Let’s Chat: A Message from Your MAC

Aksarben AAHAM Spring Conference

March 17, 2026

Your Presenter

- Aileen Sigler
  - Analyst, Provider Outreach and Education
  - 28 years Medicare experience
  - Previous positions:
    - Part A claims processing
    - Customer service
    - DDE Remote
    - Internal training



Objective & Agenda

Objective: Knowledge of coding, billing, and payment to accurately manage and resolve common challenges.

Agenda

- Data spotlight: Nebraska claims
- Educational opportunities
- Other news and updates



Review the legal disclaimers at the end of the presentation.



Data Spotlight: Nebraska Claims

Data Specifics

- Submitted December 1, 2025 – February 28, 2026
  - Data as of March 12, 2026
- All Part A and Part B provider types
  - All bill types
- Nebraska only



Number of Claims in Data Sample

- 244,777 unpaid claims
  - Denied – 189,297
    - Question of medical necessity or coverage criteria
  - Unprocessable (Part B) – 31,113
    - Missing or incorrect information
  - Rejected (Part A) – 13,422
    - Technical or billing error
  - Returned to Provider (RTP) (Part A) – 10,945
    - Sent to provider’s online location (TB9997) for correction



Top 5 Categories – Part A

- Advance Beneficiary Notice of Noncoverage (ABN) inconsistency
- Claim not submitted timely
- Medicare is not the primary payer
- Outpatient overlaps Part A skilled nursing claim
- Outpatient therapy threshold over applied

Top 5 Categories – Part B

- Duplicate charge
- Patient has managed care
- Noncovered charge
- Service not separately payable
- Medicare is not the primary payer



ABN Inconsistency

- Reason Code 31711
- W7009 or W0235 assigned to claim
  - Noncovered service, provider liable
- Revenue line contains modifier:
  - GA, KB, GL, GY or TS
- Occurrence Code 32 is present without GA modifier

Medicare Advance Written Notices of Noncoverage booklet: https://www.cms.gov/files/document/mln006266-medicare-advance-written-notices-non-coverage.pdf

Resolution and Prevention – ABN

- Verify claim is coded accurately
  - If HCPCS is incorrect, change to appropriate and resubmit
- Ensure ABN is appropriate in circumstance
  - Cannot shift liability to beneficiary in all situations
- Updated R-131 as of March13, 2026



FFS ABN form and instructions: https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-abn

Claim Not Submitted Timely

- Reason Code 39011
- Claim submitted > one year after date of service
  - Use “through” date if claim spans more than one day
- No appeal rights
- Errors caused by incorrect third-party payment and recoupment not justification for waiving timeliness

Resolution and Prevention – Timely

- Verify eligibility of the patient
  - Ask questions about other coverage
- If you have good cause, submit by mail to our Claims Manager:
  - Hardcopy claim form
  - Letter of explanation
  - Supporting documentation



Timely Filing of Claims: https://www.wpsgha.com/guides-resources/view/52

Medicare is Not the Primary Payer

- Reason Codes 34538, 34540
- Records indicate beneficiary has a _____ plan primary to Medicare
  - Working Aged
  - Disability
- Claim must be sent to EGHP first



Medicare Secondary Payer booklet: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/msp_fact_sheet.pdf

Resolution and Prevention – MSP

- Gather MSP data
  - Check patient's record
  - Ask questions about coverage
- Contact the BCRC to update records
- Bill primary payer first
  - Send secondary claim with payment or denial information
    - Ensure appropriate codes are present

SE21002 – Billing for Services When Medicare is a Secondary Payer: https://www.cms.gov/files/document/se21002.pdf

Overlaps Part A SNF Stay

- Reason Code C7252
- Date of service within from and through dates of SNF Part A claim
- Services subject to SNF Consolidated Billing



Resolution and Prevention – SNF Overlap

- Verify dates of service
- Confirm patient was in a Part A stay
  - Medicare-certified bed
  - Receiving skilled services
  - SNF benefit days remaining
- Check SNF Consolidated Billing exclusion lists
  - Is exclusion based on place of service?

CMS SNF Consolidated Billing web page: https://www.cms.gov/medicare/coding-billing/skilled-nursing-facility-snf-consolidated-billing



Therapy Threshold Over Applied

- Reason Code 7V822
- Outpatient PT/SLP limit over applied



Resolution and Prevention – Therapy

- Therapy above threshold is medically necessary
  - Submit KX modifier
    - Medical record justifies use
- Therapy above threshold is not medically necessary
  - Submit GA modifier
    - Patient given ABN
  - Submit Occurrence Code 32
    - Date ABN given

Medicare Claims Processing Manual, Chapter 5 – Part B Outpatient Rehabilitation and CORF/OPT Services, Section 10.3.3: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c05.pdf



Duplicate Charge

- Duplicate charge paid ?002XX on Claim >001XXXXXXXXXX
- Do not automatically resubmit claim without research
  - Wait for initial claim to finish processing
    - Consider payment floor
    - Holding for medical review
  - Is payment bundled into another service?
  - Is a modifier necessary?



Patient Has Managed Care

- Collection of fee-for-service during period of managed care
- Verify entitlement and benefits
  - Medicare Advantage plan replaces traditional Medicare



MA Plan Directory: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/ma-plan-directory

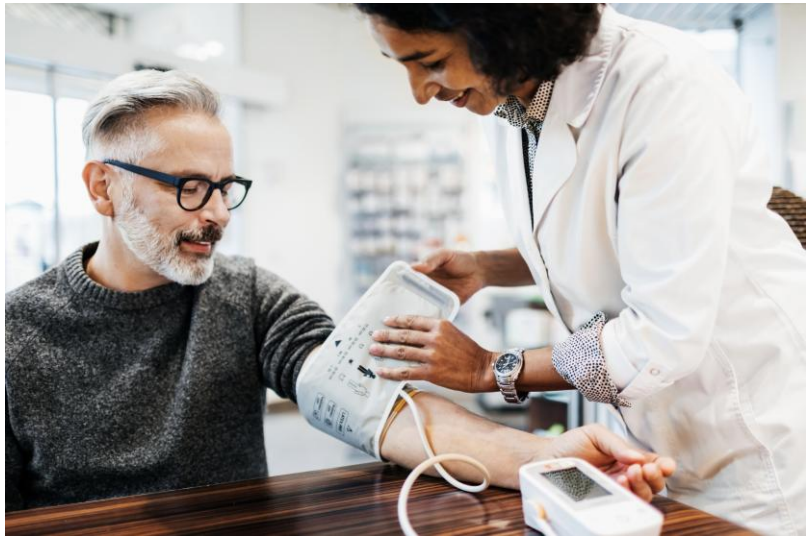
Noncovered Charge

- Procedure code submitted is a noncovered service
- Locate code on Physician Fee Schedule(PFS) Relative Value File
  - Status code column
- Not required to bill Medicare

PFS Relative Value Files: https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files

Service Not Separately Payable

- Separate payment not made for this service
- Payment may be bundled with another code
- Verify claim is coded correctly





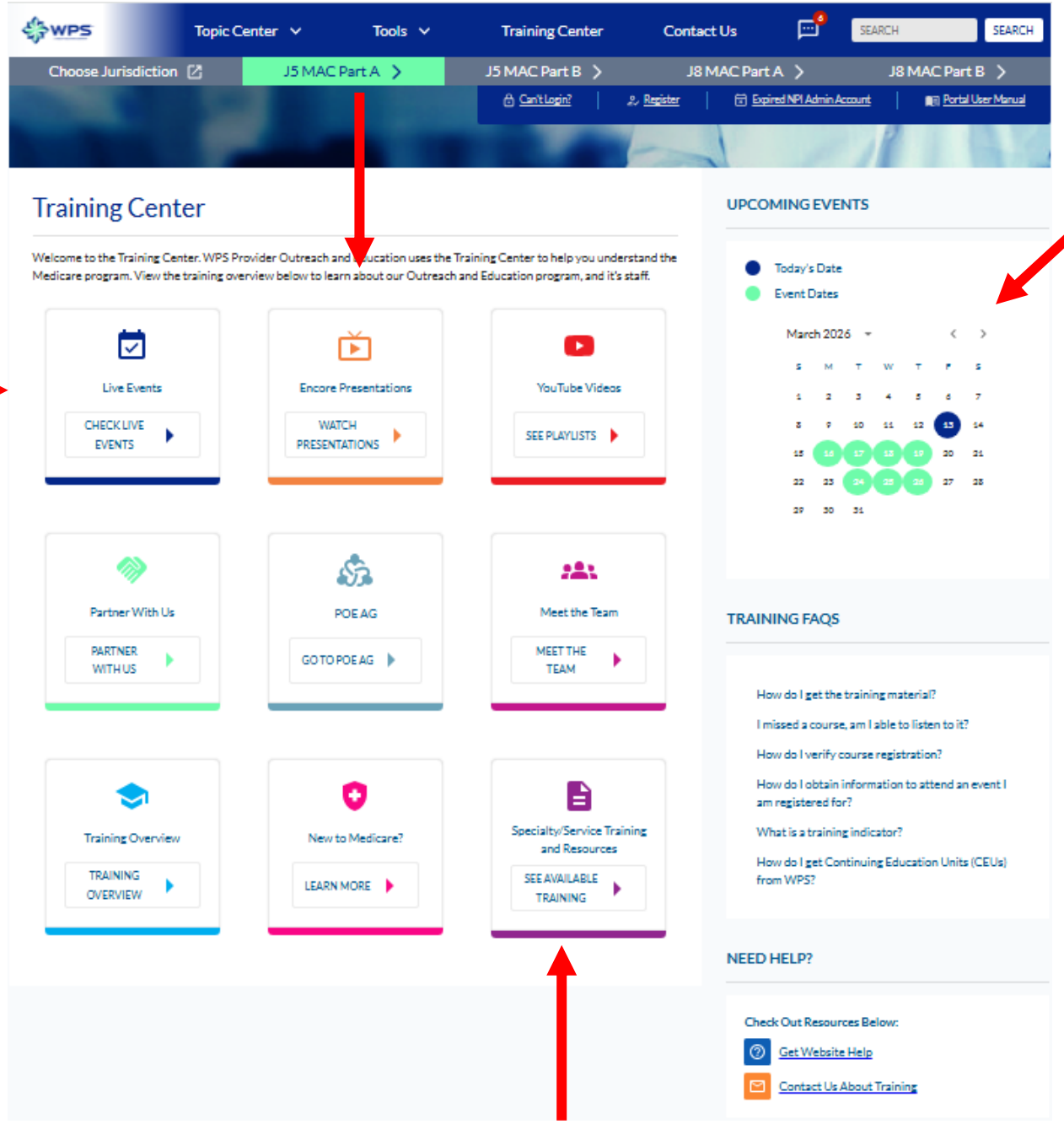
Educational Opportunities

WPS Training Center

- Live Events page
  - Register for live webinars
  - Download materials
- Encore Presentations page
  - Recordings of prior events
  - Download materials
- YouTube videos
  - Links to playlists of prior webinars
  - On-demand education



Training Center





Other News and Updates

CAH Reassignment Errors

- Method II claims with Reason Codes 31006/31007
  - Edits temporarily disabled until January 1st
- Attending and rendering practitioners must reassign billing rights to CAH
  - Form 855-I in PECOS
  - Use PTAN for CAH, not clinic
  - CAH should maintain formal attestation from each practitioner
    - They will not bill Medicare separately

CR 13900: https://www.cms.gov/files/document/r13041otn.pdf

MLN 006400: https://www.cms.gov/files/document/mln006400-information-critical-access-hospitals.pdf



Changes to the Inpatient Only List

- CMS phasing out Inpatient Only List
  - Beginning in 2026
  - Over three years
- 285 procedures removed
  - Mostly musculoskeletal



MM 14361 Hospital Outpatient Prospective Payment System: January 2026 Update: https://www.cms.gov/files/document/mm14361-hospital-outpatient-prospective-payment-system-january-2026-update.pdf

OPPS Drug Acquisition Cost Survey

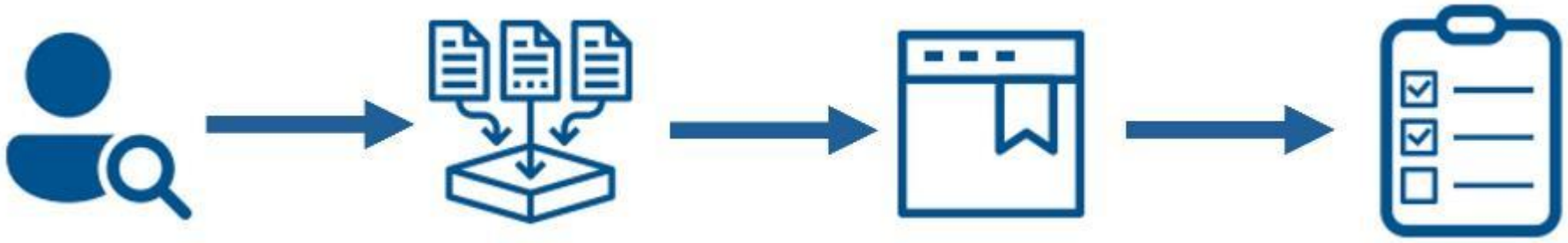
- Periodic survey of acquisition costs required by law
  - Data used to set payment rates
- Current survey closes March 31st at 11:59 PM ET
- Learn more:
  - Training webinar
  - FAQs
  - Registration Guide
  - Submitter User Guide
  - Data Template



OPPS Drug Acquisition Cost Survey web page: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient-pps/outpatient-prospective-payment-system-opps-drug-acquisition-cost-survey

ODACS Fact Sheet

- Identify a submitter
- Gather your data
- Bookmark the ODACS website
- Be prepared to register



How to Prepare for the ODACS fact sheet: https://www.cms.gov/files/document/fact-sheet-how-prepare-survey.pdf

Hospital Price Transparency Changes

- Machine-readable files must include:
  - Median, 10th percentile, and 90th percentile allowed amounts
  - Total count of amounts
  - Dollar amounts rather than estimates
  - Official attestation and NPI



https://www.cms.gov/newsroom/fact-sheets/cy-2026-opps-ambulatory-surgical-center-final-rule-hospital-price-transparency-policy-changes

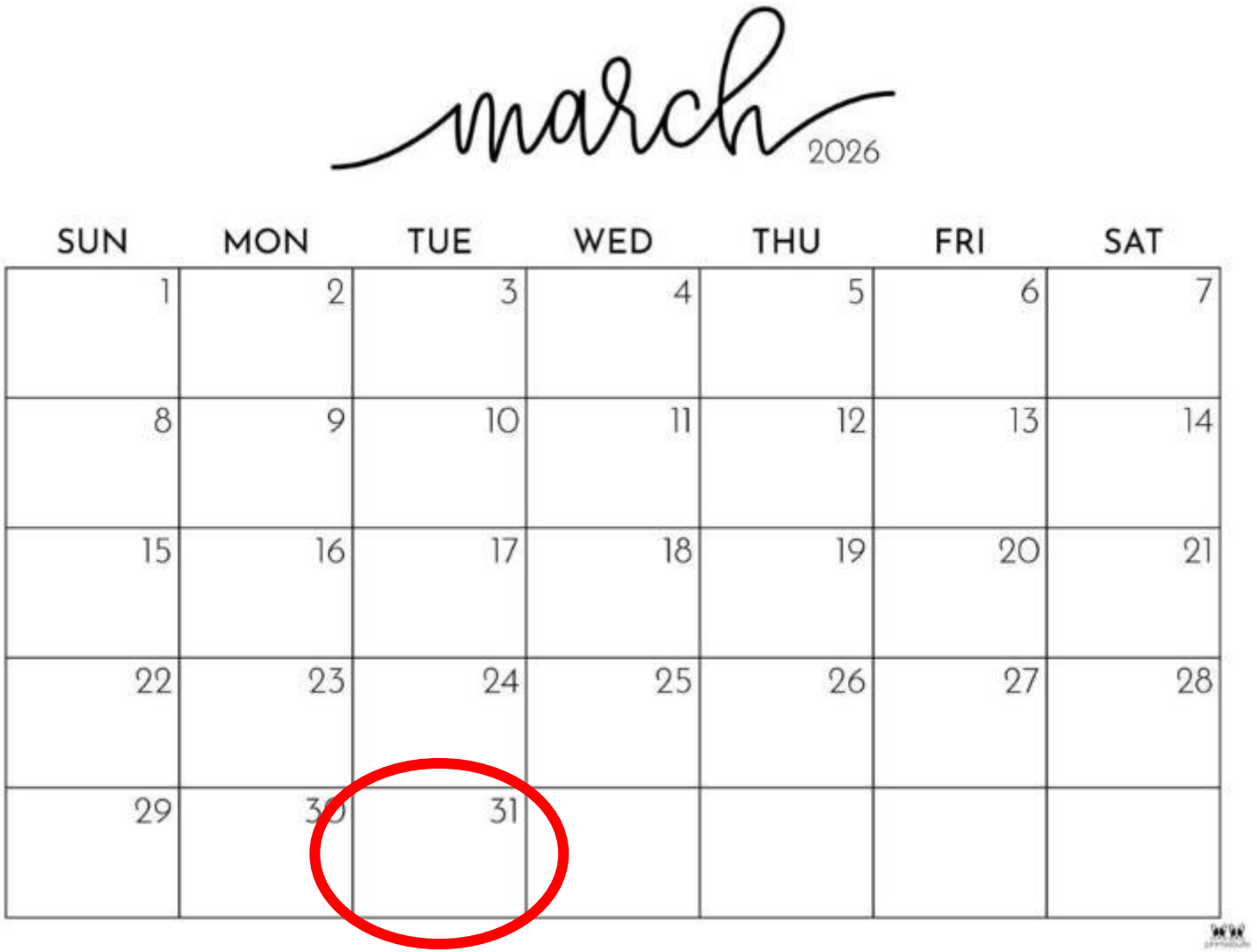
Additional Details

- Lookback of at least 12 months
  - No more than 15 months
- 35% reduction of Civil Monetary Penalties
  - Hospital waives right to ALJ hearing
- Effective January 1
  - Enforcement begins April 1





Questions



Send any follow-up questions by March 31, 2026

thank you



https://cmsmacfedramp.gov1.qualtrics.com/jfe/form/SV_bCsIdQBnSfzDzq5?EventType=1&Title=Aksarben%20AAHAM%20Spring%20Conference&Topic=A&Date=03%2F17%2F2026&Presenter=AS

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The basis for answers given today rely on facts given in the question. Medicare rules determine final coverage.

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