Virtual Conference – Medicare Essentials: Preparing Claims for Submission

10/19/2022

national government SERVICES

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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Objectives

- In this session, we will review the basic concepts you need to know to prepare your claim for submission to Medicare as well as the basics of fraud, abuse, and benefit integrity

Agenda

- Timely Filing
- Submission/Transmission Options (FISS DDE, EDI, etc.)
- Required UB-04 Required FLs
- Claim Flow and Editing
- Fraud and Abuse
- References, Resources, Wrap up
  - Questions?

Timely Filing

Did You Know

- Submitting claims correctly the first time can save time and money, and ensure timely, accurate Medicare reimbursement
- Prior to claim submission
  - Check with appropriate internal departments to ensure all services rendered are reported on the claim
  - Ensure all required data elements are entered accurately and completely

What is a Clean Claim?

- Claim does not require us to investigate or develop externally on prepayment basis
- Clean claims must
  - Be filed in the timely filing period
  - Pass all edits
  - Not require external development
  - Include all information necessary to adjudicate claim and all supporting documentation (if required)

Timely Filing Guidelines

- All Medicare FFS claims must be filed no later than one calendar year after date service
  - Applies to initial submissions and adjusted/corected claims
- Generally, start date is DOS or "From" date on claim
  - Inpatient claims: timely filing based on date of discharge
  - Outpatient claims spanning multiple service dates: timely filing based on line item date of service

Timely Filing Exceptions

- Administrative error
- Retroactive Medicare entitlement
- Retroactive entitlement involving Medicaid
- Retroactive disenrollment from MAO plan
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 70 – Time Limitations for Filing Part A and Part B Claims

Submission/Transmission Options (FISS DDE, EDI, etc)

Claim Submission

- Providers may submit EMC
  - Claim data transmitted directly via FISS DDE entry
  - Using 837I electronic claim form
  - Batch transmission via claims clearinghouse
  - NGS EDI information available online
- UB-04/CMS 1450 hardcopy claim form
  - Must have approved ASCA waiver
    - ASCA Requirements for Paper Claim Submission

Fiscal Intermediary Standard System

- National Government Services uses to process claims and maintain records
- Providers access through online computer system
  - Patient information
  - Claim status
    - Processing ("in suspense")
    - Paid/processed
    - Rejected
    - Denied
    - Returned to provider for correction

ASCA Waiver

- ASCA prohibits payment of claims NOT billed electronically
- Provider must request and obtain pre-approval to submit paper claims if
  - Provider can demonstrate HIPAA standard does not permit submission of particular type of claim electronically
  - Disability of all provider's staff prevents use of computer
  - Other rare circumstances

Required UB-04 Form Locators

UB-04 (CMS-1450) Claim Form

- Uniform institutional provider bill
- Designed and maintained by NUBC
- Electronic claims mirror UB-04 claim fields
  - Claim data transmitted directly via DDE entry
  - Batch transmission via claims clearinghouse

Required UB-04 Claim Form Locators

- FL 1: Billing provider name, address, telephone number
- FL 3a: Patient control number
- FL 4: Type of bill
  - First character: type of facility
  - Second character: bill classification
  - Third character: frequency definition

TOB Examples

- TOB 111: Hospital (1), inpatient Part A (1), admission through discharge (1)
- TOB 131: Hospital (1), outpatient (3), admission through discharge (1)
- TOB 210: SNF (2), inpatient part A (1), no-pay claim (0)
- TOB 778: Clinic (7), FQHC outpatient (7), cancel claim (8)

Required UB-04 Claim Form Locators

- FL 5: Federal Tax ID Number
  - Format is NN-NNNNNNN
- FL 6: Statement Covers Period
  - From-through dates
  - Format is MMDDYY
- FL 8: Patient's Name and Identifier
  - Last name, first name, middle initial, patient identifier if different than insured's identifier

Required UB-04 Claim Form Locators

- FL 9: Patient's Address
- FL 10: Patient's Birth Date
  - Format is MMDDCCYY
  - If unknown, 00000000
- FL 11: Patient's Sex
  - M or F

Required UB-04 Claim Form Locators

- FL 12: Admission/SOC Date
  - Required for inpatient or HH
  - Format is MMDDYY
- FL 14: Priority (Type) of Admission/Visit
- FL 15: Point of Origin for Admission/Visit
  - Not required on TOB 14X
- FL 17: Patient Discharge Status

Required UB-04 Claim Form Locators

- FLs 35, 36: Occurrence Span Codes, Dates
  - Required for inpatient claims
  - OSC format is two alpha-numeric digits
  - Date format MMDDYY
- FLs 39, 40, 41: Value Codes, Amounts
  - VC format is two alpha-numeric digits
  - Amount format is up to nine numeric digits (0000000.00)

Line-Item DOS

- Single line-item DOS required on claim page 2 for every service provided
- On each line, report
  - Revenue code
  - HCPCS/HIPPS code, modifiers (as applicable)
  - Date of service
  - Units of service
  - Charges

Required UB-04 Claim Form Locators

- FL 42: Revenue Code
  - Format is four-digit numeric code
  - Revenue code 0001 Totals line also required
    - Sum of charges/noncovered charges billed
- FL 44: HCPCS/Rates/HIPPS Rate Codes
  - HCPCS code identifies procedure/service rendered
  - HIPPS code identifies RUG code and Assessment Indicator for SNF claims
  - Format is five digit alpha-numeric

Required UB-04 Claim Form Locators

- FL 45: Service Date
  - Format is MMDDYY
- FL 46: Units of Service
- FL 47: Total Charges
  - Sum of covered charges for reported line item
  - 0001 Revenue code line reports sum of claim's covered charges

Required UB-04 Claim Form Locators

- FL 48: Noncovered Charges
  - Sum of noncovered charges for reported line item
  - 0001 Revenue code line reports sum of claim's noncovered charges

Required UB-04 Claim Form Locators

- FL 50A, B, C: Payer Identification
  - If Medicare is primary, enter Medicare on line A
  - Otherwise, identify primary payer(s) first, then Medicare as secondary (line B) or tertiary (line C)
- FL 51A, B, C: Health Plan ID
  - Report ID corresponding to Payer Identification lines
- FL 52A, B, C: Release of Information Certification Indicator
  - Displays whether provider has signed statement permitting release of data to other organizations

Required UB-04 Claim Form Locators

- FL 56: Billing Provider NPI
- FLs 58A, B, C: Insured's Name
- FLs 59A, B, C: Patient's Relationship to Insured
- FL 67: Principal Diagnosis Code
  - Condition chiefly responsible for admission
- FL 69: Admitting Diagnosis
  - For inpatient hospital claims subject to QIO review

Claim Flow and Editing

Did You Know…

- It is important to understand how a claim that is submitted to Medicare processes through FISS. This will help providers understand how and where claim errors occur.

System Drivers

- Claim path
  - Prescribed route followed by all claims
  - Made up of drivers
    - Drivers house edits for claims
    - **Not all bill types hit same drivers**

Claim Path Drivers

TOB	Claim Path Driver	TOB	Claim Path Driver
01	Status/Location/Adjustment Driver	55	Benefits Utilization Edit Driver
02	Control Driver	60	Additional Development Request Driver
04	UB04 Claim Data Element Edit Driver	63	HHPPS Pricer
05	Consistency Edit Driver (I)	65	PPS Pricer Driver
06	Consistency Edit Driver (II)	70	Payment Driver
15	Administrative Edit Driver	80	MSP Primary Driver
25	Duplicate Edit Driver	85	MSP Secondary Driver
30	Entitlement Edit Driver	89	Clean Up Driver
35	Lab HCPCS Edit Driver	90	CWF Driver
40	ESRD Edit Driver	99	Session Termination Driver
50	Medical Policy Driver		

Claim Path Samples

TOB	Driver Claim Path
11X	01, 02, 04, 05, 06, 15, 25, 30, 35, 50, 55, 65, 70, 80, 85, 89, 90, 99
12X, 13X, 14X, 22X, 23X, 71X, 74X, 75X, 76X, 77X, 85X	01, 02, 04, 05, 06, 15, 25, 30, 35, 50, 55, 70, 80, 85, 89, 90, 99
21X	01, 02, 04, 05, 15, 25, 30, 50, 55, 65, 70, 80, 85, 89, 90, 99

Reason Codes

- Five-position alphanumeric code
- Directs claim edit or process
  - "Traffic cops"

Reason Codes

POSITION 1	POSITIONS 2-5
1 = Consistency Edits	0125 - 9999
3 = FISS	0000 - 9799
4 = File maintenance	Alpha 001 - Alpha 899
5 = Medical Review	0000 - 9999
7 = Site Specific (non-medical)	0000 - 9999
A–Z = CWF (except W)	Current CWF Codes
W = OCE/MCE and Grouper	0001 - 2999

Adjustment Driver 01 and Control Driver 02

- Adjustment Driver 01
  - Obtains MAC number
  - Checks MBI
  - Establishes beneficiary shell record
  - Updates beneficiary data
- Control Driver 02
  - Controls flow from driver to driver

UB04 Claim Data Element Edit Driver 04

- Numeric/alphanumeric data checks
- "Face of claim" validity checks
- Initialize fields
- Reason code range: 10125-19999
- Common reason codes
  - 12206: sum of covered days and noncovered days must equal the statement covers period
  - 19904: claim does not indicate a three-day qualifying hospital stay (occurrence span code 70) prior to admission to the SNF; or, hospital stay is prior to Part A effective date

Consistency Edit Drivers 05 and 06

- Validate field ranges
- Payer ID
- Value code, condition code
- Occurrence code, occurrence span code
- TOB specific
- Shared system common edits

Consistency Edit Drivers 05 and 06

- Reason code range: 30001–31299 (common to all bill types); 31300–31649
- Common reason codes
  - 30966: NPI/OSCAR number either invalid or missing
  - 31153: therapy revenue code of 42X, 43X, 44X, or 47X (except 471) billed without required HCPCS modifier 'GN', 'GO' or 'GP'
  - 31255: TOB 12X, 13X, 22X, 23X, 34X, 74X, or 75X billed with revenue code 042X must have occurrence code 29; if occurrence code 29 billed, revenue code 042X must be present

Administrative Edit Driver 15

- OCE and MCE interface
- MSP insurer
- Line items and HCPCS
- Attending/other physicians
- Grouper and interface
- Provider and provider specific

Administrative Edit Driver 15

- Adjustment reason code
- ESRD consistency
- Revenue code
- OPPS
- Supplemental diagnosis code and procedure

Administrative Edit Driver 15

- Reason code range: 31650–32999; W0001–W2999 (MCE/IOCE and Grouper)
- Common reason codes
  - 32005: statement covers “from” date is prior to provider's effective date
  - 32242: noncovered revenue code is shown with covered charges greater than zero
  - 32402: HCPCS code(s) reported have not been billed with a valid revenue code for the DOS

Duplicate Edit Driver 25

- TOB edits
- Common edit modules
- Edits to line level
  - Edits for HCPCS code (if required for revenue code)
- Duplicate suspect elimination

Duplicate Edit
Common Reason Codes

- Reason code range: 38000–38599
- Common reason codes
  - 38035: this outpatient claim is a duplicate to a previously submitted claim.
  - 38038 : whether any revenue code lines are equal or not, OPPS bill types (12X, 13X, 14X, 76X, 75X, 34X, or any bill containing condition code 07) cannot have overlapping dates when the provider numbers are equal, unless condition code G0 or 20 or 21 is present on the claim

Entitlement Edit Driver 30

- Entitlement
  - Effective and termination dates
    - E.g., HMO, hospice
- Timeliness edits
  - Does claim meet timeliness regulation standards?
- Reason code range: 39000–39499
- Common reason code
  - 39011: The claim was not submitted timely. Medicare regulations require claims to be submitted within one year of DOS on the claim

Lab/HCPCS Driver 35

- DME pricing
- Orthotic/prosthetic pricing
- Mammography pricing
- Hemophilia pricing
- Pap smear pricing
- ASC pricing and radiology pricing
- Lab pricing
- Reason code range: 36300-36999

ESRD Edit Driver 40

- Duplicate processing
- Pricing edits
- ESRD parameter edits
- Historical data analysis
- Reason code range: 36000–36299
- Common reason code
  - 36138: If claim contains one of the following HCPCS codes: 82330, 82040, 84075, 84460, 84450, 82247, 82248, 82310, 82435, 82465, 82550, 82374, 82565, 82977, 82947, 83615, 84100, 84132, 84155, 84295, 84478, 84520 or 84550, then HCPCS modifier CD, CE or CF must also be present

Medical Policy Driver 50

- Medical Policy Driver 50
  - Medical policy parameter edits
- Reason code range: 39500–39699
- Common reason code
  - 39508: beneficiary's benefits have been exhausted relative to this skilled nursing facility claim, which is subject to benefit period determinations

Benefit Utilization Driver 55

- Benefit Utilization Driver 55
  - Applies utilization
- Reason code range: 50000–59999 (Utilization)
- Common reason codes
  - 52MUE: All line items on the claim have units of service that are in excess of the medically reasonable daily allowable frequency
  - 56900: Claim denied: provider failed to submit documentation requested by the intermediary within 45 days

Additional Development Request Driver 60

- Produce ADR requests by site
- Track requests
- Determines action (reject/denial) for claims not receiving provider responses
- Sets claim up for generation of ADR
- Reason code range: 39700-39799

Prospective Payment System Pricing Driver 65

- Accesses the appropriate Pricer and formats the Pricer input
  - CMS Pricer
  - SNF Pricer
  - Hospice Pricer
- Reason code range: 37000-37150

Payment Driver 70

- Applies common payment modules
  - Claim examples
    - ESRD
    - OPPS
- Reason code range: 37500-37999
- Common reason code
  - 37574: no-pay code equal to 'n' must be present for inpatient claims containing condition code '04' and '69' and the provider is a non-acute facility

MSP Primary Driver 80

- Individual MSP code editing
- MSP primary type edits
- Handles MSP edits from CWF
- Reason code range: 34000-34499

MSP Secondary Driver 85

- Builds/updates MSP insurer record
- MSP pay module
- Apply MSP pay changes
- MSP type edits
- MSP pay interface

MSP Secondary Driver 85

- Reason code range: 33000–33999; 34500–34900
- Common reason code
  - 34538: claim was submitted as Medicare primary and rejected since a positive working elderly record exists at CWF

Did You Know…

- Medicare is not always primary payer. Therefore, providers must also check for MSP files before submitting claims to Medicare.
  - Claims submitted as Medicare primary will be rejected for MSP (cost-avoided) if an active MSP file exists on CWF and there is no explanatory coding on the claim to indicate why Medicare is primary.

Clean Up/Final Online Edits Driver 89

- Modifies claim record
- Called when claim is fully rejected or denied
- Reason code range: NCOVD, 31949–31954, 31956–31958, 31960–31976, 31978–31979, 31981–31982, 31984–31989, 39928–39929, 39933, 80002
- Common reason code
  - 39929: Each line of charges on this claim has been rejected and/or rejected and denied.

CWF Driver 90

- Sets CWF reason codes
- Recycles
- Creates transmit file

CWF Utilization and Consistency Edits

- CWF Utilization Edits
  - Entitlement
  - Frequency
  - Days
  - Overlaps
  - Deductible
  - Coinsurance
- CWF Consistency Edits
  - Age
  - Year
  - Occurrence codes
  - Revenue codes
  - Diagnostic codes
  - Correct deductible

CWF Utilization and Consistency Edits

- Reason code range: begins with any alpha character except 'W'
- Common reason codes
  - U5200: beneficiary is not entitled to Medicare coverage for the type of services billed on claim
  - U5210: beneficiary's entitlement for Medicare coverage was terminated prior to first DOS provided on claim
  - U5220: services billed on claim were provided prior to date the beneficiary was entitled to Medicare coverage

CWF Utilization and Consistency Edits

- U5233: services on this claim fall within or overlap MA HMO enrollment period. For inpatient PPS claims, the admission date falls within the HMO enrollment period
- U5600: DOS reported on this claim are duplicate to claim with same DOS that has previously processed

Session Termination Driver 99

- Updates files
- Only driver that finalizes claims
  - P B9996 – Payment floor
  - P B9997 – Final online
  - P B9998 – Final offline
  - P B9999 – Final purge
- Transmits/accepts responses from CWF

Session Termination Driver 99

- Reason code range: 37151–37199
- Common reason code
  - 37192: Medicare payment has been made

Claims Status/Locations

- When a claim is submitted for processing, the claim will receive a status/location; the basic status/locations include
  - P B9997 – Claim processed
  - S XXXXX – Claim suspended
  - R B9997 – Claim rejected
  - T B9997 – Claim returned
  - D B9997 – Claim denied

Claim Status – Provider Action

- If claim has been returned (T B9997)
  - Log into FISS/DDE
  - Make necessary claim corrections
- If claim has been rejected (R B9997)
  - No action may be needed, determined by reason code
  - May have to resubmit (or adjust) claim, if appropriate
- If claim has been denied (D B9997)
  - Determine if an appeal is needed
  - Documentation must support services rendered

Duplicate Claim

- Definition: An exact duplicate is a claim or claim line exactly matching another claim or claim line with respect to following elements
  - MBI
  - TOB
  - NPI number
  - From and through dates of service
  - Total charges (on line or on bill)
  - HCPCS/CPT codes, or procedure code modifiers
- Results in rejection reason code 38XXX
  - Tip: Adjust claim rather then submit new claim

Double Trouble: Beware of Duplicate Submissions

- Duplicate and overlap submissions account for highest percentage of Medicare claim rejections
- To avoid duplicate submissions
  - Be aware of Medicare claim processing timeframes
  - Ensure facility's internal billing policies in accord with Medicare regulations
  - Communicate with other areas of facility to avoid double billing
  - Identify automated claim submission processes which may result in duplicate billings

Preventing Claim Duplicates/Overlaps

- Before submitting claim for inpatient/outpatient services, review patient file to identify other inpatient/outpatient services for DOS
- Review FISS Inquiry Claim Summary screen to ensure claim not already processing
  - If so, wait for claim to finish processing, then adjust claim to add services
- Include all inpatient/outpatient services (coding, charges) for DOS on single claim

Fraud and Abuse

Improper Payment

- CMS term used to identify payments that do not meet Medicare program requirements
  - May include overpayment and/or underpayment
  - Does not necessarily mean expenditures should not have happened
  - Typically due to insufficient documentation to determine whether the services meet Medicare program requirements
  - Improper payment does not always means fraud and/or abuse

Did You Know

- Fact Sheet: 2020 Estimated Improper Payment Rates for Centers for Medicare & Medicaid Services (CMS) Programs
  - 2020 Medicare FFS improper $25.74 billion (6.27%) distributed in improper payments
    - Compares to the FY 2019 estimated improper payment rate of 7.25%, representing $28.91 billion in improper payments
      - The decrease was driven by reductions in the improper payment rates for home health and skilled nursing facility claims

Did You Know

- Medicare 2021 FFS improper $25.03 billion (6.26%) distributed in improper payments
  - Fact Sheet: CMS Improper Payments Fact Sheet (11/15/2021)
- CMS
  - Employs multi-faceted efforts to target the root causes of improper payments, with an emphasis on prevention-oriented activities and
  - Continues aggressive enforcement of fraud and abuse

Fraud

- Fraud occurs when someone intentionally falsifies information or deceives Medicare
- Examples of fraud include, but are not limited to
  - Incorrect reporting of diagnoses or procedures
  - Billing for services not furnished or supplies not provided
  - Deliberate duplicate billing

Abuse

- Abuse occurs when providers do not follow good medical practices, resulting in unnecessary costs to Medicare
- Examples of abuse include, but are not limited to
  - Improper billing practices
  - Unbundling of services
  - Unnecessary transfers to acute and PPS exempt units

Benefit Integrity

- It is every person's ethical responsibility to report fraudulent activity
- CMS actively investigates fraudulent and abusive billing practices
- Providers obligated by law to conform to Medicare requirements
- Ethical thin ice statements
  - "No one will ever find out"
  - "We can hide it"

OIG and DOJ

- OIG fights waste, fraud and abuse and works to improve the efficiency of Medicare and Medicaid programs plus more
  - Mission: Provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of HHS programs, as well as the health and welfare of the people they serve
- DOJ
  - Mission: Uphold the rule of law, to keep our country safe, and to protect civil rights.

Hot Tip

- Beneficiaries and others can collect rewards for reporting fraud and abuse, if their information leads directly to the recovery of Medicare money
  - Whistleblower
    - Contact the OIG Hotline to submit complaint
      - OIG Hotline online form
      - Hotline telephone number: 1-800-447-8477
- Medicare Fraud & Abuse webpage

Resources

CMS Resources

- CMS website
- MLN Matters® articles
- CMS Transmittals
- CMS Internet-Only Manuals (IOMs)

CMS Resources

- MLN® Fact Sheet: Medicare Billing: CMS-1450 and the 837I & Form CMS-1450 (ICN MLN006926)
- MLN® Listing: Medicare Learning Network (MLN) Provider Compliance Products
- Provider Compliance Fast Facts

Official UB-04 Data Specifications Manual (NUBC Manual)

- The Official UB-04 Data Specifications Manual is available from the NUBC website
  - Maintains codes needed to complete Form CMS-1450 (UB-04 claim) and compliant X12N 837 institutional claim
  - Responsible for design and printing of the UB-04 form
  - Data elements referenced in manual are also used in the electronic claim standards and the manual contains a Mapping crosswalk between the UB-04 and the HIPPA 5010 (837) electronic transaction

Thank You!

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

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