national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Hospital, CMHC, CORF/ORF and ESRD Facilities Quarterly Top Claim Errors

7/22/2025

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.*

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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

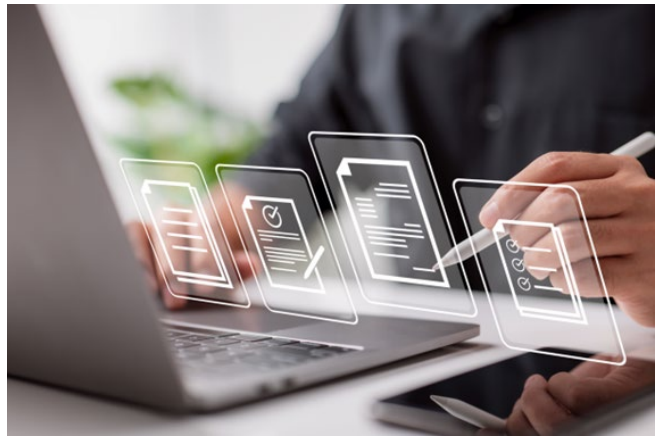
- Provider Outreach and Education Consultants
  - Andrea Freibauer
  - Christine Janiszcak
  - Jean Roberts, RN, BSN, CPC

Agenda

- Understanding and Locating Claim Errors
- Top Denial Reason Codes
- Top Rejection Reason Codes
- Top RTP Reason Codes
- Stay in the Know With NGS!
- Questions?

Understanding and Locating Claim Errors

Benefits of Preventing Claim Errors



Financial

Increase Medicare cash flow by correctly submitting claims first time

Avoid expense of resubmitting, adjusting, or appealing incorrect claims

Time

Utilize staff time more efficiently by avoiding “claim error rollercoaster” – researching and fixing errors

Ensure claims 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 located in processing
  - Reason codes – indicate status of claim
- When transaction/claim passes FISS edits, subject to CWF edits
  - Nationwide repository for Medicare beneficiary and claim information
  - If claim passes CWF edits, returns to FISS for finalization/adjudication
- After claims finalized/adjudicated, providers need to
  - Identify claim payments, rejections and denials
  - Determine if next steps needed for rejections and denials
    - Utilize FISS DDE, RA or other methods

FISS Status/Locations

- S XXXXX – Claim suspended (processing)
- P B9997 – Claim finalized/adjudicated
  - Doesn't always mean paid
- T B9997 – Claim RTP
  - Claim has error(s) that need to be corrected and returned to us in FISS (PF9)
  - Providers must check RTP claims often as we don't consider them received
- 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?

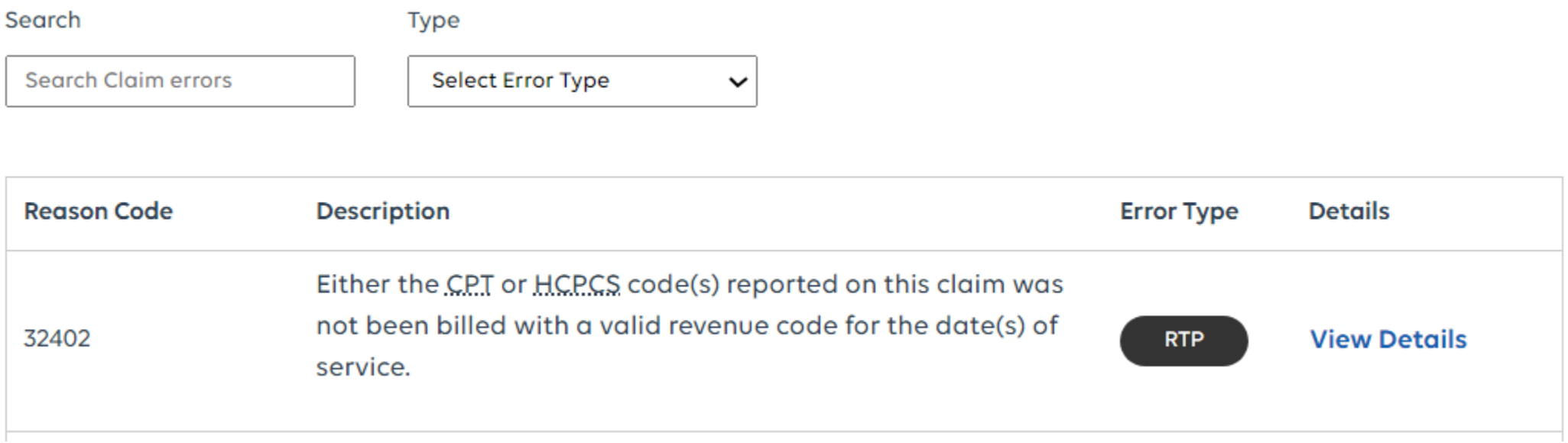
- Five-digit codes that direct outcome of claim edit or process
- Review reason code to determine next steps
  - Correct claim online and resubmit
  - Appeal claim
  - Adjust claim
  - Submit new claim
  - No action may be needed

Locating Reason Codes in FISS DDE

- Reason code file
  - Inquiries (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)

Tips For Avoiding/Correcting Claim Errors

- Research reason codes on our website
  - Part A and your state > Resources > Claims and Appeals > Top Claim Errors



Top Denial Reason Codes

Denials: April – June 2025

Jurisdiction 6

CMHC	CORF/ ORF	ESRD	IP Hospital	OP/ OPPS
-	39928	-	59118	39928
-	-	-	55A18	5WEXC
-	-	-	59091	54NCD

Jurisdiction K

CMHC	CORF/ ORF	ESRD	IP Hospital	OP/ OPPS
39928	-	-	59118	39928
-	-	-	59301	5WEXC
-	-	-	59138	54NCD

Denial Reason Code 39928

- Each line of charges 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 our current LCDs and Billing and Coding Articles
  - If you disagree with denial, you have appeal rights

Denial Reason Code 59118

- TOB 11X claim contains valid ICD-10 procedure code but one of following applies:
  - Does not contain valid ICD-10 diagnosis code for PTA of carotid artery (NCD 20.7)
  - ICD-10 diagnosis code I672 and one code from ICD-10 diagnosis code list for PTA and stenting not all present
- Avoiding/Correcting this error
  - Ensure all Medicare coverage, documentation and medical necessity requirements met before billing claim
    - CMS IOM Publication 100-03, *Medicare National Coverage Determinations* Manual, Chapter 1, Part 1, Section 20.7
  - If you disagree with denial, you have appeal rights

Denial Reason Code 59138

- TOB 11X claim with DOS on/after 3/6/2024 denied due to NCD 110.23 (formerly 110.8.1)
- Claim contains valid ICD-10 procedure code per NCD and either
  - "CR13604" in Remarks and diagnosis code D46.A, D46.B, D46.C, D46.0, D46.1, D46.4, D46.9, D46.20, D46.21, D46.Z or D46.22 not present
  - "CR13604" not in Remarks and diagnosis codeD46.A, D46.B, D46.C, D46.0, D46.1, D46.4, D46.9, D46.20, D46.21, D46.Z or D46.22 present
- Avoiding/Correcting this error
  - Ensure all Medicare coverage, documentation and medical necessity requirements met before billing claim
    - MLN Matters® *MM13604: National Coverage Determination 110.23: Allogeneic Hematopoietic Stem Cell Transplantation*
    - CMS Change Request 13939: *International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) - July 2025*
    - CMS IOM Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 2, Section 110.23
  - If you disagree with denial, you have appeal rights

Denial Reason Code 54NCD

- Line level reason code indicating billed diagnosis codes do not support medical necessity of services
- Avoiding/Correcting this error
  - Review coverage guidelines for service being denied to ensure medical necessity of services being provided to beneficiary
  - Review Submit an Adjustment to Correct Claims Partially Denied by Automated LCD-NCD Denials article on our website under Appeals tab

Denial Reason Code 55A18

- Automated denial
- Clinical trial for allogeneic hematopoietic stem cell transplantation (HSCT) for Myelodysplastic Syndromes (MDS) – NCD 110.23
- Avoiding/Correcting this error
  - Ensure all Medicare coverage, documentation and medical necessity requirements met before billing claim
    - CMS IOM Publication 100-03, *Medicare National Coverage Determinations* Manual, Chapter 1, Part 1, Section 110.23
  - If you disagree with denial, you have appeal rights

Denial Reason Code 5WEXC

- Claim does not qualify for Medicare payment due to principal diagnosis code billed
- Avoiding/Correcting this error
  - Ensure all Medicare coverage, documentation and medical necessity requirements met before billing claim
    - Review our current LCDs and Billing and Coding Articles
    - Check for errors such as typos or transposed numbers
  - If additional medical circumstances exist or more specific diagnosis code appropriate, indicate when submitting appeal

Resources and 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
  - ICD-10

Top Rejection Reason Codes

Rejections: April – June 2025

Jurisdiction 6

CMHC	CORF/ ORF	ESRD	IP Hospital	OP/ OPPS
-	39929	U5233	38200	39929
-	38032	38065	38005	U5333
-	U5233	U5210	38017	38200

Jurisdiction K

CMHC	CORF/ ORF	ESRD	IP Hospital	OP/ OPPS
39929	39929	U5233	38005	U5233
-	38200	38065	38200	39929
-	C7010	U538Q	38017	38200

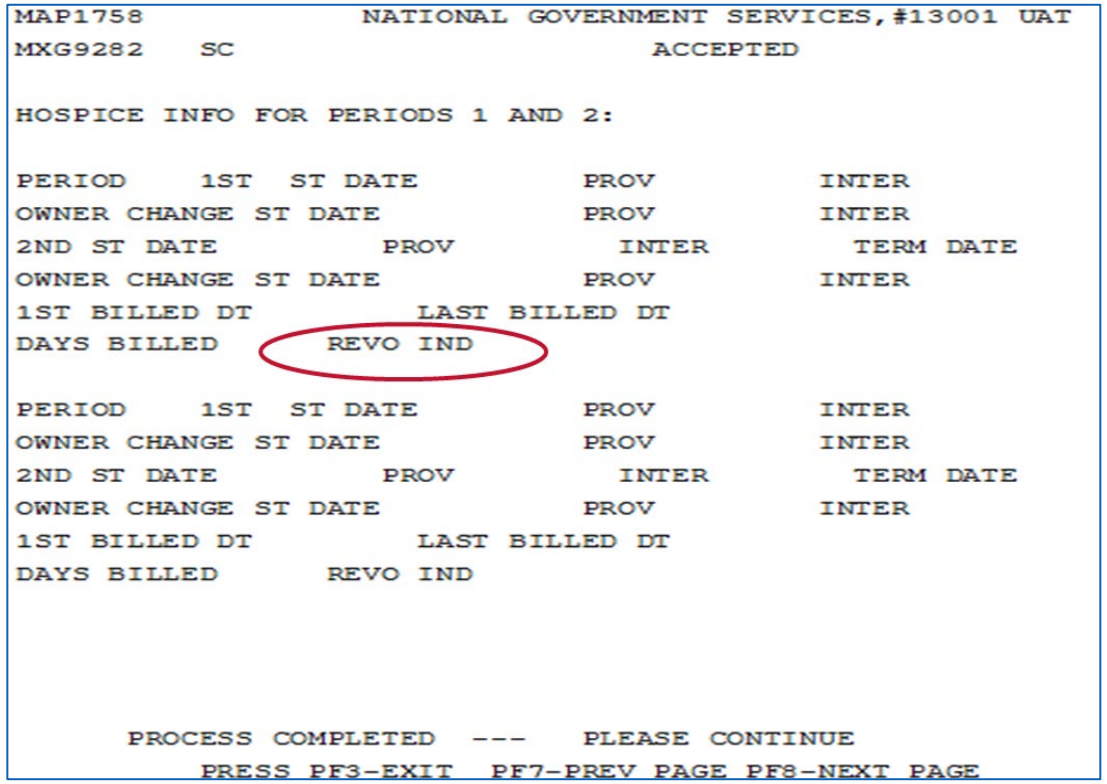
Rejection Reason Code U538Q

- Services billed while beneficiary unlawfully present in US
- Avoiding/Correcting this error
  - Verify eligibility using self-service tools before submitting claim
  - If appropriate, make corrections and submit claim adjustment

Rejection Reason Code C7010

- Service dates on claim overlap hospice election period and CC 07 not present
- Avoiding/Correcting this error
  - Verify if beneficiary elected Medicare hospice benefit via FISS, NGSConnex or IVR
  - Determine if services rendered related to terminal illness
    - If related, bill hospice agency
      - May not pay if services weren't coordinated with agency, beneficiary not liable!
    - 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 IP stay
    - Hospice beneficiary also enrolled in MAO plan

CWF Hospice Election Period MAP 1758



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MAP1758              NATIONAL GOVERNMENT SERVICES,#13001 UAT
MXG9282   SC                          ACCEPTED

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
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- Review hospice election period information
  - Start date
  - Billed date(s)
  - Provider number
  - Revocation indicator code
    - Blank/0 = No revocation on file
    - Code 1 = Revoked by beneficiary
    - Code 2 = Revoked by MAC

Rejection Reason Code C7010 – Resources

- CMS Hospice page
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 9, Section 40.1
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 11, Section 30.4
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 100.5

Rejection Reason Code 39929

- Each line of charges 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 right view (PF11) of claim page 2 (MAP171D)

Rejection Reason Code U5210

- Beneficiary's Medicare entitlement terminated prior to DOS
- Avoiding/Correcting this error
  - Verify eligibility using self-service tools before submitting claim
  - Determine effective dates of Medicare coverage – can be different for Part A and Part B
    - Part A coverage for IP services
    - Part B coverage for OP services (may have multiple effective dates)

Rejection Reason Code U5233

- Service dates on claim fall within or overlap MA HMO enrollment period
  - For IP PPS claims, admission date falls within MA 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 MA HMO entitlement dates
  - Determine if billed correctly for your facility type and take appropriate action

Rejection Reason Code U5233 – Facility Actions

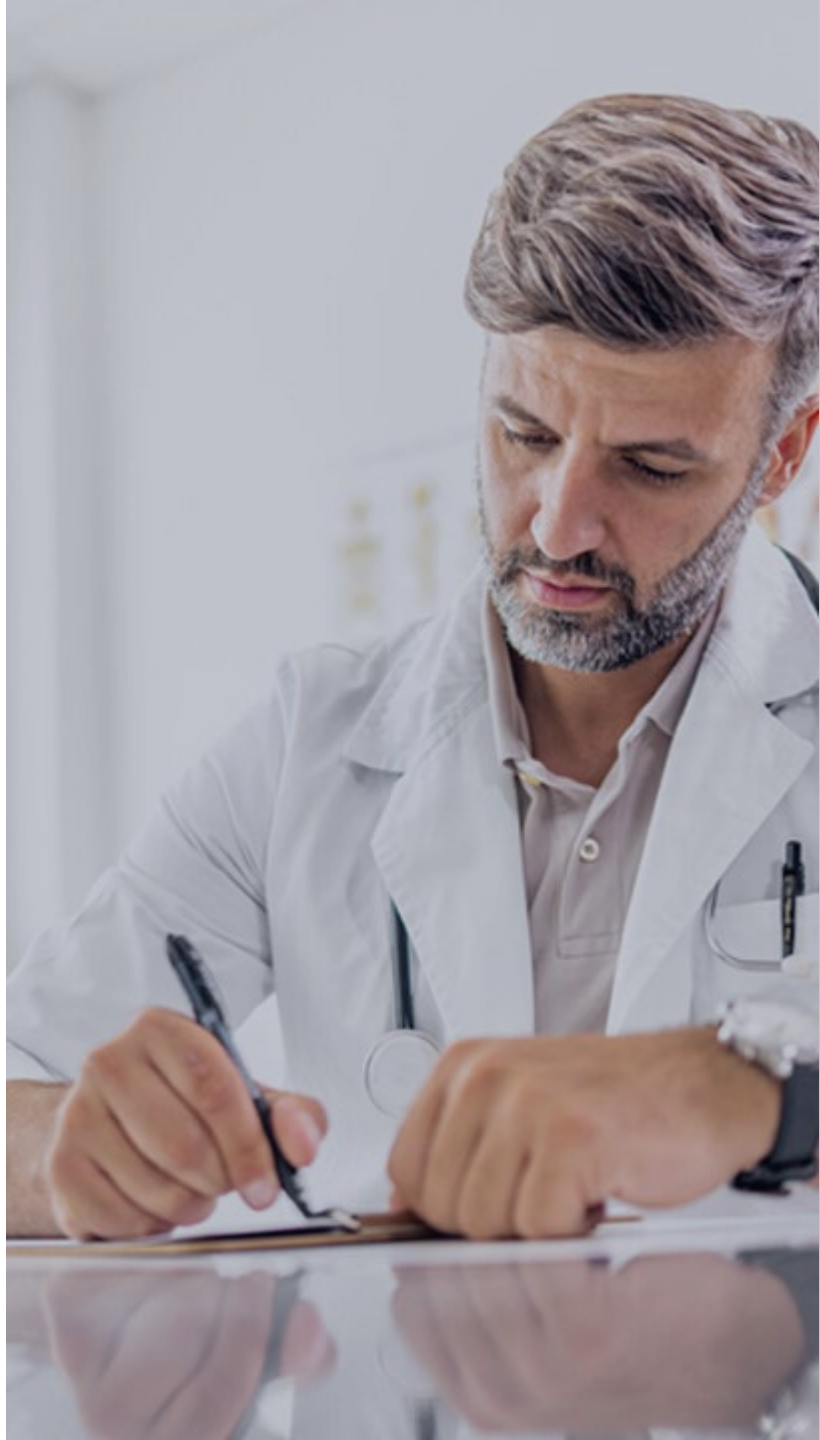
- All facilities
  - For services within effective and termination dates of MA HMO period
    - Submit to MA HMO plan
      - If OP facility, do not bill us, bill only MA HMO plan
      - If IP hospital paid under PPS and beneficiary not enrolled in MA HMO at admission, (enrolled later in stay), bill us rather than MA HMO
        - IP facilities paid under PPS = ACHs, IPFs, IRFs and LTCHs
- Non-PPS IP hospitals (CAHs, Cancer, Children's)
  - For services that overlap effective or termination dates of MA HMO period
    - Split services and bill MA HMO and us accordingly (per coverage dates)

Rejection Reason Code U5233 – Facility Actions (cont.)

- Hospitals submit informational claims after billing MA HMO
  - Follow Hospital Billing for Beneficiaries Enrolled in Option Code C Medicare Advantage Organization Plans
    - Non-teaching hospitals (ACHs, IRFs, LTCHs) and CAHs
      - Report CC 04 and covered charges
        - Note: IRFs report HIPPS code based on PAI assessment with OC 50 and date
    - Teaching hospitals (ACHs, IPFs, IRFs, LTCHs)
      - Report CCs 04, 69 and covered charges (if N&AH only, report noncovered charges)
        - Teaching ACHs paid IME or N&AH via claim
        - Other teaching hospitals paid DGME through cost report

Avoiding/Correcting Duplicates and Overlaps

- Before submitting claims
  - Verify DOS not previously submitted
    - Review RA and/or use self-service tools
  - Are all charges from coordinating departments listed on claim?
- When duplicate/overlap rejection received
  - Review information billed on claim
  - Do previously processed claim(s) need to be adjusted, cancelled or appealed?
    - Your facility may need to contact overlapping facility
- All additions and/or corrections to processed claims must be adjustment claims
  - Do not submit new claims



Rejection Reason Codes 38005 and 38017

- Reason code 38005
  - Duplicate of previously submitted IP claim where TOB equals 11X, 18X OR 41X and following same on both claims
    - MBI
    - Provider number
    - Statement from and through dates
    - Revenue code
    - CPT/HCPCS codes and modifiers (if required by revenue code file)
- Reason code 38017
  - IP claim contains service dates that overlap previously processed IP claim (TOB 11X, 18X OR 41X)

Rejection Reason Code 38032

- OP claim duplicate to previously submitted OP claim for same provider number and DOS
  - At least one diagnosis code matches
  - At least one revenue code line matches
  - At least one HCPCS code matches
  - History claim includes HCPCS code modifier LT, RT, E1-E4, FA, F1-F9, TA or T1-T9 for same DOS and incoming or history claim
    - Has blank HCPCS code modifier
    - Modifier not equal to LT, RT, E1-E4, FA, F1-F9, TA OR T1-T9

Rejection Reason Code 38065

- Duplicate TOB 72X for same provider number – one claim pending and one claim finalized
- Both claims include automated multi-channel chemistry (AMCC) CPT codes on same LIDOS
  - 82040, 84075, 84460, 84450, 82247, 82248, 82310, 82435, 82465, 82550, 82374, 82565, 82977, 82947, 83615, 84100, 84132, 84155, 84295, 84478, 84520, 82330 or 84550

Rejection 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)

Top RTP Reason Codes

RTPs: April – June 2025

Jurisdiction 6

CMHC	CORF/ ORF	ESRD	IP Hospital	OP/ OPPS
-	U5065	U5065	U5065	34977
-	34963	36164	32242	34963
-	31408	36205	30993	34986

Jurisdiction K

CMHC	CORF/ ORF	ESRD	IP Hospital	OP/ OPPS
W7118	34963	36164	U5065	34977
31576	31408	U5065	38119	34963
38206	U5065	36205	31137	38038

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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RTP Reason Code 30993

- Claim submitted with MBI and MBI/HICN combination not found in MBI cache or CWF MBI Crosswalk
- Avoiding/Correcting this error
  - Review MBI entered on claim
  - If appropriate, correct and resubmit claim (PF9)

RTP Reason Code 31137

- IP PPS admission through discharge claim (TOB 111) and admission date less than from date
  - Admission date must equal from date for these types of claims
    - Unless payment window applies or admitted before Part A entitlement date
  - IP PPS hospitals must bill admission through discharge or 60 days after admission, if they choose, and every 60 days thereafter
    - Appropriate interim TOB and PSC must be used for extended billing
- Avoiding/Correcting this error
  - Review dates entered on claim
  - If admitted before Part A entitlement, follow Inpatient Admission Prior to Medicare Entitlement Job Aid
  - If appropriate, correct and resubmit claim (PF9)

RTP Reason Code 31408

- Claim contains revenue code series 42X and OC 35 missing, or OC 35 present and no billing line in revenue code series 42X
- Avoiding/Correcting this error
  - When billing for PT services (revenue code series 42X), OC 35 required to indicate date treatment started
  - Review revenue codes and OCs entered on claim
  - If appropriate, correct and resubmit claim (PF9)

RTP Reason Code 31576

- CMHC TOB 76X required to bill valid community mental health revenue code
  - 001, 250, 430-439, 78X, 900, 904, 914-916, 918 or 942
- Avoiding/Correcting this error
  - Review TOB and revenue code(s) entered on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 32242

- Revenue code non-billable for this TOB and covered charges greater than zero
- Avoiding/Correcting this error
  - Review revenue codes entered on claim
  - If appropriate, correct and resubmit claim (PF9)

RTP Reason Code 34963

- One of 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 and resubmit claim (PF9)
  - Reason Code: 34963

RTP Reason Code 34977

- TOB 13X or 14X and practice address does not exactly match address on Provider Practice Address Query screen (MAP1AB2) in FISS DDE or PECOS
- Avoiding/Correcting this error
  - Verify address billed and ensure address matches exactly
  - If appropriate, correct and resubmit claim (PF9)

RTP Reason Code 34986

- TOB 13X or 14X
- 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
- Avoiding/Correcting this error
  - PN modifier – Non-excepted service provided at off-campus, OP, 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
  - Verify billing
  - If appropriate correct by updating PN modifier to applicable claim line(s) and resubmit (PF9)

RTP Reason Code 36164

- ESRD TOB 72X claim with DOS on/after 01/01/2025 and one of following HCPCS codes present on revenue line
  - J0278, J0290, J0606, J0636, J0692, J0713, J0878, J0879, J0882, J0887, J0911, J1580, J1642, J1756, J1956, J2185, J2310, J2357, J2405, J2550, J2704, J2916, J2997, J7050 or Q0139
- One of following applies
  - HCPCS code billed without modifier JZ and revenue line with same LIDOS and HCPCS code not present with modifier JW
  - HCPCS code present on revenue line with modifier JW but without prior revenue line containing same HCPCS code and LIDOS
- Avoiding/Correcting this error
  - Review HCPCS codes and modifiers billed on claim
  - If appropriate, correct and resubmit claim (PF9)

RTP Reason Code 36205

- One of following applies for TOB 72X
  - Revenue code 0821 present and VC D6 not present
  - VC D6 present with value not greater than 1.0
- Avoiding/Correcting this error
  - Review billing (TOB, revenue code, VC)
  - If appropriate, correct and resubmit claim (PF9)

RTP Reason Code 38038

- OPPS TOB (12x, 13x, 14x, 76x, 75x, 34x) or any claim containing CC 07 cannot have overlapping dates when provider numbers same unless CC G0, 20 or 21 present
- Avoiding/Correcting this error
  - Submit adjustment claim (TOB XX7) to add any charges to first claim processed
  - If appropriate, correct and resubmit claim (PF9)

RTP Reason Code 38119

- Claim DOS part of continuing stay and claim immediately preceding DOS on claim not finalized
- Avoiding/Correcting this error
  - All non-PPS 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 RA)
  - 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 on RA, resubmit claim (PF9)

RTP Reason Code 38206

- Partial hospitalization claim for same beneficiary and provider with LIDOS within seven days after through date for incoming claim
  - TOB 131 with CC 41 and history claim TOB 131, 132, 133, 134 or 137
  - TOB 851 with CC 41 and history claim TOB 851, 852, 853, 854, 857
  - TOB 761 and history claim TOB 761, 762, 763, 764 or 767
- Avoiding/Correcting this error
  - Review billing
  - If appropriate, correct and resubmit claim (PF9)

RTP 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 claim (PF9)

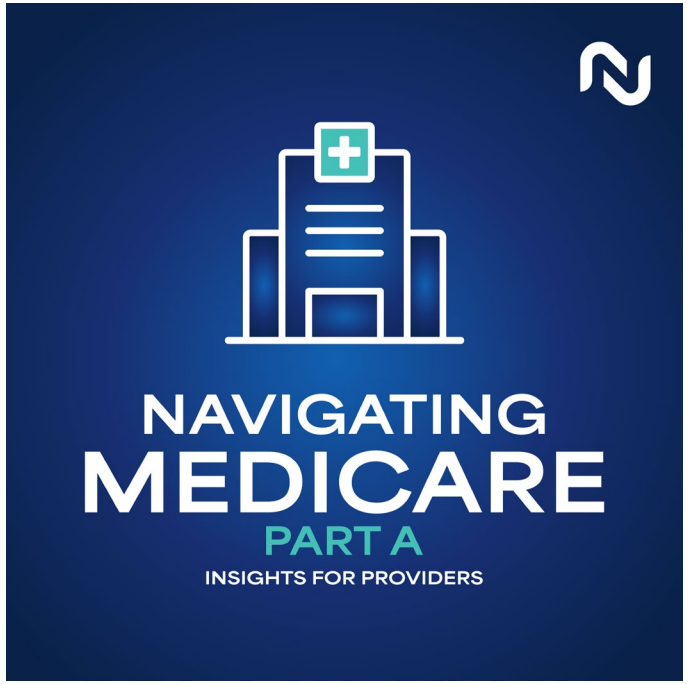
RTP Reason Code W7118

- Invalid TOB
- Avoiding/Correcting this error
  - Review TOB entered on claim
  - If appropriate, correct and resubmit claim (PF9)

Stay in the Know With NGS!

Listen to Our Part A Podcast

Navigating Medicare: Part A Insights for Providers



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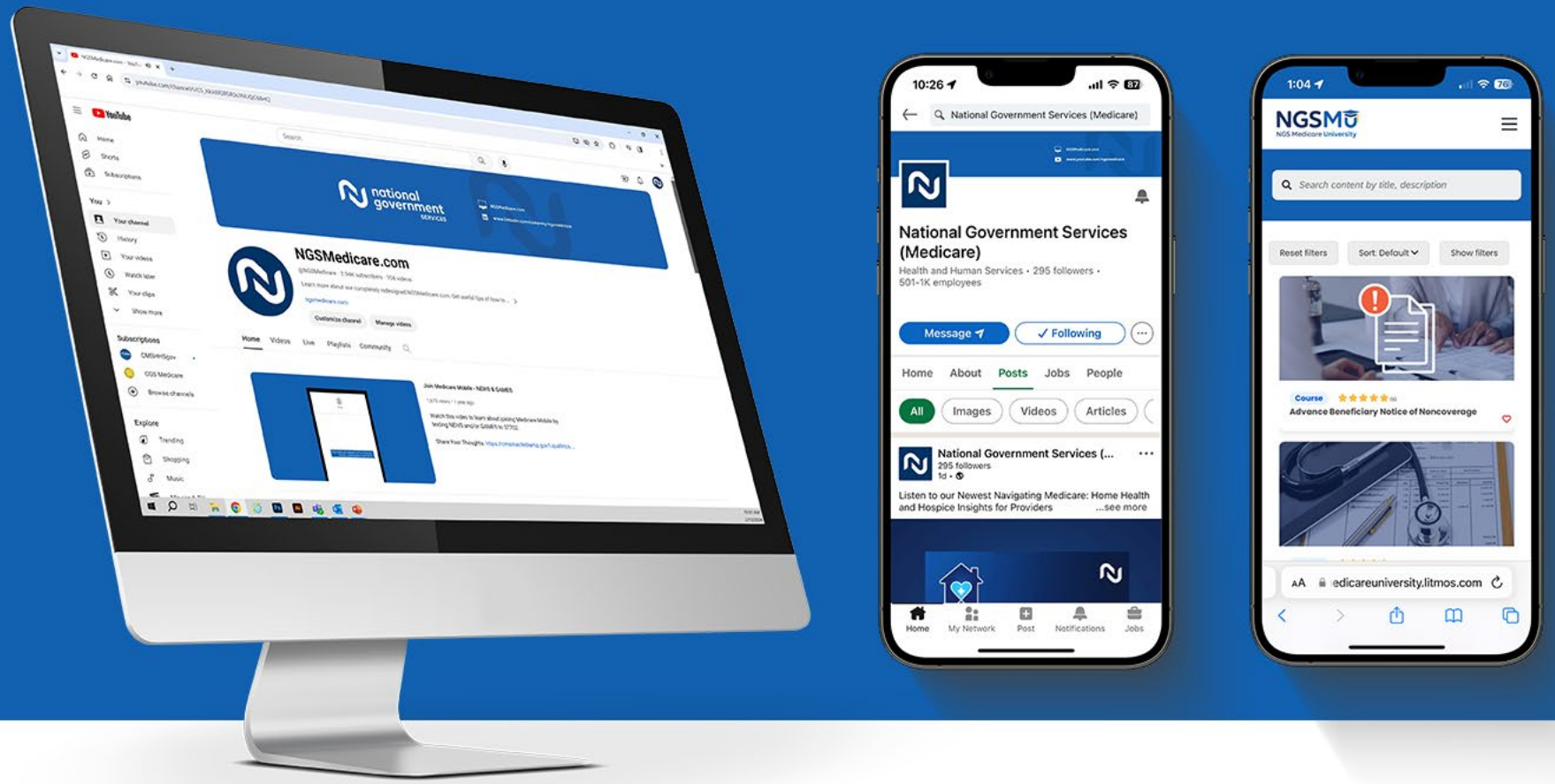

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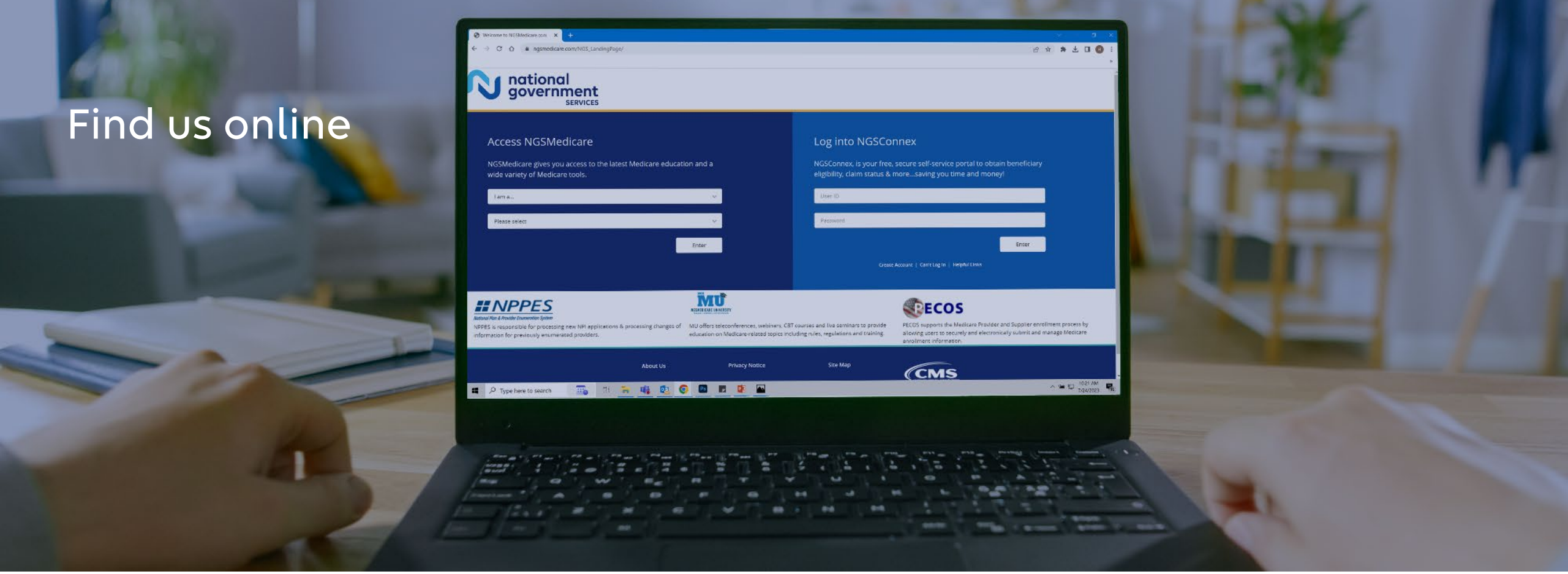

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

[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

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Questions?

Thank you!