national government SERVICES

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CAH, FQHC and RHC Quarterly Top Claim Errors

7/23/2025

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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
  - Mimi Vier

Agenda

Understanding and Locating Claim Errors

Top Denial Reason Codes

Top Rejection Reason Codes

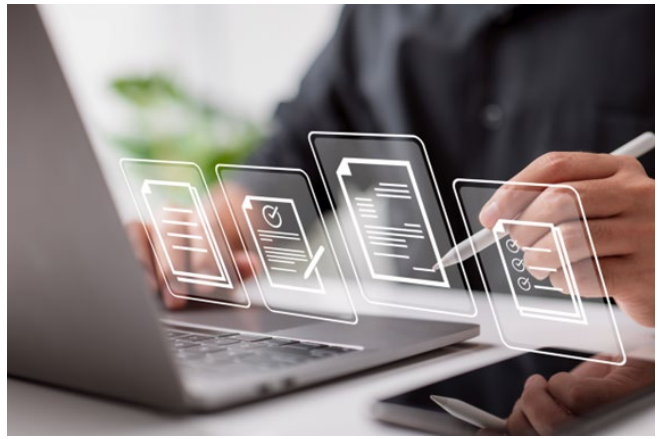
Top RTP Reason Codes

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 the first time

Avoid 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 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
- 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 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?

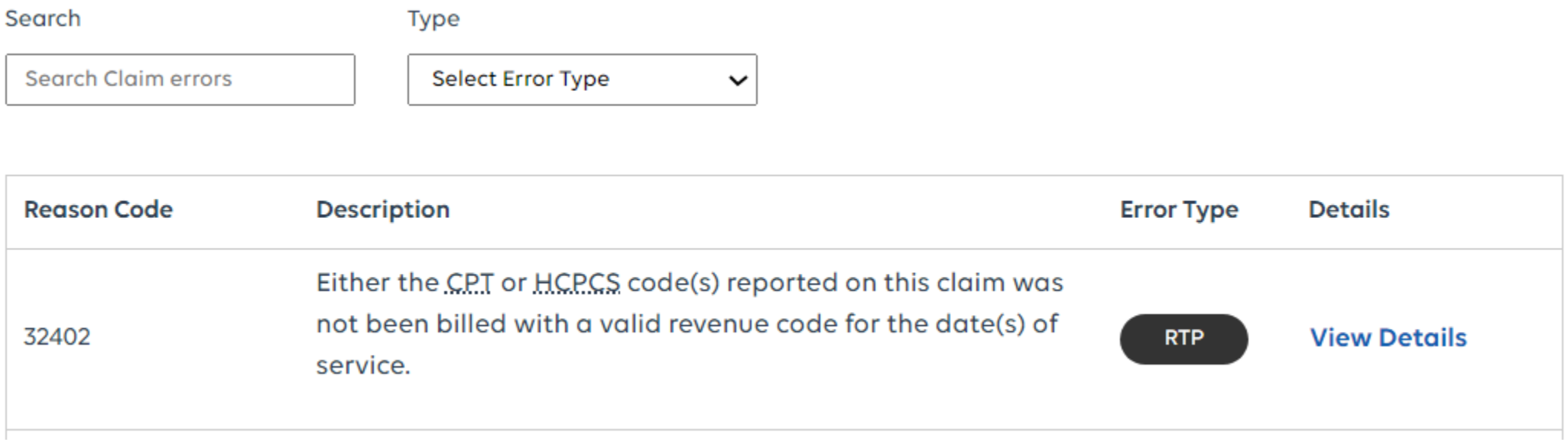
- Five-digit codes that direct outcome of claim edit or process
- Review reason code to determine next steps
  - Correct claim online and resubmit
  - Appeal claim
  - Adjust claim
  - Submit new claim
  - No action may be needed

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)
    - 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



Top Denial Reason Codes

Denials: April – June 2025

Jurisdiction 6

CAH	FQHC	RHC
39928	5WEXC	39928
5WEXC	55B31	5WEXC
52MUE	-	-

Jurisdiction K

CAH	FQHC	RHC
39928	5WEXC	39928
52MUE	-	5WEXC
5WEXC	-	-

Denial 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 our current LCDs and Billing and Coding Articles
  - If you disagree with denial, you have right to appeal

Denial 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

Denial Reason Code 55B31

- Medical review denial for services not documented in medical records (incomplete/insufficient information)
- Avoiding/Correcting this error
  - Always ensure complete documentation submitted and documentation supports services billed
  - Review appropriate chapter(s) of CMS IOM Publication 100-02, *Medicare Benefit Policy Manual* for your facility type for coverage and documentation requirements

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
    - Look for typos and transposed numbers
  - If additional medical circumstances exist or more specific diagnosis code appropriate, indicate when submitting appeal

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 Rejection Reason Codes

Rejections: April – June 2025

Jurisdiction 6

CAH	FQHC	RHC
38105	38312	38200
U5233	U5233	U5233
39929	39934	C7010

Jurisdiction K

CAH	FQHC	RHC
38105	U5233	38200
39929	38312	U5233
U5233	39934	38031

Rejection 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 right view (PF11) of claim page 2 (MAP171D)

Rejection 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 us

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
  - 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

Reason Code C7010 - Resources

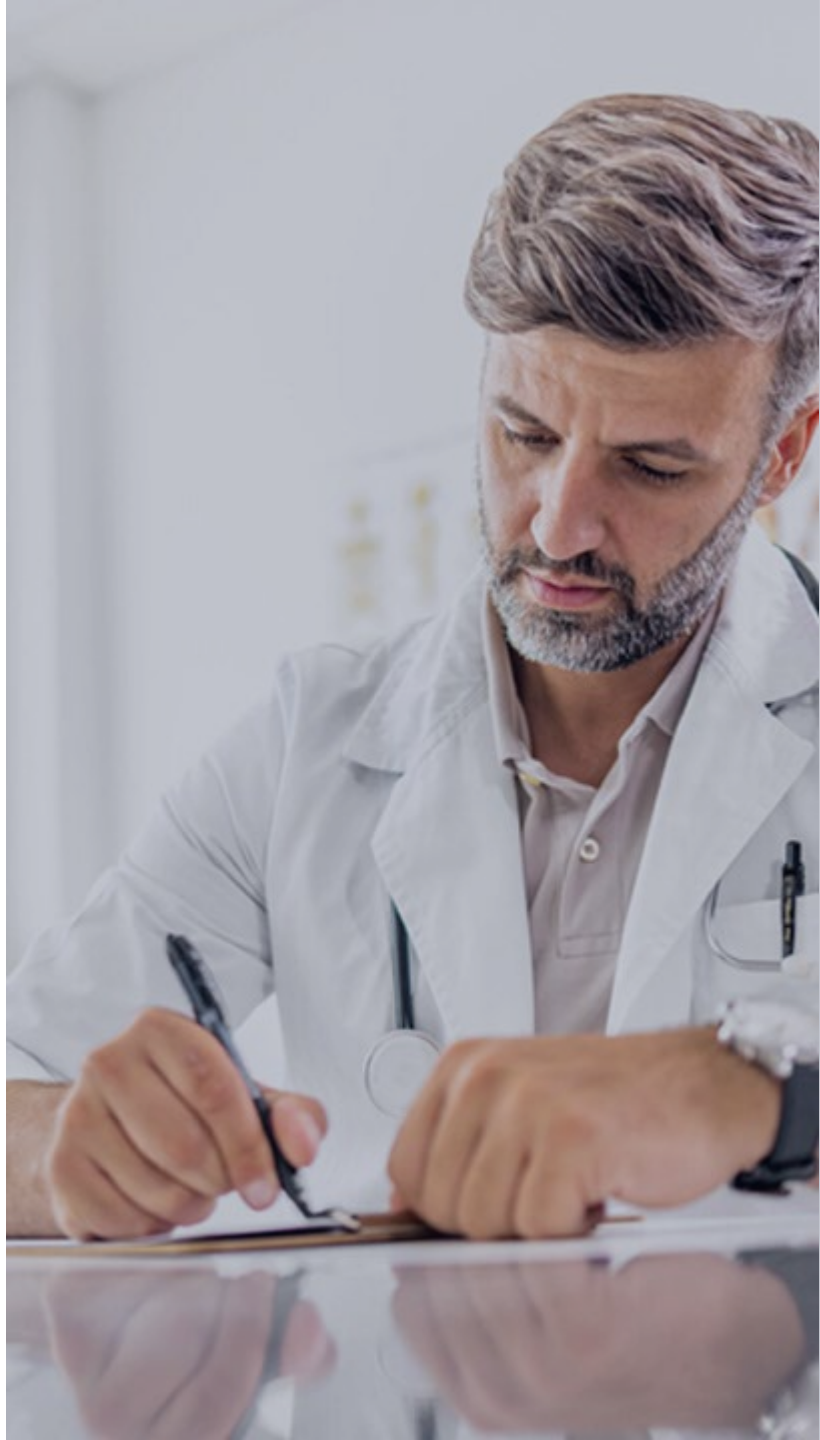
- CMS Hospice page
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 9, Section 40.1
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 11, Section 30.4
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 100.5

Rejection Reason Code U5233

- Services on claim fall within or overlap MA HMO enrollment period
- Avoiding/Correcting this error
  - Services within MA HMO enrollment period must be submitted directly to MA HMO plan for reimbursement
  - 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

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 Code 38031

- OP claim possible duplicate to previously submitted OP claim for same provider number
  - Statement from and through dates overlap
  - At least one revenue code line matches
  - Same diagnosis code(s)

Rejection Reason Code 38031

- TOB 77X claims
  - Diagnosis codes same or different
  - HCPCS code matches but different revenue code
  - HCPCS code modifier LT, RT, E1-E4, FA, F1-F9, TA or T1-T9 and either claim contains one of these modifiers (or blank), same HCPCS code and same DOS
  - Other HCPCS code modifiers, at least one HCPCS code same (or blank)
- History claim TOB 71X and incoming claim TOB 71x or 77x
  - Same diagnosis, beneficiary, DOS, and provider
  - Even if revenue code line matching history claim missing LIDOS or HCPCS code on either claim

Rejection Reason Code 38105

- Claims cannot overlap DOS with another claim for different TOBs but same provider number, regardless if same or different revenue code line(s)
- TOBs 13X, 14X, 83X, 85X
- Exceptions:
  - One claim only for pap smear or mammography screening
  - One claim has OSC 74 and other claim within those OSC dates
  - One claim for repetitive Part B services only (CAH 85X TOB)

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 code and modifier (if required by revenue code file)

Rejection Reason Code 38312

- FQHC PPS claim with LIDOS matching another LIDOS on previously submitted claim and all of the following match:
  - MBI
  - PTAN
  - LIDOS

Top RTP Reason Codes

RTPs: April – June 2025

Jurisdiction 6

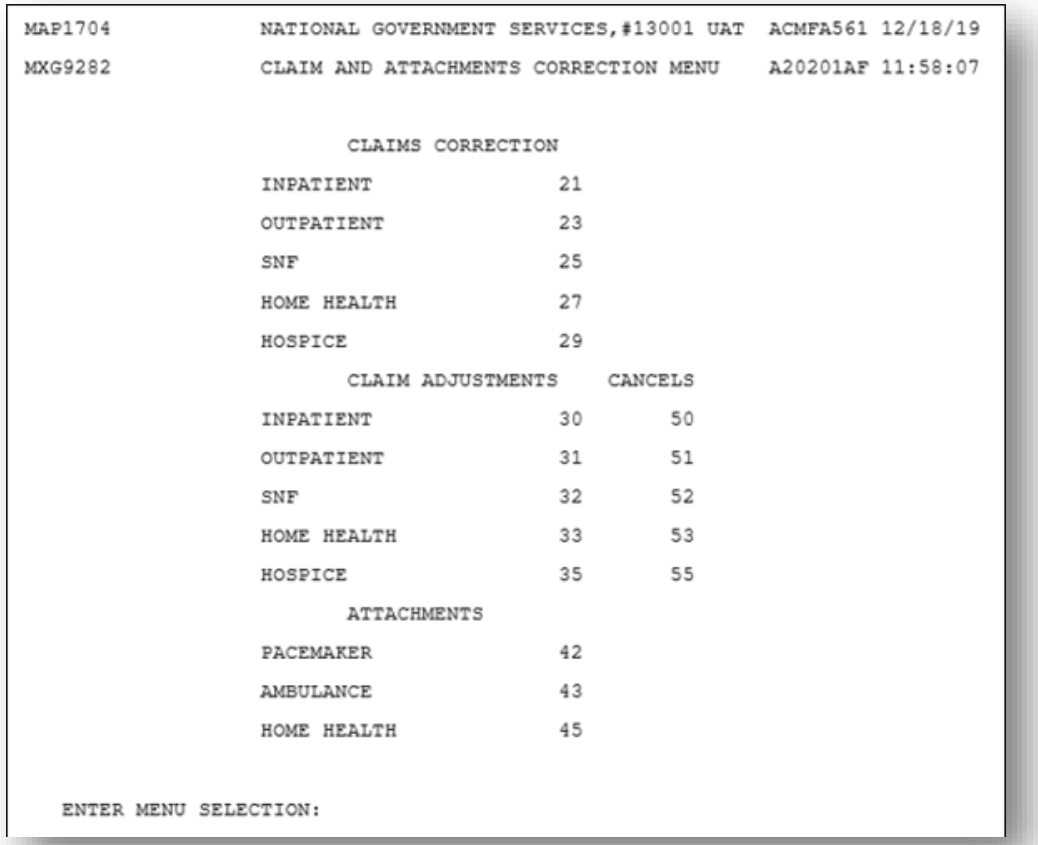
CAH	FQHC	RHC
32402	W7088	39910
34963	37098	32402
34072	34963	34963

Jurisdiction K

CAH	FQHC	RHC
34963	W7088	E0401
32402	37098	34963
32391	34963	31300

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 31300

- One of the following applies:
  - Payer ID code not equal to A, B, C, D, E, F, G, H, L, or Z
  - Payer ID code L and VC 42 present but TOB not 11X, 18X, 21X, or 41X
- Avoiding/Correcting this error
  - Verify payer ID code and coding
  - Review MSP Billing Code Table under Prepare and Submit a Medicare Secondary Payer Claim
  - Review Billing Medicare Part A When Veteran's Administration Eligible Medicare Beneficiaries Receive Services in Non-VA Facilities
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 32391

- Method II CAH provider (XX1300-XX1399) billing professional services revenue code 96X, 97X, 98X, but not 964
  - Claim contains valid HCPCS code and DOS, but no PC/TC indicator present for HCPCS code billed
- Avoiding/Correcting this error
  - Review revenue code(s) and HCPCS code(s) entered on claim
    - If claim contains unlisted HCPCS code(s), update claim with more specific HCPCS code for services rendered
    - If a more specific HCPCS code cannot be identified, contact the American Medical Association to request valid code be assigned for such services
    - For HCPCS identified as restricted or carrier priced under the MPFSDB, contact PCC for coverage
  - If appropriate, correct and resubmit (PF9)

RTP 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 (HCPCS 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 CPT/HCPCS code and resubmit (PF9)

RTP Reason Code 34072

- One of the following applies:
  - Submitted as Medicare primary but open Working Aged (12) record on CWF
  - Claim has OC 18 (beneficiary's retirement date) and OC 18 date same as or prior to MSP CWF record effective date or equal to claim from date
  - Claim has OC 25 (date benefits terminated by primary payer) and OC 25 date prior to DOS, not equal to OC 18 date or within/after DOS but MSP CWF record has spouse as policy holder
- Avoiding/Correcting this error
  - Verify retirement date and correct if appropriate or add claim coding
  - Refer to Collect and Report Retirement Dates on Medicare Claims and Prevent an MSP Rejection on a Medicare Primary Claim
  - Once corrected or additional information added, resubmit claim (PF9)

RTP Reason Code 34963

- Attending physician information on claim page 5 not correct due to:
  - Organizational NPI instead of individual attending physician's NPI
  - Attending physician listed either 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
  - Claim through date of service equal to or greater than attending physician's termination date on PECOS Enrolled Physician inquiry screen
  - Physician or non-physician practitioner NPI for specialty **not** eligible as attending physician enrolled in PECOS in approved status
- Avoiding/Correcting this error
  - Verify billing
  - If appropriate, correct and resubmit (PF9)

RTP 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)

RTP Reason Code 39910

- RTP for one or more of the following reasons:
  - TOB must be 72X if modifier CD, CE or CF on claim
  - Revenue code 881 does not require HCPCS code
  - Modifier CG required on RHC (TOB 71X) claim on revenue code line 52X or 900
    - MLN Matters® SE1611: *Rural Health Clinics (RHCs) Healthcare Common Procedure Coding System (HCPCS) Reporting Requirement and Billing Updates*
  - Do not include charges for vaccines on RHC or FQHC claim (not visit if only service)
  - TOB 12X invalid for billing HCPCS G9141 for vaccines (H1N1) or any flu vaccine
  - Claim for same-day transfer requires same admission, from and through dates, patient status 02, 03 or 04 and CC 40
- Avoiding/Correcting this error
  - Verify billing
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code E0401

- One of the following applies regarding TOB:
  - Invalid
  - Inconsistent with provider number (PTAN)
  - Inappropriate when billing revenue code 403
- Avoiding/Correcting this error
  - Verify TOB, PTAN and revenue codes billed on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code W7088

- TOB 77X (FQHC) submitted and at least one specific payment code G0466 - G0470 not present
- Avoiding/Correcting this error
  - Review CPT/HCPCS coding on claim
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 60.2 for descriptions and billing requirements
    - Federally Qualified Health Centers (FQHC) Center
  - If appropriate, correct and resubmit (PF9)

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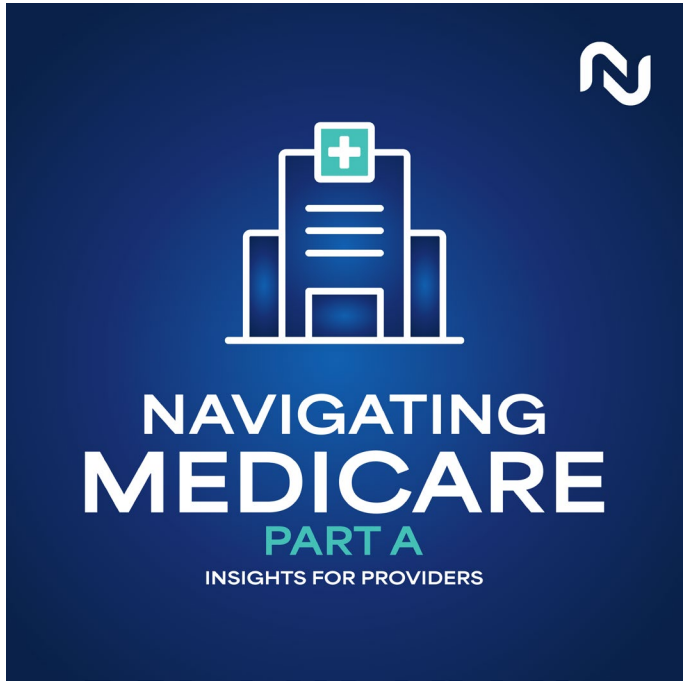

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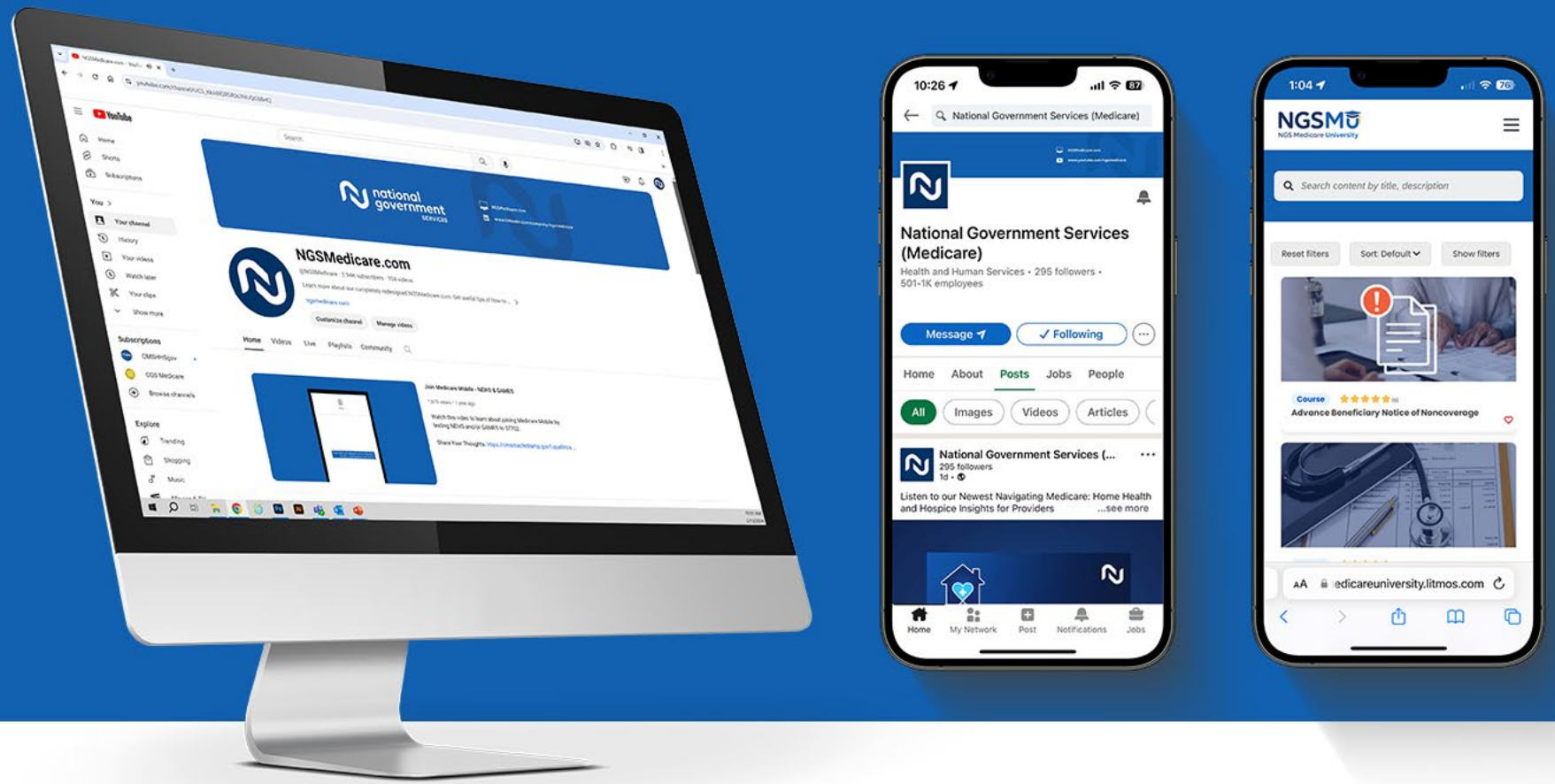

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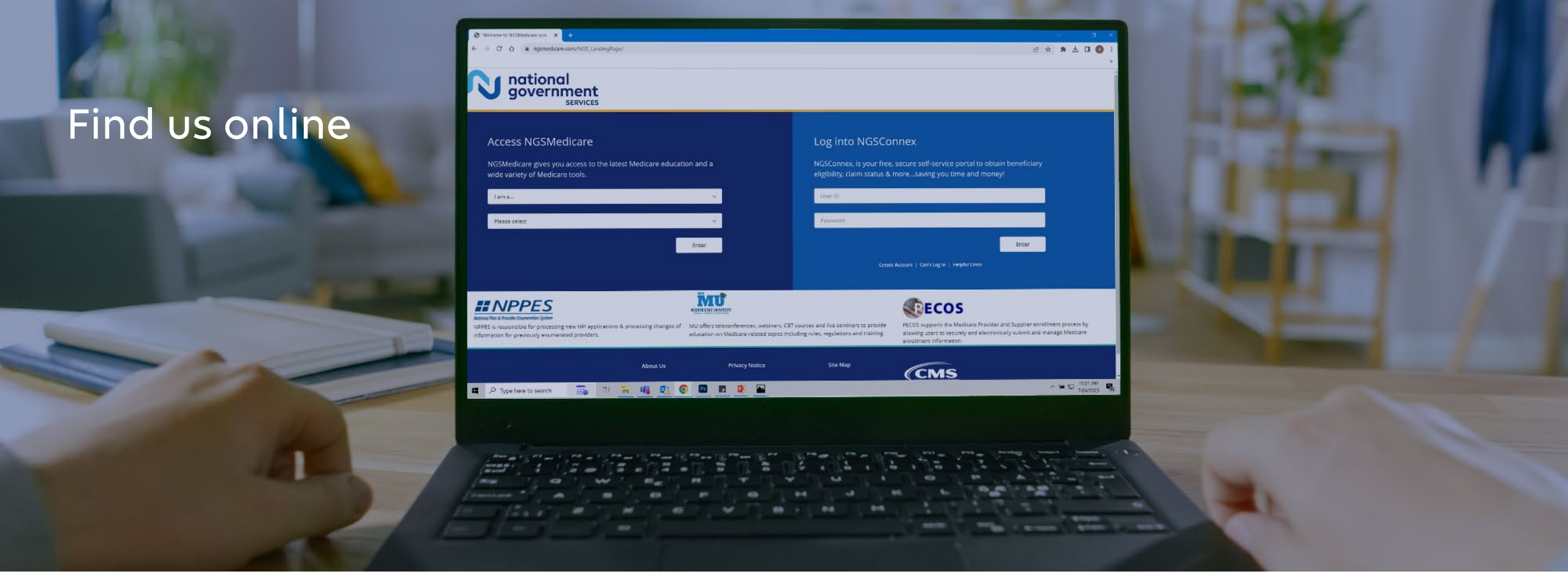

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