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Steps to Claim Corrections

3/28/2024

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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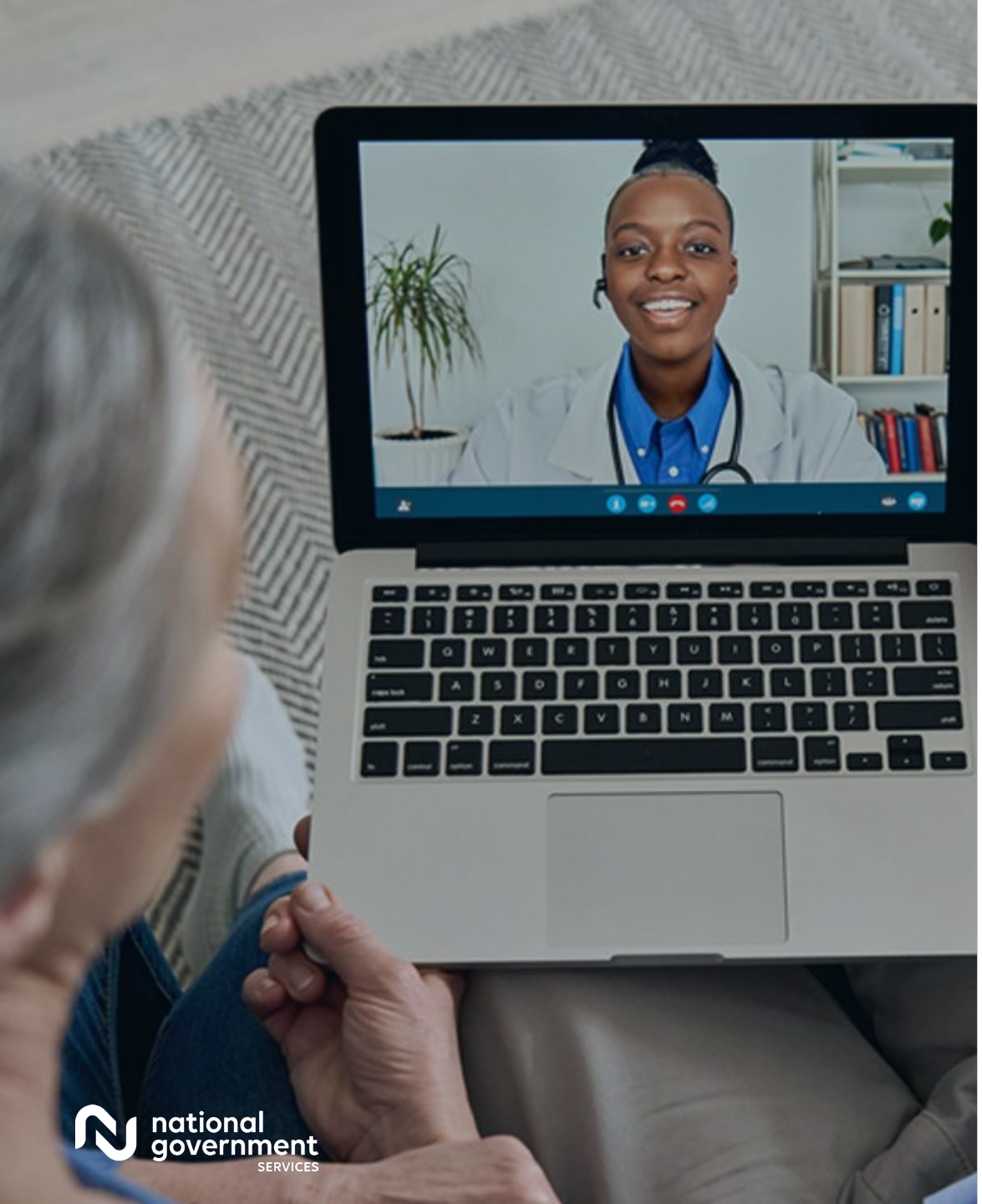

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Objective

After this session, attendees will be more familiar with the difference between an unprocessable claim, what constitutes clerical error reopenings, when to submit redeterminations and 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

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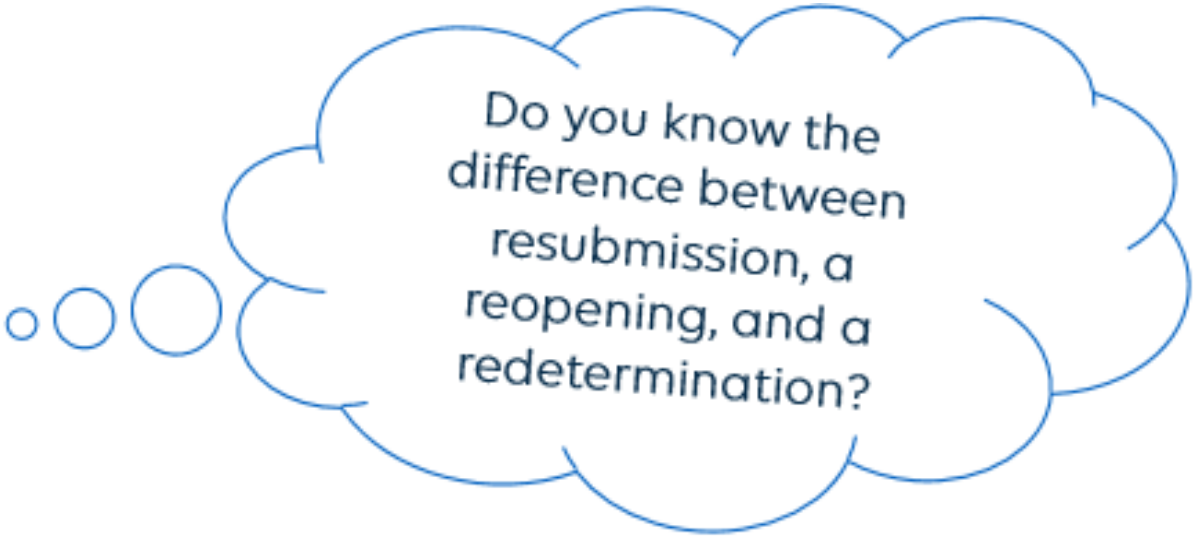
Resubmit, Reopen or Redetermination

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

Telephone Reopening Unit

- Requests that can be completed via the Telephone Reopening Unit (TRU) or Part B Reopening Request Form
  - 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)
  - 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
- These requests cannot be completed through NGSConnex

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
- 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

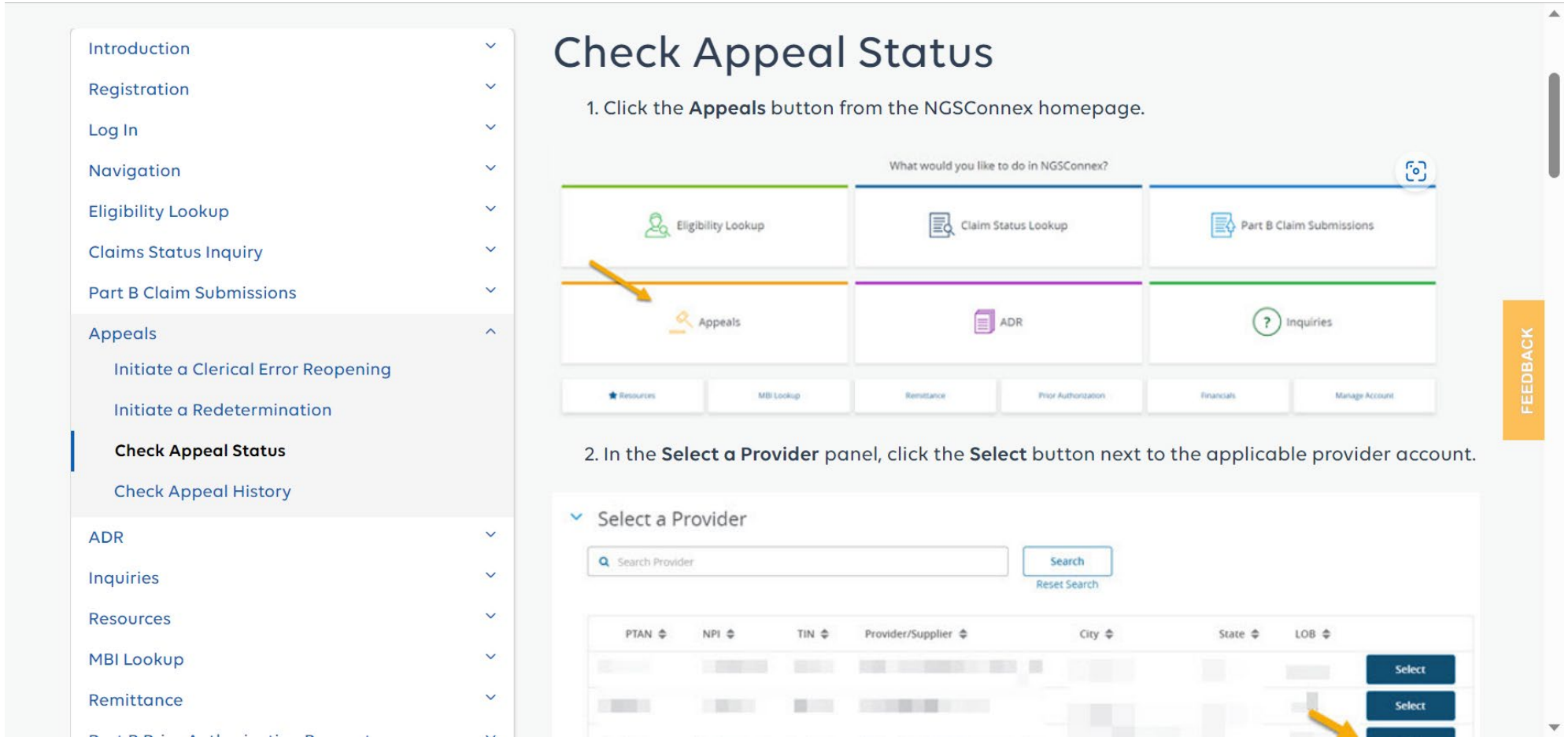
Redetermination Documentation

- 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

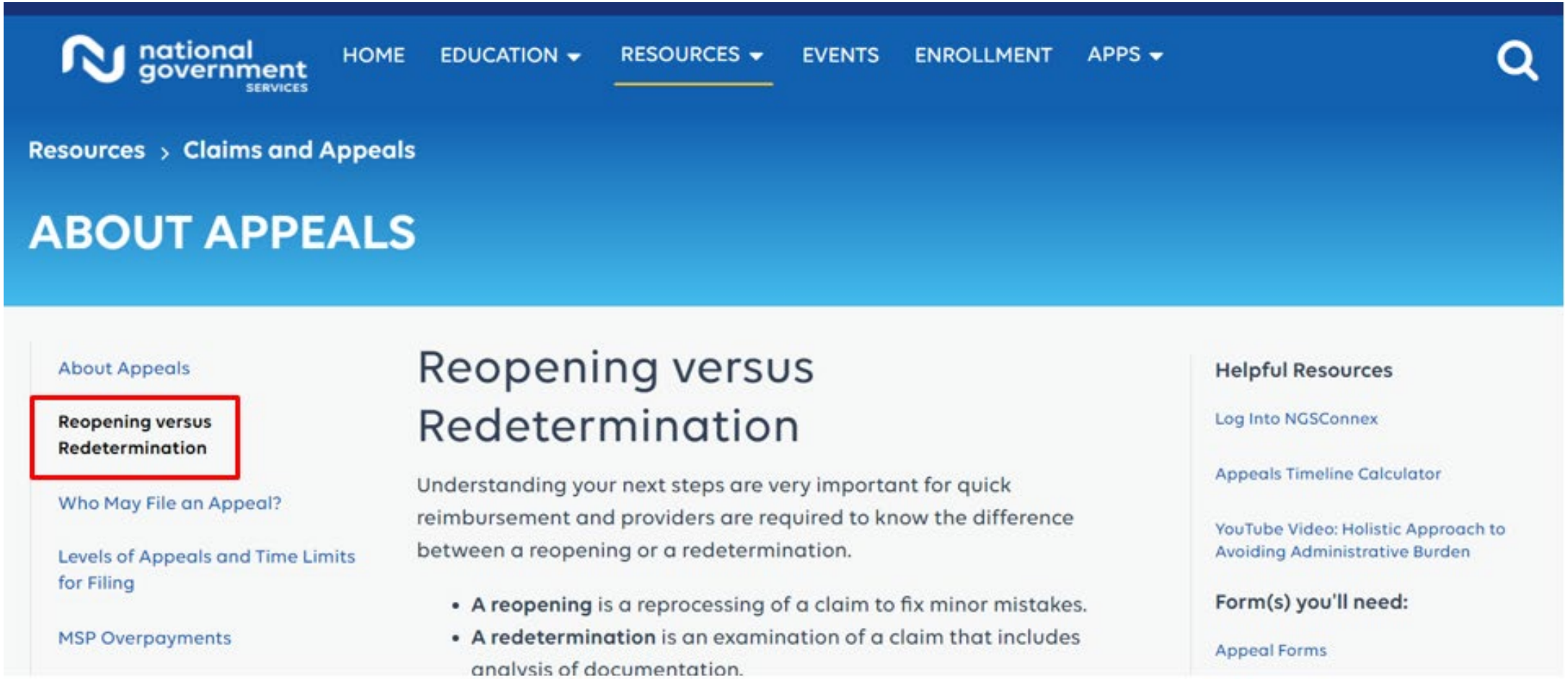
NGSConnex User Guide



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 (cont.)



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
- 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 the reason you qualify for the extension and mail to address indicated on the bottom of the form
- Part B Reopening Request Form

- Preclaim
  - A provider who believes they meet the qualifications for an extension
  - 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 the reason you qualify for the extension for late filing is met
- Requesting an Exception to Timely Filing

Interactive Claim Correction Scenarios

Scenario One

Remittance advice and message states

- Name or MBI was incorrect or missing with MA130

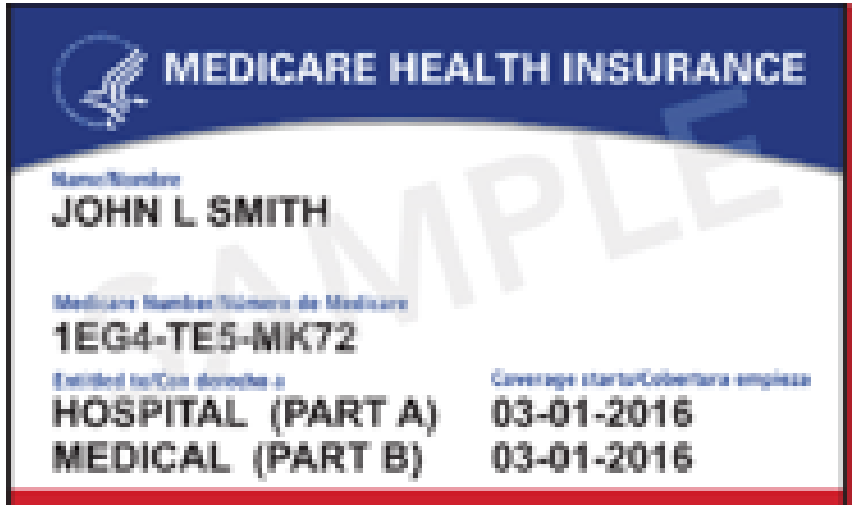
What are your next steps?

Resubmit, reopen or redetermination

- Resubmit claim
- Claim rejections with MA130 are rejected claims that shall be resubmitted

Eligibility One

- 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

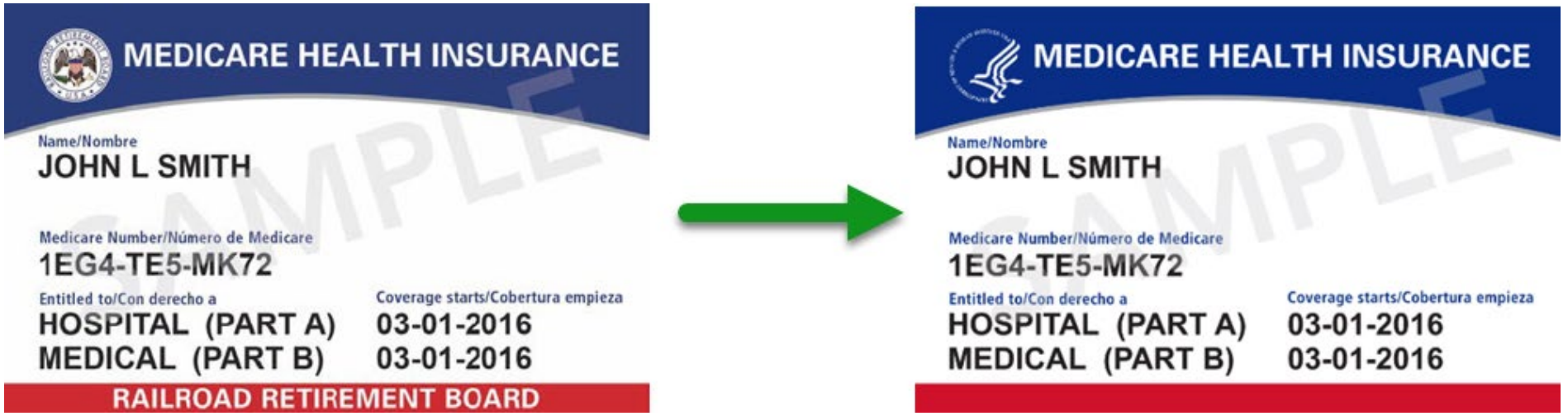
What are your next steps?

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 Two

- 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

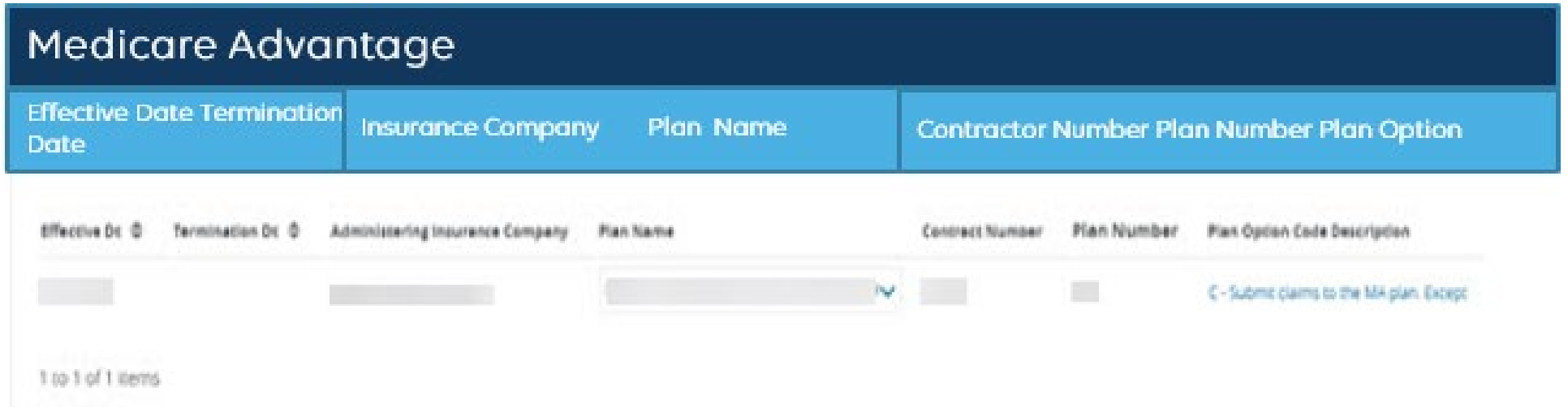
- Resubmit to correct payer or
- Reopen claim if adding modifier(s) (hospice related)
- If you can correct claim by doing CER, correct the initial claim determination

Eligibility Three

- 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

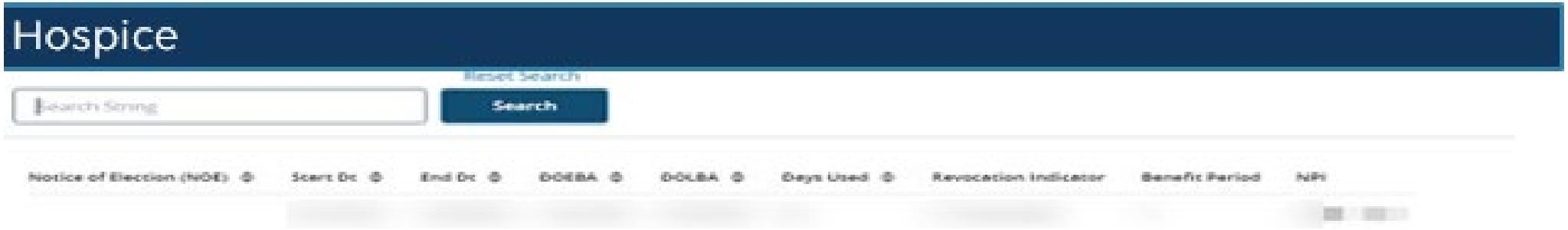
- OA 109: Claim not covered by this payer/contractor; you must send the claim to correct payer/contractor



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

Hospice Eligibility

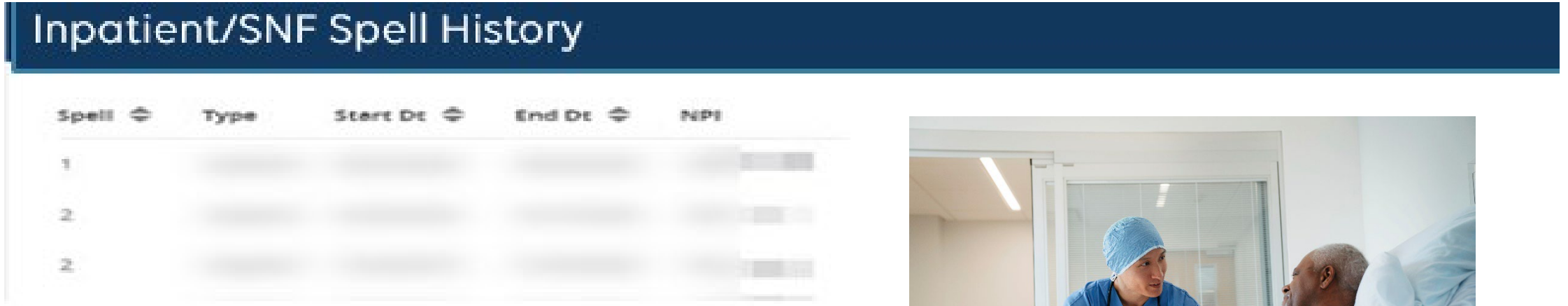
- N90: Covered only when performed by the attending physician



  - 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

- 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: How To Get Started – Five Easy Steps
  - 277: How To Get Started – Five Easy Steps

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 Example One

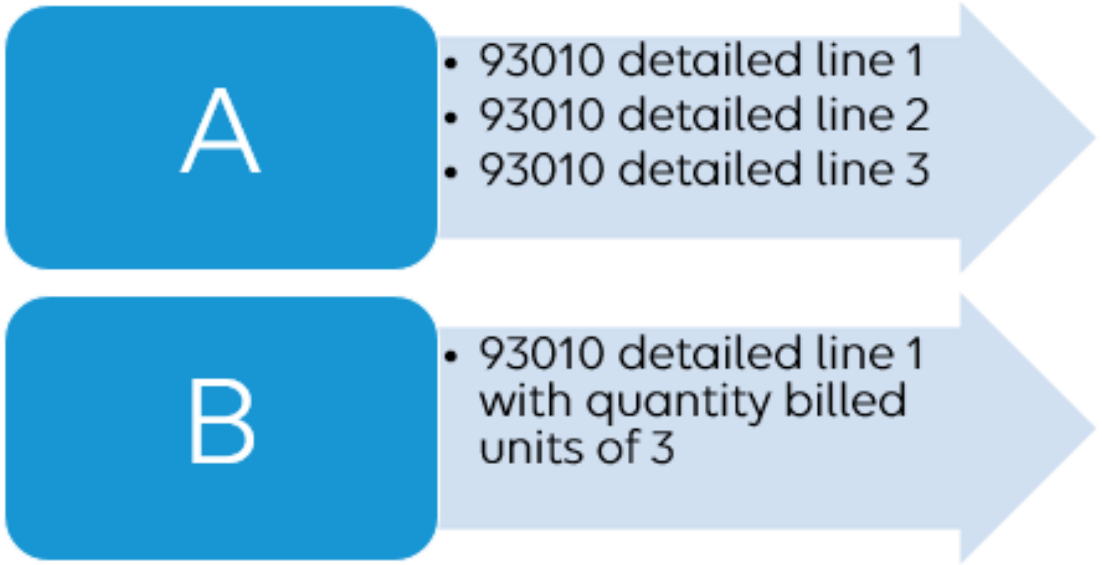
- Partially paid or denied claims
  - 338: Exact duplicate claim/service
    - ✓ Providers are required to report and submit all services on one claim and report units of service on each line of claim
- Example
  - 22853: Insertion of cage or mesh device to spine bone and disc space
  - MUE is four
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

Modifiers to Prevent Duplicates

- 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 Two

- Example: 93010 routine electrocardiogram (ECG)
  - Which is appropriate billing



- Repeat Procedures – Modifiers 76 and 77

Duplicate Example Three

- 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

NPP New Patient Care Codes

- D463: New patient qualifications were not met
- M13: Only one initial visit is covered per specialty per medical group
  - 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 New Patient Care Codes

- 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

NPP 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 Established Care Codes

- 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
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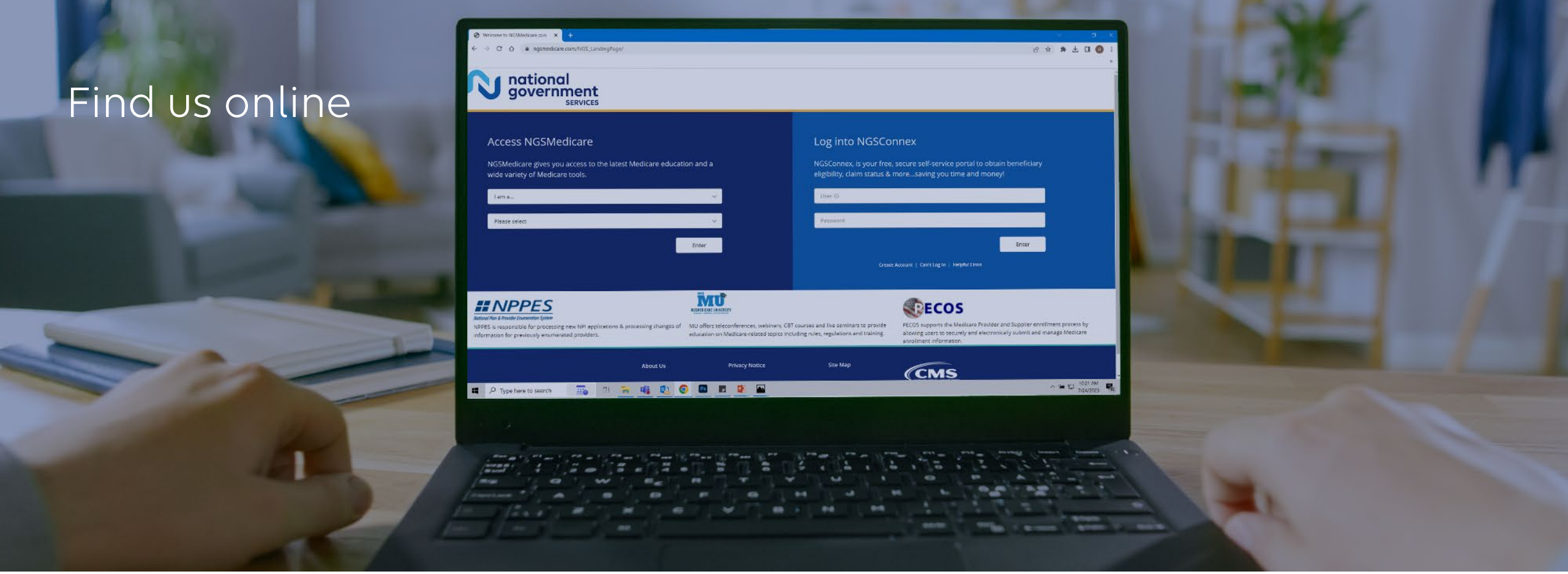

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