national government SERVICES

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Skilled Nursing Facility and Swing Bed Quarterly Top Claim Errors

4/30/2025

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

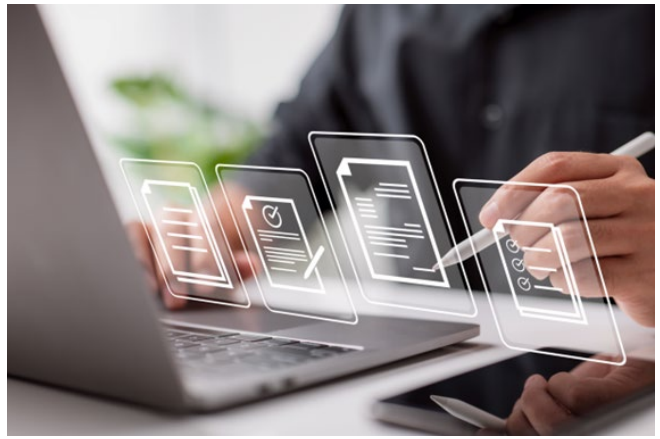
- Provider Outreach and Education Consultants
  - Andrea Freibauer
  - Kathy Mersch

Agenda

- Understanding and Locating Claim Errors
- Top Denial Reason Codes
- Top Rejection Reason Codes
- Top Return to Provider (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 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
- Claims follow 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, 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 correction 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?

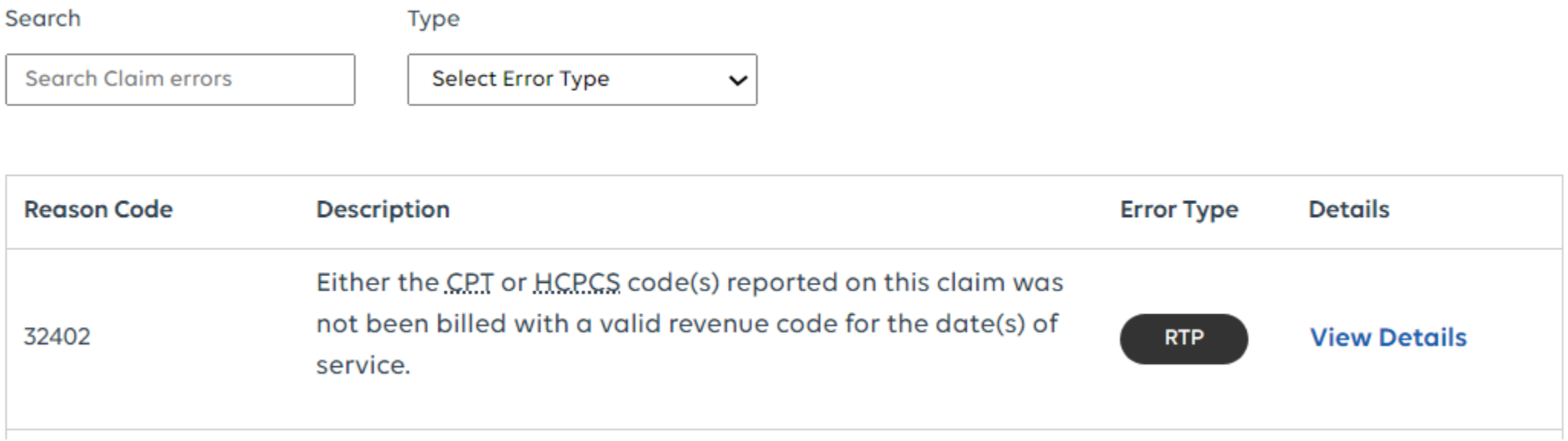
- Five-digit codes that direct outcome of claim edit or process
- Review reason code to determine next steps
  - Correct claim online and resubmit
  - Appeal claim
  - Adjust claim
  - Submit new claim
  - No action may be needed

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 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: January – March 2025

Jurisdiction K

SNF IP	SNF OP	Swing Bed
56900	39928	-
55S08	-	-
55S19	-	-

Jurisdiction 6

SNF IP	SNF OP	Swing Bed
56900	39928	-
55S34	5WEXC	-
55S25	7FLUD	-

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 current National Government Services LCDs and Billing and Coding Articles
  - If you disagree with denial, you have the right to appeal

Denial Reason Code 56900

- Requested medical records not received within time limit and 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
  - View ADRs online in FISS DDE
    - Hard-copy ADRs not sent for claims pending in status locations SB6099 or SB6098
    - Providers who cannot submit electronic attachments will see all claims requiring medical documentation in status/location SB6001

Denial Reason Code 55S08

- Insufficient documentation to support that beneficiary had qualifying IP hospital stay prior to admission to SNF and no waiver indicated
- Avoiding/Correcting this error
  - No action necessary if denial was desired outcome
  - QHS billed with OSC 70 and inpatient hospital stay dates
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 8, Section 20.1
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 6, Section 30

Denial Reason Code 55S19

- Documentation submitted did not support SNF services medically reasonable and necessary for treatment of beneficiary's illness or injury
- Avoiding/Correcting this error
  - Ensure medical records show beneficiary met coverage requirements
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 8, Section 30
  - CMS IOM Publication 100-08, Medicare Program Integrity Manual
    - Chapter 3, Sections 3.4.1.3, 3.6.2.1,and 3.6.2.2
    - Chapter 6, Section 6.1.4

Denial Reason Code 55S25

- SNF claim denied for no MDS found in repository
- Avoiding/Correcting this error
  - Ensure staff properly completes and submits MDS
  - Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual
  - CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 6, Section 6.1.4
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 8, Section 30

Denial Reason Code 55S34

- Documentation submitted did not include required certification for SNF stay
- Avoiding/Correcting this error
  - Ensure medical records include physician's certification that beneficiary meets coverage requirements
  - Remember - certifications must be obtained at time of admission or as soon thereafter as is reasonable and practicable
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 8, Section 40
  - CMS IOM Publication 100-01, *Medicare General Information*, Eligibility and Entitlement Manual, Chapter 4, Section 40

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 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

Denial Reason Code 7FLUD

- Another claim found within same flu season and no medical justification present for additional flu vaccine
- Avoiding/Correcting this error
  - Prior to providing flu vaccine, verify if beneficiary already received during current flu season (August 1–July 31)
    - MLN® Fact Sheet: Checking Medicare Eligibility
  - When medically necessary, ensure documentation reflects reason(s)
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 50.4.4.2(C)
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 10

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: January – March 2025

Jurisdiction K

SNF IP	SNF OP	Swing Bed
U5607	U5233	19904
7B908	38200	38001
38007	39929	38200

Jurisdiction 6

SNF IP	SNF OP	Swing Bed
38007	U5233	38200
38200	38200	13313
U5607	C7010	38001

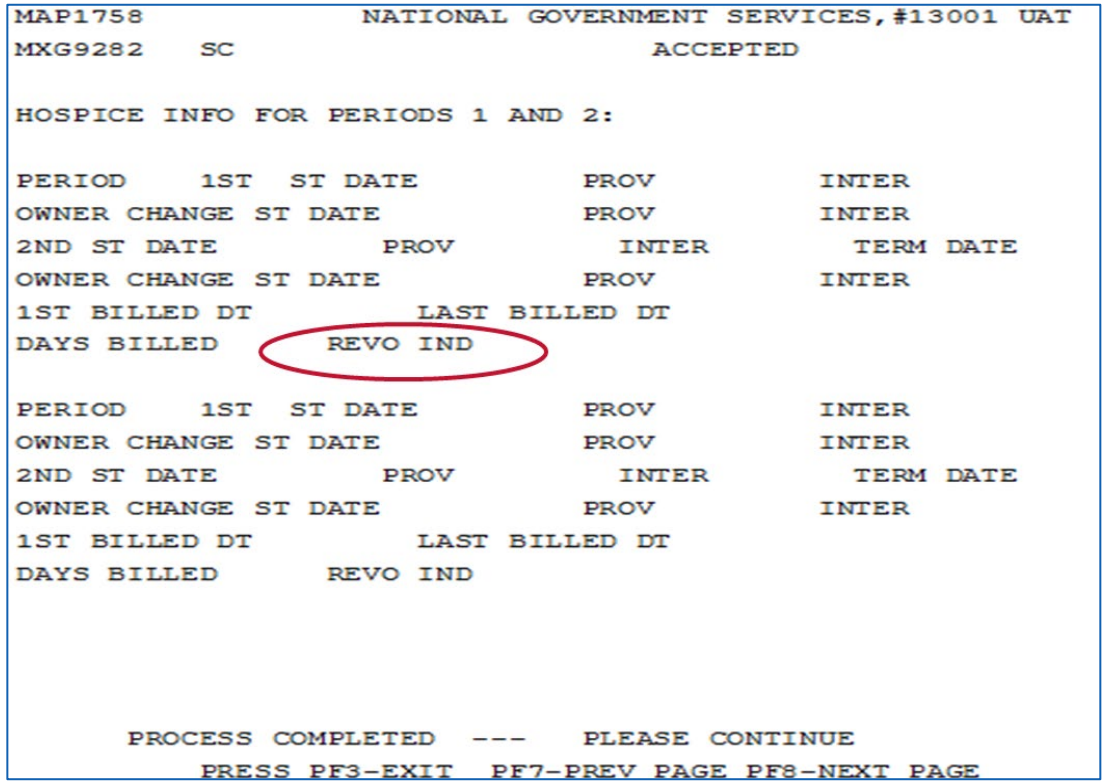
Rejection Reason Code U5233

- Services 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 and take appropriate action
    - SNF-covered services during HMO enrollment period requires informational claim billed to Medicare using CC 04 with covered charges (benefit period purposes)
    - IP SNF claims which overlap effective or termination date of HMO period must be split and services billed to HMO and Medicare according to coverage dates

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

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 13313

- One of the following applies:
  - Three-day qualifying stay requirement not met (OSC 70 thru date not three or more days later than from date)
  - Subsequent 183, 184, 213 and 214 TOB when initial 182/212 or 180/210 TOB rejected with reason code 13303
- Avoiding/Correcting this error
  - Verify information billed
  - If appropriate, make corrections and submit new claim

Rejection Reason Code 19904

- Claim does not indicate beneficiary had QHS prior to admission to SNF/swing bed or hospital stay prior to beneficiary's Part A effective date
- Avoiding/Correcting this error
  - Verify claim TOB
  - Verify if beneficiary had QHS and if yes:
    - First claim in continuing stay – submit cancel adjustment and once finalized submit new claim with OSC 70 and dates
    - Claims without patient status 30 – submit adjustment (217 TOB) to add OSC 70 and dates

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

Rejection Reason Code 7B908

- No Medicare payment can be made since Medicare beneficiary's benefits were exhausted relative to this SNF claim
- Avoiding/Correcting this error
  - If claim rejection was not desired outcome
    - Determine if all earlier claims submitted correctly (benefit period)
    - Submit adjustment(s)/new claims to correct when necessary

Rejection Reason Code U5607

- Admit date less than from date and no previously processed history claims present with same admit date, same provider number and patient status 30
- Avoiding/Correcting this error
  - Verify MBI, provider number, admit date, DOS and patient status on this claim and previously processed claim(s) for this admission
  - If this claim is in error, correct and resubmit.
  - If previously processed claim(s) incorrect, submit cancel for claim(s) in error
    - Resubmit claim(s) for stay in sequential order after receiving RA for each claim as submitted

Rejection Reason Codes 38001 & 38007

- Reason code 38001
  - IP claim contains DOS equal to or overlapping denied IP claim
- Reason code 38007
  - Duplicate of previously submitted SNF claim where TOB equals 21X or 51X and the following same on both claims:
    - MBI
    - Provider number
    - Statement from and through DOS
    - Revenue code
    - HCPCS and modifiers (if required by revenue code file)

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)

Avoiding/Correcting Duplicates & Overlaps

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

Top RTP Reason Codes

RTPs: January – March 2025

Jurisdiction K

SNF IP	SNF OP	Swing Bed
38119	U5065	13314
38117	31413	32242
U5065	31438	76050

Jurisdiction 6

SNF IP	SNF OP	Swing Bed
38119	U5065	32242
38117	34963	12302
12302	31498	13314

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 12302

- Sum of covered and non-covered days must equal total number of days in statement covers period (DOS)
- Avoiding/Correcting this error
  - Verify patient status
    - Status 30 (still patient), count through date in day calculation
    - Same day transfers (same admission, from and through date, CC 40 present and patient status of 02, 03, 05, 50, 51, 61, 62, 63, 65, 66, 71, 72, 82, 83, 85, 89, 90, 91, 93 or 94) - claim must show one non-covered day
    - If not same day transfer, but same from and through dates, then claim must show one covered day
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 13314

- One of the following applies
  - OSC 70 from date greater than claim admission from date
  - OSC 80 (prior same-SNF stay) from date greater than claim admission from date and PPS indicator equal to N
- Avoiding/Correcting this error
  - Review OSC and dates entered on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 31413

- Claim contains revenue code series 44X and OC 45 missing, or OC 45 present and no billing line in revenue code series 44X
- Avoiding/Correcting this error
  - When billing for speech/language pathology services (revenue code series 44X), OC 45 required to indicate date treatment started
  - Review revenue codes and OCs entered on claim
  - If appropriate, correct and resubmit (PF9)

RTP Reason Code 31438

- One of the following applies
  - Valid influenza/PPV HCPCS code not present on claim with CC A6
    - Effective and termination dates of codes identified in HCPCS code file (6Z)
  - Type of service on contractor HCPCS code file (6Z) not equal to “V” for HCPCS code billed
- Avoiding/Correcting this error
  - Ensure billing valid code for DOS
    - If appropriate, correct and resubmit (PF9)
  - References:
    - CMS Flu Shot reference page
    - MLN® Educational Tool: Medicare Preventive Services
    - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 50.4.4.2
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 10

RTP Reason Code 32242

- Revenue code non-billable for this TOB and covered charges on claim greater than zero (0)
- Avoiding/Correcting this error
  - Review revenue codes entered on claim
  - If appropriate, correct and resubmit (PF9)

RTP 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
    - Note – For therapy claims, MD signing treatment plan can be used as attending
  - If appropriate, correct attending physician information on claim and resubmit (PF9)

RTP Reason Code 38117 & 38119

- Claim DOS part of continuing stay and claim immediately preceding DOS on claim not processed
- Avoiding/Correcting this error
  - All IP SNF and 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 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)

RTP Reason Code 76050

- OP claim contains revenue code 636 with units greater than 500 or any other revenue code with units greater than 1000
- Avoiding/Correcting this error
  - Review units billed on claim
  - If keying error, correct units
  - If units correct, add remarks indicating “units are correct“
    - Not required to give additional information regarding service(s) in question
  - Once corrected, 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 (PF9)

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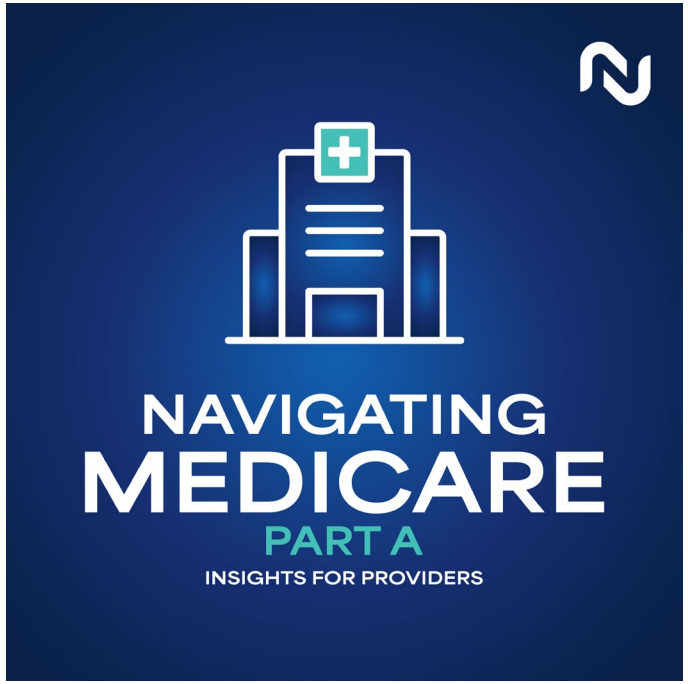
Navigating Medicare: Part A Insights for Providers



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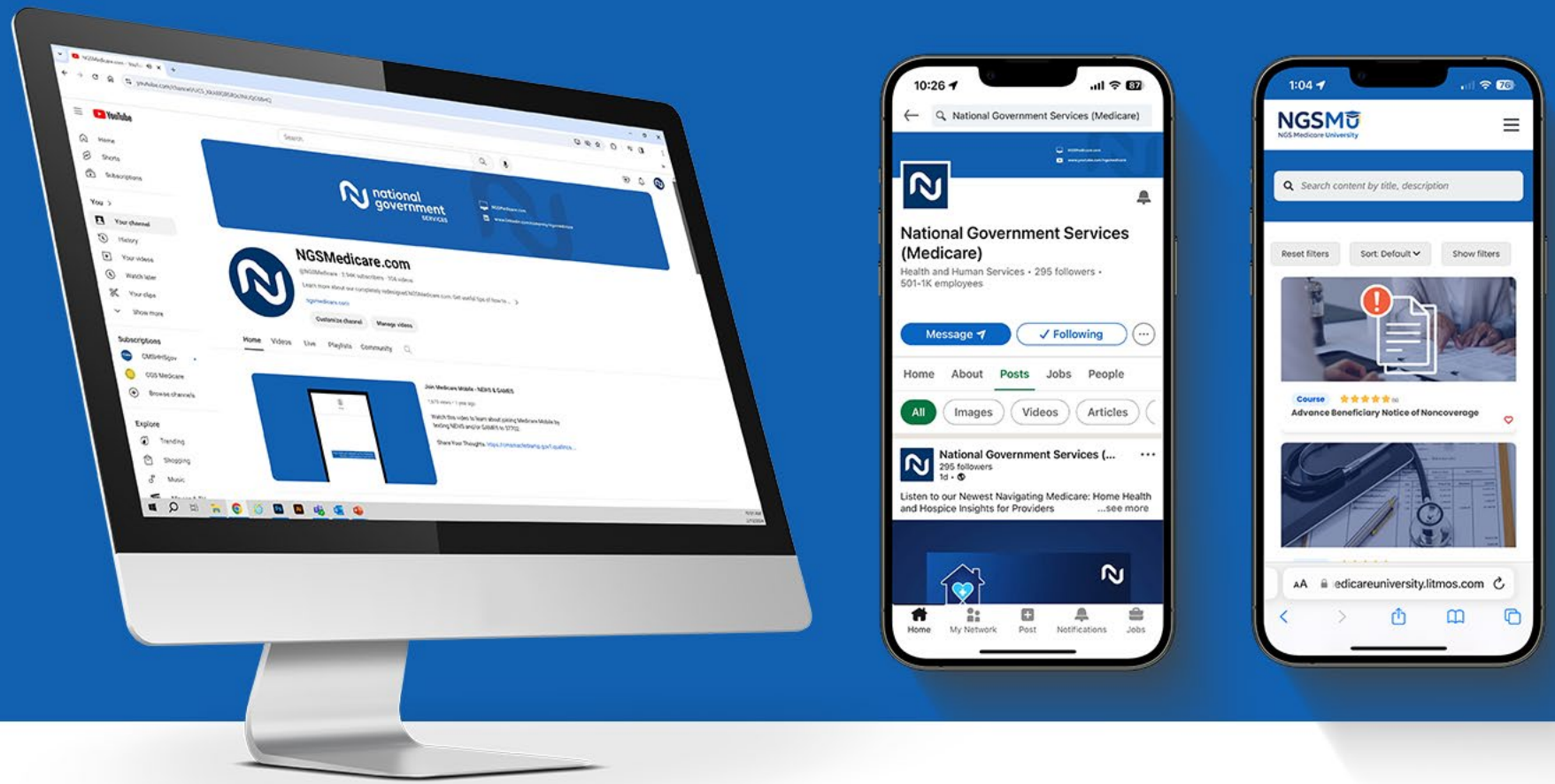

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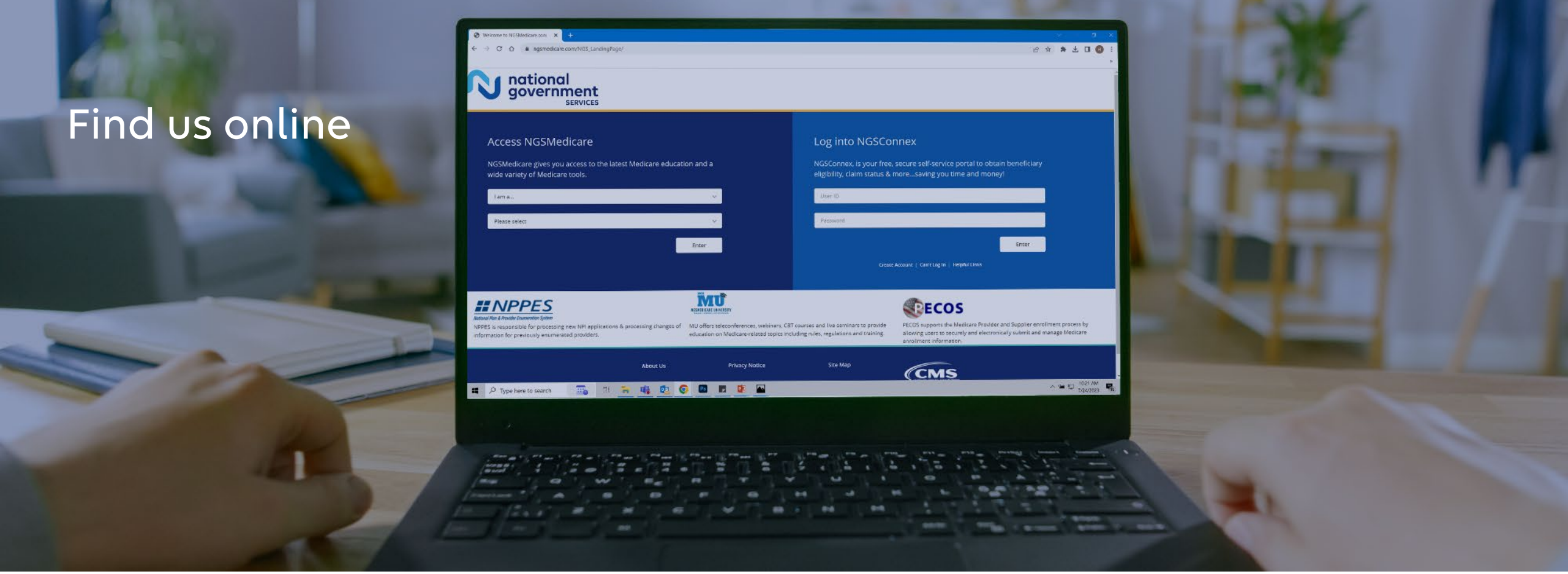

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Online resources, event calendar, LCD/NCD, and tools

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Questions?

Thank you!