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National Government Services

How to Identify and Address Overlapping Medicare Claims

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Jhadi Grace
  - Provider Outreach and Education Consultant
- Kim Thomas, CPC
  - Provider Outreach and Education Consultant

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Objectives

- Assist Part A providers in identifying and addressing overlapping claim rejections

Agenda

- Overlap Overview
- Interactive Voice Response
- Overlap Situations
- Provider Type Reason Codes
- Request for Assistance

Overlap Overview

- When a claim is processed and posted to CWF, subsequent claims for the same DOS may result in overlapping claim rejection
  - Subsequent/overlapping claim may be submitted by same or different provider

Overlap Overview

- Common causes for same provider overlap rejections:
  - Charges should be combined on one claim
  - Outpatient claim submitted before allowing time for inpatient claim(s) to finalize
  - Claims should be submitted in service date sequence
- Common causes for different provider overlap rejections:
  - Did not report a leave of absence (LOA) on claim
  - Services are subject to consolidated billing
  - Incorrect patient discharge status (PDS) code was submitted

Outpatient Claim Overlap Situations

- Outpatient claim was processed with incorrect DOS
  - Caused other facility's inpatient claim to reject due to overlapping dates
- Outpatient claim processed with services classified under three-day/one-day rule
  - Outpatient claim must be cancelled and services must be included on inpatient claim
- Outpatient repetitive claim was processed; patient had inpatient stay within FROM and THROUGH dates of outpatient claim
  - Inpatient claim must be submitted and finalized
  - Bill outpatient repetitive claim with LOA OSC 74 with entire inpatient stay as FROM and THROUGH dates

Leaves of Absence (LOA)

- Definition:
  - Patient is absent at midnight census, but not discharged
- LOA days do not apply to utilization days
- Date of discharge is day patient left the hospital
  - Beneficiary cannot be an inpatient of two institutions at same time
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3 - Inpatient Hospital Billing Section 40.2.6 "Leave of Absence"

LOA Billing

- LOA days are shown on claim as follows
  - OSC 74 with FROM and THROUGH dates of leave
  - Report days of leave as non-covered days (VC 81)
  - Revenue code 018X
    - Enter zero (0) for charges
  - Units = number of LOA days

Inpatient Overlap Situations

- Claim overlapping another facility's claim when dates do not fall within their DOS
  - Facility with claim for the earliest DOS may have billed an incorrect PDS code
    - If PDS code is incorrect, it can indicate a patient is still in your facility after discharged and admitted to another facility
      - Submit adjustment to update PDS code on your claim
    - If other facility has submitted incorrect PDS code, contact other facility and ask them to update PDS code on claim

Patient Discharge Status (PDS) Codes

- Improper use of PDS codes can affect claims processing and cause overlap
- Be sure to enter correct PDS code on claim
  - Facility that discharged patient must bill with PDS code reflecting same-day admission to a subsequent facility, if applicable
- *MLN Matters Special Edition Article SE1411*

Other Common Causes for Overlaps

- Billing wrong admit/discharge date
- Patient was admitted to SNF, Home Health or Hospice
- SNF didn't discharge patient
- Patient had service in same facility, different department
- Billing interrupted stay (IPF/IRF/LTCH) incorrectly or not at all

Same-Day Transfers

- Billing requirements:
  - Same date in FROM and THROUGH statement fields
  - Report 81 value code – one noncovered day
  - All accommodation charges and units in covered field
  - CC 40
  - PDS code equals facility where patient was transferred

Transfer Reminders

- Discharge must be corrected to transfer if patient is admitted to another facility the same day or post-acute care transfer rules apply
- CWF edits to ensure accurate coding and payment for discharges and/or transfers

Left Against Medical Advice (LAMA)

- Patient LAMA
  - PDS code 07
- If patient is admitted to another facility same day after LAMA
  - Discharging hospital must code their claim as discharge to appropriate facility
    - If claim has already been billed, discharging facility must submit a claim adjustment and update PDS code appropriately to reflect admission elsewhere

Common Claim Billing Errors

- Claim billed with PDS code 01 (patient discharged to home or self care); patient went home and started home health episode of care within three days of discharge
  - Adjust claim to correct PDS code to 06 (discharged/transferred to home under care of organized home health service organization)
- Claim billed with PDS code 01; patient went home, but was admitted to another hospital on same day
  - Adjust claim to correct PDS code to 02 (discharged/transferred to a short-term general hospital for inpatient care)

Preventing Overlapping Claims

Steps to Identify Potential Claim Overlaps

- Prior to claim submission
  - Use the IVR to verify patient's eligibility and check for:
    - Medicare Advantage Plan information
    - Home Health
    - Hospice Election
    - Last Date of Billing Activity (LDBA)
  - Determine if new claim's DOS overlap claim submitted from within your facility
  - Determine if new claim's DOS overlap claim submitted from another facility
    - Communicate with other facility to resolve overlap

What is the IVR?

- Interactive Voice Response
  - Research application used to provide general/common Medicare beneficiary and/or claim information
  - Text-to-speech technology
  - Uses natural language
  - Allows you to speak directly into the telephone to make a selection

Using IVR to Identify Overlaps

- For complete IVR instructions access the IVR guide
  - Part A IVR User Guide
- Information you need to provide
  - NPI number
  - PTAN
  - Last five (5) digits of your TIN
  - Patient's Medicare Number
  - Patient's name as it appears on their Medicare card
  - DCN of the claim that rejected for overlap

Using IVR to Identify Overlaps

- Information IVR will provide
  - Type of claim
    - Home Health
    - Hospice
    - Inpatient
    - Outpatient
  - Provider name
  - Claim date range
  - Provider address

Information IVR Cannot Provide

- Overlap that cannot be identified without assistance from PCC
- Overlap that has been corrected
- Information on reason codes C7108, C7171, C7172, C7240, C7246, C7251, C7253, C7256, C7257, C7262, C7265, C7266, C7533, C7556, C7277
  - See following slides for reason code narratives

Reason Codes IVR Cannot Provide

- C7108: outpatient claim has already been paid; no Medicare payment can be made
- C7171: duplicate physician services on rural health clinical bill
- C7172: claim duplicates services filed on A or B claim
- C7240: claim duplicates claim previously processed for influenza vaccine/administration

Reason Codes IVR Cannot Provide

- C7246: incoming inpatient claim contains CABG or participating Center of Excellence demo number, and there is Part B/DME claim with DOS equal to, overlapping, or within Part A claim
- C7251: outpatient claim contains therapy services on same day of inpatient SNF claim
- C7253: outpatient claim (TOB 23X) with revenue code 54X and modifier code equal to Part B claim with HCPCS code A0380, A0390, A0425–A0436, A0999 and modifier HCPCS code

Reason Codes IVR Cannot Provide

- C7256: outpatient claim contains same HCPCS codes and modifier codes to DMERC or Part B claim with same HCPCS codes and modifier codes and detail line-item DOS
- C7257: SNF inpatient Part B claim is submitted with same HCPCS codes and modifier codes, if present, and detail line-item DOS equals to DMERC or Part B claim with same HCPCS codes and modifier codes and detail line-item DOS

Reason Codes IVR Cannot Provide

- C7262: claim is duplicate of claim previously processed for influenza vaccine/administration
- C7265: claim is duplicate of claim previously processed for influenza vaccine or pneumococcal service
- C7266: HCPCS code 11055, 11056, 11057, 11719, 11720, 11721 has been paid within six months of G0245, G0246 or G0247

Reason Codes IVR Cannot Provide

- C7533: HHA DME/prosthetic charges overlap carrier supplier bill
- C7556: duplicate billing by RHC and physician/practitioner
- C7277: claim is duplicate of Part B claim with HCPCS for ‘new patient’ with same DOS

Reason Codes – What Do They Mean

First Position	Type of Reason Code
1	CMS unibill editor
3	FISS application
5	Medical policy
7	Customer site specific (NGS reason code)
C	Crossover reject (CWF)
E	Consistency edit reject (CWF
M	Master record at another site
N	Name/personal character mismatch
T	True not in file on CMS batch system
U	Utilization reject (CWF)
W	FISS I/OCE / Grouper errors

Common Home Health Overlap Rejection

- RC U5390 - claim has FROM/THROGH dates that overlap a home health episode and a therapy revenue code/HCPCS code is reported
  - Therapies must be billed to home health agency
    - Home Health Consolidated Billing
- If patient receives home health care within three days of discharge
  - Inpatient claim must report PDS code 06 (discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care)
  - Contact home health agency if CWF needs updating

CWF: HHA Episode Information (MAP1757)

```
MAP1757              NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 03/11/20
MXG9282   SC _                          ACCEPTED                A2020200 13:32:31

HH-REC  CN                  NM           IT     DB             SX


                          TECHCOM   PROCOM
MAMMO RSK     MAMMO DATES  0000      0000
                           0000      0000
                           0000      0000

TRANSPLANT INFO:    COV IND    TRAN IND    DIS DATE
                                            000000
                                            000000
                                            000000


          EPISODE       EPISODE         DOEBA         DOLBA
           START          END
         00000000      00000000       00000000      00000000


       PROCESS COMPLETED  ---   PLEASE CONTINUE
           PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
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Common Hospice Overlap Rejection

- RC C7010 – claim has FROM/THROUGH dates that overlap a hospice election period
  - Services related to hospice are billed to hospice
  - Services not related to hospice terminal illness billed to traditional Medicare
    - Report CC 07
  - Contact hospice if CWF needs updating

CWF: Hospice Period Information (MAP1758)

```
MAP1758            NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 03/11/20
MXG9282   SC _                        ACCEPTED              A2020200 13:33:34

HOSPICE INFO FOR PERIODS 1 AND 2:

PERIOD    1ST  ST DATE          PROV          INTER
OWNER CHANGE ST DATE           PROV          INTER
2ND ST DATE          PROV          INTER          TERM DATE
OWNER CHANGE ST DATE           PROV          INTER
1ST BILLED DT          LAST BILLED DT
DAYS BILLED      REVO IND

PERIOD    1ST  ST DATE          PROV          INTER
OWNER CHANGE ST DATE           PROV          INTER
2ND ST DATE          PROV          INTER          TERM DATE
OWNER CHANGE ST DATE           PROV          INTER
1ST BILLED DT          LAST BILLED DT
DAYS BILLED      REVO IND



      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
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Common Outpatient Overlap Rejection

- RC 38035 – outpatient claim duplicates or overlaps previously processed claim which was medically denied
  - At least one revenue code and/or HCPCS are equal, DOS are the same, or
  - One line-item DOS is the same
  - Commonly seen when overlapping claim reports additional or updated information

Adhere to Claim Processing Rules

- If changes need to be made or additional services need to be added, **do not submit new/additional claim**
  - Wait for original claim to process
  - Adjust processed claim with update/additional services

Common SNF Overlap Rejection

- RC 38119 – prior inpatient SNF/non-PPS claim not received
  - Commonly seen when inpatient SNF/non-PPS inpatient claims spanning several consecutive months (sequential claims) not submitted in sequential order
- RC 38117 – prior inpatient SNF/non-PPS claim pending in the system
  - Commonly seen when next SNF inpatient/non-PPS inpatient sequential claim submitted before prior claim processed

Sequential Billing

- Use CWF, IVR, NGSConnex to verify whether the prior month's claim completely processed
  - Subsequent claims in the stay should not be submitted until the prior month's claim has processed and finalized

Claim Adjustments using FISS DDE

Step 1: Gather Required Information

- Claim change reason code chart
  - Describes reason why claim is changing
  - Two-digit alpha-numeric code
    - Entered on claim page 1 (condition code)
- Adjustment reason code
  - Describe reason for adjustment
  - Two-digit alpha code
    - Entered on claim page 3 in adjustment reason code field

Claim Change Reason Codes (Condition Codes) for Adjustments

D0 (zero)	Changes to service dates
D1	Changes to charges
D2	Changes to revenue/HCPCS/HIPPS rate codes
D3	Second or subsequent interim PPS bill
D4	Changes in ICD-10-CM diagnosis/procedure code • Use for IP acute care hospital, LTCH, IRF and SNF
D8	Change to make Medicare the primary payer
D9	Any other change (Remarks required)
E0 (zero)	Change in patient status

FISS Adjustment Reason Code File

- Listing of adjustment reason codes located in FISS DDE Inquiry menu (01) Adjustment Reason Code file (16)

FISS Adjustment Reason Code File

```
MAP1821            NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 11/06/14
MXG9282   SC           ADJUSTMENT REASON CODES INQUIRY       C201442P 09:00:59
                                SELECTION SCREEN          MNT: MXG9282  110614
CLAIM TYPES:
I = INPATIENT/SNF, O = OUTPATIENT, H = HOME HEALTH/CORF, A = ALL CLAIMS
PLAN CODE: 1        REASON CODE:
S PC RC HC TYPE                    NARRATIVE
  1  BF BF H HHPPS FINAL NOT RECEIVED
  1  BL BL A This overpayment is a result of a claim being processed with
  1  BM TB A ORIGINALL PROCESSED A SBLACK LUNG, NOW MAKE MEDICARE PRIME.
  1  CA CA I This claim adjustment is a result of the cost outlier approval.
  1  CB CB A This overpayment is the result of the credit balance report.
  1  CC CC A This overpayment is a result of the change in the charge amount.
  1  CD CD I This overpayment is a result of a Quality Improvement Organizati
  1  CE OT A REVENUE CODE CORRECTION.
  1  CF CF A This overpayment is a result of a change in coverage.
  1  CH OT O CORRECTION OF OUTPATIENT CASH DEDUCTIBLE.
  1  CI OT A CORRECTION OF PATIENT CASH DEDUCTIBLE.
  1  CN OT I CHANGE IN COV TO NONCOV/NONCOV TO COV DAYS
  1  CO CO I This overpayment is a result of a Quality Improvement Organizati
  1  CP CP I This overpayment is a result of a partially approved cost outlie
  1  CR CR A A claim reconsideration adjustment has been processed.
       PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD
```

Step 2: Access the Claim

- Log into FISS DDE
- Select Claims Correction Menu (option 03)
- Select option from Claim and Attachments Correction Menu
  - Based on processed/rejected claim type
    - Inpatient – 30
    - Outpatient – 31
    - SNF – 32
    - Home Health – 33
    - Hospice – 35

Step 2: Access the Claim

- Enter MBI and DOS
  - List of processed claims will be displayed
  - To view list of rejected claims that can be adjusted, overwrite ‘P’ in status field with ‘R’
- Select claim to be adjusted by placing ‘U’ in SEL field
  - Claim opens at page 1
  - TOB automatically changes to XX7
  - System pulls in DCN from claim to be adjusted

Step 3: Make Adjustments to Claim

- On claim page 1, enter claim change reason code in CC field
  - Only one claim change reason code should be reported per adjustment claim
  - If more than one applies, choose the most appropriate claim change reason code
- When reason for adjustment is to make changes to claim lines, make appropriate claim adjustments on claim page 2
  - Change units, codes, rates; recalculate total charges

Step 3: Make Adjustments to the Claim (claim change reason code, PDS code)

```
 MAP1711    PAGE 01  NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 07/28/15
 MXG9282    SC                INST CLAIM ADJUSTMENT            C201531P 10:58:37
 HIC                    TOB 137  S/LOC S B0100 OSCAR                SV:    UB-FORM
NPI                TRANS HOSP PROV                    PROCESS NEW HIC
PAT.CNTL#:                          TAX#/SUB:                    TAXO.CD:
 STMT DATES FROM 080312  TO 080412  DAYS COV      N-C        CO       LTR
 LAST                               FIRST J                MI    DOB 06051917
 ADDR 1 123 MAIN ST.                          2 SYRACUSE, NY
 3                                  4                                CARR:
 5                                  6                                 LOC:
ZIP 13203      SEX M MS U ADMIT DATE        HR    TYPE 1 SRC 1 D HM       STAT 01
   COND CODES 01 D1 02 _  03    04    05    06    07    08    09    10
 OCC CDS/DATE 01          02          03          04          05
              06          07          08          09          10
   SPAN CODES/DATES 01                02                03
04                  05                06                07
08                  09                10                FAC.ZIP 19801
  DCN                          
       V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
01 A2       718.34 PR 2   02 76       37.00       03
04                        05                      06
07                        08                      09
       PROCESS COMPLETED  ---   PLEASE CONTINUE
      PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT  PF9-UPDT
```

Step 3: Make Adjustments to Claim

- Delete revenue code lines by placing a ‘D’ on the first position of the revenue code
  - Press the <Home> key
  - Press the <Enter> key
    - This will delete the entire revenue code line
- Add new charges by first deleting Total Charge (0001) line, adding new line(s)
- Make sure Total Charge line (0001) added and recalculated

Step 3: Make Adjustments to Claim

- On claim page 3, enter adjustment reason code
- On claim page 4, enter Remarks
  - For any situation where an adjustment requires some explanation
  - When claim change reason code D9 is used, Remarks are mandatory
    - CC D9 causes claim to kick out to manual processing and remarks will be read by a claims reviewer
  - Remarks otherwise not mandatory for adjustments

Step 3: Make Adjustments to the Claim (adjustment reason code)

```
MAP1713    PAGE 03  NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 07/28/15
MXG9282    SC                INST CLAIM ADJUSTMENT            C201531P 11:06:06
HIC                    TOB 137  S/LOC S B0100  PROVIDER
NDC CODE                                                OFFSITE ZIPCD:
 CD  ID     PAYER                    OSCAR        RI AB              EST AMT DUE
A Z        MEDICARE                                 Y                      0.00
B                                                                          0.00
C                                                                          0.00
DUE FROM PATIENT          0.00          0.00    SERV FAC NPI  0000000000
MEDICAL RECORD NBR                       COST RPT DAYS      NON COST RPT DAYS
DIAG CODES 01 72402       02              03              04              05
06              07              08              09                END OF POA IND
ADMITTING DIAGNOSIS                E CODE                HOSPICE TERM ILL IND
IDE                       GAF             0.0000      PRV
PROCEDURE CODES AND DATES 01                      02
03                04                    05                    06
ESRD HOURS 00  ADJUSTMENT REASON CODE OT  REJECT CODE          NONPAY CODE
ATT PHYS          NPI                  L DOCTOR                F A          M     SC 99
OPR PHYS          NPI                  L DOCTOR                F A          M     SC 99
OTH OPR           NPI 0000000000       L                       F            M     SC
REN PHYS          NPI 0000000000       L                       F            M     SC
REF PHYS          NPI 0000000000       L                       F            M     SC
      PROCESS COMPLETED   ---    PLEASE CONTINUE
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Step 4: Submit & Verify Claim Adjustment

- Review changes to ensure accuracy
- Hit <F9/PF9> to resubmit claim for processing
- Verify that claim was stored correctly by going into Inquiries submenu (Option 01) and choosing Claims Summary option (Menu 12)
  - Available next day after updating claim (<F9/PF9>)
  - Key patient's MBI and FROM and THROUGH dates of adjustment claim
  - Adjustment should appear in 'S' Location
  - TOB = XX7

Avoid a Common Adjustment Error

- When claims reject, charges are placed into the "NCOV CHARGES" (noncovered charges) field on claim page 02
- Claim lines must be deleted and added as new covered charge lines when claim is adjusted
- Be sure the 0001 Totals line is re-added and calculated appropriately

Inquiries

- Providers are encouraged to work together with the other provider/facility to resolve these types of billing issues
- Written inquiries can be sent to
  - Medicare Correspondence Request Form
  - My Inquiries in NGSConnex
    - Include records supporting admit/discharge dates and times if possible

Summary

- Educated on how to correct an overlapping claim
- Identified what to report on a claim to prevent an overlap situation
- Explained how to use the IVR to identify claim overlaps
- Reviewed claim adjustment process using FISS/DDE

Thank You!

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

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