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Part B Claim Submission Learning Day

Medicare Part B Top Ten Denials

5/9/2023

NGSMU
NGS Medicare University
Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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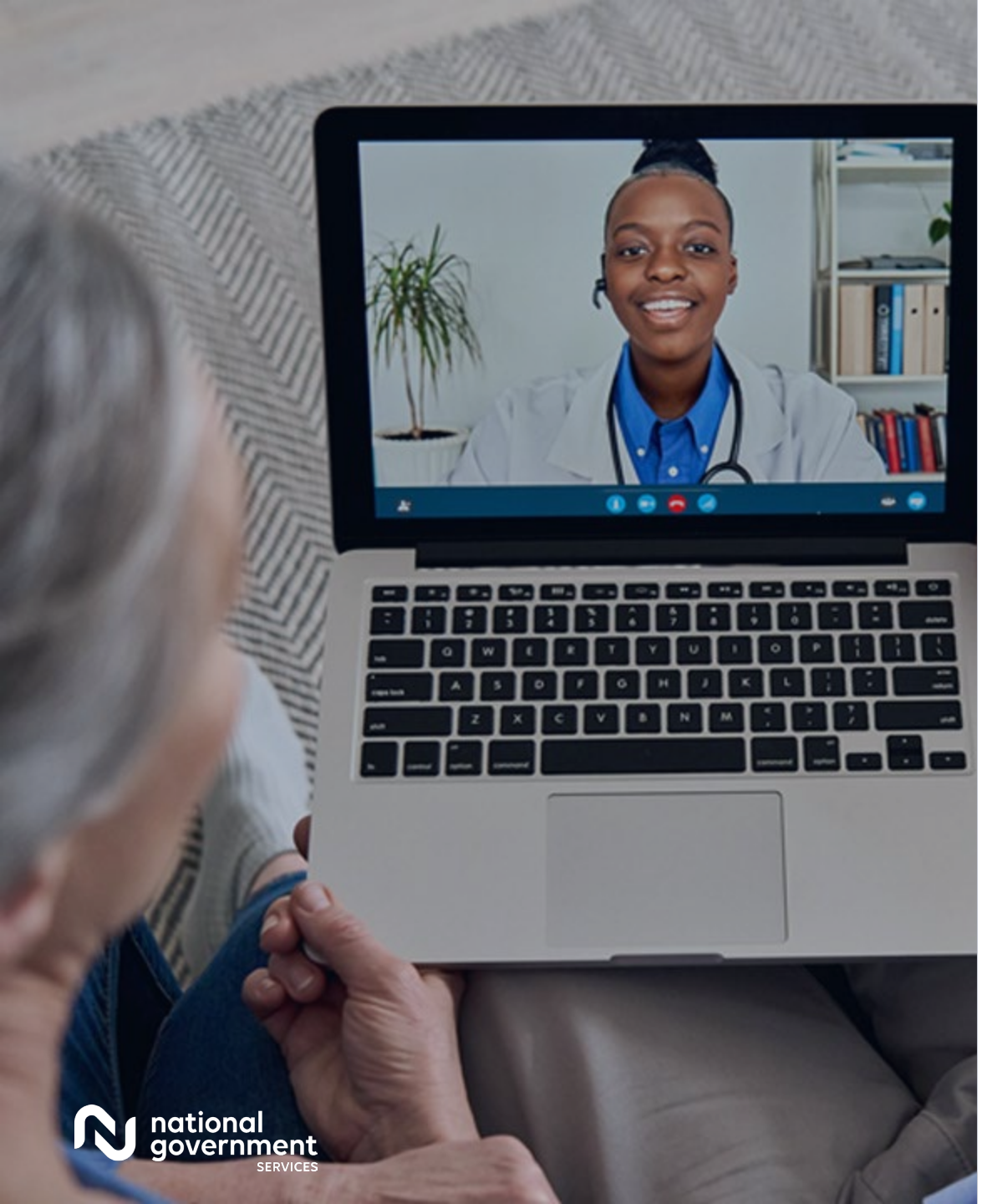

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Objective

By utilizing internal claim reporting information, we will help to identify the top ten Part B claim denials and provide solutions to prevent them in the future.

Today's Presenters

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- Jennifer Lee
  - Provider Outreach and Education Consultant
- Jennifer DeStefano
  - Provider Outreach and Education Consultant

Agenda

- Q1 2023 Claim Denial Data
- Duplicate Billing
- Beneficiary Eligibility
- Noncovered Services
- Invalid CPT/HCPC
- Timely Filing
- Excluded/Bundled Services
- Reopening Versus Appeal
- Reopenings
- Appeals

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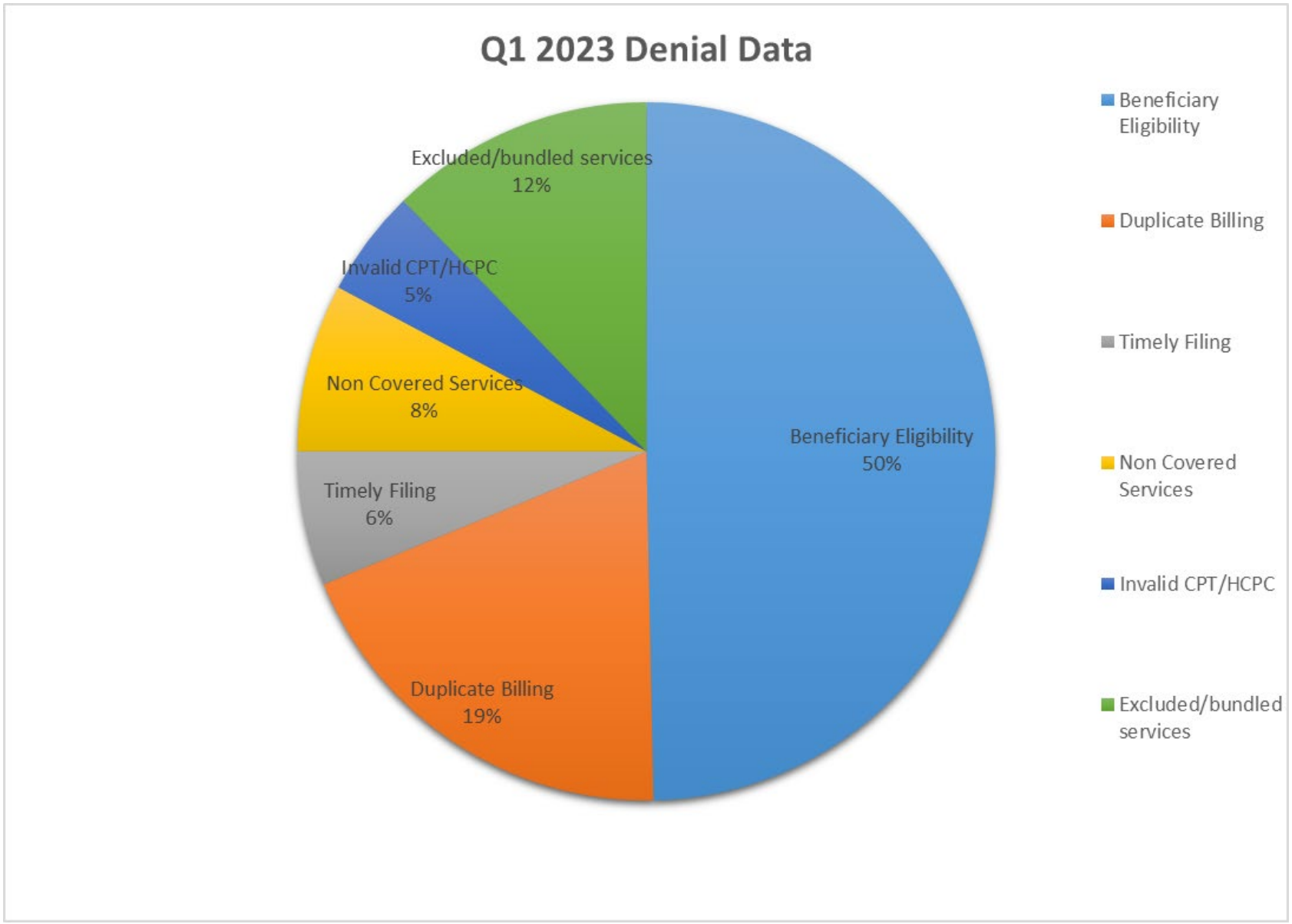
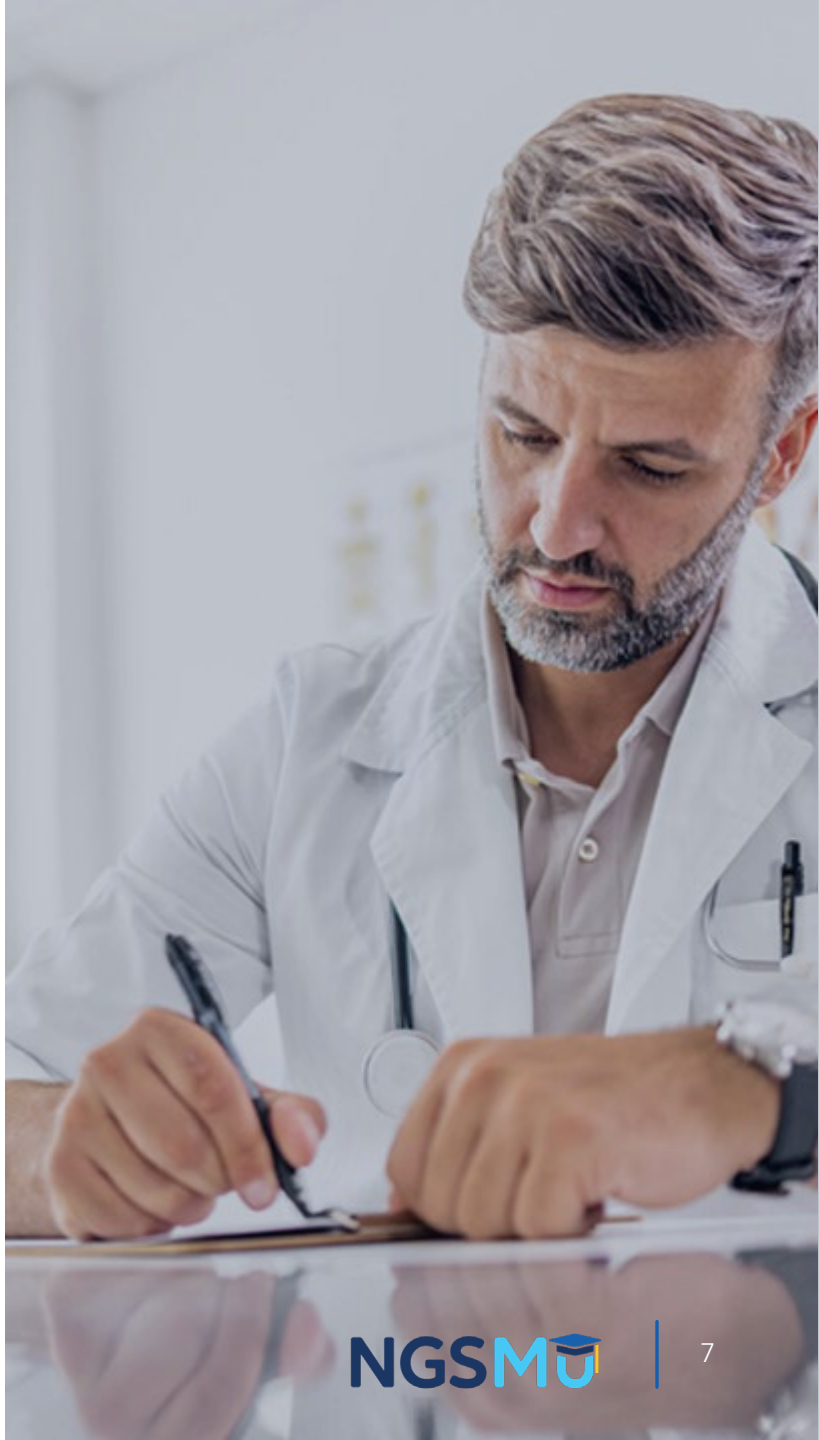
Q1 2023 Claim Denial Data


Q1 2023 Denial Data
Excluded/bundled services
12%
Invalid CPT/HCPC
5%
Non Covered Services
8%
Timely Filing
6%
Duplicate Billing
19%
Beneficiary Eligibility
50%
Beneficiary Eligibility
Duplicate Billing
Timely Filing
Non Covered Services
Invalid CPT/HCPC
Excluded/bundled services



Duplicate Billing

Duplicate Billing

- Message Code OA-18
  - Exact duplicate claim/service
- Issues caused by duplicate billing
  - May delay payment
  - Increases administrative costs to the Medicare Program
  - Could be identified as an abusive biller; or
  - May result in an investigation for fraud if a pattern of duplicate billing is identified

Elements Compared to Identify an Exact Duplicate

- Patient's Medicare number
- PTAN/NPI
- From and through date of service
- Type of service
- Place of service
- Procedure codes
- Billed amount

Tip to Avoiding Duplicate Claims

- Use NGSConnex or the IVR to verify the status of the original claim
  - Denied/rejected
  - Pending
  - Approved to pay
- Electronic claim submitters
  - Check your EDI validation report to verify claims were received and accepted
  - Check your software system to verify claims are not set up for automatic rebill every 30 days
  - Review your remittances
- Review your remittance advice for denial/rejection reason
- Do not resubmit a claim to correct an original denial
  - May need to submit a reopening or appeal
- Tips for Avoiding Duplicate Billing Denials

EDI - Duplicate Claims

- Electronic claims that are duplicates to already received electronic claims will not be accepted into the Part B claims processing system
  - JK only
  - Will not appear on the remittance advice
- 277 CA report rejection codes
  - CSCC: A3 – Return as unprocessable
  - CSC: 78 – Duplicate of an existing claim/line

Beneficiary Eligibility

Beneficiary Eligibility

- Message code PR-31
  - Patient cannot be identified as our insured
  - Common reasons for denial
    - ✓ MBI invalid/incorrect
    - ✓ No Part B entitlement on date of service
- Resolution
  - Ensure MBI is valid, submit claim again
  - Verify eligibility in self-service tools, if no entitlement, check with patient

Medicare Advantage Plan

- Message code OA-109
  - Claim/service not covered by this payer/contractor, you must send the claim/service to the correct payer/contractor
  - Most commonly identifies that the patient is an MA plan enrollee
- Resolution
  - Check eligibility file for MA plan information
  - Submit claim to MA plan

Hospice

- Message code PR-B9
  - Patient is enrolled in a hospice
  - Covered only when performed by the attending physician
- Remark code N90
  - Covered only when performed by the attending physician
- Resolution
  - Services provided by attending physician?
  - GV modifier
  - Services provided are not related to terminal condition?
  - GW modifier
  - Reopen - To add the appropriate modifier
  - If related to hospice, work directly with hospice program for reimbursement
- The Medicare Hospice Benefit: Effects on Other Provider Types

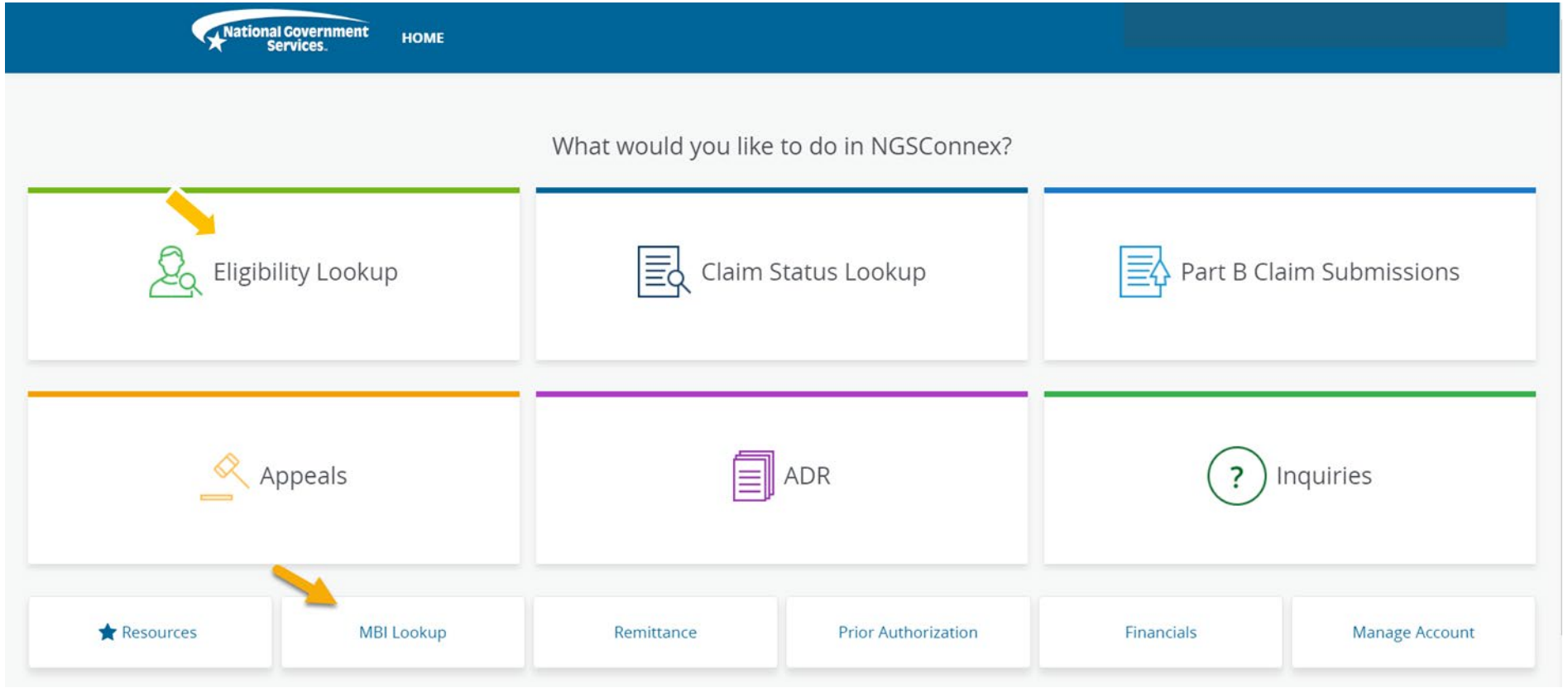
Medicare Secondary Payer (MSP)

- Message code CO-22
  - This care may be covered by another payer per COB
  - The patient has insurance that is primary to Medicare
- Resolution
  - Check eligibility file for the primary insurer
  - Submit claim to primary payer
  - You may submit a MSP claim once the primary has finalized the claim
- If patient is retired, no longer has that insurance
  - Contact BCRC
  - MSP file must be closed in order to process a primary claim

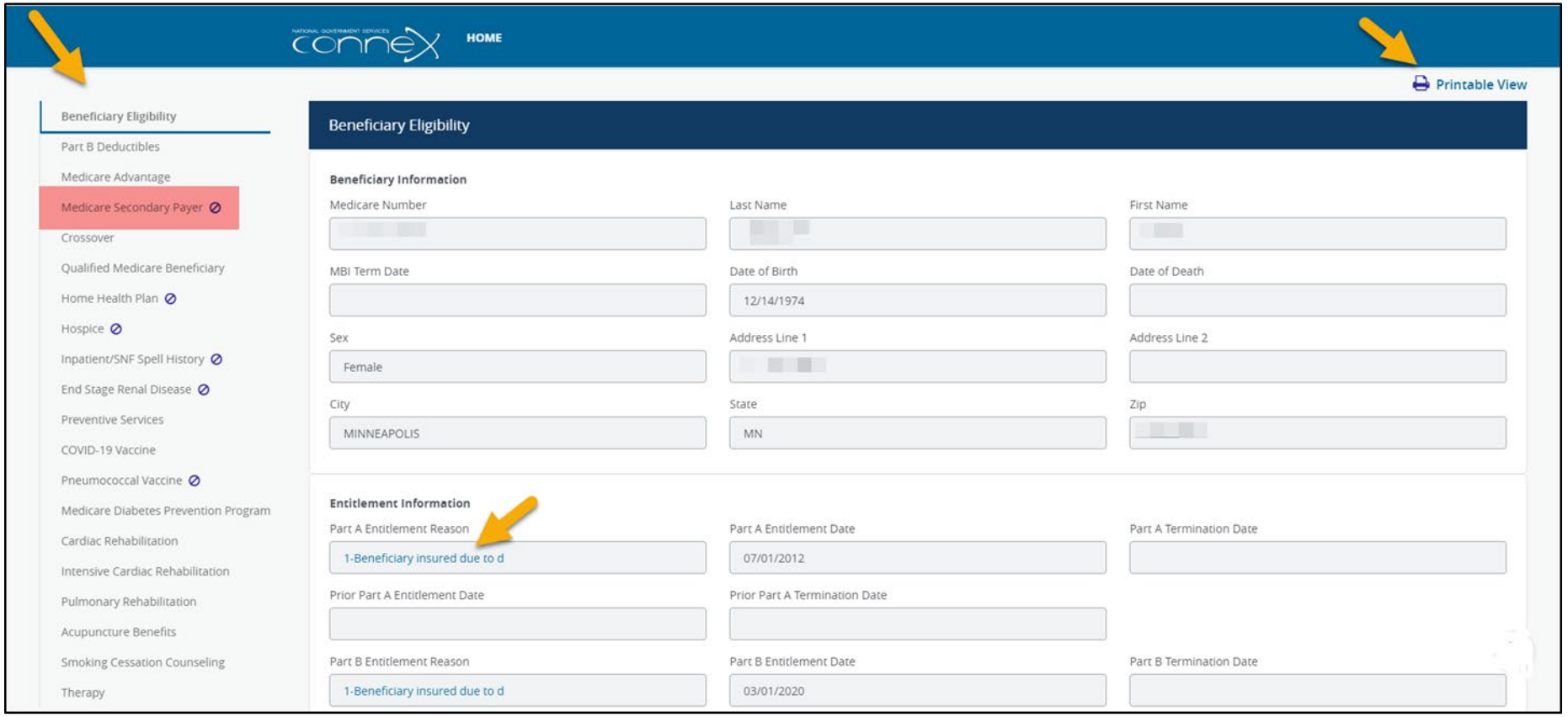
Beneficiary Eligibility Verification

- Prior to claim submission, verify your patient's eligibility using one of our self-service tools
  - NGSConnex
  - Interactive Voice Response System

NGSConnex Eligibility Verification (1)



NGSConnex Eligibility Verification (2)



Eligibility Resources

- Checking Eligibility and Knowing your Point of Contact
- CMS IOM Publication 100-09, *Medicare Administrative Contractor (MAC) Beneficiary and Provider Communications Manual*, Chapter 6, Section 50.1
- NGSConnex User Guide

Noncovered Services

Noncovered Services (1)

- Message Code PR-204
  - This service/equipment/drug is not covered under the patient's current benefit plan
  - Medicare Fee-for-Service does not cover the service that has been billed for the condition
  - The CPT/HCPC on the claim is not a covered Medicare service/equipment or drug
- There are multiple reasons for denial which includes the following, but is not limited to
  - Status A Code
  - Status R Code
  - Status X Code
  - Hearing Aid/Hearing Aid Related
  - Wheel Chair only Transports
  - Medical Therapy Management Services by a Pharmacist
  - Removal of Intrauterine Device (without complication)

Noncovered Services (2)

- Resolution
  - Utilize the following resources, as well as the most current CPT/HCPCS coding books, to verify if the code you want to bill to Medicare is a covered service
    - ✓ Medicare Physician Fee Schedule Database (MPDB)
    - ✓ CMS Internet Only Manual (IOM)
    - ✓ Medicare Coverage Data Base

Invalid CPT/HCPC

Invalid CPT/HCPC

- Message Code CO-16
  - Claim/service lacks information or has submission/billing error(s)
- Remark Code M51
  - Missing/incomplete/invalid procedure code(s)
- Resolution
  - Utilize the following resources, as well as the most current CPT/HCPCS coding books, to verify if the code you want to bill to Medicare is a covered service
    - ✓ Medicare Physician Fee Schedule Database (MPDB)
    - ✓ CMS Internet Only Manual (IOM)
    - ✓ Medicare Coverage Data Base

Timely Filing

Timely Filing

- Message code CO-29/PR 29 (unassigned claims)
  - The time limit for filing has expired
- Remark code N211
  - You may not appeal this decision
  - The time limit for filing has expired
- All claims must be submitted within one year from the date of service
  - Span date claims use the “To” date

Timely Filing Exceptions

- An exception to the filing limit may be requested if good cause is determined CMS defines good cause as
  - ✓ Administrative error by Medicare contractor
  - ✓ Retroactive entitlement
  - ✓ Retroactive MA plan disenrollment
  - ✓ Retroactive entitlement involving Medicaid
- Exceptions may be mailed to NGS before or after the claim is submitted
  - Preclaim: Completed 1500 claim form, a letter explaining reason claim is being filed late, documentation
  - Postclaim: Part B Reopening form with documentation
- Requesting an Exception to Timely Filing

Excluded/Bundled Services

Excluded Services

- Message Code PR-204
  - This service is not covered under patient's current benefit plan
  - Statutory exclusion
- Examples
  - Cosmetic surgery, custodial care, hearing aids and auditory implants
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual* , Chapter 16, General Exclusions From Coverage

Bundled Services

- Message Code CO-97
  - Payment is included in another service on the same day
- Remark Code N20
  - Service not payable with other service rendered on the same date
- This includes multiple scenarios
  - MPFSDB Status B
  - MSFSDB Status E drug codes
  - MSFSDB Status X drug codes
  - MPFSDB Status T when billed with Status A, C, or D codes on the same date by the same rendering provider when a rendering provider performs both the surgical procedure and anesthesia on the same DOS
  - Some DME codes
- Fee Schedule Assistance > Procedure Status Indicators

Reopening Versus Appeal

Reopening vs. Redetermination

- Reopening
  - To correct a claim(s) determination resulting from minor errors
  - Mathematical or computational mistake
  - Inaccurate data entry
  - Computer errors
  - Incorrect data items
  - Transposed procedure or diagnostic codes

- Redetermination
  - First level of the Medicare appeal process
  - For partially paid or denied claim(s) resulting from more complex issues that require analysis of documentation
  - Coverage of furnished items and service
  - Overpayment determinations
  - Medical necessity claim denials
  - Determination on limitation of liability provision

Reopening

Methods to Initiate a Reopening

- NGSConnex
  - Preferred method
    - ✓ *NGSConnex Part B User Guide*
- Telephone Reopening Unit
  - JK: 888-812-8905
  - J6: 877-867-3418
- Written Reopening
  - J6

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    P.O. Box 6475
    Indianapolis, IN 46206-6475
  - JK

    National Government Services, Inc.
    P.O. Box 7111
    Indianapolis, IN 46207-7111
  - Reopenings for Minor Errors and Omissions

Large Various Adjustment Macro

- The Large Various Adjustment Macro (LVAM) form is an excel spreadsheet and shall be typed entirely to include an internal claim number (ICN)
  - If you cannot type the request, please make sure your handwriting is legible
  - Any incomplete LVAM request may be sent back to the provider as an incomplete submission
- The Large Various Adjustment Macro (LVAM) form includes
  - Patient's name
  - Patient's HIC/MBI
  - Date of service
  - ICN
  - Procedure code
  - Explain correction needed
- Examples of services that can be corrected through our LVAM process
  - Changing modifiers
  - Procedure codes
  - Adding diagnosis codes
  - Increasing billed amount
  - Changing the quantity billed

Reopenings Handled by Telephone Reopening Unit or Written Reopening

- Assignment of claims (carrier errors only)
- CLIA certification denials
- Adding or changing order/referring/supervising physician
- Duplicate denials
- MA plan denials (clinical trial or hospice related only)
- Modifier GV and GW
- Updated fee schedule allowance
- HIC/MBI corrections (carrier error only)
- MSP – Medicare now primary
- Patient paid amount (carrier error only)
- Add/change rendering provider
- Place of Service Changes

Appeals

Methods to Initiate a First Level Appeal

- NGSConnex
  - Preferred method
    - ✓ *NGSConnex Part B User Guide*
- Electronic Submission of Medical Documentation (ESMD)
    - ✓ Submit an Appeal Electronically via esMD
- Written Appeal
  - JK

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  - J6

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    P.O. Box 6475 Indianapolis, IN 46206-6475
  - Part B Redetermination Request Form

The Five Levels of Appeal

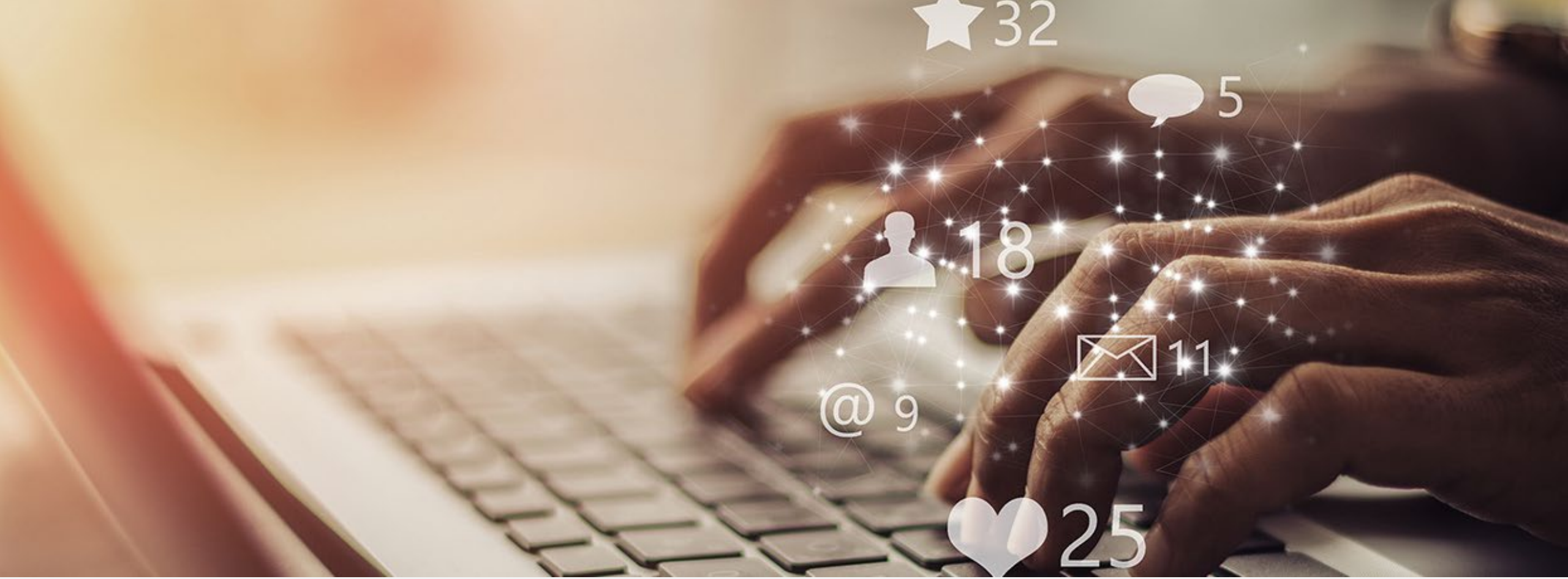
- Level One – Redetermination
  - 120 days from date of receipt of the initial determination notice
  - No minimum
- Level Two - Reconsideration (QIC)
  - 180 days from date of receipt of the redetermination decision
  - No minimum
- Level Three - Administrative Law Judge (ALJ)
  - 60 days from the date of receipt of the reconsideration (QIC decision)
  - For requests filed on or after 1/1/2022, at least $180 remains in controversy
- Level Four - Medicare Appeals Council (MAC)
  - 60 days from date of receipt of the ALJ decision
  - No minimum (none)
- Level Five - Federal Court Review
  - 60 days from date of receipt of the MAC decision
  - For requests filed on or after 1/1/2023, at least $1,850 remains in controversy.
  - For requests filed on or after 1/1/2022, at least $1,760 remains in controversy
- How to Avoid Costly Appeals

Appeal Documentation

- Include appropriate documentation for service
  - Provide at the time of the initial appeal request
  - Additional information/documentation will not be requested
  - The medical documentation must be signed and dated by the physician
  - Only you can decide which documentation best supports your claim
- A guide to assist your office with the documentation required
  - Medical Records to Support an Appeal

Questions?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course Code.



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