national government SERVICES

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Quarterly Review of Top Part A Claim Errors

10/23/2024

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2601_10/18/2024

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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

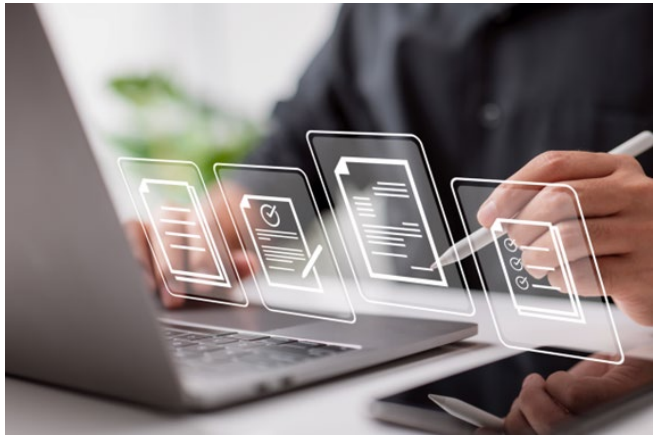
- Provider Outreach and Education Consultants
  - Andrea Freibauer
  - Jean Roberts, RN, BSN, CPC

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” 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

- 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

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: July–September 2024

Jurisdiction 6

CAH	CMHC	CORF/ ORF	ESRD	FQHC	IPPS/IP Psych	OP/ OPPS	RHC	SNF IP	SNF OP	Swing Bed
39928	-	39928	-	5WEXC	59144	39928	39928	56900	39928	-
52MUE	-	-	-	56900	5ND07	5WEXC	5WEXC	55S29	5WEXC	-
5WEXC	-	-	-	55B00	59091	54NCD	59132	55S25	-	-

Jurisdiction K

39928	39928	39928	-	5WEXC	59301	39928	5WEXC	55S29	39928	-
5WEXC	-	-	-	-	5ND07	5WEXC	39928	56900	5WEXC	-
54NCD	-	-	-	-	59144	54NCD	55B31	39928	-	-

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

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 54NCD

- Line level reason code indicates that 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 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
    - Hardcopy 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 59144

- TOB 11X with Discharge Date on/after 3/6/2024
  - Contains both
    - ICD-10 procedure code
      - 30233Y3, 30240G2, 30240G3, 30243G2, 30243G3, 30243Y2, 30243Y3, or 30233C0, 30243C0, 30233U2, 30233U3, 30243U2, or 30243U3
    - Diagnosis code
      - C847A, C9000, C9001, C9002, C9440, C9441, C9442, D471, D474, D7581, D5700, D5701, D5702, D571, D5720, D57211, D57212, D57219, D5740, D57411, D57412, D57419, D5780, D57811, D57812, D57819, D5703,D5709,D57213, D57218, D57413, D57418, D57813, D57818, D5742, D57431, D57432, D57433, D57438, D57439, D5744, D57451, D57452, D57453, D57458, or D57459
  - Claim 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

Resources and References

- LCDs, Billing and Coding Articles and NCDs
  - National Government Services Mediclal 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: July – September 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	38200	U5233	U5233	39934	U5233	38001
U5233	-	U5233	10418	38312	38005	39929	38200	38019	39929	19904
39929	-	38200	U5233	U5210	37574	34538	C7010	7B908	C7010	13313

Jurisdiction K

38105	39929	39929	38200	U5233	37574	U5233	39929	39934	U5233	19904
39929	-	38032	10418	38312	38200	39929	38200	38200	39929	39934
U5233	-	38031	U5233	39721	38005	38200	U5233	U5607	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/noninpatient 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 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 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 38019

- SNF TOB 21X, 28X, or 51X overlaps previous inpatient SNF claim, TOB 21X, 28X, or 51X
- 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 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)
- Avoiding/Correcting this error
  - Before submitting claim, verify DOS and ensure not previously submitted
  - Review remittance advice or use self-service tools

Reason Code 37574

- IP claim contains CC 04 and 69 indicating beneficiary enrolled in HMO during claim DOS
- Avoiding/Correcting this error
- Review remittance advice or use self-service tools to verify HMO enrollment prior to claim submission
- Verify information billed
- If appropriate, make corrections and submit new claim

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

Reason Code 38001

- IP claim contains DOS equal to or overlapping denied IP claim
- Avoiding/Correcting this error
  - Verify information billed
  - If appropriate, adjust, cancel or appeal previously processed claim

Top Return to Provider (RTP) Reason Codes

RTPs: July – September 2024

Jurisdiction 6

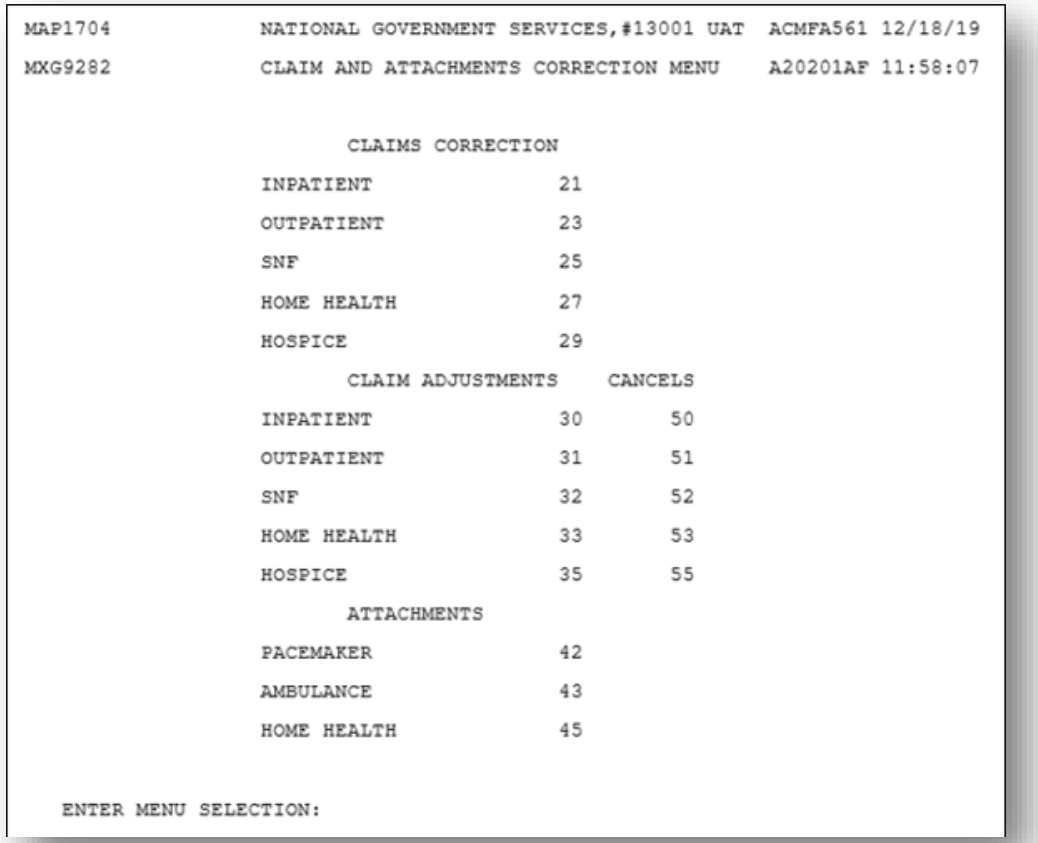
CAH	CMHC	CORF/ ORF	ESRD	FQHC	IPPS/IP Psych	OP/ OPPS	RHC	SNF IP	SNF OP	Swing Bed
34963	-	34963	U5065	31836	32242	34977	39910	38119	U5065	32242
32402	-	U5605	12402	34963	U5065	34963	34963	38117	32402	13314
31408	-	30993	34963	W7088	12302	34986	31407	12302	34963	12302

Jurisdiction K

34963	W7218	34963	36618	34963	38119	34977	31836	38119	U5065	32242
32402	30729	U5065	U5065	W7088	38117	34963	39910	38117	34963	34963
19301	W7118	31408	76050	37098	7A000	34985	34963	U5606	32402	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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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 32242

- Revenue code nonbillable 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)

Reason Code 38117 and 38119

- Claim DOS part of continuing stay and claim immediately preceding DOS on claim not processed
- Avoiding/Correcting this error
  - All inpatient SNF and nonPPS 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 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 noncovered 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 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)

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)

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)

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)

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)

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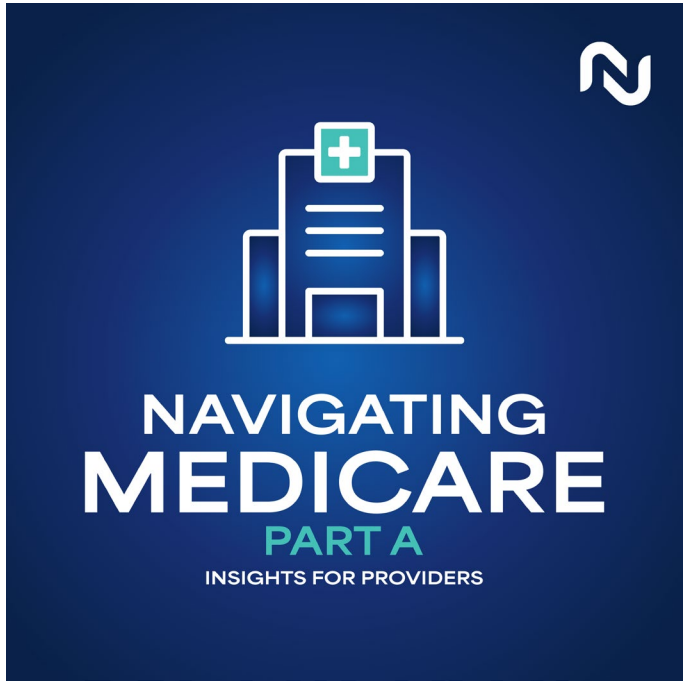
Navigating Medicare: Part A Insights for Providers



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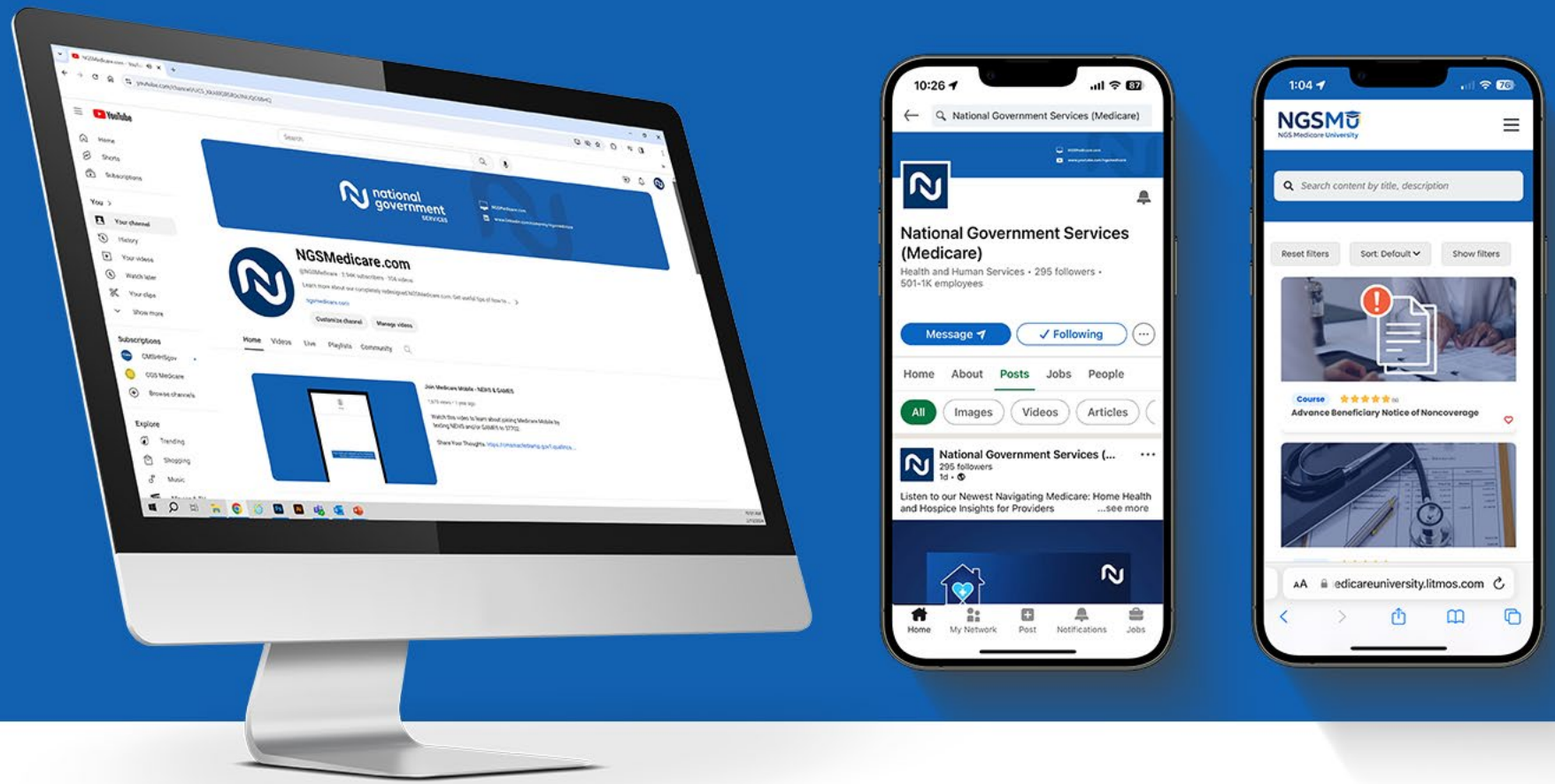

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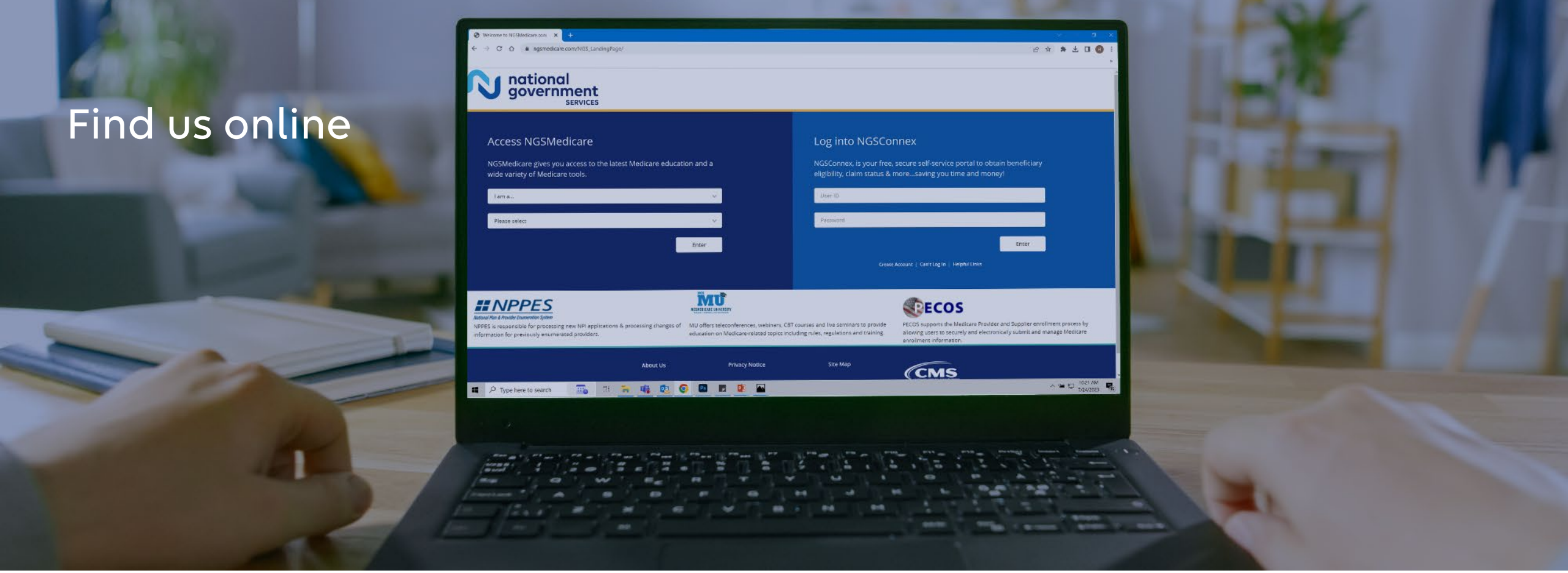

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Thank you!