Critical Access Hospital Top Outpatient Denials, Rejects and Return to Provider Reason Codes

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Today's Presenters

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Objective

- Provide personalized education on your facility's top claim submission errors (top reason codes) so you can prevent these errors in the future

Agenda

- Impact of claim rejections/RTPs/denials
- Provider self-service options
- Preventing and adjusting rejections
- Preventing and correcting RTPs
- Preventing and appealing denials
- References, resources and wrap up
- Questions and answers

How Claim RTPs, Rejections and Denials Impact Providers

- Financial
  - In some cases, no Medicare payment
  - Expense of resubmitting claim correctly
- Time
  - Loss of staff time
  - More time spent researching claim rejections

Benefits of Preventing Claim RTPs, Rejections and Denials

- Increase Medicare cash flow
- Ensure claims are Medicare-compliant upon first claim submission
- Ensure claims are filed timely with Medicare
- Avoid being investigated for Medicare program integrity (fraud & abuse)
- Use staff time better

Top Claim Submission Errors

- NGS website
  - Resources >Claims & Appeals > Top Claim Errors
    - Denials
    - Rejects
    - Return to Provider
  - For each contract J6/JK

Claims Status/Locations in FISS

- Submitted claims categorized into a status/location
  - S XXXXX – Claim suspended
  - P B9997 – Claim processed
  - R B9997 – Claim rejected
    - May have to adjust claim, submit new claim, or no action needed
  - T B9997 – Claim RTP
    - Review reason code for claim correction instructions
  - D B9997 – Claim denied
    - May have to appeal claim or have reopened

Reason Code Types

First Position	Type of Reason Code
1	CMS unibill editor
3	FISS application
5	Medical policy
7	Customer site-specific – NGS specific reason code
C	Crossover reject (CWF)
E	Consistency edit reject (CWF)
M	Master record at another site (CWF)
U	Utilization reject (CWF)
W	FISS Medicare code editor (MCE)/integrated outpatient code editor (IOCE)/Grouper errors

Top CAH Reason Code Errors

- Rejects
  - 38105
  - U5233
  - 39929
  - 38200
  - 34538, C7010 and U5210
- RTPs
  - 32402
  - 36602
  - 32372
  - 34072
  - E51#6
- Denials
  - 39928
  - 7C387
  - 5WEXC
  - 52MUE
  - 54NCD

Provider Self-Service Options

Medicare Eligibility Checklist

- Verify all information before preparing claim
  - Is patient entitled to Medicare coverage?
  - Is patient's identifying information reported accurately?
  - Does patient have Part A?
  - Does patient have Part B?
  - Is patient enrolled in hospice?
  - Does patient have MAO plan coverage?
  - Does patient have insurance that is primary to Medicare (MSP situation)?

Tools to Use

- Patient
- MSP questionnaire
  - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1
- Mainframe systems access
  - FISS
  - CWF
  - IVR
  - NGSConnex
  - CMS' HETs

What is FISS?

- Allows remote user connectivity to Medicare mainframe
- Used to process claims and maintain records
- Providers use FISS to
  - Access CWF
  - Research coding
  - Track submitted claims
  - Enter/correct/adjust/cancel claims
  - View reports

What is CWF?

- Assists in verifying patient's eligibility
  - Providers access through online claims system
- Maintains national beneficiary records
  - Entitlement, date of birth, date of death
  - Recent benefit periods (including any deductibles due)
  - HH episode
  - Preventive services
  - Hospice enrollment
  - MSP information
  - MAO plan enrollment

What is the IVR?

- Interactive Voice Response system
  - 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 selection

What is NGSConnex?

- Alternative to FISS DDE, CWF, IVR, HETS, Provider Contact Center for certain information
- Allows providers to access beneficiary eligibility, claim, payment information online
- Allows providers to submit appeals, claim-specific inquiries, submit credit balance reports and A&R inquiries through the portal

HIPAA Eligibility Transaction System (HETS)

- Allows users to submit HIPAA compliant 270 eligibility request files over a secure connection and receive 271 response files
  - HETS 270/271 Companion Guide
- Replaces CWF eligibility transactions HIQA, HIQH, ELGA and ELGH
  - Provider access revocations began 2/1/2020
  - CWF Eligibility Sunset
  - CWF Eligibility Sunset Frequently Asked Questions (FAQ)

Top Rejects

Reject Reason Code 38200

- Claim is exact duplicate of previous claim
  - Following fields on history and incoming claim is/are same:
    - MBI
    - TOB
    - Provider identification number
    - From and through DOS
    - Total charges (on line or on bill)
    - HCPCS/CPT codes, or procedure code modifiers

Reject Reason Code 38200

- Commonly seen when duplicate batch of claims are submitted
  - First batch processes, resubmitted batch receives rejection
  - On occasion, exact duplicates submitted on same day both reject

Tips for Preventing Claim Rejections for Reason Code 38200

- Review claims' status to determine if your facility has previously submitted claims
  - Utilize CWF, IVR or NGSConnex
- Adjust claims to make changes to previously submitted/processed claims
  - Do not resubmit claims when previously submitted/processed claims do not process/pay as expected, unless reason code indicates to do so

Reject Reason Code 38105

- Outpatient TOBs 14X, 13X and 85X cannot have overlapping dates when provider numbers are equal
  - Whether any revenue codes are equal or not

Watch Out For Duplicates

- If a provider continues to submit duplicate claims, MAC can initiate program integrity action
  - CR8121 “Clarification of Detection of Duplicate Claims Section of the CMS Internet Only Manual”

Reject Reason Code U5233

- Claim submitted to traditional (FFS Medicare) for patient who elected/enrolled in MAO plan
  - MAO plans replace traditional Medicare; traditional Medicare is not secondary or supplemental
  - MAO plans are offered by private companies approved by CMS and can be set up in different ways (HMO)

MAO Plan Enrollment/Disenrollment

- Enrollment
  - When newly eligible for Medicare due to age or disability
  - When Medicare eligibility changes from disability to age
  - When enrolling in Part B during general enrollment (must have Part A)
  - During annual enrollment period (October 15 – December 7)
    - Generally, effective 1st of month after beneficiary applies; there are exceptions
- Disenrollment
  - During annual disenrollment period (January 1 – February 14)
    - Generally, effective first of month after member disenrolls; there are exceptions
- Special events apply to enrollment and disenrollment

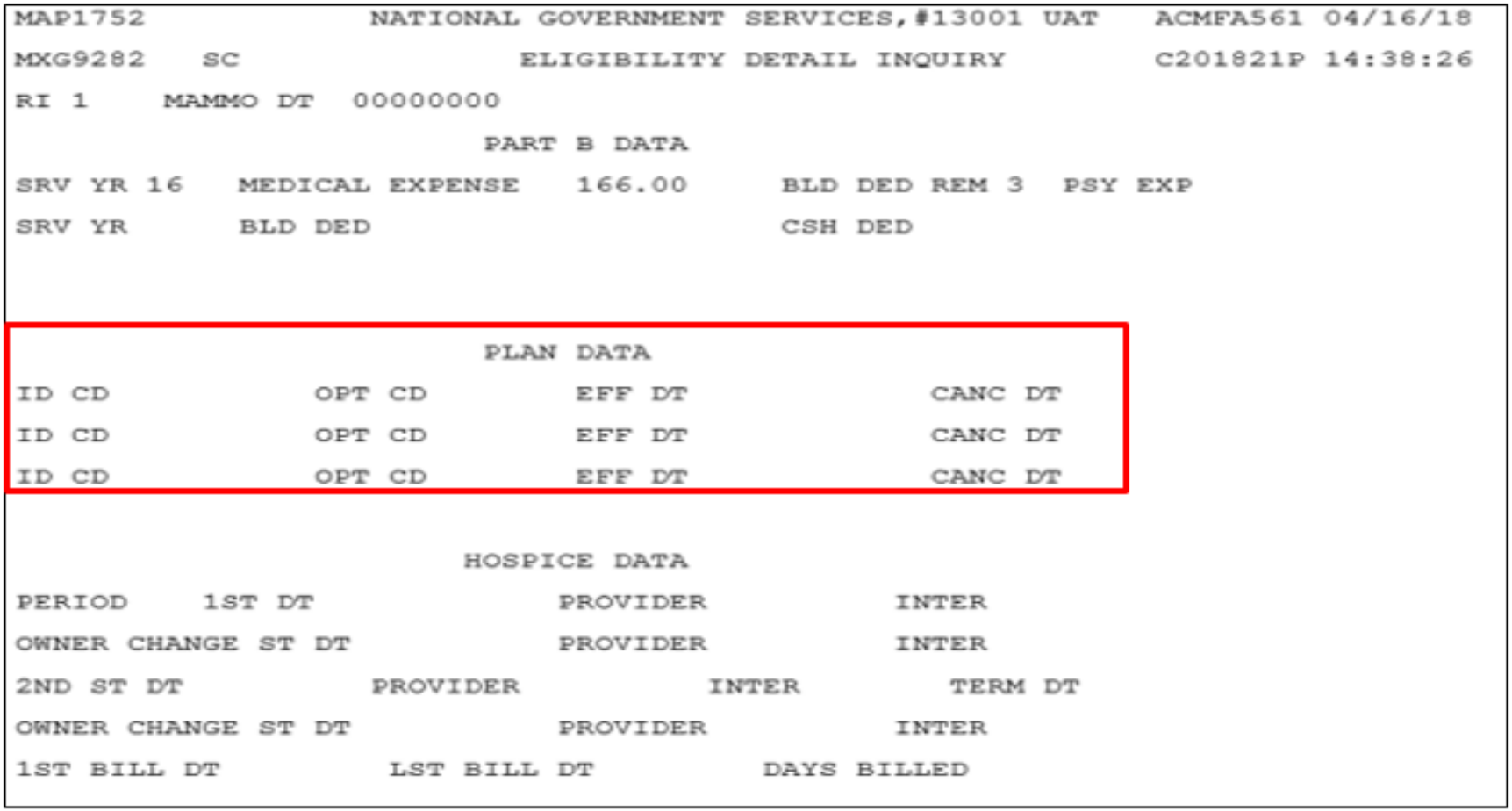
Identifying Beneficiary Enrolled In MAO Plan

- Eligibility information available on CWF
  - FISS Inquiry (01) Beneficiary/CWF option (10)
- Call IVR
  - Choose option 1 for eligibility
  - IVR releases plan number, name/address, telephone number and effective/termination dates
  - Choose “I have a question” option (if you have MAO plan ID and need name and address)
- NGSConnex - provider online inquiry portal

Risk-Based vs. Cost-Based MAO Plans and Who to Bill?

- "OPT CD" field can have two values:
  - C = Risk-based plan
    - Most common type of plan
    - Submit all claims to MAO plan (IP and OP)
    - Submit IP **informational** claims to traditional Medicare (MAC)
    - Do not submit OP claims to traditional Medicare (MAC)
  - 1 = Cost-based plan
    - Submit all claims to traditional Medicare (MAC)

FISS Eligibility Detail (Screen 2)



```
MAP1752              NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 04/16/18
MXG9282    SC                ELIGIBILITY DETAIL INQUIRY         C201821P 14:38:26
RI 1     MAMMO DT   00000000

                            PART B DATA
SRV YR 16    MEDICAL EXPENSE    166.00      BLD DED REM 3   PSY EXP
SRV YR       BLD DED                        CSH DED


                            PLAN DATA
ID CD              OPT CD          EFF DT               CANC DT
ID CD              OPT CD          EFF DT               CANC DT
ID CD              OPT CD          EFF DT               CANC DT


                          HOSPICE DATA
PERIOD     1ST DT               PROVIDER            INTER
OWNER CHANGE ST DT              PROVIDER            INTER
2ND ST DT            PROVIDER             INTER          TERM DT
OWNER CHANGE ST DT              PROVIDER            INTER
1ST BILL DT           LST BILL DT           DAYS BILLED
```

NGSConnex – MAO Information Panel

MAO Plan Listing

- CMS MA Plan Directory
  - View directory by contract number or contract name
- Call IVR
  - Choose “I have a question” option if you have an MAO plan ID and need contact information
  - IVR releases name/address and telephone number

Tips for Preventing Claim Rejections for Reason Code U5233

- Ensure registration/admission staff is checking to determine if patient enrolled in MAO plan prior to submitting claims
  - For MAO option code 1 plans, submit
    - All claims to traditional Medicare
  - For MAO option code C plans, submit
    - OP claims to MAO plan only (not to traditional Medicare)
    - IP claims to MAO plan and then informational claims to traditional Medicare

References and Resources – U5233

- CMS IOM Publications
  - 100-02, *Medicare Benefit Policy Manual*, Chapter 9, Section 20.4, Election by Managed Care Enrollees
  - 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 90 Patient Is a Member of a MA Organization for Only a Portion of the Billing Period
  - 100-16, *Medicare Managed Care Manual*
- NGS website
  - Education > Job Aids and Manuals
    - Medicare Beneficiary Eligibility Checklist
    - Reason Code: U5233

Reject Reason Code 39929

- 39929
  - Each line of charges on this claim has been rejected and/or rejected and denied
  - Check line level reason codes
  - Review and determine whether adjustment of new claim needs to be submitted
- Utilize FISS DDE Inquiries menu option 01
  - Claim Summary option 12

Tips for 39929

- Check MAP171D for line level reason codes and to determine line level reject for each line billed on the claim
  - From claim page (2) MAP1712; <PF11/F11> to Third Right view (MAP171D)
- If appropriate make need correction and submit a new claim

FISS DDE 01/12 claim page 2

```
MAP1712   PAGE 02 NATIONAL GOVERNMENT SERVICES, #13001 UAT   ACMMA561 02/22/13
 TC98548   SC               INST CLAIM INQUIRY                C201314P 13:01:20
                                                  REV CD PAGE 01
 MID XXXXXXXXXX                     TOB 851  S/LOC R B9997   PROVIDER XXXXXX

                             TOT    COV                          SERV  RED
 CL REV  HCPC MODIFS   RATE UNIT   UNIT TOT CHARGE NCOV CHARGE DATE  IND
 1  0360 29580 50           00001           100.00 100.00      072416
 2  0636 J2405              00001             1.00   1.00      072416
 3  0001                                    101.00

 39928                                                  <= REASON CODES
           PRESS PF3=EXIT  PF5=UP PF6=DOWN  PF7=PREV  PF8=NEXT  PF11=RIGHT
```

MAP171D

```
MAP171D   PAGE 02  NATIONAL GOVERNMENT SERVICES #06201 UAT   ACMFA722 08/13/20
  KXT2938   SC               INST CLAIM ENTRY                 A20203CP 08:20:51
  DCN 20000000000004XXX       MID              RECEIPT DATE 081320  TOB 851
  STATUS S  LOCATION B0100    TRAN DT          STMT COV DT 000000   TO 000000
  PROVIDER ID 242578         BENE NAME ,
  NONPAY CD     GENER HARDCPY       MR INCLD IN COMP          CL MR IND
  TPE-TO-TPE    USER ACT CODE       WAIV IND    MR REV URC    DEMAND
  REJ CD        MR HOSP RED         RCN IND     MR HOSP-RO    ORIG UAC
  MED REV RSNS
  OCE MED REV RSNS
          HCPC/MOD IN    SERV                          -----REASON-CODES------
   REV  HCPC MODIFIERS   DATE  COV-UNT   COV-CHRG   ADR
                                                    FMR
  ORIG                    ORIG REV         MR      ODC
  OCE OVR   CWF OVR   NCD OVR   NCD DOC   NCD RESP   NCD#          OLUAC
          NON       NON     DENIAL OVER ST/LC  MED  ------------ANSI------------
  LUAC  COV-UNT   COV-CHRG  REAS  CODE OVER   TEC  ADJ  GRP ------REMARKS------
  TOTAL                          LINE ITEM REASON CODES
        PROCESS COMPLETED  ---   PLEASE CONTINUE
      PRESS PF2-1712  PF3-EXIT  PF5-UP  PF6 DOWN  PF7-PREV  PF8-NEXT  PF10-LEFT
```

Reject Reason Code 34538

- Claim was submitted as Medicare primary and a positive Working Aged MSP record is on CWF
  - Beneficiary has EGHP coverage that is primary to Medicare per MSP Provisions
  - MSP VC 12
  - MSP Primary Payer ID code A
  - Claim does not indicate reason Medicare is primary such as a retirement date

Reject Reason Code 34538

- Provider action:
  - Check CWF to verify MSP record is open and correct
    - Compare MSP record information to MSP information you collected from beneficiary or representative
      - If MSP record is correct, submit claim to primary insurer and once you receive payment, adjust rejected claim to Medicare secondary
      - If MSP record is incorrect, adjust rejected claim back to Medicare primary
        - » Must provide reason Medicare is primary on claim such as retirement dates (OC 18 for beneficiary's and/or OC 19 with spouse's)
        - » If Medicare is primary for other reason, contact BCRC to update record before adjusting rejected claim

Tips for Preventing Claim Rejections for Reason code 34538

- Determine primary payer before submitting claim
  - Must check for MSP records for beneficiary in CWF for each service using HETS, NGSConnex or IVR
    - MSP record includes MSP VC or Primary Payer Code for applicable MSP Provision(s) – See Chart
  - May need to collect MSP information from beneficiary for every IP admission or OP encounter (some exceptions) by asking questions about other insurance using CMS' MSP questionnaire or your own form
  - Collect additional information such as retirement dates
  - Compare MSP record information to collected MSP information and use MSP knowledge to determine

Tips for Preventing Claim Rejections for Reason code 34538

- Submit claim to appropriate primary payer
  - If other insurer is primary, submit claim to that plan first and then to Medicare as secondary
  - If Medicare primary, submit Medicare primary claim and indicate reason on claim such as retirement date(s)
    - If reason is not retirement, contact BCRC to correct MSP record first
    - Phone: 855-798-2627 or Fax: 405-869-3307
    - Benefits Coordination & Recovery Center (BCRC) contacts
- References:
  - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1
  - MSP articles on our website under Claims & Appeals > Medicare Secondary Payer

MSP Value Code Chart

MSP VC	MSP Provision	Primary Payer Code
12	Working aged, age 65 and over, EGHP, 20 or more employees	A
13	ESRD with EGHP in coordination period	B
14	No-Fault Insurance (automobile and other types)	D
15	WC or WC Set-Aside	E or W
16	Public Health Services; research grants	F
41	Federal Black Lung Program	H
43	Disabled, under age 65, LGHP, 100 or more employees	G
47	Liability Insurance	L

Benefits Coordination & Recovery Center

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Contacts

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- Group Health Plan Recovery
- Non-Group Health Plan Recovery
- Reimbursing Medicare
- Commercial Repayment Center Portal
- Medicare Secondary Payer Recovery Portal
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- Archive

Contacts

Note: Submit all payments, forms, documents and/or correspondence to the return mailing address indicated on recovery correspondence you have received. Otherwise, refer to the contact information provided on this page.

Benefits Coordination & Recovery Center (BCRC)

BCRC Customer Service Representatives are available to assist you Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays, at toll-free lines: 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired).

Note: For information on how the BCRC can assist you, please see the **Coordination of Benefits** page and the **Non-Group Health Plan Recovery** page.

Data Collections (Coordination of Benefits)

Please mail correspondence related to reporting a case, coordination of benefits, etc. to:

Medicare - Data Collections

P.O. Box 138897 Oklahoma City, OK 73113-8897

Fax:

1-405-869-3307

Reject Reason Code C7010

- Claim submitted to traditional Medicare for beneficiary who elected Medicare hospice benefit
- Preventing this reason code
  - Verify if beneficiary elected Medicare hospice benefit via FISS, NGSConnex, IVR or HETS
  - Determine if services rendered to patient are or are not related to terminal illness
    - If related, bill hospice agency
    - If not related, bill traditional Medicare with condition code 07

Reject Reason Code C7010

- Special rules for certain situations
  - Beneficiary elects or revokes Medicare hospice benefit during inpatient stay
  - Hospice beneficiary also enrolled in MAO plan
- Resources:
  - Reason Code C7010 - Preventing Claim Rejections for Hospice Enrollment

Reject Reason Code C7010

- Revocation Indicators:
  - Blank/0 = No revocation on file
  - Code 1 = Revoked by beneficiary
  - Code 2 = Revoked by MAC

MAP1758 CWF Hospice Election Period

```
MAP1758              NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 08/11/15
MXG9282    SC                          ACCEPTED                 C201531P 13:16:01

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
```

NGSConnex – Hospice Information

Reject Reason Code U5210

- CMS records indicate that the beneficiary's entitlement for Medicare coverage was terminated prior to the first date of service on the claim.

Beneficiary/CWF – Eligibility Detail

- From FISS Online Inquiries submenu, type ‘10’ (Beneficiary/CWF) at Enter Menu Selection prompt
  - On Beneficiary/CWF screen, type beneficiary’s
    - MBI
    - Last name and first initial
    - Sex (gender)
    - Date of birth in MMDDYYYY format
  - Press <Enter> key
  - Scroll to PF8>CWF Inquiry

CWF: Beneficiary Information (MAP1755)

```
MAP1755            NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 03/11/20
MXG9282   SC _                      ACCEPTED                  A2020200 13:30:21

CLAIM              NAME          D.O.B.          SEX     INTER 58300

APP DT         REASON CD 1  DATE/TIME 20200711328  REQ ID BDMS
DISP CD 01   TYPE 3  CENT D.O.B    D.O.D
A:CURR-ENT DT 060111  TERM DT        PRI-ENT DT         TERM-DT
B:CURR-ENT DT 060111  TERM DT        PRI-ENT DT         TERM-DT

LIFE: RSRV 60  PYSCH 190

 CURRENT                  BENEFIT PERIOD DATA
FRST BILL DT  000000  LST BILL DT 000000  HSP FULL DAYS 60  HSP PART DAYS 30
SNF FULL DAYS 20  SNF PART DAYS 80  INP DED REMAIN  1408.00  BLD DED PNTS 3
PRIOR                    BENEFIT PERIOD DATA
FRST BILL DT  000000  LST BILL DT 000000  HSP FULL DAYS     HSP PART DAYS
SNF FULL DAYS     SNF PART DAYS     INP DED REMAIN          BLD DED PNTS

CURR B: YR 20  CASH 198.00  BLOOD 3  PSYCH 02200.00  PT          OT
PRIR B: YR 19  CASH 185.00  BLOOD 3  PSYCH 02200.00  PT          OT

      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
```

Return to Provider (RTPs)

RTP Reason Code 32402

- CPT/HCPCS code reported on claim not billed with valid revenue code for DOS
- Preventing this reason code
  - Verify in FISS DDE whether CPT/HCPCS code and revenue code combination valid
    - From Main Menu, select 01 (Inquiries) and then 14 (HCPC Code) / 1E (New HPCS Screen)
      - Revenue code(s) must be reported with CPT/HCPCS code displayed
      - If several revenue codes displayed, choose most appropriate one
      - If revenue code field blank, any revenue code may be used

RTP Reason Code 32404

- Revenue code file indicates a HCPCS code is required
- Preventing this reason code
  - Verify in FISS DDE whether
    - HCPCS code was not entered on claim and is required or
    - HCPCS code entered on claim is not valid

RTP Reason Code 32404

- From Main Menu, select 01 (Inquiries) and the 13 (revenue code)
  - **Valid values/HCPCS code**
    Y = Required
    N = Not required
    V = Verify valid HCPCS code
- 14 (HCPC Code) / 1E (New HPCS Screen)

Revenue Code (MAP1761)

```
MAP1761            NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 03/11/20
MXG9282   SC                REVENUE CODE TABLE INQUIRY       A2020200 13:49:33

               REV CD 0320
EFF DT 070166     IND R                        TERM DT

NARR Radiology - Diagnostic - General Classification

        ALLOW:              HCPC:              UNITS:              RATE:
 TOB      EFF-DT TRM-DT      EFF-DT TRM-DT      EFF-DT TRM-DT      EFF-DT TRM-DT
 ---    ---------------    ---------------    ---------------    ---------------
 11X    Y 070166           V                  N                  N
 12X    Y 070166           Y 080100           Y 070198           N
 13X    Y 070166           Y 100188           Y 070166           N
 14X    Y 070166 033106    Y 100188           Y 070166           N
 18X    Y 070166           V                  N                  N
 21X    Y 070166           V                  N                  N
 22X    Y 070166           Y 040101           Y 040101           N
 23X    Y 070166           Y 040101           Y 040101           N
 28X    Y 070166           V                  N                  N
 32X    N                  V                  N                  N

      PROCESS COMPLETED  ---   PLEASE CONTINUE
        PRESS PF3-EXIT  PF6-SCROLL FWD
```

RTP Reason Code 36602

- For 85X TOB claims, the CPT/HCPCS code billed as a professional services is not reimbursed as a physician service
- Correct the revenue code and/or the CPT/HCPCS code
- Check the MPFS database and review the PC/TC indicator field

Resources and Tools RTP Reason Code 36602

- Helpful tools for reason codes 36602 and 32391:
- Medicare Physician Fee Schedule Look Up Tool
- How to Use the Searchable Physician Fee Schedule
  - PC/TC indicator definitions starts on page 22

RTP Reason Code 32372

- The Zip Code in the offsite ZIPCD field
  - Claim page 3
  - MAP1713
- Does not match any of the valid zip codes in our files for off-site clinics
- Correct or remove the offsite zip code
- Enter the main office zip code

Claim Page 03 – MAP1713

```
MAP1713    PAGE 03  NATIONAL GOVERNMENT SERVICES #14013 UAT    ACMFA781 09/16/20
MXG9282    SC                 INST CLAIM UPDATE                A20204AF 15:38:07
MID                TOB 131   S/LOC S B0100   PROVIDER
NDC CD                              OFFSITE ZIP          ADJ MBI              IND
 CD   ID     PAYER                    OSCAR          RI AB              EST AMT DUE
A                                                                          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 10             11             12             13             14
15             16             17             18                  END OF POA IND
ADMITTING DIAGNOSIS                E CODE              HOSPICE TERM ILL IND
IDE                       GAF            0.0000      PRV E1165
PROCEDURE CODES AND DATES 07                    08
09                  10                  11                  12
ESRD HRS 00   ADJ REAS CD      REJ CD         NONPAY CD      ATT TAXO
ATT PHYS          NPI                  L FOX                  F            M T   SC
OPR PHYS          NPI 0000000000       L                      F            M     SC
OTH OPR           NPI 0000000000       L                      F            M     SC
REN PHYS          NPI 0000000000       L                      F            M     SC
REF PHYS          NPI 0000000000       L                      F            M     SC
31687                                                          <== REASON CODES
 PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT
```

RTP Reason Code 34072

- Claim submitted as Medicare primary, a positive working aged record is on CWF and OC 18 with beneficiary's retirement date is on claim
  - Verify retirement date billed with OC 18
    - For working aged MSP provision, retirement date = coverage end date

Reason Code 34072 – Provider Action

- Verify:
  - Is claim's DOS within effective and termination dates of open MSP record?
  - Is retirement date the same as or prior to open MSP record date?
  - Is correct retirement date OC correct (18 for beneficiary's or 19 for spouse's)?
  - Is OC 25 and date primary insurance benefits terminated present?
  - Is patient relationship code correct on open MSP records?
    - 01 = Beneficiary
    - 02 = Spouse
    - Patient relationship codes in CWF are different than those in FISS (01 = spouse, 18 = beneficiary)

RTP Reason Code E51#6

- Revenue code is shown but the total charges for the revenue code/center is equal to zero
  - Verify the information was keyed correctly
  - Make any appropriate changes
- Reason codes that beginning with an “E” are consistency edits coming from CWF

RTP Tips and Resources

- FISS Claims Correction submenu to review and correct RTP claims
  - Option 03 from FISS DDE Main Menu
- Check RTPs routinely
  - Such as daily, every other day or weekly (based on claim volume)
- Review reason code(s) to determine what needs to be corrected
- Correct claim and hit PF9 on keyboard to resubmit

Denials

Denial Reason Code 39928

- 39928 - Each line of charges on claim denied by Medical Review
- Our website > Resources
  - Medical Policies (LCDs & Billing/Coding Articles)
  - National Coverage Determinations CMS IOM 100-03
  - Resources> Compliance> Medical Review
    - Medical Review Focus Areas
  - Resources > Compliance >Targeted Probe and Educate
    - Pre-payment and post-payment reviews
    - Review topics based on existing data analysis procedures

FISS DDE 01/12 claim page 2

```
MAP1712   PAGE 02 NATIONAL GOVERNMENT SERVICES, #13001 UAT   ACMMA561 02/22/13
 TC98548   SC               INST CLAIM INQUIRY                C201314P 13:01:20
                                                  REV CD PAGE 01
 MID XXXXXXXXXX                    TOB 851  S/LOC R B9997   PROVIDER XXXXXX


                            TOT    COV                          SERV  RED
 CL REV  HCPC MODIFS   RATE UNIT   UNIT TOT CHARGE NCOV CHARGE DATE  IND
 1  0360 29580 50           00001           100.00 100.00      072416
 2  0636 J2405              00001             1.00   1.00      072416
 3  0001                                    101.00




 39929                                                  <= REASON CODES
           PRESS PF3=EXIT  PF5=UP PF6=DOWN  PF7=PREV  PF8=NEXT  PF11=RIGHT
```

MAP171D

```
MAP171D   PAGE 02  NATIONAL GOVERNMENT SERVICES #06201 UAT   ACMFA722 08/13/20
  KXT2938   SC               INST CLAIM ENTRY                  A20203CP 08:20:51
  DCN 20000000000004XXX       MID              RECEIPT DATE 081320  TOB 851
  STATUS S  LOCATION B0100    TRAN DT          STMT COV DT 000000   TO 000000
  PROVIDER ID 242578         BENE NAME ,
  NONPAY CD     GENER HARDCPY       MR INCLD IN COMP          CL MR IND
  TPE-TO-TPE    USER ACT CODE       WAIV IND    MR REV URC    DEMAND
  REJ CD        MR HOSP RED         RCN IND     MR HOSP-RO    ORIG UAC
  MED REV RSNS
  OCE MED REV RSNS
         HCPC/MOD IN    SERV                          -----REASON-CODES------
   REV  HCPC MODIFIERS   DATE  COV-UNT   COV-CHRG   ADR
                                           FMR
  ORIG                    ORIG REV         MR      ODC
  OCE OVR   CWF OVR   NCD OVR   NCD DOC   NCD RESP   NCD#          OLUAC
         NON       NON     DENIAL OVER ST/LC  MED  ------------ANSI------------
  LUAC  COV-UNT   COV-CHRG  REAS  CODE OVER   TEC  ADJ  GRP ------REMARKS------
  TOTAL                         LINE ITEM REASON CODES
       PROCESS COMPLETED  ---   PLEASE CONTINUE
     PRESS PF2-1712  PF3-EXIT  PF5-UP  PF6 DOWN  PF7-PREV  PF8-NEXT  PF10-LEFT
```

Importance of Documentation

- Medical necessity is underlying basis for Medicare coverage
- Providers must maintain complete medical records documenting services reasonable and necessary
  - Documentation is deciding factor in determining medical necessity of service in absence of any written statutory or administrative guidance

Medical Record Documentation Tips

- Documentation must support reason service was considered reasonable and medically necessary for patient
  - Follow documentation guidelines in LCDs as well as CMS IOMs and NCDs
- Medical records must be complete and legible
  - Ensure that all services include necessary signatures and credentials of professionals
- CMS MLN® Fact Sheet: *Complying with Medical Record Documentation Requests*

Denial Reason Code 7C387

- 7C387 - Unacceptable ICD-10 principle diagnosis code for dental services
- Limited coverage of dental services under Medicare
  - Where coverage exists, service not excluded
  - When services excluded from coverage:
    - Not required to Inform beneficiary of noncoverage
    - May issue a voluntary notice of noncoverage
    - Correctly bill to reflect any written notice provided

Dental Services Exclusion

- SSA Section 1862 (a)(12) - Medicare does not cover services in connection with care, treatment, filling, removal, or replacement of teeth or structures directly supporting
- Medicare may cover dental services that are:
  - Integral part of covered procedure (e.g., reconstruction of jaw following accidental injury),
  - For extractions done in preparation for radiation treatment for neoplastic diseases involving jaw
  - Oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances
    - Coverable under Part A if performed by dentist on hospital's staff or under Part B if performed by a physician

Additional Resources Denial Reason Code 7C387

- CMS IOM 100-02, *Medicare Benefit Policy Manual,* Chapter 16, General Exclusions from Coverage
- CMS IOM 100-04, *Medicare Claims Processing Manual,* Chapter 18, Preventive and Screening Services
- CMS MLN Booklet® *"Items and Services That Are Not Covered Under the Medicare Program"*

Denial Reason Code 5WEXC

- Unacceptable principal diagnosis code was billed on this claim. If additional medical circumstances exist or a more specific diagnosis code exist – submit an Appeal

Tips for Denial Reason Code 5WEXC

- Tips for appealing the denial:
  - Send medical documentation to support the denied services this should include the medical history, physical exam, results of pertinent diagnostic tests, doctor's order and any other documentation to support the denied services
  - Refer to CMS IOM 100-02, *Medicare Benefit Policy Manual,* Chapter 16 and CMS IOM 100-04, *Medicare Claims Processing Manual,* Chapter 18

Denial Reason Code 52MUE

- It has been determined that all the lines items on the claim have units of service that are in excess of the medically reasonable daily allowable frequency
- The excess charges due to the units of service greater than the maximum allowable can't be billed to the Medicare beneficiary and is not subject to an ABN

Resources Denial Reason Code 52MUE

- Medically Unlikely Edits

Appeals

- If disagree with decision or changing to more specific diagnosis code, must submit appeal
  - Five levels of appeal – first level is Redetermination
    - Must be submitted within 120 days from date of receipt of the initial determination notice
    - No amount in controversy threshold
    - May be submitted via NGSConnex or in writing via US Mail
- Resources > Claims and Appeals >Appeals:
  - Appeals
  - CMS MLN® Publication: *Medicare Parts A & B Appeals Process*

Denial Reason Code 54NCD

- Line level reason code to indicate that none of the diagnosis codes on the claim support the medically necessity of the services. Service denied and the provider is liable

Resources to Prevent Reason Code 54NCD: NCD ICD-10 Resources

- CMS NCDs ICD-10 conversions
- Lab NCDs and ICD-10

54NCD Adjustments

- Submit an Adjustment to Correct Claims Partially Denied by Automated LCD-NCD Denials
  - Adjustments only allowed for line item denial reason codes 55A00, 55A01, 52NCD, 53NCD, or 54NCD and the 59xxx series– except when all claim lines were denied
    - Other line item denials can be appealed
  - Add diagnosis codes (when appropriate); cannot add charges nor change HCPCS codes

Submit Adjustment to Correct Claims Partially Denied by Automated LCD/NCD Denials

- Claims denied without medical review may be corrected through electronical claim adjustment
  - No ADR was sent
  - No documentation submitted
- Process allows additional diagnosis codes to be added to justify services denied for lack of appropriate diagnosis according to LCD/NCD
- Cannot be used to add charges or change HCPCS codes on denied lines

Reason Codes 54NCD: How to Submit Adjustments

Electronic 837 claims	FISS/DDE Provider Online System
Use condition code D9 and add remarks	Enter “LN” in the “Adjust Reason Code” field
Add diagnosis code (ensuring the diagnosis code is appropriate for the beneficiary and supported in the medical records)	Use condition code D9 and add remarks
Make the charges and units covered	Add diagnosis code (ensuring the diagnosis code is appropriate for the beneficiary and supported in the medical records)
Enter “LN adjust” in the 2300 BILLING NOTE (NTE) segment NTE02 data element where the NTE01 data element equals “Add”	Delete the denied line and reenter the charges as covered

References and Resources

References and Resources – FISS/CWF

- NGS FISS logon ID and password required
  - User logon ID and password for individual use only
  - CWF accessed in FISS Inquiry Beneficiary/CWF option 10
  - *NGS FISS DDE Provider Online Guide*
- Medicare University CBTs

References and Resources – IVR

- Interactive Voice Response System
  - National Government Services Part A Provider IVR User Guide
  - Part A IVR Flow Chart
  - Part A IVR Navigation Guide
  - Part A Touch-Tone Card/Eligibility Checklist
- NGS Interactive Voice Response Conversion Tools
  - Beneficiary Name to Number Converter
  - PTAN and Beneficiary Medicare Number Converter
  - IVR Conversion Tables

References and Resources – NGSConnex

- NGSConnex website
  - User requirements
    - Internet access
    - E-mail address
  - Training materials
    - Quick Steps Job Aid
    - Rules of Behavior
    - CBT
  - Call Provider Contact Center for assistance
- *NGSConnex User Guide*

References and Resources – HETS

- CMS website
  - Research, Statistics, Data and Systems > HIPAA Eligibility Transaction System (HETS) Help (270/271)
- CMS website has section devoted to HETS, including:
  - Vendor and registration information
  - HETS 270/271 Companion Guide
- NGS EDI Solutions
- NGS EDI: Network Service Vendors

Wrap-Up

What You Should Do Now…

- Review references, resources and wrap up slides and use available resources
- Share this information with appropriate staff
- Take actions necessary to prevent claim rejections, RTPs and denials by Medicare
  - This may involving searching your internal system and/or procedures and making necessary changes
- Attend our future educational events

Thank You!

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

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