagree with denial, you have appeal rights

Denial Reason Code 59118

- TOB 11X claim contains valid ICD-10 procedure code but one of following applies
  - Does not contain valid ICD-10 diagnosis code for PTA of carotid artery
  - ICD-10 diagnosis code I672 and one code from ICD-10 diagnosis code list for PTA and stenting not all present
- Avoiding/Correcting this error
  - Ensure all Medicare coverage, documentation and medical necessity requirements met before billing claim
    - CMS 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 appeal rights

Denial Reason Code 59138

- TOB 11X claim with DOS on/after 3/6/2024 denied due to NCD 110.23 (formerly 110.8.1)
- Claim contains valid ICD-10 procedure code per NCD and either
  - "CR13604" in Remarks and diagnosis code D46.A, D46.B, D46.C, D46.0, D46.1, D46.4, D46.9, D46.20, D46.21, D46.Z or D46.22 not present
  - "CR13604" not in Remarks and diagnosis codeD46.A, D46.B, D46.C, D46.0, D46.1, D46.4, D46.9, D46.20, D46.21, D46.Z or D46.22 present
- Avoiding/Correcting This Error
  - Ensure all Medicare coverage, documentation and medical necessity requirements met before billing claim
    - MLN Matters® *MM13604: National Coverage Determination 110.23: Allogeneic Hematopoietic Stem Cell Transplantation*
    - CMS Change Request 13939: *International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) - July 2025*
    - CMS IOM Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 2, Section 110.23
  - If you disagree with denial, you have appeal rights

Denial Reason Code 54NCD

- Line level reason code indicating billed diagnosis codes do not support medical necessity of 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 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 our current LCDs and Billing and Coding Articles
    - Check for errors such as typos or transposed numbers
  - If additional medical circumstances exist or more specific diagnosis code appropriate, indicate when submitting appeal

Resources and 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
  - ICD-10

Top Rejection Reason Codes

Rejections: January – March 2025

Jurisdiction K

CMHC	CORF/ ORF	ESRD	IP Hospital	OP/ OPPS
39929	38200	U5233	38005	U5233
U5200	U5233	38065	38200	39929
U5233	39929	U5210	38017	38200

Jurisdiction 6

CMHC	CORF/ ORF	ESRD	IP Hospital	OP/ OPPS
-	39929	38065	38005	U5233
-	U5233	U5233	38200	39929
-	38032	34538	38017	34538

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
  - When submitting primary claim, report explanatory coding to indicate reason Medicare primary
  - Submit adjustment (TOB XX7); do not resubmit or rejects as duplicate
  - If MSP record correct, submit claim to primary EGHP
    - Once response received, submit adjustment to change claim to MSP/conditional
  - If MSP record incorrect because Medicare primary, submit adjustment to change back to primary and report explanatory coding
    - If no coding, refer beneficiary/other party to BCRC to change MSP record first

MSP Resources and References

- Collect and Report Retirement Dates on Medicare Claims
- Correct or Adjust a Claim Due to an MSP-Related Issue
- Correct a Beneficiary's MSP Record
- Prevent an MSP Rejection on a Medicare Primary Claim
  - Explanatory claim coding examples: OC 18 and beneficiary's retirement date and/or OC 19 and spouse's retirement date
- Prepare and Submit a Medicare Secondary Payer Claim
- Prepare and Submit an MSP Conditional Claim
- BCRC – Contacts
  - Provider should not contact BCRC to change MSP record

Rejection Reason Code 39929

- Each line of charges 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 right view (PF11) of claim page 2 (MAP171D)

Rejection Reason Code U5200

- Beneficiary not entitled to Medicare coverage for type of service billed on claim
- Avoiding/Correcting this error
  - Verify eligibility using self-service tools before submitting claim
  - If appropriate, correct information and submit new claim

Rejection Reason Code U5210

- Beneficiary's Medicare entitlement 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 IP services
    - Part B coverage for OP services (may have multiple effective dates)

Rejection Reason Code U5233

- Service dates on claim fall within or overlap MA HMO enrollment period
  - For IP 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

- All facilities
  - For services within effective and termination dates of MA HMO period
    - Submit to MA HMO plan
      - If OP facility, do not bill us, bill only MA HMO plan
      - If IP hospital paid under PPS and beneficiary not enrolled in MA HMO at admission, (enrolled later in stay), bill us rather than MA HMO
        - IP facilities paid under PPS = acute-care hospitals, IPFs, IRFs and LTCHs
- Non-PPS IP hospitals (CAHs, Cancer, Children's)
  - For services that overlap effective or termination dates of MA HMO period
    - Split services and bill MA HMO and us accordingly (per coverage dates)

Rejection Reason Code U5233 – Facility Actions (cont.)

- Hospitals submit informational claims after billing MA HMO
  - Follow Hospital Billing for Beneficiaries Enrolled in Option Code C Medicare Advantage Organization Plans
    - Non-teaching hospitals (acute-care, IRFs, LTCHs) and CAHs
      - Report CC 04 and covered charges
        - Note: IRFs report HIPPS code based on PAI assessment with OC 50 and date
    - Teaching hospitals (acute-care, IPFs, IRFs, LTCHs)
      - Report CCs 04, 69 and covered charges (if N&AH only, report noncovered charges)
        - Acute-care teaching hospitals paid IME or N&AH via claim
        - Other teaching hospitals paid DGME through cost report

Avoiding/Correcting Duplicates & Overlaps

- Before submitting claims
  - Verify DOS not previously submitted
    - Review RA and/or use self-service tools
  - Are all charges from coordinating departments listed on claim?
- When duplicate/overlap rejection received
  - Review information billed on claim
  - Do previously processed claim(s) must be adjusted, cancelled or appealed?
    - Your facility or you may need to contact overlapping facility
- All additions and/or corrections to processed claims must be adjustment claims
  - Do not submit new claims

Rejection Reason Codes 38005 and 38017

- Reason code 38005
  - Duplicate of previously submitted IP claim where TOB equals 11X, 18X OR 41X and following same on both claims
    - MBI
    - Provider number
    - Statement from and through dates
    - Revenue code
    - HCPCS codes 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 38032

- OP claim duplicate to previously submitted OP claim for same provider number and DOS
  - At least one diagnosis code matches
  - At least one revenue code line matches
  - At least one HCPCS code matches
  - History claim includes HCPCS code modifier LT, RT, E1-E4, FA, F1-F9, TA or T1-T9 for same DOS and incoming or history claim
    - Has blank HCPCS code modifier
    - Modifier not equal to LT, RT, E1-E4, FA, F1-F9, TA OR T1-T9

Rejection Reason Code 38065

- Duplicate 72X TOB for same provider number – one claim pending and one claim finalized
- Both claims include automated multi-channel chemistry (AMCC) HCPCS codes on same LIDOS
  - 82040, 84075, 84460, 84450, 82247, 82248, 82310, 82435, 82465, 82550, 82374, 82565, 82977, 82947, 83615, 84100, 84132, 84155, 84295, 84478, 84520, 82330 or 84550

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)

Top RTP Reason Codes

RTPs: January – March 2025

Jurisdiction K

CMHC	CORF/ ORF	ESRD	IP Hospital	OP/ OPPS
W7118	U5065	36164	U5065	34977
30729	34963	U5065	38119	34963
W7191	31408	36227	31137	38038

Jurisdiction 6

CMHC	CORF/ ORF	ESRD	IP Hospital	OP/ OPPS
-	34963	36164	U5065	34977
-	U5065	U5065	34932	34963
-	30993	36205	32242	38038

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 30729

- Invalid entry in treatment authorization code field
- Format for valid UTN
  - First two positions must equal one of the entries in PAR
  - Third position = A or H
  - Last 11 positions must be numeric and not contain spaces
- Avoiding/Correcting this error
  - Review UTN submitted in treatment authorization code field
  - If appropriate, correct and resubmit claim (PF9)
  - Prior Authorization Details

RTP Reason Code 30993

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

RTP Reason Code 31137

- IP PPS admission through discharge claim (111) and admission date less than from date
  - Admission date must equal from date for these types of claims
    - Unless payment window policy applies
  - IP PPS hospitals must bill admission through discharge or 60 days after admission, if they choose, and every 60 days thereafter
    - Appropriate interim TOB and patient discharge status code must be used for extended billing
- Avoiding/Correcting this error
  - Review dates entered on claim
  - If appropriate, correct and resubmit claim (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 claim (PF9)

RTP Reason Code 32242

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

RTP Reason Code 34932

- IP acute care hospital claim does not contain valid end of POA indicator (valid values = X or Z)
  - Exempt facilities include
    - Hospitals paid under any PPS other than acute care IPPS (IPFs, IRFs, LTCHs)
    - Maryland Waiver Hospitals
    - CAHs, Cancer Hospitals, Children's Hospitals
- Avoiding/Correcting this error
  - Review POA indicator entered on claim
  - If appropriate, correct and resubmit claim (PF9)
  - Hospital Acquired Conditions and Present on Admission Resource for Acute Care Hospital Facilities

RTP Reason Code 34963

- One of 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
  - If appropriate, correct attending physician information and resubmit claim (PF9)
  - Reason Code: 34963

RTP Reason Code 34977

- TOB 13X or 14X and practice address 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 claim (PF9)

RTP Reason Code 36164

- ESRD TOB 72X claim with DOS on/after 01/01/2025 and one of following HCPCS codes present on revenue line
  - J0278, J0290, J0606, J0636, J0692, J0713, J0878, J0879, J0882, J0887, J0911, J1580, J1642, J1756, J1956, J2185, J2310, J2357, J2405, J2550, J2704, J2916, J2997, J7050 or Q0139
- One of following applies:
  - HCPCS code billed without modifier JZ and revenue line with same LIDOS and HCPCS code not present with modifier JW
  - HCPCS code present on revenue line with modifier JW but without prior revenue line containing same HCPCS code and LIDOS
- Avoiding/Correcting this error
  - Review HCPCS codes and modifiers billed on claim
  - If appropriate, correct and resubmit claim (PF9)

RTP Reason Code 36205

- One of following applies for 72X TOB
  - Revenue code 0821 present and VC D6 not present
  - VC D6 present with value not greater than 1.0
- Avoiding/Correcting this error
  - Review billing (TOB, revenue code, VC)
  - If appropriate, correct and resubmit claim (PF9)

RTP Reason Code 36227

- 72X TOB where one of following applies
  - TDAPA HCPCS code present with modifier AX, revenue code other than 0636 and covered charges on revenue line greater than zero
  - TPNIES HCPCS code present with modifier AX, revenue code other than 027X and covered charges on revenue line greater than zero
  - CRA TPNIES HCPCS code present with modifier AX, revenue code not equal to 0823, 0833, 0843, 0853 or 0889 and covered charges on revenue line greater than zero
- Note – edit bypassed for AKI claims identified with CC 84
- Avoiding/Correcting this error
  - Review billing (HCPCS code, modifier, revenue code, charges)
  - If appropriate, correct and resubmit claim (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 (TOB XX7) to add any charges to first claim processed
  - If appropriate, correct and resubmit claim (PF9)

RTP Reason Code 38119

- Claim DOS part of continuing stay and claim immediately preceding DOS on claim not finalized
- Avoiding/Correcting this error
  - All 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 RA)
  - 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 on RA, resubmit claim (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 claim (PF9)

RTP Reason Code W7118

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

RTP Reason Code W7191

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

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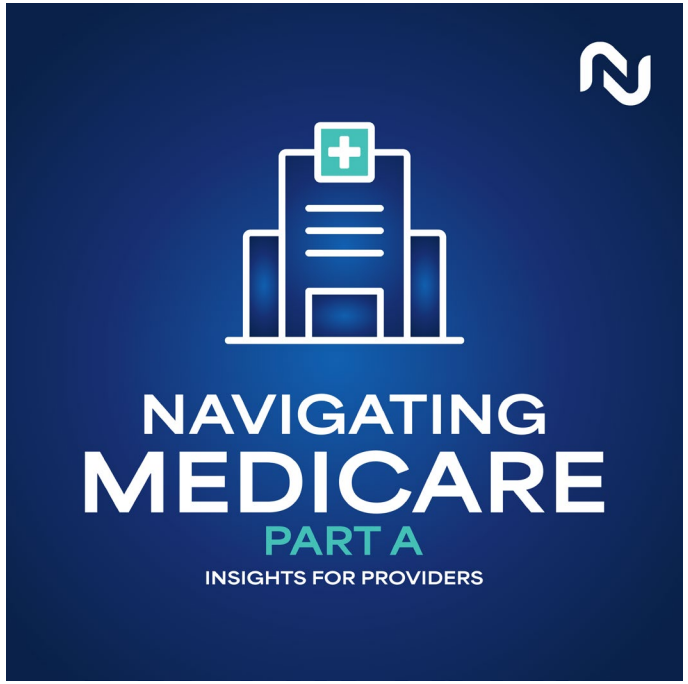

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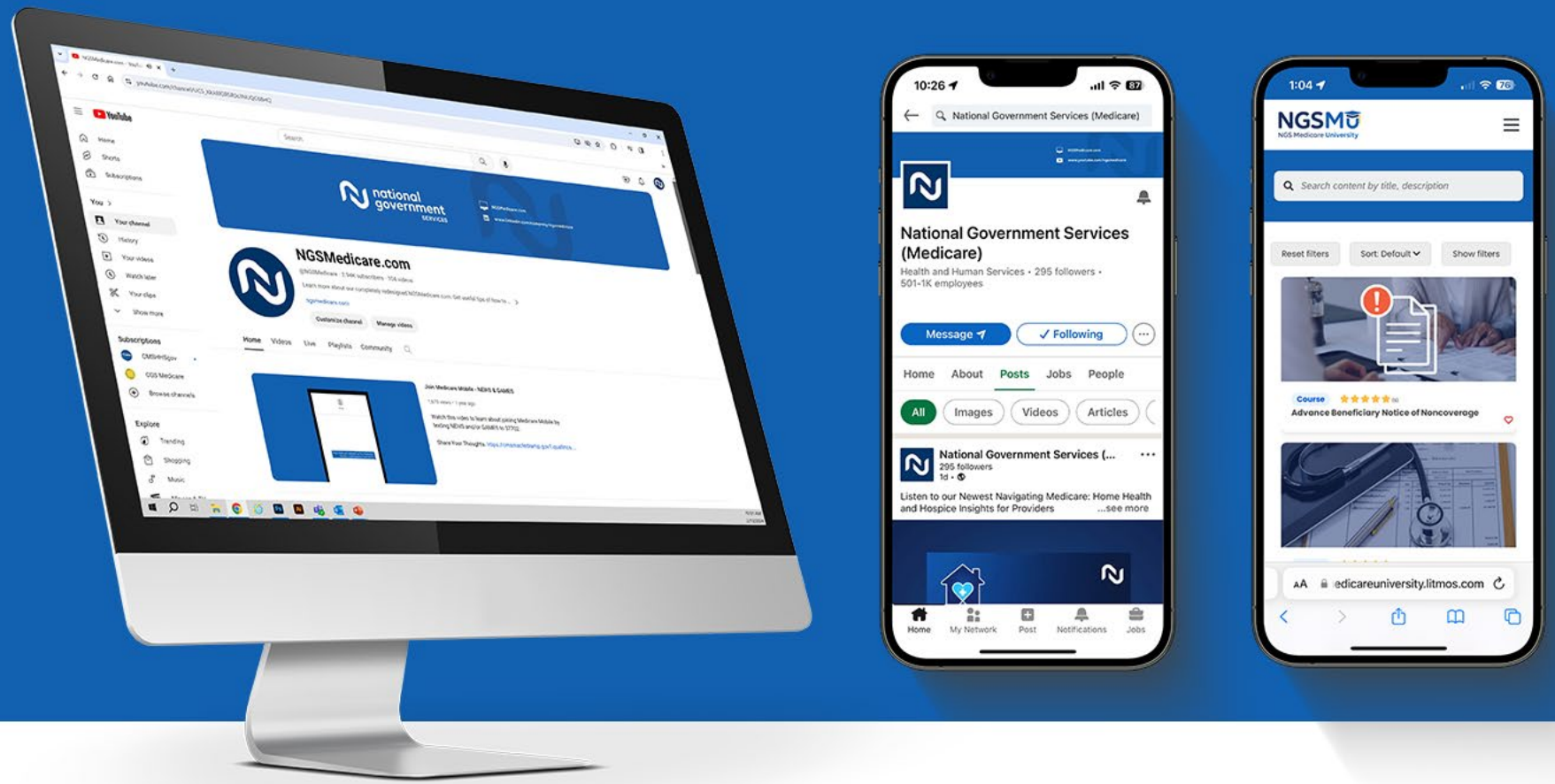

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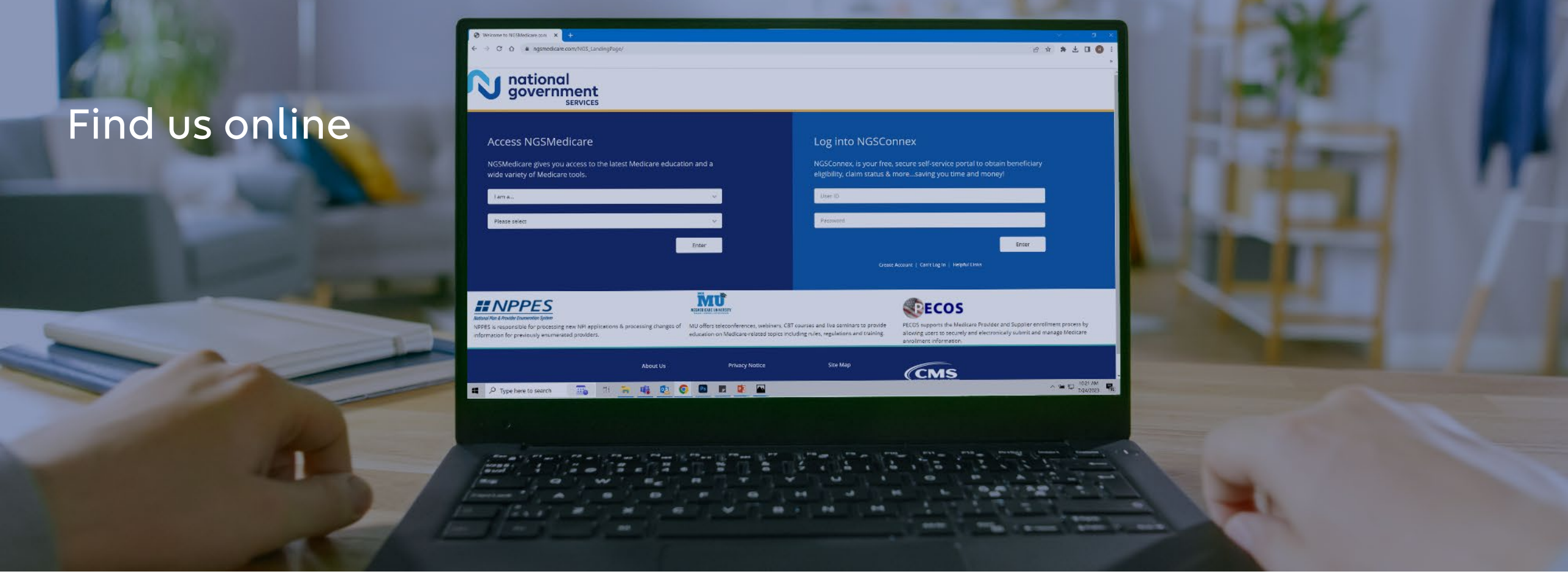

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Thank you!