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# Steps to Claim Corrections

9/29/2022

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.

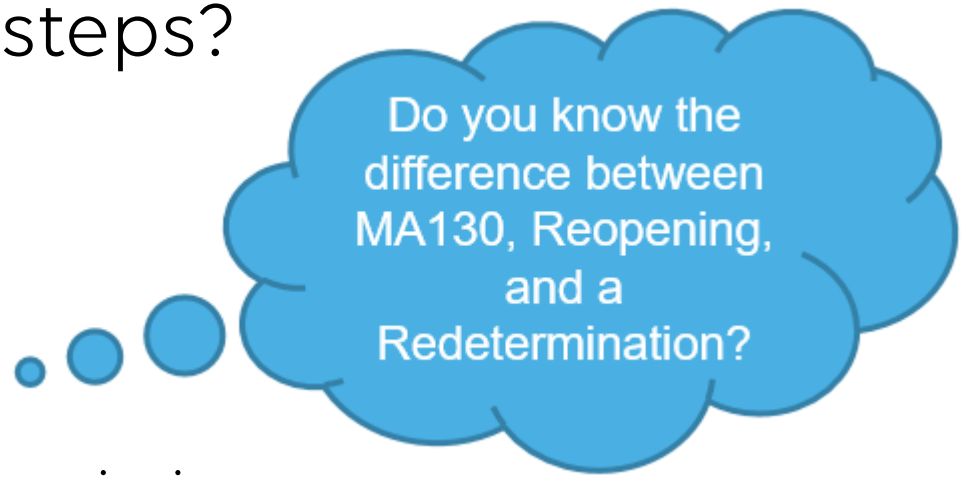
# Agenda

- Resubmissions for Unprocessable Claims
- Reopening for Clerical Error Reopenings
- Redeterminations for First Level of an Appeal
- 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 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

# NGSConnex Reopening

- Providers who are registered to use NGSConnex, our secure web portal, shall submit reopening requests electronically
- Platform for claim corrections that avoid having to submit paper request or phone calls
- Quickest route to correct claim(s) that contained errors and faster way of receiving reimbursements

# 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

# Redetermination

# 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?

# 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 slows down processing of your appeal

# Redeterminations 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

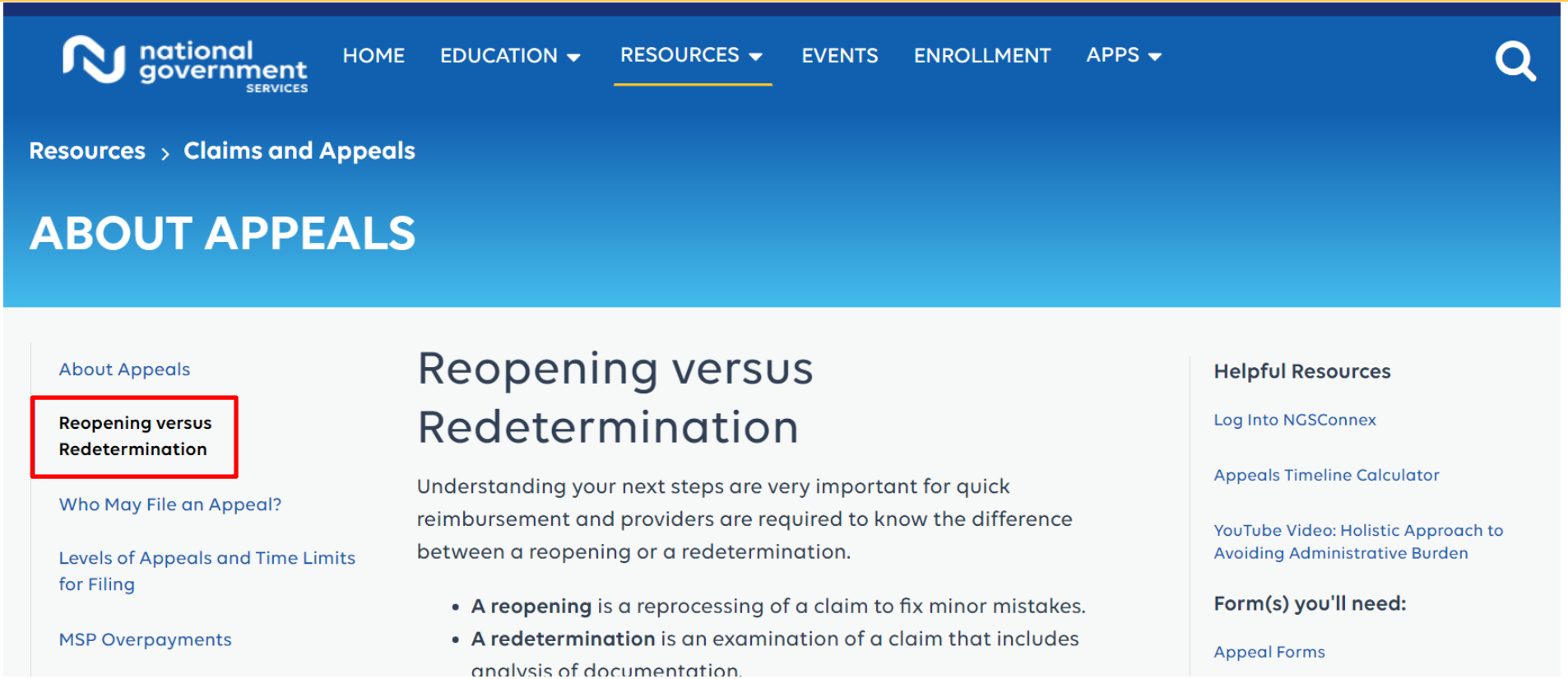
# NGSConnex Redetermination

- Providers who are registered to use NGSConnex, our secure web portal, shall submit redeterminations requests electronically
- Platform for claim reviews that avoid having to submit paper redeterminations and faster way of receiving reimbursements

# 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



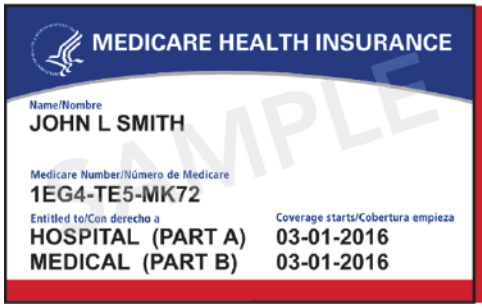
# Interactive Claim Correction Scenarios

# 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



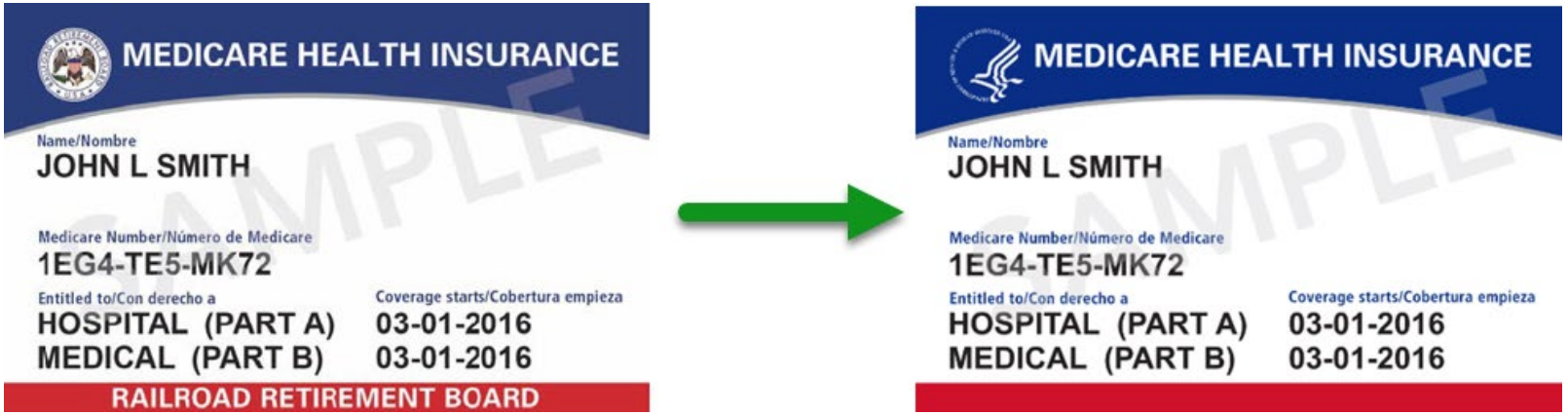

**USE THE MBI NOW**

# 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

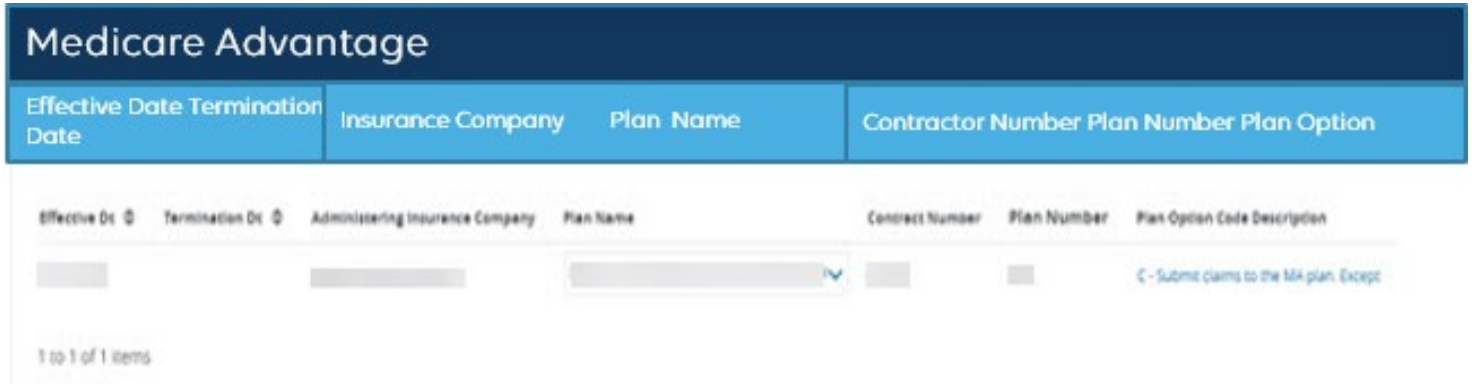
- Remittance advice and message states
  - Claim not covered by this payer/contractor; you must send claim to correct payer/contractor
- What are your next steps?
- Resubmit, reopen or redetermination
  - Resubmit to correct payer or
  - Reopen claim if adding modifier(s) (hospice related)
  - If you 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: How to Check Beneficiary Eligibility

# Medicare Advantage Plan Eligibility

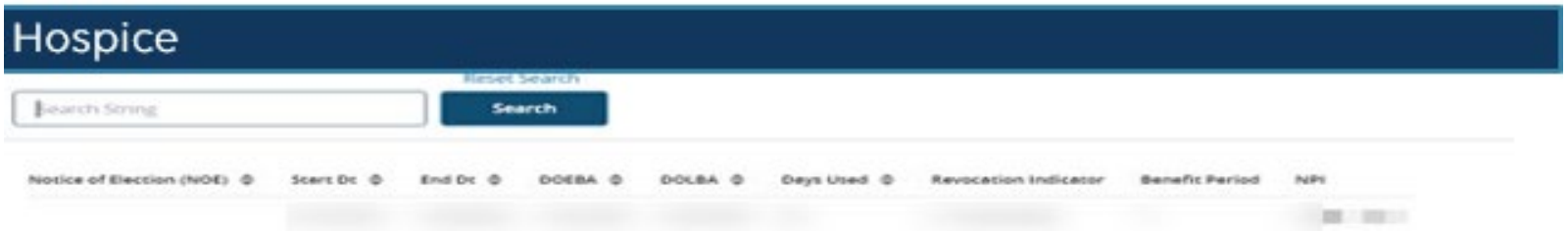
- OA 109: Claim not covered by this payer/contractor; you must send the claim to correct payer/contractor




- 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
  - OA 22: This care may be covered by another payer per coordination of benefits
  - MA04 = 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

- OA 22: This care may be covered by another payer per coordination of benefits
- MA92: Missing plan information for other insurance


- 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
- NGS Attachment Resource Tools

# 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

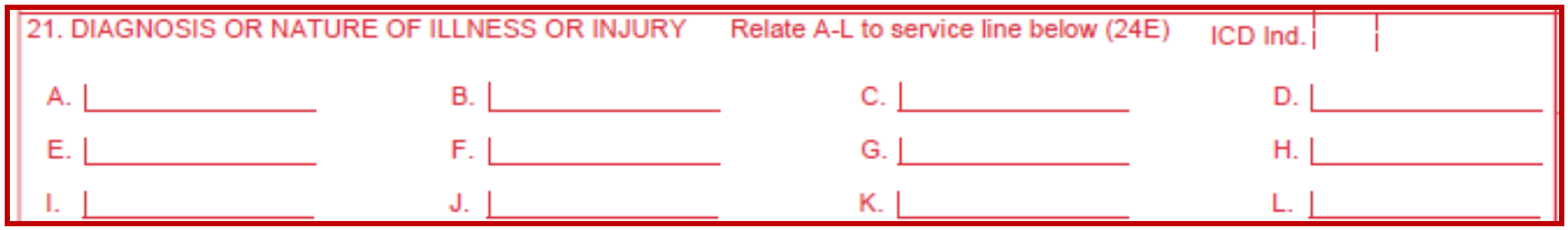
- "Medical necessity" assures services are reasonable and necessary for diagnosis or treatment of illness/injury
- Procedure code is billed with incompatible diagnosis, for payment purposes and ICD-10 code(s) submitted is not covered under a local or national coverage determination

# Scenario Seven

- Remittance advice and message states
  - Noncovered services
    - You believe services should be allowed, because you have valid diagnosis; initial claim submitted incorrectly
- What are your next steps
- Resubmit, reopen or redetermination
  - Reopen claim
  - Changing procedure code(s) or diagnosis code(s) could result in a CER
  - If you can correct claim by doing CER, correct the initial claim determination

# Diagnoses

- M76: Missing/incomplete/invalid diagnosis or condition
- M81: You are required to code to highest level of specificity



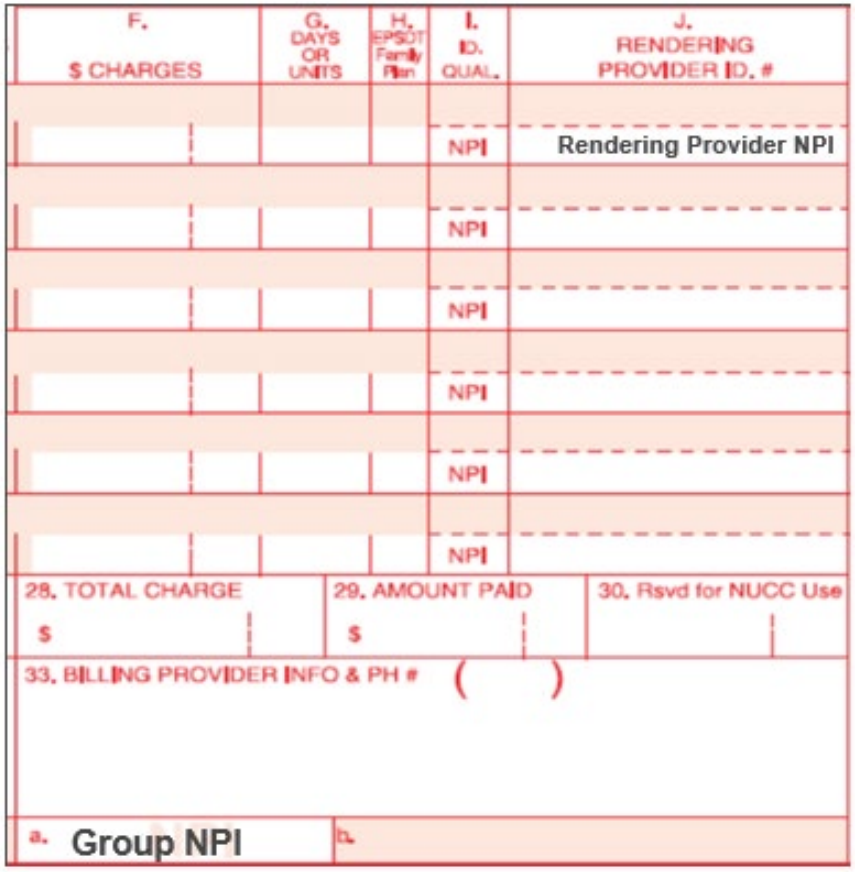

- Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

# Scenario Eight

- Remittance advice and message states
  - CO 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
  - MA112 – Missing/incomplete/invalid rendering/group practice information with MA130
- What are your next steps
- Resubmit, reopen or redetermination
  - Resubmit with rendering/group NPI

# Provider Information

- CO16: Claim lacks information or has submission/billing error(s)
- MA112: Missing, incomplete or invalid group practice information
- N290: claim was filed with an invalid or missing rendering NPI



# Referring/Ordering Provider Information

- N265/N286: Missing/incomplete/invalid referring/ordering provider primary identifier

| Qualifier | Provide Role |
|---|---|
| DN | Referring physician |
| DK | Ordering physician |
| DQ | Supervising physician |


- Order and Referring File

# Scenario Nine

- Remittance advice and message states
  - Procedure code inconsistent with modifier used or required modifier missing with MA130
- What are your next steps
- Resubmit, reopen or redetermination
  - Resubmit
    - Adding or removing modifier

# CPT/HCPCS and Modifier

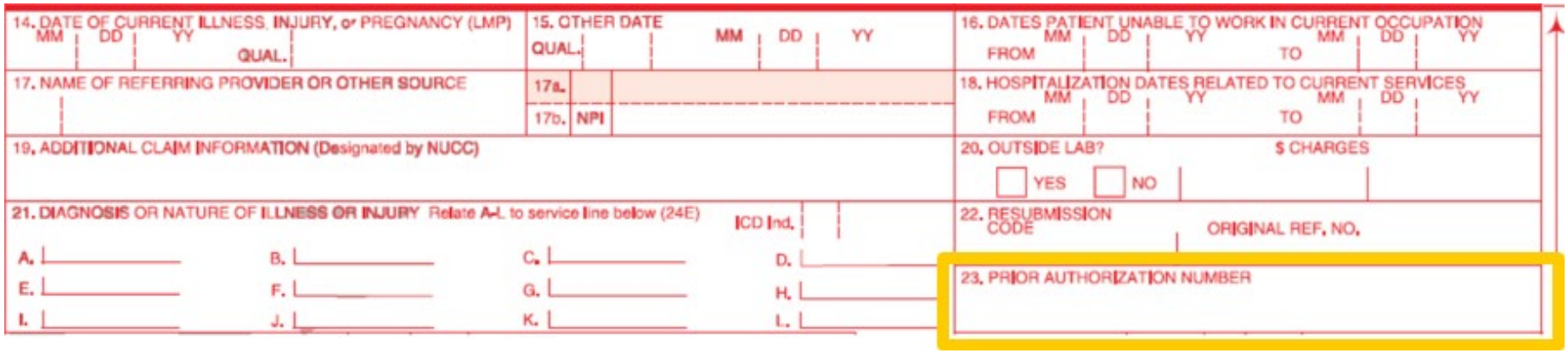
- Procedure code inconsistent with modifier used or required modifier missing
  - Common error among providers is billing inappropriate modifier with procedure code
  - Services within global period E/M and surgery modifiers
    - For example, a claim is submitted with office visit, CPT code 99215–26. Modifier 26 should not be appended to evaluation and management codes.

# Scenario Ten

- Remittance advice and message states
- Missing/incomplete/invalid CLIA certification number
- What are your next steps
- Resubmit, reopen or redetermination
  - Resubmit
  - Verify CLIA number is correctly entered in item 23

# CLIA

- MA120: Missing/incomplete/invalid CLIA certification number




- Clinical Laboratory Improvement Amendments (CLIA) Categorization of Tests

# CLIA Claim Requirements

- CLIA regulates laboratories that test patient specimens and ensures laboratories produce accurate and reliable test results
- Certificate of waiver permits laboratories to perform only waived tests, that are simple and accurate with little risk of error
  - Certain testing methods for glucose and cholesterol
  - Fecal occult blood tests
  - Pregnancy tests
  - Some urine tests

# CLIA Claim Denial

- CO B7: Provider was not certified/eligible to be paid for this procedure/service on this date of service
  - Check CLIA certificate number to make sure laboratory service being billed is within scope of certificate type
- MA120 = Missing/incomplete/invalid CLIA certification number
  - Some clinical laboratory tests must also be submitted with HCPCS modifier QW

# CLIA Waived

- Waived laboratories must
  - Enroll in the CLIA program
  - Pay applicable certificate fees every two years
  - Follow manufacturer's test instructions
    - Enter CLIA in item 23
- Clinical Laboratory Improvement Amendments (CLIA)

# 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

# MSP and CLIA Resources and References

- Medicare Secondary Payer
- Prepare and Submit an MSP Claim
- MLN® Booklet: *Medicare Secondary Payer*
- Clinical Laboratory Fee Schedule
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 16

# 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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