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Quarterly Review of Top Part A Claim Errors

07/24/2024

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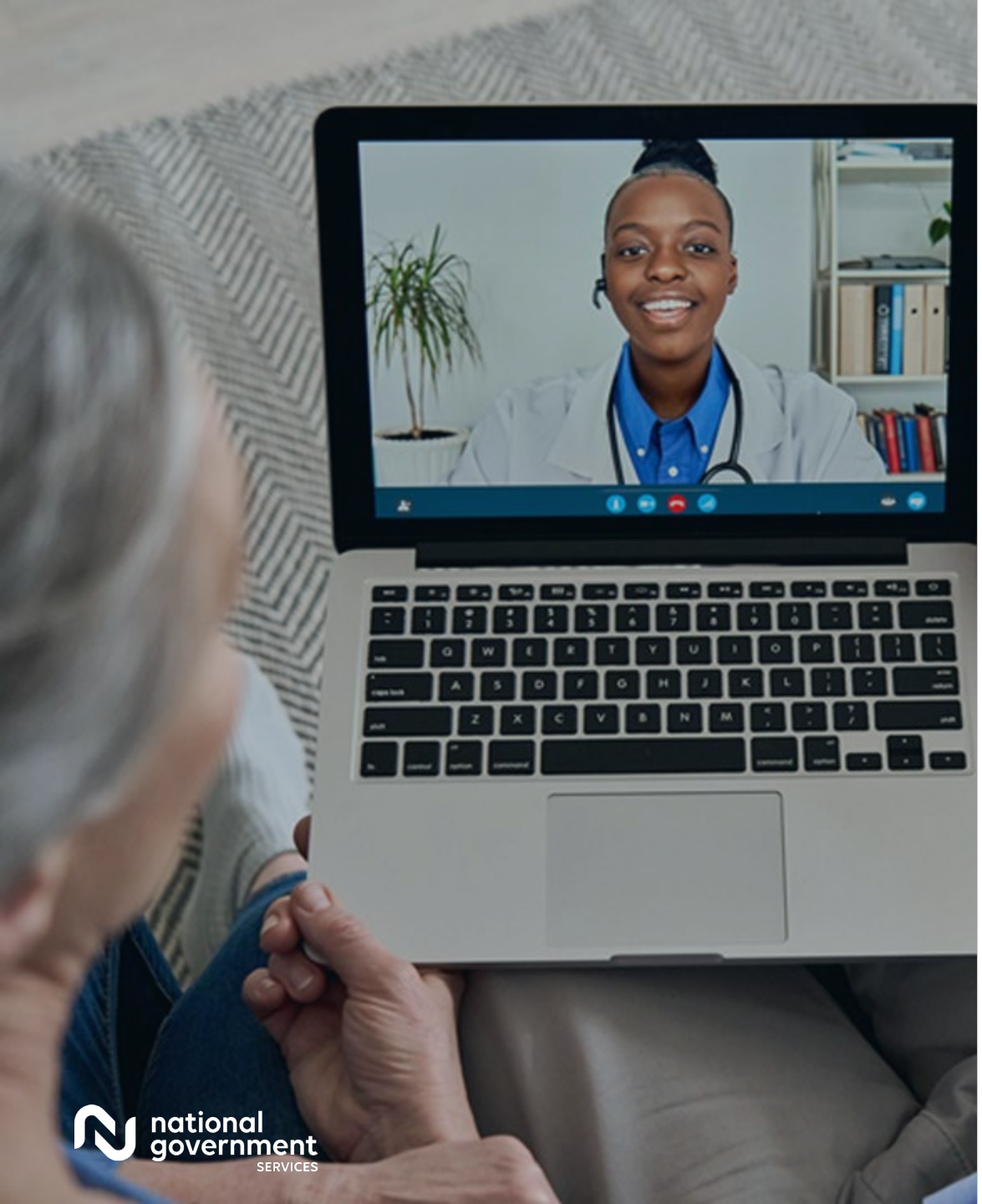

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Objective

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
Andrea Freibauer

Top Denial Reason Codes
Andrea Freibauer

Top Reject Reason Codes
Andrea Freibauer

Top Return to Provider (RTP) Reason Codes
Andrea Freibauer

Stay in the Know With NGS!
Andrea Freibauer

Questions?
Andrea Freibauer and Jean Roberts

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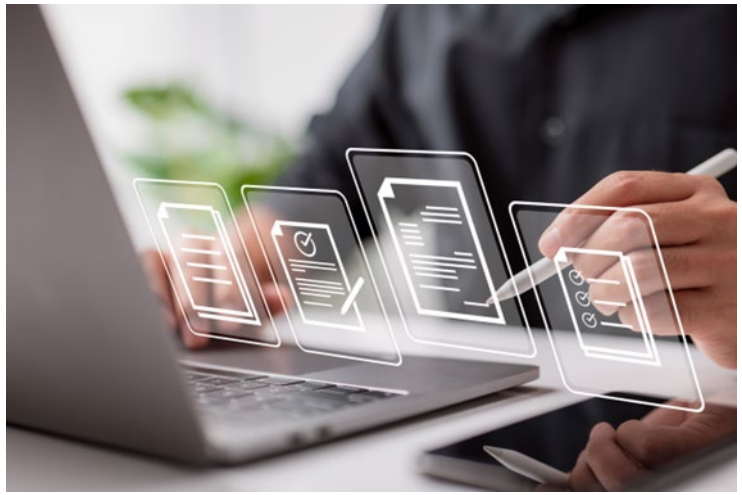
Understanding and Locating Claim Errors

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” in 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

- Claims process through FISS, follow specific paths based on claim type, and 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 utilizing FISS DDE, remittance advice, and other methods

FISS Status/Locations

- S XXXXX – Claim suspended (processing)
- P B9997 – Claim finalized/adjudicated
  - Doesn't always mean paid
- T B9997 – Claim 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
  - “Traffic cops” of FISS
- 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

Search

Search Claim errors

Type

Select Error Type

Reason Code	Description	Error Type	Details
32402	Either the CPT or HCPCS code(s) reported on this claim was not been billed with a valid revenue code for the date(s) of service.	RTP	View Details

Top Denial Reason Codes

Denials: April – June 2024

- **Jurisdiction 6**

CAH	CMHC	CORF/ ORF	ESRD	FQHC	IPPS/IP Psych	OP/ OPPS	RHC	SNF IP	SNF OP	Swing Bed
39928	39928	39928	-	5WEXC	59118	39928	39928	56900	39928	-
52MUE	-	-	-	56900	NCD07	54NCD	5WEXC	55S05	54NCD	-
5WEXC	-	-	-	59130	59301	5WEXC	59132	55S07	5WEXC	-

- **Jurisdiction K**

CAH	CMHC	CORF/ ORF	ESRD	FQHC	IPPS/IP Psych	OP/ OPPS	RHC	SNF IP	SNF OP	Swing Bed
39928	39928	39928	-	5WEXC	59301	39928	5WEXC	56900	39928	-
52MUE	-	-	-	-	59118	5WEXC	39928	55S05	5WEXC	-
5WEXC	-	-	-	-	59144	56900	-	55S29	-	-

Reason Code 39928

- Each line of charges on 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

Reason Code 52MUE

- All line items on claim have UOS exceeding medically reasonable daily allowable frequency
  - Excess charges due to UOS 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 denied services were reasonable and medically necessary, you have right to submit appeal
  - Review CMS MUE tables prior to claim submission
    - ✓ Updated quarterly – ensure referencing correct file for DOS
    - ✓ If units rendered exceed allowed units for that service, determine whether excess units rendered and billed correctly

Reason Code 5WEXC

- Claim does not qualify for Medicare payment due to principal diagnosis code supplied
- 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

Reason Code 56900

- Automatic denial when requested medical records not received within 45-day time limit from ADR date
- 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

Reason Code 54NCD

- Line level reason code indicating none of the diagnosis codes on claim support medical necessity of the services
- Provider liable
- 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

Reason Code 59118

- Claim contains valid ICD-10 procedure code for Percutaneous Transluminal Angioplasty (PTA) of carotid artery but diagnosis code(s) missing or invalid
  - TOB 11X
- Avoiding/correcting this error
  - Review coverage guidelines for this service and ensure claim coded appropriately
    - ✓ CMS National Coverage Determination (NCD) 20.7 *Percutaneous Transluminal Angioplasty (PTA)*
    - ✓ CMS Internet-Only Manual (IOM) Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 1, Section 20.7
    - ✓ MLN Matters® ICD-10 & Other Coding Revisions to National Coverage Determinations: July 2023 Update
    - ✓ NCA - Percutaneous Transluminal Angioplasty (PTA) of the Carotid Artery Concurrent with Stenting (CAG-00085R8) - Decision Memo

Reason Code 59301

- Inpatient 11X claim did not include covered diagnoses and procedure code(s) as required per NCD for Implantable Cardiac Defibrillators (ICDs)
- Avoiding/correcting this error
  - Ensure all coverage and medical necessity requirements met prior to rendering service
    - ✓ CMS Change Request 10865 National Coverage Determination (NCD) 20.4 Implantable Cardiac Defibrillators (ICDs)
    - ✓ MLN Matters® *MM12104 Claims Processing Instructions for National Coverage Determination (NCD) 20.4 Implantable Cardiac Defibrillators (ICDs)*
    - ✓ MLN Matters® Special Edition Article *SE20006 NCD 20.4 Implantable Cardiac Defibrillators (ICDs)*
    - ✓ CMS IOM Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Part 1, Section 20.4 Implantable Cardioverter Defibrillators (ICDs)
  - Review Submit an Adjustment to Correct Claims Partially Denied by Automated LCD-NCD Denials article on our website under Appeals tab

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 Reject Reason Codes

Rejections: April – June 2024

- **Jurisdiction 6**

CAH	CMHC	CORF/ ORF	ESRD	FQHC	IPPS/IP Psych	OP/ OPPS	RHC	SNF IP	SNF OP	Swing Bed
38105	-	39929	38200	U5233	7K073	U5233	U5233	39934	U5233	38200
U5233	-	38032	38065	38312	38200	39929	38200	38200	39929	13313
39929	-	U5233	U5233	39934	38005	34538	39934	U5607	38031	19904

- **Jurisdiction K**

CAH	CMHC	CORF/ ORF	ESRD	FQHC	IPPS/IP Psych	OP/ OPPS	RHC	SNF IP	SNF OP	Swing Bed
38105	W7027	39929	U5233	U5233	7K073	U5233	U5233	39934	U5233	19904
U5233	39929	38200	38200	38312	37574	39929	38200	38200	39929	39934
39929	-	C7010	U5210	39934	38200	38200	39929	38007	38200	38200

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

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

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

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)
- Avoiding/correcting this error
  - All additions and/or corrections to processed claims must be adjustment claims, not new claims
  - Before submitting claim, ensure has not been previously submitted
  - Review remittance advice or use self-service tools

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)

Reason Code 38105

- Whether any revenue code lines equal or not, outpatient claims cannot overlap dates of another claim, different TOBs but same provider number
  - 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)
- Avoiding/correcting this error
  - Verify billing
  - Additions and/or corrections to processed claims must be adjustment claims, not new claims

Reason Code 38312

- FQHC PPS claim with line item DOS matching another line item DOS on previously submitted claim and all of the following match:
  - MBI
  - PTAN
  - Line item DOS
- Avoiding/correcting this error
  - Verify DOS billed
  - Query DOS using self-service tools before submitting new claim
  - If not changing denied lines, additions and/or corrections to processed claims must be adjustment claims, not new claims

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

Top RTP Reason Codes

RTPs: April – June 2024

- **Jurisdiction 6**

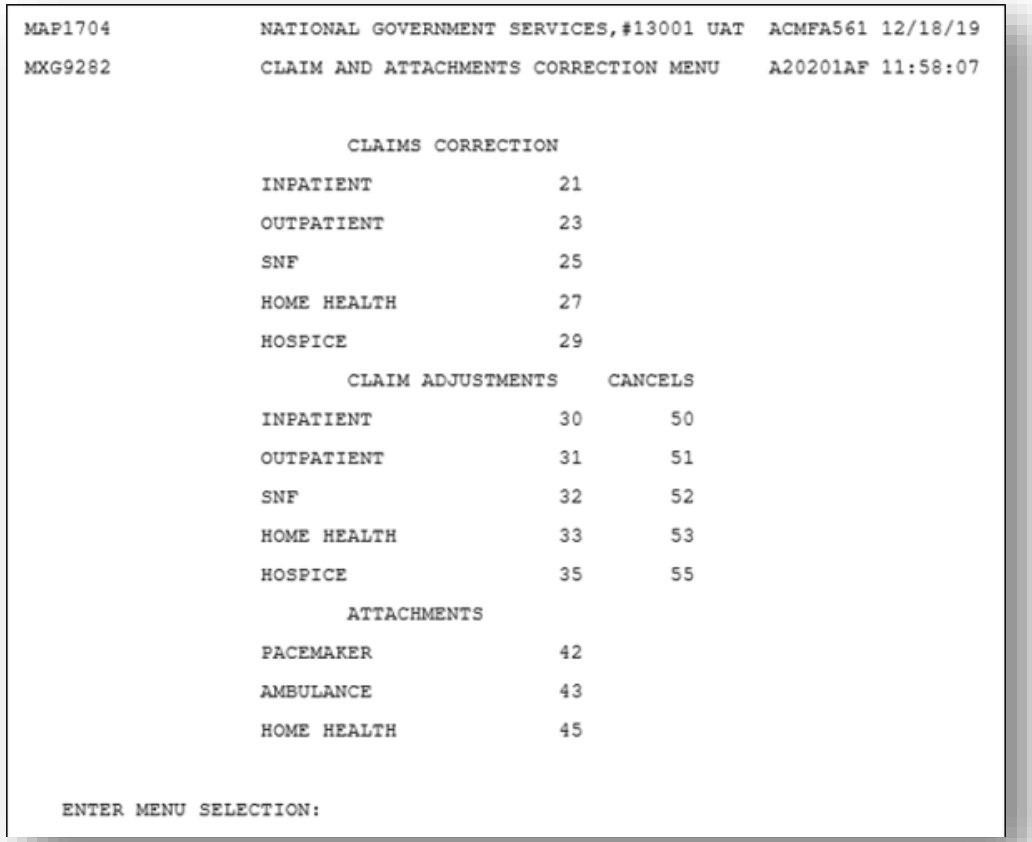
CAH	CMHC	CORF/ ORF	ESRD	FQHC	IPPS/IP Psych	OP/ OPPS	RHC	SNF IP	SNF OP	Swing Bed
34963	-	34963	U5065	34963	12302	34977	34963	38119	U5065	12302
12402	-	U5605	12402	W7088	U5065	34963	39910	38117	34963	32242
32402	-	31408	32006	32078	37554	31438	U5065	12302	32415	13314

- **Jurisdiction K**

CAH	CMHC	CORF/ ORF	ESRD	FQHC	IPPS/IP Psych	OP/ OPPS	RHC	SNF IP	SNF OP	Swing Bed
34963	W7118	34963	12402	W7088	38119	34977	39910	38119	U5065	32242
32402	30729	U5065	U5065	34963	38117	34963	34963	38117	31255	38119
19301	31576	32243	76050	37098	10404	34984	E0401	12302	31498	E0401

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



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
  - If appropriate, correct attending physician information on claim and resubmit (PF9)

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)

Reason Code 12302

- Sum of covered and non-covered days must equal total number of days in statement covers period
- 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)

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)

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)

Reason Code 12402

- JG modifier billed on claim with TOB other than 12X or 13X
- Avoiding/correcting this error
  - Verify TOB and if JG modifier applicable to billed service
  - If appropriate, correct and resubmit (PF9)

Reason Code 32402

- HCPCS code reported on claim not billed with valid revenue code for DOS
- Avoiding/correcting this error
  - Verify billing
  - If appropriate, correct and resubmit (PF9)

Other RTPs by Provider Type

- CAH
  - 19301 - If operating physician required or present (or any name present), physician's last and first name must be present
- CMHC
  - 30729 - Invalid entry in treatment authorization code field
  - 31576 - Missing valid community mental health revenue code
  - W7118 - Invalid TOB
- CORF/ORF
  - 31408 - Revenue code 42X must have OC 35
  - 32243 - Revenue code present without charges (blank or equals zero)
- ESRD
  - 32006 - Statement covers To date greater than provider's termination date on file
  - 76050 - Outpatient claim contains revenue code 636 with units greater than 500 or any other rev code with units greater than 1000

Other RTPs by Provider Type (continued)

- FQHC
  - 32078 - Incorrect or missing rev code for TOB and PTAN billed
  - 37098 - FQHC PPS supplemental rate not present for MA plan
- Inpatient Hospital/IPPS
  - 10404 - Invalid condition code
  - 37554 - CC 69 only allowed when provider is PPS teaching hospital with IME
- Outpatient Hospital/OPPS
  - 31438 - CC A6 on claim without flu/PPV HCPCS code
  - 34984 - Modifier ER missing and address on claim matches provider practice address query screen
- SNF
  - 13314 - OSC 70 from date greater than admission from date
- SNF Outpatient
  - 31255 - Revenue code 42X must have OC 29 present
  - 31498 - Required diagnosis not present when billing for vaccine (flu, pneumococcal, Covid-19, hepatitis)
  - 32415 - Vaccine HCPCS code on claim without CC A6

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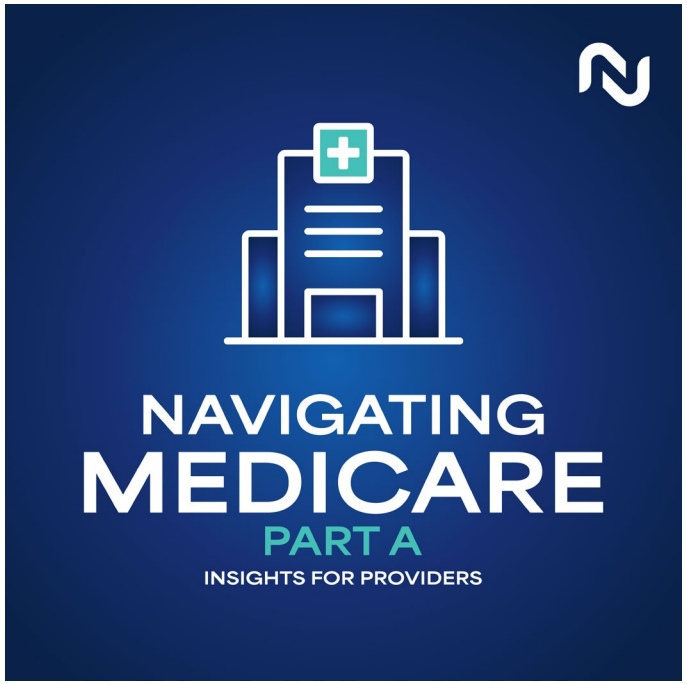

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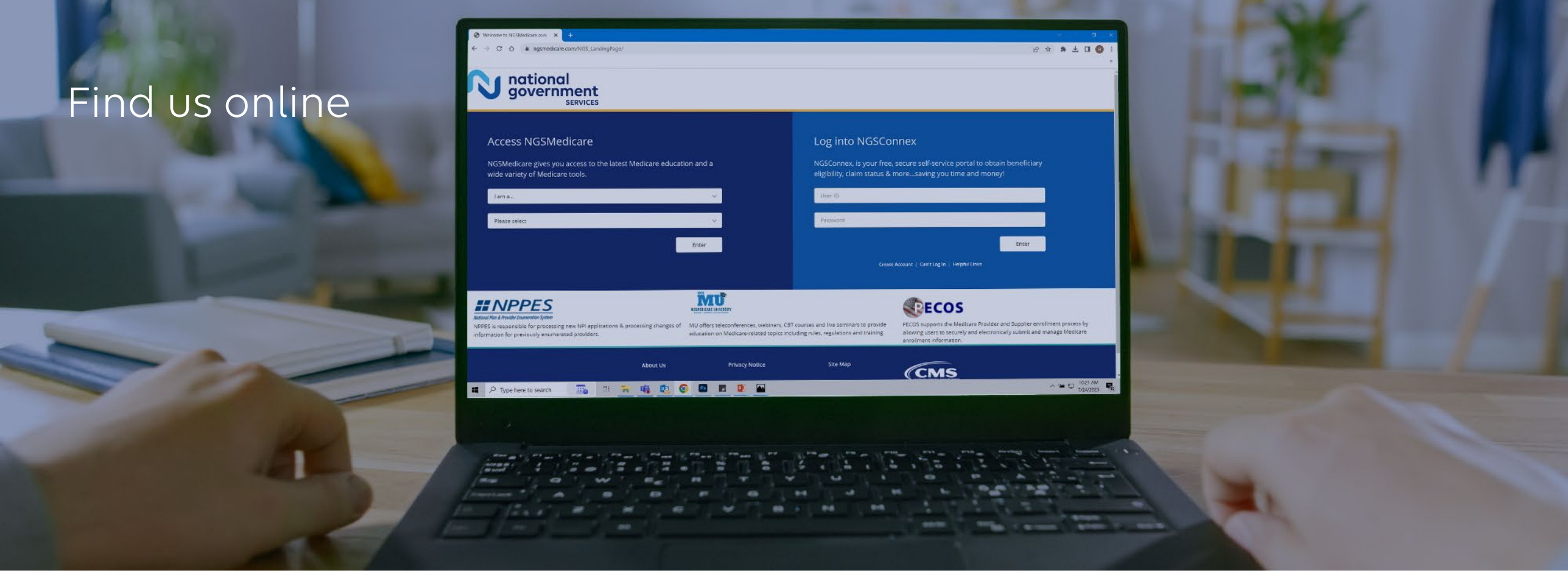

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