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# Steps to Claim Corrections

2/28/2023

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

# Today's Presenters

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# Objectives

- After this session, attendees will be more familiar with the difference between an unprocessable claim, what constitutes clerical error reopenings and when to submit redeterminations
- Also, understanding next steps for claim corrections

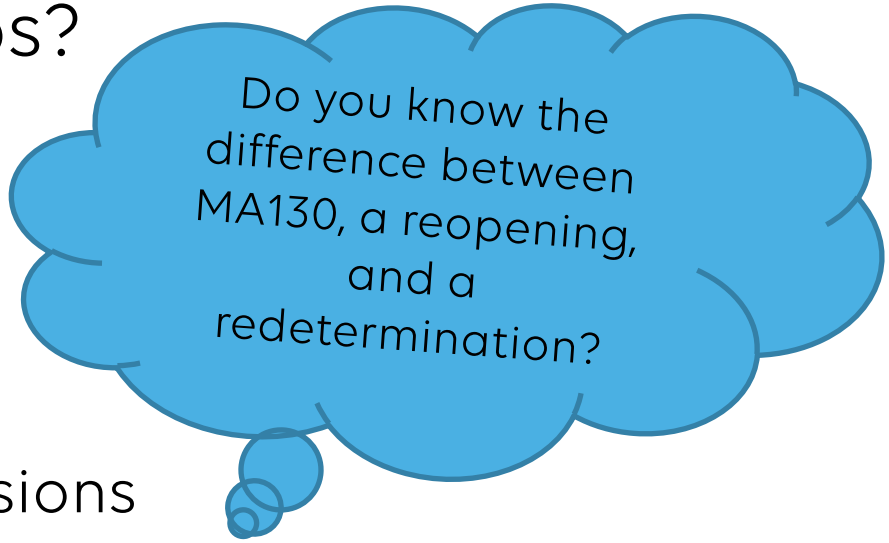
# Agenda

- Resubmissions for Unprocessable Claims
- Reopening for Clerical Error Reopenings
- Redeterminations for First Level of an Appeal
- Requesting an Exception to Timely Filing
- Interactive Scenarios

# Resubmit, Reopen or Redetermination

# Resubmit, Reopen or Redetermination

- What are your next steps?
- Resubmit
  - Unprocessable
- Reopen
  - Minor clerical errors or omissions
- Redetermination
  - Claims that require analysis of documentation



# Claim Guidelines

- If the claim is still in process, you will need to wait until it finalizes before any additional action can be taken
- Depending on the error, you can resubmit, reopen or appeal a claim that has been submitted to NGS for processing
- Review your remittance advice to determine next steps

# Resubmissions

# Resubmission of Unprocessable Claims

- Claim rejections CO16, MA130
  - Claim lacks information or has submission billing error(s), which is needed for adjudication
  - Claims received contain incomplete or invalid information will be "rejected" and returned as unprocessable
- Unprocessable claims
  - No appeal rights
  - No reopening rights
- Resubmit a new claim with corrected information

# Reopenings

# Clerical Error Reopenings

- Reopening is reprocessing of claim to fix minor mistakes
  - Mathematical or computational mistake
  - Transposed procedure or diagnostic codes
  - Inaccurate data entry
  - Computer errors
  - Incorrect data items

# TRU Changes

- Adding or changing order/referring/supervising physician
- Add/change rendering provider
- Assignment of claims (contractor errors only)
- CLIA certification denials
- Duplicate denials
- Fee schedule corrections (contractor error only)
- HICN/MBI corrections (contractor error only)
- Medicare Advantage plan denials (clinical trial or hospice only)
- Modifier GV and GW
- MSP (Medicare now primary)
- Patient paid amount (contractor error only)
- Place of service changes
- All other requests need to be done through NGSConnex or in writing

# Redetermination

# Redetermination First Level Appeal

- Redeterminations are more complex issues that require analysis of documentation
  - Coverage of furnished items and service
  - Medical necessity claim denials
  - Determination on limitation of liability provision
  - Overpayment determinations from NGS probe reviews
  - Post payment CERT, RAC and/or SMRC denials

# Redetermination

- First Level of Appeal
- Time Limit
  - 120 days from date of receipt of the initial determination notice
- Amount in Controversy
  - No minimum amount

# Redetermination Submissions

- Decision made within 60 days of receipt
- Refrain from submitting duplicate appeal requests via paper or NGSConnex
- Duplicate submissions will not speed up the process
  - Will cause administrative delays and slow down processing of your appeal

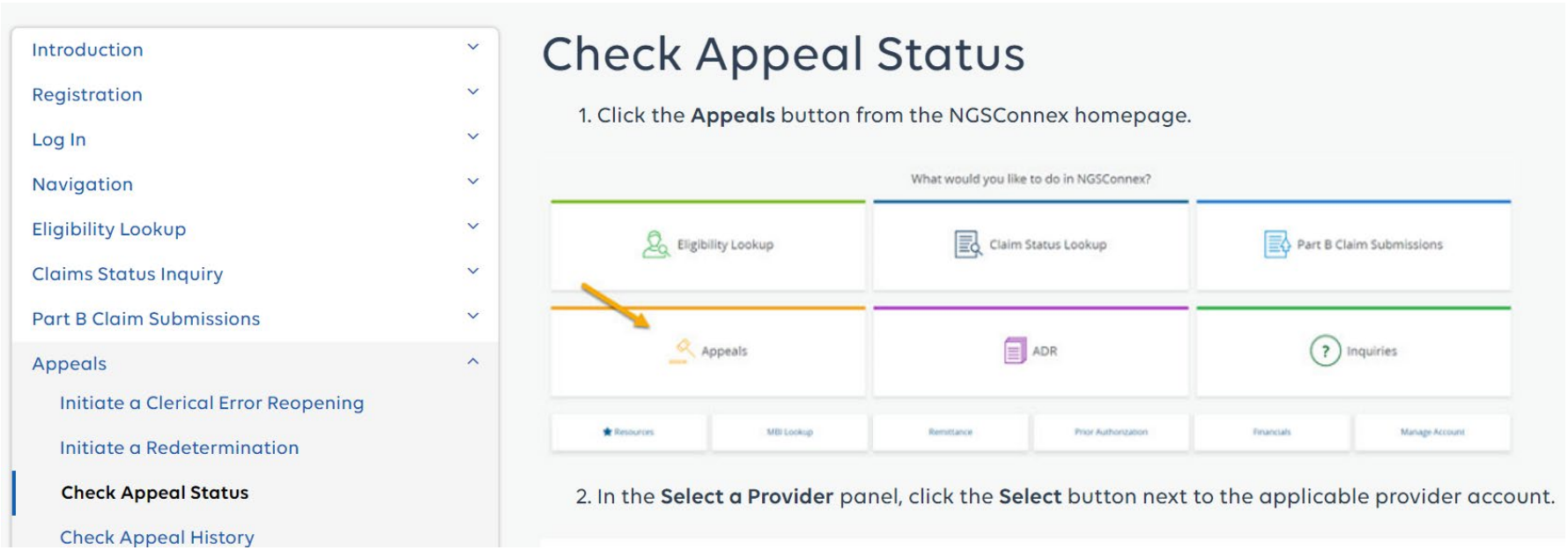
# Redetermination Documentation

- Submitting unnecessary or excessive documentation may lead to a delay in processing appeal
  - Inpatient services
    - Submit only reports relevant to the denial on claim
    - Do not submit patient's entire hospital stay
  - Critical care
    - Submit notes for NP or specialty denied on claim
    - Total time spent by provider performing service
  - Anesthesia
    - Submit only those reports and records that apply to case
- What Documents are Needed?

# NGSConnex

- Providers who are registered to use NGSConnex, our secure web portal, shall submit reopening or redetermination requests electronically
- Quickest route to correct claim(s) that contained errors and faster way of receiving reimbursements for reopenings
- Able to check a redetermination status

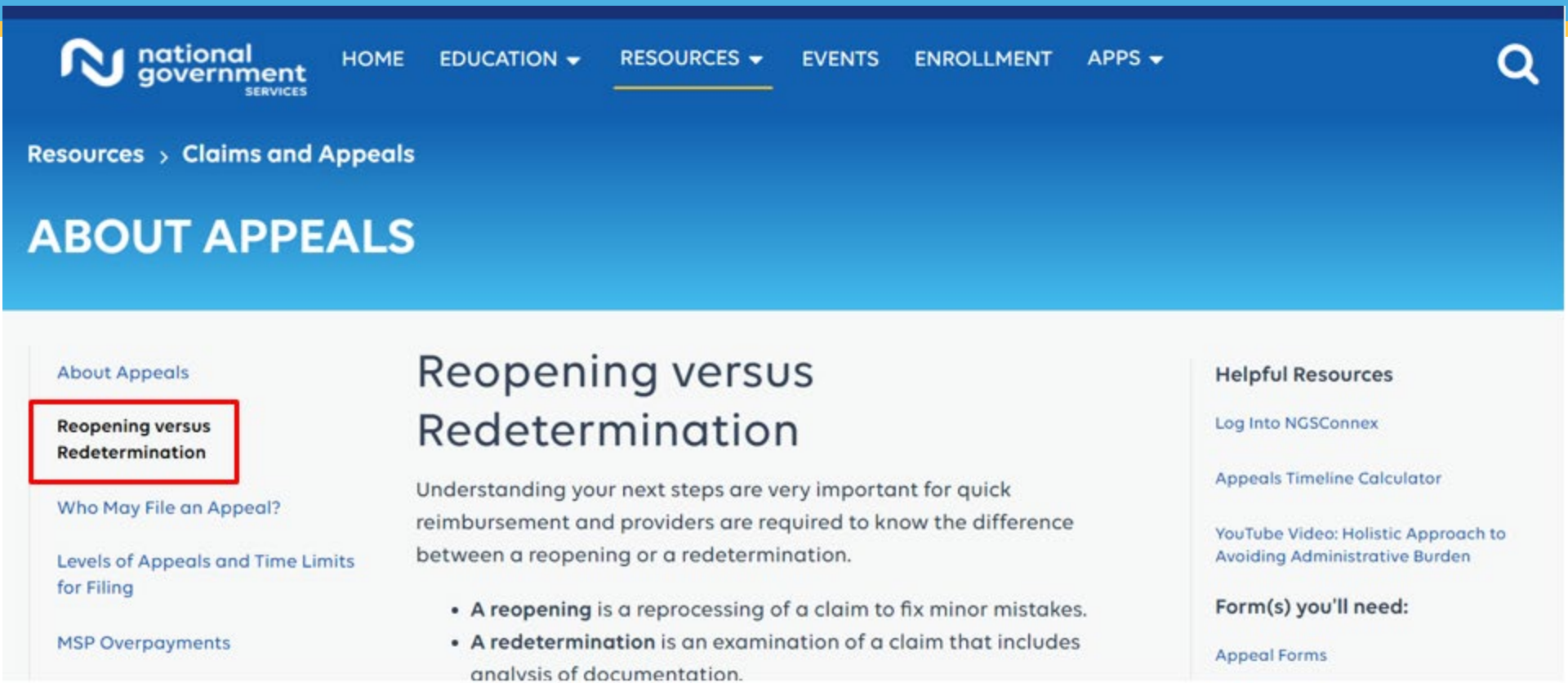
# NGSConnex User Guide



# Reopening Versus Redetermination

- Reopening
  - Correct a claim(s) determination resulting from minor errors, you should use reopening process
  - Documentation cannot be submitted with reopening request when using NGSConnex
- Redetermination
  - Partially paid or denied claim(s) resulting from more complex issues that require analysis of documentation
  - Documentation shall be submitted with redetermination request when using NGSConnex

# Reopening Versus Redetermination



# Requesting an Exception to Timely Filing

# Requesting an Exception to Timely Filing

- The Patient Protection and ACA of 2010 amended the timely filing requirements to one calendar year after the date of service
  - No appeal rights for claims denied based on timely filing limit (not appropriate to use a redetermination form)
  - Beneficiaries are not responsible for untimely claims
    - Deductible and/or coinsurance amounts may be appropriate

# Claim Filing Time Limits

- Limit is one calendar year from date of service
  - Claims not submitted timely are provider-liable
    - Beneficiary cannot be charged
- Exceptions
  - MLN Matters® *MM7270 Revised: Changes to the Time Limits for Filing Medicare Fee-For-Service Claims*
  - Administrative error
  - Retroactive Medicare entitlement, including when State Medicaid agencies involved
  - Retroactive disenrollment from Medicare Advantage Plan or PACE Provider Organization

# Requesting a Waiver to Extend the Timely Filing Requirement

- Post Claim
  - Claim has been submitted and denied for timely filing
  - Complete a Part B Reopening Request Form and attach the documentation to establish good cause and mail to address indicated on the bottom of the form
  - Part B Reopening Request Form

# Requesting a Waiver to Extend the Timely Filing Requirement

- Pre-Claim
  - A provider who believes they meet the qualifications for "good cause"
  - Submit to the Claims Manager
    - A completed CMS -1500 claim form, along with the appropriate documentation
    - A letter explaining the reason the claim is being filed beyond a year after the date of service
    - Documentation to provide "good cause" for late filing is met
    - Addresses to Mail Your Request

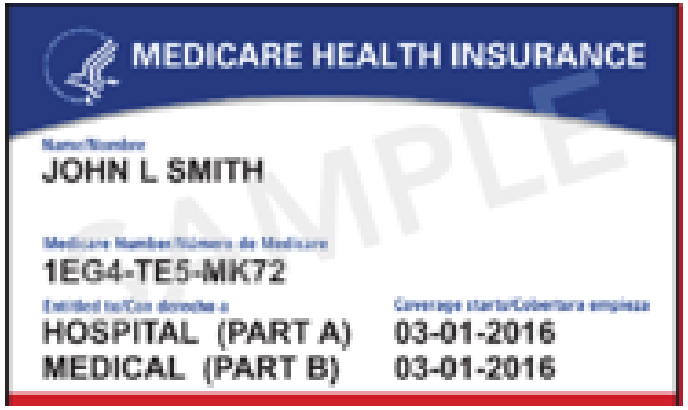
# Interactive Claim Correction Scenarios

# Scenario One

- Remittance advice and message states
  - Name or MBI was incorrect or missing with MA130
- What are your next steps?
- Resubmit, reopen or redetermination
  - Resubmit claim
  - Claim rejections with MA130 are rejected claims that shall be resubmitted

# Eligibility

- PR 31: Patient cannot be identified as our insured
  - Incorrect or missing patient's name or Medicare number
  - Patient does not have Medicare Part B entitlement
  - Always check eligibility via IVR or NGSConnex prior to submitting a claim

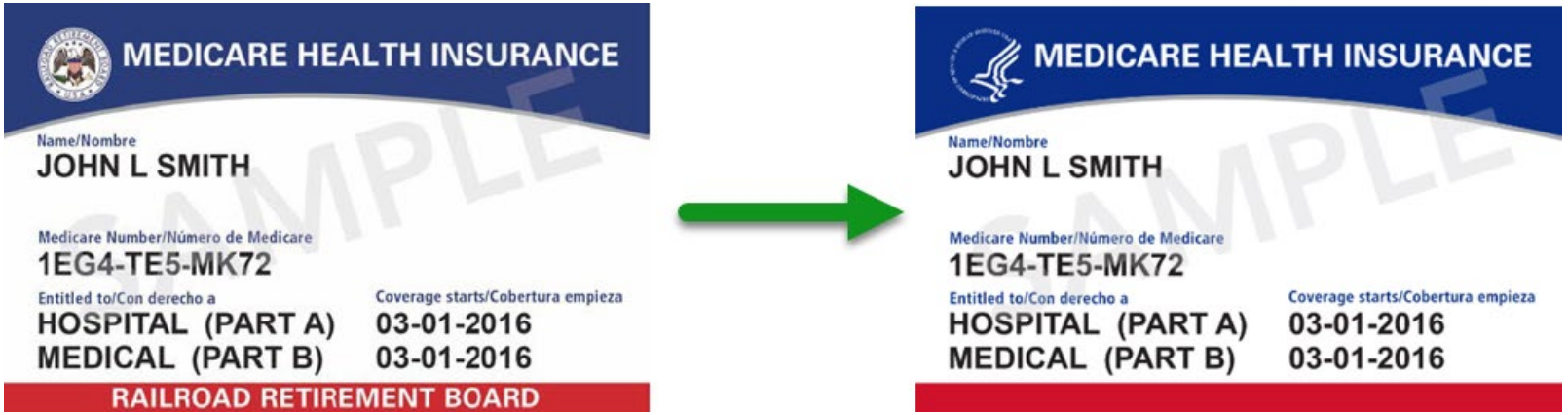


# Scenario Two

- Remittance advice and message states
  - Misdirected claim for RRB beneficiary
- What are your next steps?
- Resubmit, reopen or redetermination
  - Submit to correct contractor
  - Claim denials that state misdirected shall be submitted to appropriate RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999

# Eligibility

- N105: This is a misdirected claim/service for an RRB beneficiary




- RRB: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999

# Scenario Three

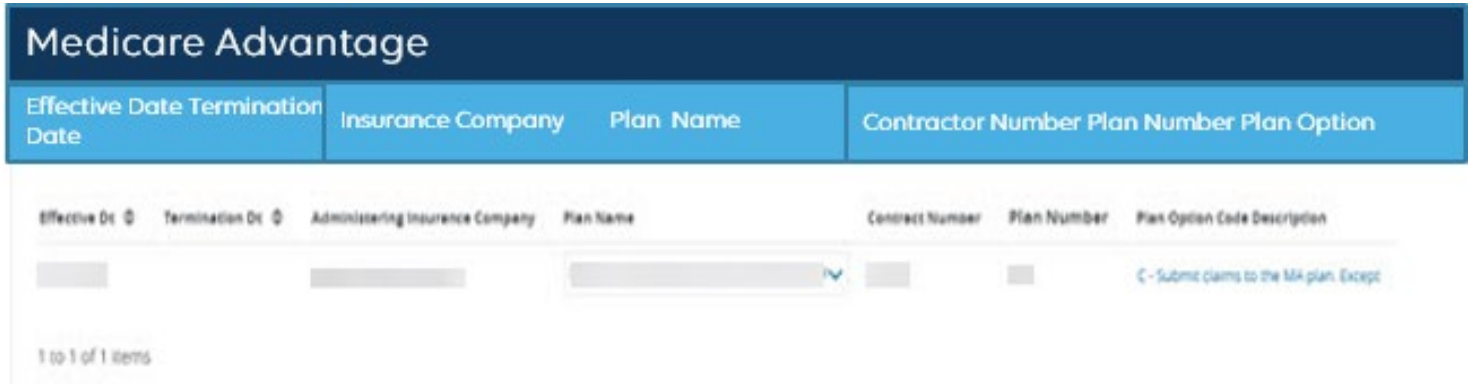
- Remittance advice and message states
  - Claim not covered by this payer/contractor; you must send claim to correct payer/contractor
- What are your next steps?
- Resubmit, reopen or redetermination
  - Resubmit to correct payer or
  - Reopen claim if adding modifier(s) (hospice related)
  - If you can correct claim by doing CER, correct the initial claim determination

# Eligibility

- OA 109: Claim not covered by this payer/contractor; you must send the claim to the correct payer/contractor
  - Medicare Advantage
  - N90 – Hospice related services
  - N538 – Skilled nursing facility consolidated billing
- NGSConnex: Initiate Eligibility Lookup

# Medicare Advantage Plan Eligibility

- OA 109: Claim not covered by this payer/contractor; you must send the claim to correct payer/contractor




- Visit CMS website for complete list: [MA Plan Directory]

# Hospice Eligibility

- N90: Covered only when performed by the attending physician


  - Modifier GW: service not related to the hospice patient's terminal condition
  - Modifier GV: Attending physician not employed or paid under agreement by patient's hospice provider
- Hospice General Requirements

# SNF Eligibility

- N538: Facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents


- SNF Consolidated Billing

# Scenario Four

- Remittance advice and message states
  - This care may be covered by another payer per coordination of benefits
  - Secondary payment cannot be considered without identity of or payment information from primary payer and information was either not reported or was illegible
- What are your next steps?
- Resubmit, reopen or redetermination
  - Resubmit with primary insurance data
    - If insurance is primary to Medicare – send to that insurance first and Medicare as secondary

# MSP Eligibility

- OA22: This care may be covered by another payer per coordination of benefits
- MA92: Missing plan information for other insurance
- MA04: Payment information from primary payer and information was either not reported or was illegible

Medicare Secondary Payer

| Effective Date | Termination Date | Validity Indicator | Type | Insurer Name |
|---|---|---|---|---|
| 01/01/2018 | | Y | Working Aged (12) | |
| | | | | |

- Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P

# Scenario Five

- Remittance advice and message states
  - Information requested was not provided, not provided timely or was insufficient with MA130
- What are your next steps?
- Resubmit, reopen or redetermination
  - Resubmit claim
  - When documentation is not provided or is incomplete, resubmit these claims with documentation
    - For EMC providers, resubmit with PWK segment or ANSI 275
    - For paper provider, resubmit claim with documentation and line item 19 indicating documentation attached

# Missing, Incomplete or Insufficient Documentation

- N706: Missing documentation
  - Information requested was not provided or not provided timely or was insufficient/incomplete
- Common error among providers is submitting claims without documentation
  - Modifiers: AS, 22, 52, 53, 66, 80, NOC and unlisted codes
- Benefits of Electronic Attachments
  - 275
  - 277

# Scenario Six

- Remittance advice and message states
  - Noncovered services because services not deemed medically necessary
- What are your next steps?
- Resubmit, reopen or redetermination
  - Reopen or redetermination
  - Add or changing diagnosis code(s) on a denied claim could result in CER
  - If you can correct claim by doing CER, correct initial claim determination

# Medically Necessary

- PR 50: These are noncovered services because this is not deemed a medical necessity by payer
- N180: This item or service does not meet criteria for category under which it was billed
  - "Medical necessity" assures services are reasonable and necessary for diagnosis or treatment of illness/injury
  - Procedure code is billed with incompatible diagnosis, for payment purposes and ICD-10 code(s) submitted is not covered under a local or national coverage determination

# Scenario Seven

- Remittance advice and message states
  - Duplicate services
    - Exact duplicate claim/service
- What are your next steps
- Resubmit, reopen or redetermination
  - Reopen or redetermination
  - Review MUE for code
  - Correct quantity billed amounts
    - Redeterminations if over MUE
    - Reopening if combining line items and correcting MUE within MUE

# Duplicate

- Partially paid or denied claims
  - 338: Exact duplicate claim/service
    - Providers are required to report and submit all services on one claim and report units of service on each line of claim
- Example
  - 22853: Insertion of cage or mesh device to spine bone and disc space
  - MUE is four
  - Do not bill 22853 on separate line items, instead quantity bill appropriately

# Duplicate

- Claims submitted without anatomical modifier(s) may not be payable
  - Modifier required to identify procedure is repeat, or not duplicative services
  - Use anatomic modifiers and report procedures with differing modifiers on individual claim lines when appropriate
    - RT, LT, FA, F1–F9, TA, T1–T9, and E1–E4
- Centers for Medicare & Medicaid Internet-Only Manual, Publication 100-04, *Medicare Claims Processing Manual,* Chapter 23, Section 20.9.3.2

# Duplicate

- Example
  - 93010: Routine electrocardiogram (ECG)
  - Which is appropriate billing
    - A
      * 93010 detailed line 1
      * 93010 detailed line 2
      * 93010 detailed line 3
    - B
      * 93010 detailed line 1 with quantity billed units of 3

# Duplicate

- Partially paid or denied claims
  - Providers are required to report and submit all services on one claim with appropriate modifiers
- Example
  - 76942: Ultrasonic guidance for needle placement
    - If procedure is distinct, append appropriate modifier 59
    - If procedure repeated, bill with appropriate modifier(s) 76/77

# Scenario Eight

- Remittance advice and message states
  - Benefit maximum for this time period or occurrence has been reached
- What are your next steps
- Resubmit, reopen or redetermination
  - Reopen
  - KX appropriate when patient qualifies above threshold under exception regulations
  - Providers are required to pre-calculate up to therapy caps and submit initial claims with the KX modifier

# Supporting Usage of KX Modifier

- 772 and MA13
  - Benefit maximum for this time period or occurrence has been reached
  - KX modifier is indication on claim(s) that patient services have met capped amount allowed for therapy
  - Provider deems continued care medically necessary
  - Medical record documentation must be maintained to support medical necessity of continued services

# Scenario Nine

- Remittance advice and message states
  - New patient qualifications were not met
  - Only one initial visit is covered per specialty per medical group
- What are your next steps
- Resubmit, reopen or redetermination
  - Redetermination
    - NPs (Specialty 50) and PAs (Specialty 97) are now working in full scope of sub-specialty groups

# New Patient Care Codes

- D463: New patient qualifications were not met
- M13: Only one initial visit is covered per specialty per medical group
  - Medicare will not pay two E/M office visits billed by physician (or physician of same specialty from same group practice) for same beneficiary on same day
  - In multi-specialty groups, when patients are seen for first time by group member of different specialty, each specialist may bill first encounter with the patient as new patient visit

# Avoid Appeal/Redeterminations

- NPP New E/M Concurrent Care Resolution
- Submit claims with supervising specialty information in 2300/2400 loop NTE segment
  - Primary diagnoses on claims must vary, supporting care for two different clinical conditions
  - Denials we see are often based on use of the same diagnosis on both claims; therefore, enter the diagnosis specific to the specialty visit
- Nonphysician Practitioner Services

# Scenario Ten

- Remittance advice and message states
  - Coverage/program guidelines were not met
  - Service not payable with other service rendered on the same date
- What are your next steps
- Resubmit, reopen or redetermination
  - Redetermination
    - NPs (Specialty 50) and PAs (Specialty 97) are now working in full scope of sub-specialty groups

# Established Patient Care Codes

- D984: Coverage/program guidelines not met
- N20: Service not payable with other service rendered on same date
  - Medicare will not pay two E/M office visits billed by physician (or physician of same specialty from same group practice) for same beneficiary on same day
  - Patient's condition must warrant services of more than one NPP working in different specialties
  - Services provided by each NPP must be reasonable and necessary

# Avoid Appeal/Redeterminations

- NPP Established E/M Concurrent Care Resolution
- Submit claims with supervising specialty information in 2300/2400 loop NTE segment
  - Primary diagnoses on claims must vary, supporting care for two different clinical conditions
  - Denials we see are often based on use of the same diagnosis on both claims; therefore, enter the diagnosis specific to specialty visit
- Nonphysician Practitioner Services

# Reducing Reopening and Redeterminations

- Common reasons claims may be denied
  - Duplicate claim
  - Medical necessity for policy related topics
  - Medically Unlikely Edits and Correct Coding Initiatives
  - Modifier KX for use with physical therapy
- **What is the solution to avoiding claim denials?**
  - Review YouTube video *Holistic Approach to Avoiding Administrative Burden*

# References and Resources

# Unprocessable, Reopening and Redetermination Resources and References

- Reopening versus Redetermination
- Top Claim Errors – Unprocessable Claim Rejections and Corrections
- Reopenings for Minor Errors and Omissions
- Redetermination – (first level appeal)
- Modifiers Used in CMS-1500 Claim Reporting
- Medicare Secondary Payer
- Prepare and Submit a MSP Claim

# CMS and WPC Resources and References

- Washington Publishing Company
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 1, Section 80.3.1 and Chapter 29, Section 310.5

# Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?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