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Quarterly Review of Top Part A Claim Errors

May 7, 2024

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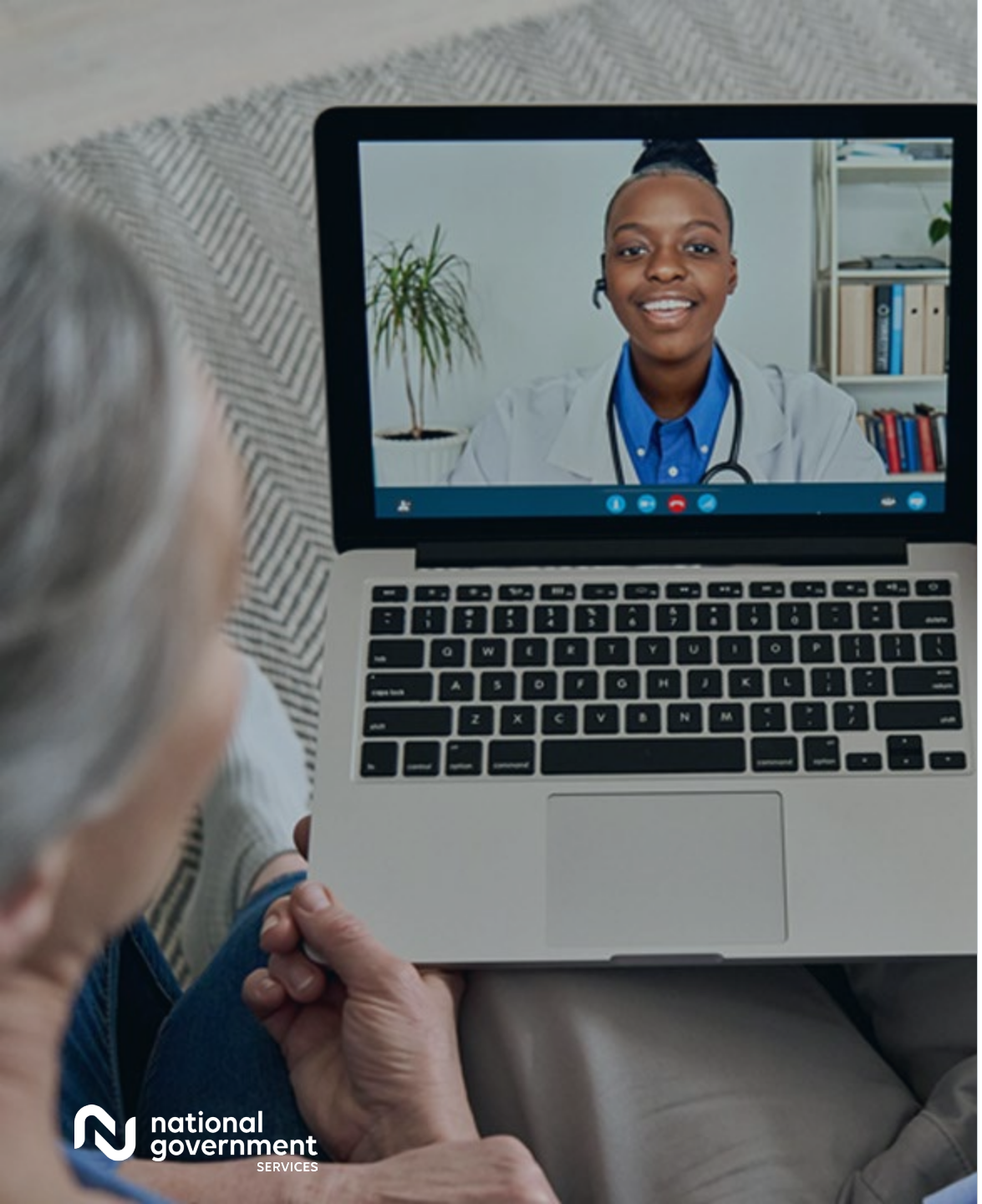

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Objective

After this session, attendees will know what the top J6 and JK Part A claim errors are based on recent data analysis, how to utilize reason codes to understand why a claim denied, rejected or RTP'd, how to prevent the most common errors and what resources to use for more information.

Today's Presenters

Provider Outreach and Education Consultants

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

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

Stay in the Know With NGS!
Andrea Freibauer

Questions?
Andrea Freibauer and Jean Roberts

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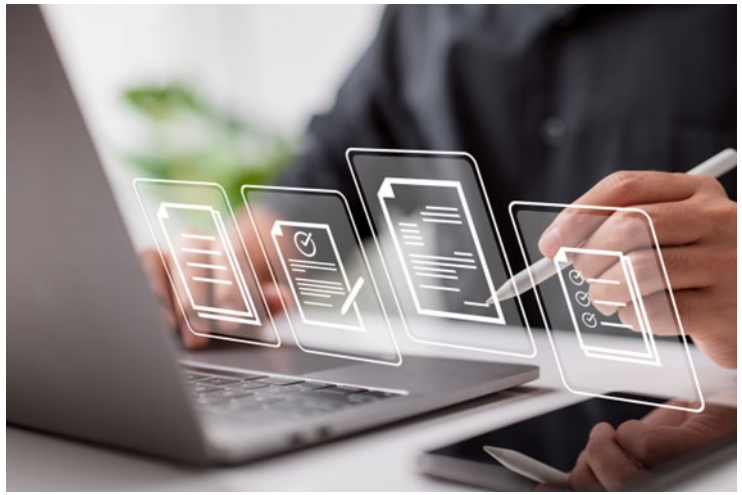
Understanding and Locating Claim Errors

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 and fixing errors

Ensure claims are submitted timely

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 type; subject to various edits
  - Status/location – where claim is in processing
  - Reason codes – indicate status of claim
- When 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
- Identify claim payments, rejections and denials and determine if next steps needed for rejections and denials
  - Utlize FISS DDE, remittance advice, or other methods

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)
  - Providers must check RTP bucket often as these 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

- Reason code file
  - Inqiuires (Main Menu Selection 01)
  - Reason Codes (Menu Selection 17)
- Finalized claims (Processed/Rejected/Denied)
  - Inquiries (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)

Tips on Avoiding/Correcting Claim Errors

- Research reason codes 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 Denial Reason Codes

J6 and JK Denials

January 2024	February 2024	March 2024
39928	39928	39928
5WEXC	5WEXC	5WEXC
54NCD	54NCD	54NCD
56900	56900	56900
52MUE	37072	52MUE
55B31	52MUE	55B31
52NCD	55B31	52NCD

Denial Reason Codes Trending

- 39928, 5WEXC, 54NCD and 56900 consistently top denials
- 52MUE and 55B31 trending down this quarter
- 52NCD trending up this quarter

Reason Code 39928

- Each line of charges on this claim has been 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 the 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

Reason Code 54NCD

- Line level reason code indicates that none of the diagnosis codes on claim support medical necessity of the services
- Provider liable
- Avoiding/Correcting this error
  - Review coverage guidelines for service being denied to ensure medical necessity of services being provided to beneficiary
  - Review information on the Appeals tab for information related to submitting an adjustment to correct claims partially denied by automated NCD denials

Reason Code 56900

- Requested medical records not received within 45-day time limit; therefore, unable to determine medical necessity of services billed
  - Automatic denial – documentation not received within 45 days of date on ADR
- Avoiding/Correcting this error
  - Respond to ADR letters promptly – if sending close to due date, FISS may not be updated in time to avoid denial
  - Utilize NGSConnex
    - ✓ Review list of incoming/current ADRs and note due dates
    - ✓ Easily upload documentation for ADRs instead of mailing

Reason Code 52MUE

- All line items on claim have units of service exceeding medically reasonable daily allowable frequency
  - Excess charges due to units of service greater than maximum allowable may not be billed to beneficiary
  - This provision cannot be waived nor subject to ABN
- Avoiding/Correcting this error
  - When you believe medical records support that denied services were reasonable and medically necessary, you have right to submit appeal
  - Review CMS MUE file prior to claim submission
    - ✓ MUE files updated on quarterly basis – ensure referencing appliable file for DOS
    - ✓ If units rendered exceed allowed units for that service, determine whether excess units rendered and billed correctly

Reason Code 55B31

- Medical Review denial for services not documented in medical records
- Avoiding/Correcting this error
  - Review current National Government Services LCDs and Billing and Coding Articles
  - Ensure all Medicare coverage, documentation and medical necessity requirements met and properly documented
  - Respond to ADRs with all requested documentation

Resources & References

- LCDs, Billing and Coding Articles and NCDs
  - National Government Services Medical Policies/LCDs
  - CMS Medicare Coverage Database
  - CMS IOM Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*
- Appeals
  - Appeals section
  - Original Medicare (Fee-for-service) Appeals
- Correct Coding
  - Medicare National Correct Coding Initiative (NCCI) Edits
  - Medically Unlikely Edits

Top Reject Reason Codes

J6 and JK Rejections

January 2024	February 2024	March 2024
39929	U5233	U5233
U5233	39934	38200
39934	39929	38312
38200	38200	39934
34538	34538	39929
C7010	38312	38001
7K073	38001	34538
U5200	C7010	C7010

Rejection Reason Codes Trending

- U5233 consistently one of the top rejections
- 39934 and 38200 remain in top four
- 38312 and 38001 trending up this quarter
- 39929 and 34538 trending down this quarter

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
  - Verify admission date, from, and through dates on claim
  - Compare admission date, from, and through dates on claim to HMO entitlement dates
  - Determine if billed correctly for your facility type and take appropriate action

Reason Code U5233 – Facility Actions

- 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 overlap effective or termination date of HMO period must be split and services billed to HMO and Medicare according to coverage dates
- Non-teaching IPPS hospitals, IRFs and LTCHs
  - Required to submit informational no-pay bills with covered charges and CC 04
  - IRF providers use appropriate HIPPS code based on PAI assessment accompanied by OC 50 and corresponding assessment date when submitting no-pay claims

Reason Code U5233 – Facility Actions (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 CC 04 and CC 69 and with covered charges
  - SNF-covered services during HMO enrollment period billed using CC 04 with covered charges

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 38200

- Claim exact duplicate of previously submitted claim
  - MBI number
  - TOB (all three positions of any TOB)
  - Provider number
  - DOS
  - 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 has not been previously submitted
  - Review remittance advice or use self-service tools

Reason Code 38312

- FQHC PPS claim with line-item DOS that matches another line-item DOS on previously submitted claim and all of the following match
  - MBI
  - Provider number
  - Line-item DOS
- Avoiding/Correcting this error
  - Verify billing
  - Additions and/or corrections to processed claims must be adjustment claims, not new claims

Reason Code 38001

- Inpatient claim contains DOS that equal or overlap previously denied inpatient claim
- Avoiding/Correcting this error
  - Verify DOS billed
  - If not changing denied lines, additions and/or corrections to processed claims must be adjustment claims, not new claims

Reason Code 39929

- Each line of charges on this 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 34538

- Claim submitted as Medicare primary but open MSP Working Aged record (VC = 12; Payer Code = A) in CWF and claim did not contain reason Medicare primary
- Avoiding/Correcting this error
  - Do not resubmit claims - will be rejected as duplicates
  - If MSP record correct, submit claim to primary EGHP
    - ✓ Once you receive payment, submit adjustment (TOB XX7) to claim to change to MSP claim
  - If MSP record is incorrect because beneficiary and/or spouse retired
    - ✓ Submit adjustment to claim to change to Medicare primary (as originally billed) and code beneficiary's retirement date with OC 18 and/or spouse's retirement date with OC 19

MSP Resources and References

- Collect and Report Retirement Dates on Medicare Claims
- Correct or Adjust a Claim Due to an MSP-Related Issue
- Prevent an MSP Rejection on a Medicare Primary Claim

Top 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

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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:
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J6 and JK RTPs

January 2024	February 2024	March 2024
34977	34977	34977
34986	34963	34963
34963	W7088	34986
34985	U5065	W7088
38119	37098	37098
38038	34986	U5065
32402	38119	38119
32405	31836	34985
32415	34985	31836

RTP Reason Codes Trending

- 34977, 34963 and 34986 consistently top three rejections
- W7088, 37098, and U5065 trending up this quarter
- 34985 and 38119 trending down this quarter

Reason Code 34977

- Practice address present on claim does not match address on Provider Practice Address Query Screen in FISS DDE or PECOS
- 13X or 14X TOB
- Avoiding/Correcting this error
  - When billing for on-campus services only:
    - ✓ Report billing provider address only in billing provider loop 2010AA
    - ✓ Do not report any service facility location in loop 2310E (or in DDE MAP 171F screen for DDE submitters)
    - ✓ Refer to SE19007 for how to bill additional scenarios
  - Verify billing
  - If appropriate, update practice address on claim to exactly match address on Provider Practice Address Query Screen in FISS DDE or in PECOS 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 DOS 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 34986

- PN modifier missing from one or more claim lines and practice location present on claim and matches entry on Provider Practice Address Query Screen in FISS DDE or PECOS
- 13X or 14X TOB
- Avoiding/Correcting this error
  - PN modifier - Non-excepted service provided at off-campus, outpatient, provider-based department (PBD) of hospital
    - ✓ Applies to non-grandfathered/non-excepted PBD and triggers payment under MPFS for DOS on/after 1/1/2017
    - ✓ Non-grandfathered = off-campus practice location has effective date on or after 11/2/2015
    - ✓ Grandfathered PBD = Practice address file in FISS needs correction
  - Verify billing and if appropriate, correct by updating PN modifier to applicable claim line(s) and resubmit (PF9)

Reason Code W7088

- FQHC PPS (TOB 77X) claim and G0466, G0467, G0468, G0469 or G0470 not present or noncovered
- Avoiding/Correcting this error
  - Verify billing
  - If appropriate, correct and resubmit (PF9)

Reason Code 37098

- FQHC PPS claim (TOB 77X) supplemental rate not present for MA plan
- Avoiding/Correcting this error
  - Verify billing
  - If appropriate, correct and resubmit (PF9)

Reason Code U5065

- Claim From Date prior to MBI effective date on CWF crosswalk file
- Avoiding/Correcting this error
  - Check/verify beneficiary's entitlement dates in CWF
  - Verify MBI number
  - If appropriate, correct and resubmit (PF9)

Reason Code 34985

- PO modifier missing from one or more claim lines and practice location present on claim and matches entry on Provider Practice Address Query Screen (MAP1AB2) in FISS DDE or PECOS
- 13X or 14X TOB
- Avoiding/Correcting this error
  - PO modifier - Services, procedures and/or surgeries provided in excepted off-campus outpatient PBD
    - ✓ Applies to grandfather/excepted PBD and paid under OPPS
    - ✓ Grandfathered = facility became PBD before 11/02/2015
  - Verify billing
  - If appropriate correct by updating PO modifier to applicable claim line(s) and resubmit (PF9)

Multiple Service Location Resources and References

- CMS Special Edition SE19007: *Activation of Validation Edits for Providers with Multiple Service Locations*
- URGENT: Billing Reminders for OPPS Providers with Multiple Service Locations
- Attention All OPPS Providers: Provider-Based Department
- Learn more about Provider Practice Address Query screen (1D) in the FISS DDE Provider Online Guide
  - Chapter IV: Inquiries Submenu (01) > Provider Practice Address Query (1D)

Reason Code 38119

- Claim DOS part of continuing stay and claim immediately preceding DOS on claim not processed
- Avoiding/Correcting this error
  - SNF inpatient claims must be submitted one month at a time, in sequential order
  - Subsequent claims in stay should not be submitted until prior month's claim processed and finalized (appears on remittance advice)
  - Before submitting next claim in sequence, verify status of prior month's claim
    - ✓ FISS Inquiry Claim Summary option - FISS DDE Provider Online Guide
    - ✓ IVR
    - ✓ NGSConnex User Guide
  - Once prior claim shown on remittance advice, resubmit RTP claim (PF9)

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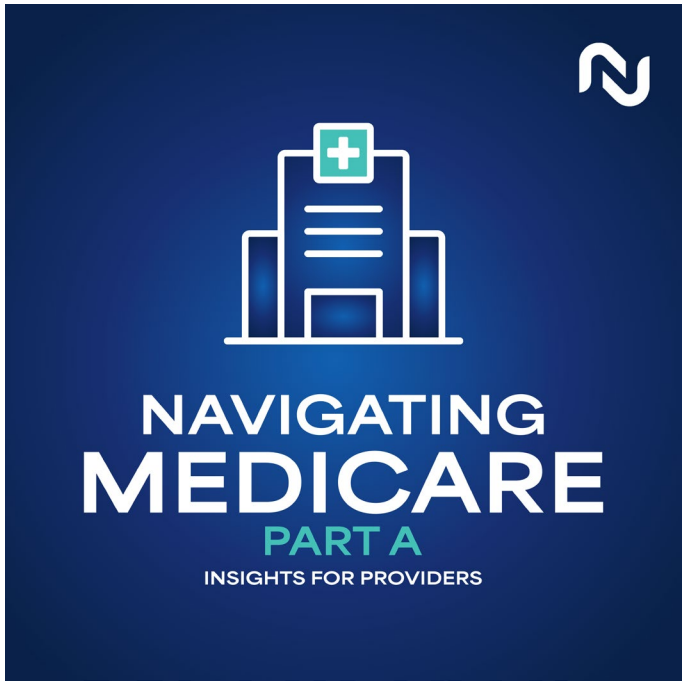

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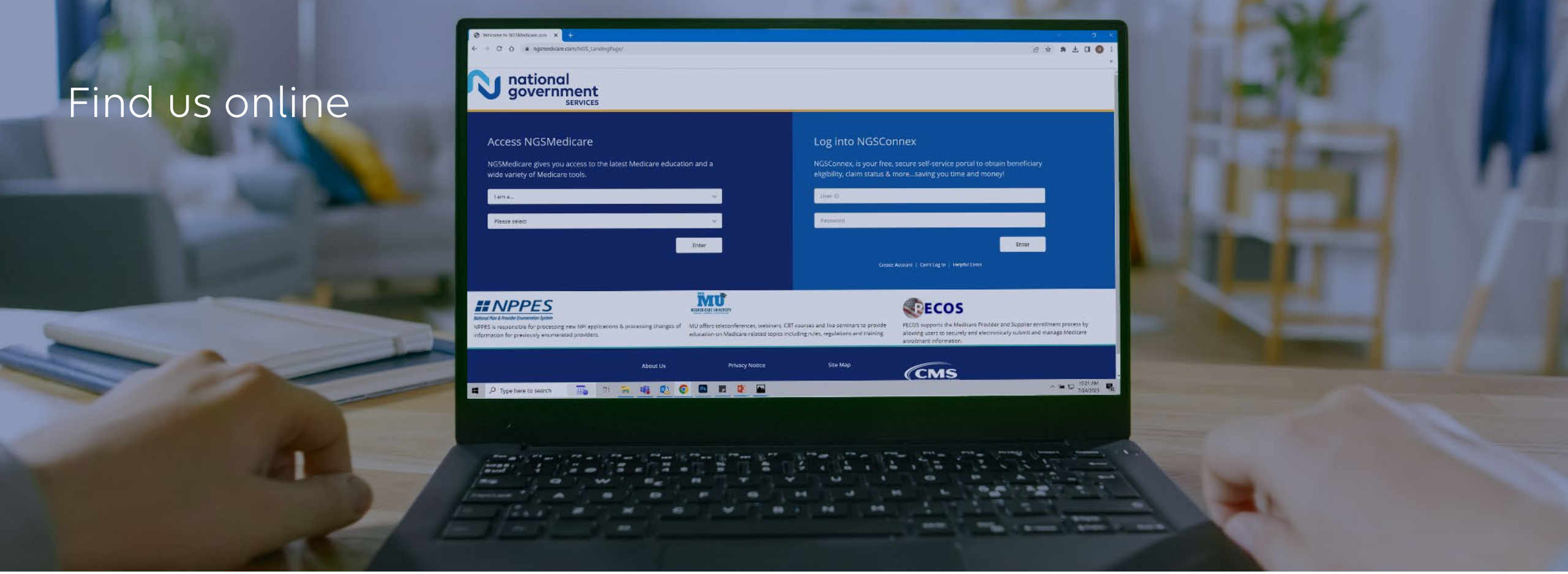

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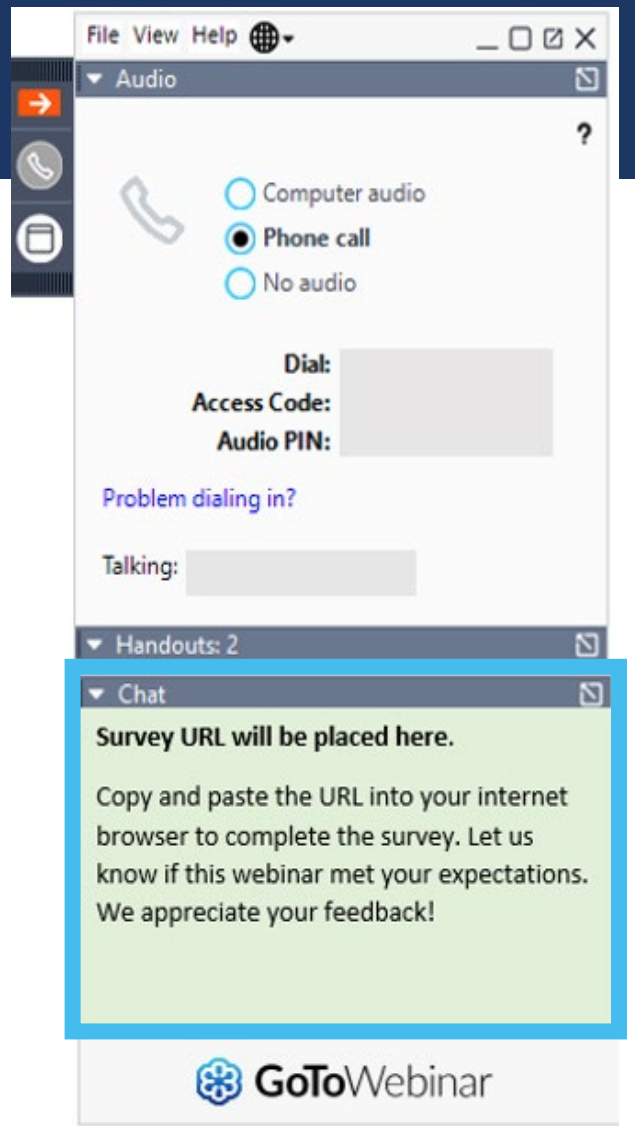

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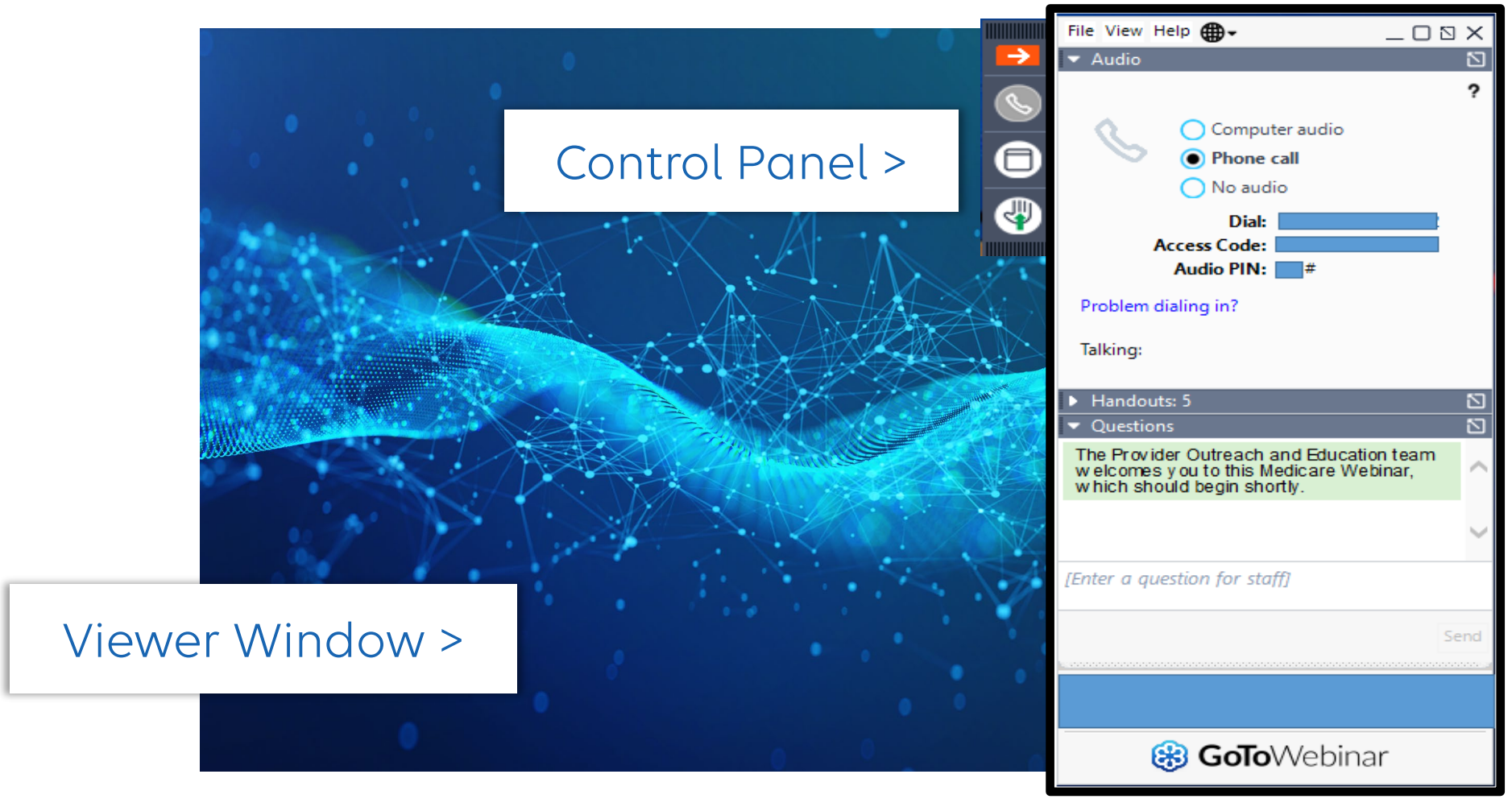

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