national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Rural Health Clinic Top Claim Errors

2/27/2024

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

NGSMU
NGS Medicare University
Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2583_0224

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS website.

Recording

Attendees/providers are never permitted to record (tape record or any other method) our educational events. This applies to webinars, teleconferences, live events and any other type of National Government Services educational events.

Objective

After this session, attendees will know what the current top RHC claim errors are, how to utilize reason codes to understand why a claim denied, rejected or RTP'd, and what resources to use to correct and prevent these errors.

Today's Presenters

Provider Outreach and Education Consultants

- Andrea Freibauer
- Jean Roberts, RN, BSN, CPC
- Mimi Vier

national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

NGSMU

Agenda

Understanding and Locating Claim Errors

Andrea Freibauer

Top Denial Reason Codes

Andrea Freibauer

Top Reject Reason Codes

Andrea Freibauer

Top Return to Provider (RTP) Reason Codes

Andrea Freibauer

Questions?

Andrea Freibauer and Jean Roberts

Understanding and Locating Claim Errors

Benefits of Preventing Claim Errors

Financial

Increase Medicare cash flow by correctly submitting claims the first time

Avoid the expense of resubmitting, adjusting, or appealing incorrect claims

Time

Utilize staff time more efficiently by avoiding the “claim error rollercoaster” – researching errors and trying to fix

Ensure claims are filed timely with Medicare

Compliance

Avoid being investigated for Medicare program integrity (fraud and abuse) by submitting Medicare-compliant claims

Claims Adjudication Process

- Once submitted, claims process through FISS
- Follows specific path based on bill type and are subject to various edits
  - Status/location – where claim is in processing
  - Reason codes – indicate status of claim
- If transaction/claim passes FISS edits, subject to various CWF edits
  - Nationwide repository for Medicare patient and claim information
  - If claim passes CWF edits, returns to FISS for finalization/adjudication
- Utilize remittance advice to identify claim payments, rejections and denials
  - Determine if next steps needed for rejections and denials

FISS Status/Locations

- S XXXXX – Claim suspended (processing)
- P B9997 – Claim finalized/adjudicated
  - Doesn't always mean paid
- T B9997 – Claim returned to provider (RTP)
  - Claim has error(s) that need to be corrected and sent back to MAC via FISS (PF9)
  - RTP claims not considered received by Medicare
- R B9997 – Claim rejected
  - No action may be needed, determined by reason code
  - May have to resubmit (or adjust) claim, if appropriate
- D B9997 – Claim denied
  - Determine if appeal needed
  - Documentation must support services rendered

What are FISS Reason Codes?

- Five-digit codes that direct outcome of claim edit or process
  - "Traffic cops" of FISS
- Review reason code to determine next steps
  - Correct claim online and resubmit
  - Appeal claim
  - Adjust claim
  - Submit new claim
  - No action may be needed

Locating Reason Codes in FISS DDE

- Finalized claims (Processed/Rejected/Denied)
  - Claims (Main Menu Selection 01)
  - Claim Summary (Menu Selection 12)
- RTP claims
  - Claims Correction (Main Menu Selection 03)
  - Then appropriate selection for type of claim
    - ✓ Inpatient (Menu Selection 21)
    - ✓ Outpatient (Menu Selection 23)
    - ✓ SNF (Menu Selection 25)

Help At Your Fingertips!

- Research top reason codes descriptions and find tips for preventing and correcting them on our website
  - Part A and your state > Resources > Claims and Appeals > Top Claim Errors

Search

Search Claim errors

Type

Select Error Type

Reason Code	Description	Error Type	Details
32402	Either the CPT or HCPCS code(s) reported on this claim was not been billed with a valid revenue code for the date(s) of service.	RTP	View Details

Top RHC Denial Reason Codes

Current Top Denials

J6	JK
39928	39928
5WEXC	5WEXC

Reason Code 39928

- Each line of charges on claim denied by medical review
- Avoiding/Correcting This Error
  - Determine line level denial codes for each line of claim
    - ✓ Claim page 2 (MAP 1712) and F11 to MAP171D
  - Ensure all Medicare coverage, documentation and medical necessity requirements met before billing claim
    - ✓ Review current National Government Services LCDs and Billing and Coding Articles
  - If you disagree with denial, you have right to appeal

Reason Code 5WEXC

- Claim does not qualify for Medicare payment due to principal diagnosis code supplied
- Avoiding/Correcting This Error
  - Ensure all Medicare coverage, documentation and medical necessity requirements met before billing claim
    - ✓ Review current National Government Services LCDs and Billing and Coding Articles
    - ✓ Look for typos and transposed numbers
  - If additional medical circumstances exist or more specific diagnosis code appropriate, indicate when submitting appeal

Documentation Tips

- Medical necessity - 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
  - Why is service reasonable and medically necessary for this 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 professional credentials
- CMS MLN Fact Sheet: *Complying with Medical Record Documentation Requests*

Resources & References

- LCDs, Billing and Coding Articles and NCDs
  - Medical Policies/LCDs – NGSMEDICARE
  - Medicare Coverage Database
  - CMS IOM Publication CMS IOM, Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*
- Correct Coding
  - Medicare National Correct Coding Initiative (NCCI) Edits
  - Medically Unlikely Edits

Appeals

- If disagree with decision or changing to more specific diagnosis code, must submit appeal
  - Five levels of appeal – must follow rules
- Redetermination (first level)
  - Submitted within 120 days from date of receipt of initial determination notice
  - No amount in controversy threshold
  - May be submitted via Connex or in writing via US Mail
- Resources:
  - National Government Services website Appeals page
  - Medicare Parts A & B Appeals Process

Top RHC Reject Reason Codes

Current Top Rejections

J6	JK
U5233	U5233
39934	39929
38200	39934
C7010	38200
39929	C7010

Reason Code U5233

- Services on claim fall within or overlap MA HMO enrollment period
  - For inpatient PPS claims, admission date falls within HMO enrollment period
- Avoiding/Correcting This Error
  - Ensure registration/admission staff checking to determine if patient enrolled in MAO/HMO plan prior to submitting claims
  - Verify admission date, from, and through dates on claim
    - ✓ Compare to MAO/HMO entitlement dates
    - ✓ Determine if correctly billing for your facility type and take appropriate action
  - Know who to bill based on MAO Option Code (1 or C)

Understanding MAOs and HMOs

- Replaces traditional Medicare (not secondary or supplemental)
- Generally, effective 1st of month after beneficiary enrolls
- When can beneficiaries enroll or change?
  - Newly eligible for Medicare due to age or disability
  - Medicare eligibility changes from disability to age
  - Enrolling in Part B during general enrollment (must have Part A)
  - Annual enrollment period (October 15 – December 7 each year)
- CY2024 MA Enrollment and Disenrollment Guidance (cms.gov)

Identifying MAO/HMO Enrollees

- Eligibility information available on CWF
  - FISS DDE 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 have MAO plan ID and need name and address
- NGSConnex provider online inquiry portal
- CMS MA Plan Directory
  - View directory by contract number or contract name

Locating MAO Option Code

```
MAP1752            NATIONAL GOVERNMENT SERVICES,#13001 UAT
MXG9282   SC               ELIGIBILITY DETAIL INQUIRY
RI 1    MAMMO DT   00000000
                              PART B DATA
SRV YR 16   MEDICAL EXPENSE   166.00     BLD DED REM 3   PSY EX
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
```

- Option code 1 plans
  - Submit all claims to traditional Medicare
- Option code C plans
  - Submit OP claims to MAO plan (not to traditional Medicare)
  - Submit IP claims to MAO plan for payment and then submit informational claims to traditional as described

Special Rules Based on Facility Type

- Outpatient facilities and inpatient/non-inpatient PPS and IRF hospitals or LTCH
  - Services within HMO enrollment period must be submitted directly to HMO
- Non-PPS inpatient hospital or inpatient SNF
  - Claims which overlap effective or termination date of HMO period need to be split and services billed to HMO and Medicare according to coverage dates
- Non-teaching IPPS hospitals, IRFs and LTCHs
  - Must submit informational no-pay encounter bills with covered charges and CC 04
  - IRF providers use appropriate HIPPS code based on PAI assessment accompanied by occurrence code (OC) 50 and corresponding assessment date when submitting no-pay claims

Special Rules Based on Facility Type (cont.)

- IPPS, IRF, and LTCH and SNF (covered services)
  - Services during HMO enrollment period submitted to MAC as informational no-pay encounter claim for benefit period purposes
  - IPPS acute care teaching hospitals billing for IME payment must bill with both condition code (CC) 04 and CC 69 and with covered charges
  - SNF-covered services during HMO enrollment period billed using CC 04 with covered charges

MAO/HMO Resources and References

- CMS IOM Publications
  - CMS IOM Publication CMS IOM, Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 9, Section 20.4 (Election by Managed Care Enrollees)
  - CMS IOM Publication CMS IOM, Publication 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)
  - CMS IOM Publication CMS IOM, Publication 100-16, *Medicare Managed Care Manual*
- NGS Job Aids and Manuals page
  - Medicare Beneficiary Eligibility Checklist
  - Reason Code U5233 - Preventing Claim Rejections for MAO Plan Enrollment

Reason Code 39934

- All revenue code lines on claim denied as noncovered and one or more lines denote beneficiary eligibility
- Avoiding/Correcting This Error
  - If claim rejection was desired outcome, no action needed
  - If claim rejection was not desired outcome, make corrections and submit new claim to MAC

Reason Code 39929

- Each line of charges on claim rejected and/or rejected and denied
- Avoiding/Correcting This Error
  - Verify line level rejection information to determine rejection for each claim line and resubmit as appropriate
    - ✓ Line level reason code(s) appear on the right view (PF11) of claim page 2 (MAP171D)

Reason Code 38200

- Claim exact duplicate of previously submitted claim
  - MBI number
  - TOB (all three positions of any TOB)
  - Provider number
  - Dates of service
  - Total charges (0001 revenue line)
  - Revenue code, HCPCS and modifiers (if required by revenue code file)
- Avoiding/Correcting This Error
  - All additions and/or corrections to processed claims must be adjustment claims, not new claims
  - Before submitting claim, ensure not been previously submitted
  - Review remittance advice or use self-service tools

Reason Code C7010

- Claim submitted to traditional Medicare for beneficiary who elected Medicare hospice benefit
- Avoiding/Correcting This Error
  - Verify if beneficiary elected Medicare hospice benefit via FISS, NGSConnex, or IVR
  - 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 and place CC 07 on claim
  - Special rules for certain situations
    - ✓ Beneficiary elects or revokes Medicare hospice benefit during inpatient stay
    - ✓ Hospice beneficiary also enrolled in MAO plan

CWF Hospice Election Period MAP 1758

```
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
```

Reason Code C7010 - Resources

- Revocation indicator codes
  - Blank/0 = No revocation on file
  - Code 1 = Revoked by beneficiary
  - Code 2 = Revoked by MAC
- CMS Hospice page

Top RHC RTP Reason Codes

RTP Tips

- Check RTPs routinely
  - Daily, every other day or weekly, based on claim volume
- RTPs not considered "received" by Medicare
  - Must be resubmitted before passes timely filing period
- Review and correct RTPs in FISS DDE Claims Correction submenu
  - Option 03 from FISS DDE Main Menu

```
MAP1704          NATIONAL GOVERNMENT SERVICES,#13001 UAT  ACMFA561 12/18/19
MXG9282          CLAIM AND ATTACHMENTS CORRECTION MENU    A20201AF 11:58:07

                          CLAIMS CORRECTION
                 INPATIENT                    21
                 OUTPATIENT                   23
                 SNF                          25
                 HOME HEALTH                  27
                 HOSPICE                      29
                          CLAIM ADJUSTMENTS      CANCELS
                 INPATIENT                    30        50
                 OUTPATIENT                   31        51
                 SNF                          32        52
                 HOME HEALTH                  33        53
                 HOSPICE                      35        55
                          ATTACHMENTS
                 PACEMAKER                    42
                 AMBULANCE                    43
                 HOME HEALTH                  45


   ENTER MENU SELECTION:
```

Current Top RTPs

J6	JK
32959	34963
39910	31836
34963	39910
32402	32402
U5065	32390

Reason Code 32959 (J6)

- Provider type and type of bill invalid combination
  - RHCs code claims using bill type 71X
- Avoiding/Correcting This Error
  - Follow official CMS RHC billing guidelines
  - Verify billing under RHC provider number and using proper type of bill
  - If appropriate, correct claim and resubmit (PF9)

Reason Code 34963

- One of the following applies:
  - Attending Physician on Claim Page 05 invalid or not present in PECOS Enrolled Physicians file (Type C Records)
  - Attending Physician NPI present on PECOS Enrolled Physicians file but first four digits of last name do not match
  - Through Date of Service on claim equal or greater than Termination Date on PECOS Enrolled Physician Inquiry screen
- Avoiding/Correcting This Error
  - Review PECOS to ensure information correct, update if necessary
  - Verify billing
  - If appropriate, correct attending physician information on claim and resubmit (PF9)

Reason Code 39910

- Modifier CG required on qualifying visit line on TOB 71X
- Avoiding/Correcting This Error
  - Modifier CG must be reported on the line representing primary reason for medically necessary face-to-face visit
    - ✓ Claims and adjustments must include modifier CG on only one line
    - ✓ Exception – medical and mental health visit on same day (both lines must have modifier CG)
  - Ensure modifier CG on revenue code 52X or 900 as appropriate
  - If appropriate, correct claim and resubmit (PF9)

Reason Code 31836 (JK)

- HCPCS on revenue code line has status code of ‘M’ but one of the following applies:
  - TOB not equal to 85X
  - TOB equal to 85X but revenue code not equal to 96X, 97X or 98X
- Avoiding/Correcting This Error
  - Verify billing
  - If appropriate, correct claim and resubmit (PF9)

Reason Code 32402

- CPT or HCPCS code reported on claim not billed with valid revenue code for claim DOS
- Avoiding/Correcting This Error
  - Verify whether CPT/HCPCS code and revenue code combination valid
  - From FISS DDE Main Menu, select 01 (Inquiries) and then 14 (HCPC Code)/1E (New HCPCS 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
  - If appropriate, correct claim to report appropriate HCPCS/CPT code and resubmit (PF9)

Reason Code U5065

- MBI effective or end date not within dates of service submitted on claim
- Avoiding/Correcting This Error
  - Review dates of service submitted on claim for accuracy
  - Verify beneficiary's entitlement dates in CWF
  - Verify beneficiary's MBI number
    - ✓ Medicare beneficiary or their authorized representative may have requested new MBI
  - If appropriate, correct claim and resubmit (PF9)

Reason Code 32390 (JK)

- Claim contains modifier AR, AQ, AB or QU but billing provider not Method II CAH provider (XX1300-XX1399)
- Avoiding/Correcting This Error
  - Verify billing correct modifier(s)
  - Verify billing under correct provider number
  - If appropriate, correct claim and resubmit (PF9)

RHC Resources and References

- CMS Rural Health Clinics page
- RHC Qualifying Visit List
- CMS IOM Publication CMS IOM, Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9 Rural Health Clinics/Federally Qualified Health Centers

Questions?

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

Connect with us on Social Media

YouTube Channel
Educational Videos

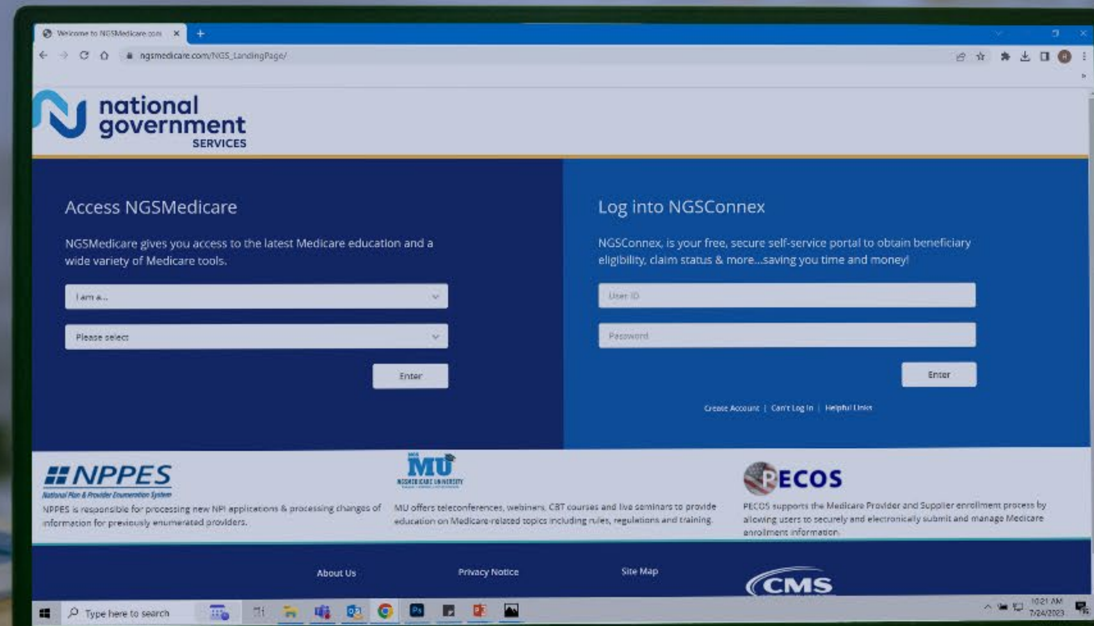
medicare mobile

Text NEWS to 37702; Text GAMES to 37702

www.MedicareUniversity.com
Self-paced online learning

LinkedIn
Educational Content

Find us online



www.NGSMedicare.com

Online resources, event calendar, LCD/NCD, and tools

IVR System

The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

NGSConnex

Web portal for claim information

Sign up for Email Updates

Subscribe for Email updates at the top of any NGSMedicare.com webpage to stay informed of news

Listen to Our Part A Podcast

Navigating Medicare:
Part A Insights for Providers

Listen to our podcast on Spotify and Apple Podcasts! We will have a new episode on the 1st and 3rd Wednesday of each month.

Spotify:

Apple Podcasts: