



Lights! Camera! Action!

Spotlight on Top Denial Reasons

Aksarben AAHAM Fall Conference - September 26, 2024



Disclaimer

We prepared this education as a tool to assist the provider community. Medicare rules change often. They are in the relevant laws, regulations and rulings on the Centers for Medicare & Medicaid Services (CMS) website.

We will provide responses to questions based on the facts given, but the Medicare rules will determine final coverage.

CMS prohibits recording of the presentation for profit-making purposes.



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Acronyms

- ABN – Advance Beneficiary Notice of Noncoverage
- ADR – Additional Documentation Request
- BCRC – Benefits Coordination & Recovery Center
- DCN – Document Control Number
- DDE – Direct Data Entry
- DOS – Date(s) of Service
- esMD – Electronic Submission of Medical Documentation
- ESRD – End-Stage Renal Disease



More Acronyms

- FISS – Fiscal Intermediary Standard System
- HCPCS – Healthcare Common Procedure Coding System
- ICN – Internal Control Number
- MSP – Medicare Secondary Payer
- MUE – Medically Unlikely Edit
- NCCI – National Correct Coding Initiative
- NCD – National Coverage Determination
- PRV – Patient Reason for Visit



Even More Acronyms

- PT – Physical Therapy
- PTAN – Provider Transaction Access Number
- RAC – Recovery Audit Contractor
- RTP – Return(ed) to Provider
- SLP – Speech Language Pathology
- SNF – Skilled Nursing Facility
- UOS – Units of Service
- VC – Value Code



Agenda

- Spotlight top denial reasons
- Zoom in on ways to fix them
- Snapshot of current review activities
- Rehearse actions for record requests
- Wrap up with recent Medicare updates



Data Specifics

- Claims submitted May 1 – July 31 of 2024
 - Data as of August 8, 2024
- All Part A provider types
 - All bill types
- Nebraska only
 - PTAN 28-XXXX



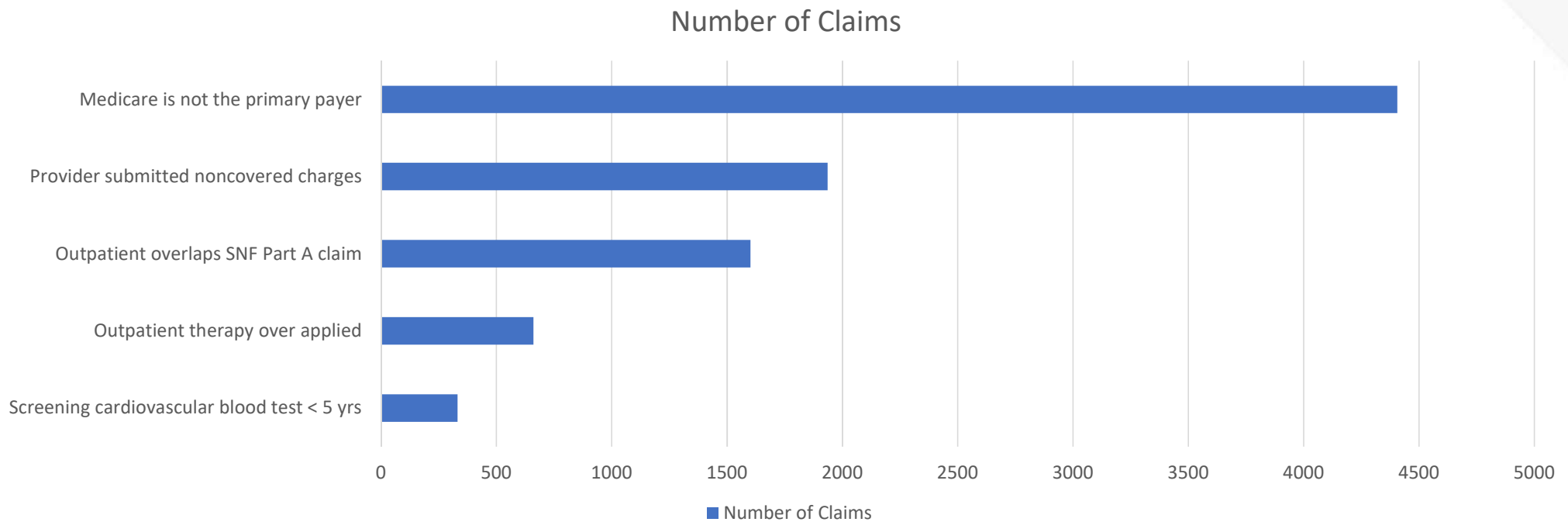
Number of Claims in Data Sample

- 25,543 processed (but unpaid) claims
 - Rejected – 12,356
 - Technical or billing error
 - Return to Provider (RTP) – 12,253
 - Sent to provider's online location (TB9997) for correction
 - Denied – 934
 - Question of medical necessity or coverage criteria
- \$12,913,384 total dollars noncovered

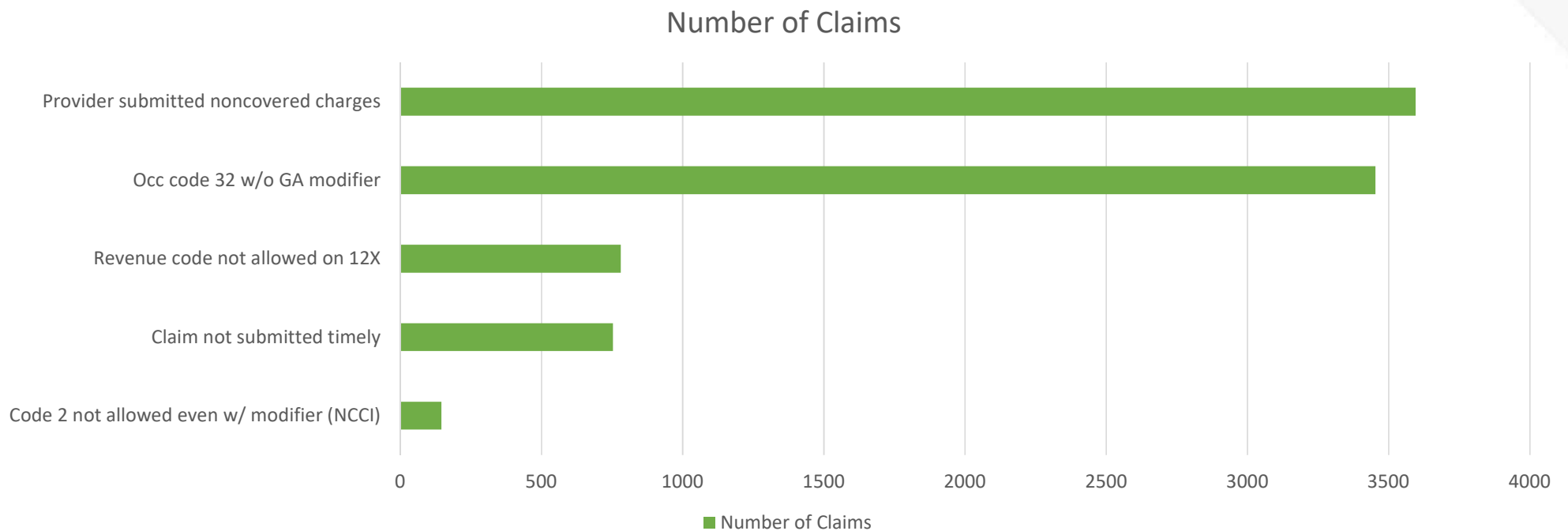
Spotlight on Top Denials



Categories of Rejection



Categories of RTP



Zoom in on Ways to Fix Errors



Medicare is Not the Primary Payer

- Reason Code 34XXX
- Records indicate beneficiary has a _____ health plan primary to Medicare
 - Working Aged
 - Disability
 - Auto or No-fault
 - Workers' Compensation

Resolution and Prevention – MSP

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

Noncovered Charges

- Reason Codes 31241, 31324, 31947, 31992, W7047, W7112
 - Charges submitted non-covered by provider
 - Line contains GZ modifier
 - Service is not separately payable
 - Line item is informational only; noncovered

Resolution and Prevention – Noncovered

- Not medically necessary
 - Give ABN if situation warrants
- Denial needed for secondary insurance
- Payment bundled into another service on claim
- Only incidental services
 - All lines noncovered for same or different reasons
 - Nothing to reimburse for

Outpatient Overlaps Part A SNF Claim

- Reason Code C7252
- Date of service within from and through dates of SNF inpatient 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?

OT/PT/SLP Threshold Over Applied

- Reason Codes 7V822, 7V824
- Outpatient rehabilitation therapy limit over applied
 - One threshold for Occupational Therapy
 - One combined threshold for Physical Therapy and Speech Language Pathology

Resolution and Prevention – OT/PT/SLP

- 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

Screening Cardiovascular Blood Test

- Reason Code U538S
- 80061 - Lipid panel
- Only allowed every 5 years
 - 60 months
- Beneficiary did not sign ABN
 - Provider liable

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Resolution and Prevention – Cardiovascular Screening Blood Test

- Patients without apparent cardiovascular disease signs or symptoms
 - Diagnosis Z13.6
- Check benefits
- Administer ABN if applicable
- Do not bill as screening if patient has conditions necessitating more frequent testing

ABN Inconsistencies

- Reason Codes 31711, W7009
- Line not covered under any benefit but contains GA modifier
- Line noncovered, provider liable, but contains GA modifier
- Occurrence Code 32 is present without GA modifier

Resolution and Prevention – ABNs

- Use correct modifiers and occurrence codes for situation
- Submit all ABN-related services as covered charges
 - Or system assigns incorrect denial code and liability
 - “Provider submitted noncovered charges”
 - Exception for GA modifier
 - GA used when some lines related to ABN, but some not

Revenue Code Not Allowed on 12X

- Reason Code W7127
- Revenue Code not allowed for inpatient Part B claim
 - Type of Bill 12X
- Beneficiary does not have Part A
- Part A hospital days are exhausted
- Patient did not qualify for inpatient care

Resolution and Prevention – 12X

- Check benefits
- Review list of unallowed Revenue Codes

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	029x	0390
0399	045x	050x	051x	052x	054x	055x	056x
057x	058x	059x	060x	0630	0631	0632	0633
0637	064x	065x	066x	067x	068x	072x	0762
082x	083x	084x	085x	088x	089x	0905	0906
0907	0912	0913	093x	0941	0943	0944	0945
0946	0947	0948	095x	0960	0961	0962	0963
0964*	0969	097x	098x	099x	100x	210x	310x

Claim Not Filed Timely

- Reason Code 39011
- Claim submitted > one year after DOS
 - 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 patient
 - Ask questions about other coverage
- If good cause, submit:
 - Hardcopy claim form
 - Part A: UB-04 as an adjustment (xx7)
 - Part B: CMS-1500
 - Letter of explanation
 - Supporting documentation
- Mail to Claims Manager

Code Unallowed Even With Modifier

- Reason Code W7020
- NCCI Procedure to Procedure Code Pair Edits
 - Code in column 2 considered component of code in column 1
 - Codes are mutually exclusive of each other

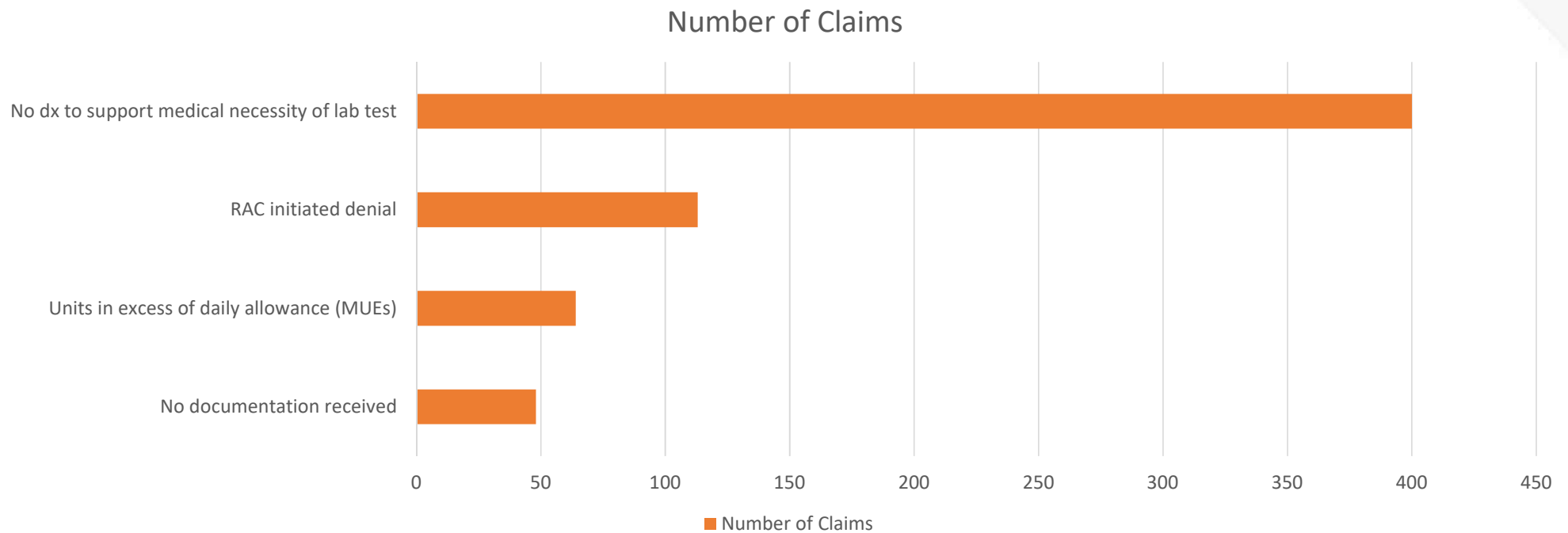
Resolution and Prevention – NCCI Edits

- Research code pair on NCCI tables
 - Modifier indicator = 0 - modifier not allowed
 - Modifier indicator = 1- modifier allowed if appropriate
- Verify claim is coded accurately
- Request Redetermination

Snapshot of Current Review Findings



Categories of Denial



Lab Test Not Supported by Diagnosis

- Reason Codes 52NCD, 53NCD, 54NCD
- HCPCS not medically necessary
 - Based on diagnosis codes(s)
- No documentation provided
 - For unique indications outside of the NCD



Resolution and Prevention – Lab NCDs

- Review applicable NCD for covered indications
- Administer ABN if applicable
 - Use Occurrence Code 32 and GA modifier
- Add covered diagnosis to diagnosis code fields
 - System may overlook if only in “PRV” field

Recovery Audit Contractor Denial

- Reason Codes 5RACB, 5RACH, 5RACM
- RAC initiated denial
 - No records received
 - Not medically necessary



Resolution and Prevention – RAC Denial

- Review list of [approved issues](#)
- Develop internal process to handle requests
- Update [contact information](#)
- Respond timely



Medically Unlikely Edits

- Reason Code 52MUE
- Number of services billed > number allowed per day
- MUE = maximum UOS reported for code on majority of appropriately billed claims
 - Same provider/supplier
 - Same beneficiary
 - Same date of service

Resolution and Prevention – MUEs

- If MUE is published, check the edit type
 - MAI 1 – adjudicated at line level
 - MAI 2 – adjudicated by date of service; absolute based on definition, policy or anatomy
 - MAI 3 – adjudicated by date of service
- Review documentation
- Verify charges
- Request a Redetermination
 - Include documentation to support UOS > MUE value

Documentation Not Received

- Reason Code 56900
- Documentation not received within 45 days
 - Date of ADR letter
 - Date claim edits for medical review
 - Status/location SB6000 for Part A pre-pay edits

Resolution and Prevention – No Doc Received

- Develop internal process to handle requests
- Respond timely



Rehearse Actions for Record Requests



Receiving and Viewing ADRs

- Letters mailed via USPS
- Pre-pay ADRs viewable in system
 - Provider Portal
 - FISS
 - Part A providers with DDE access

Taking Action

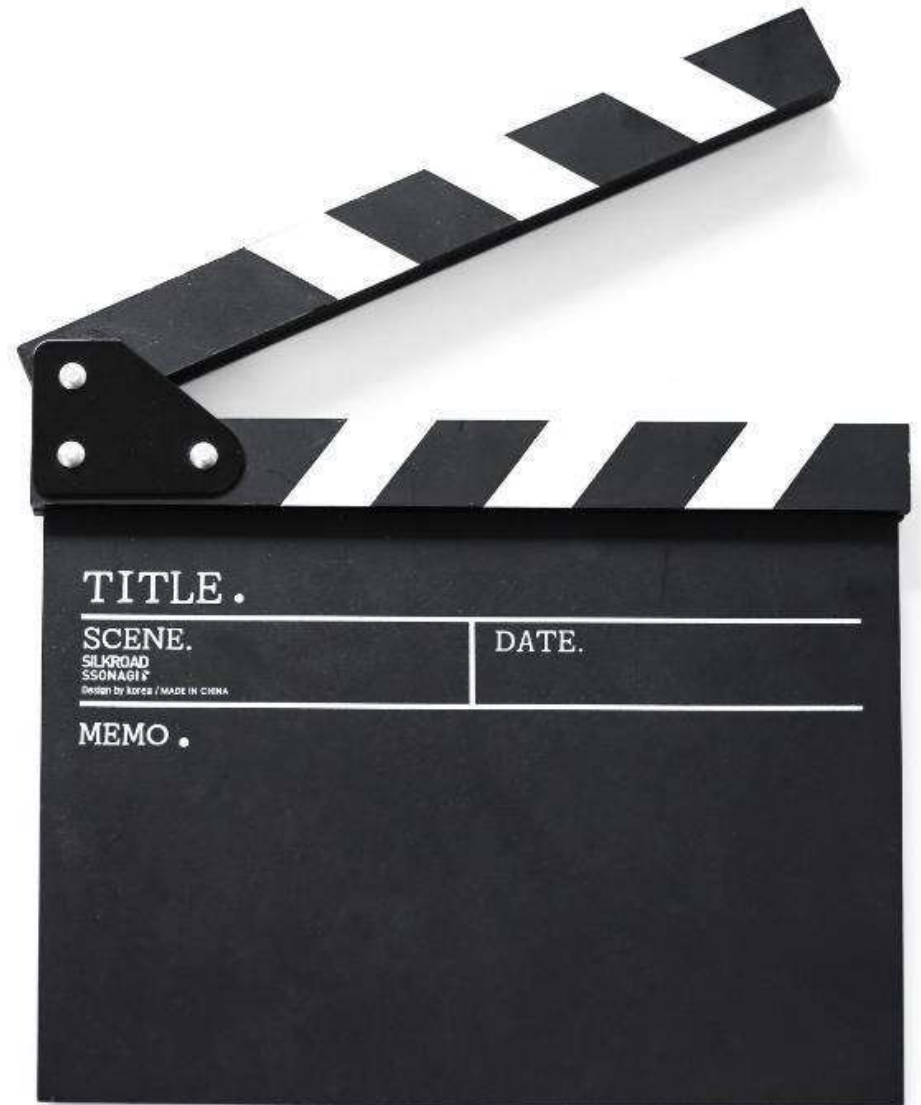
- Collect all requested documentation
- Verify documentation is complete and accurate
- Attach ADR (or another form) to include:
 - Facility contact information
 - Beneficiary Medicare number
 - Facility name and provider number
 - Claim number (DCN or ICN)
 - Date of service

Submitting Documentation

- In the Provider Portal
- By mail
 - Paper
 - CD/DVD
- By fax
- Using esMD

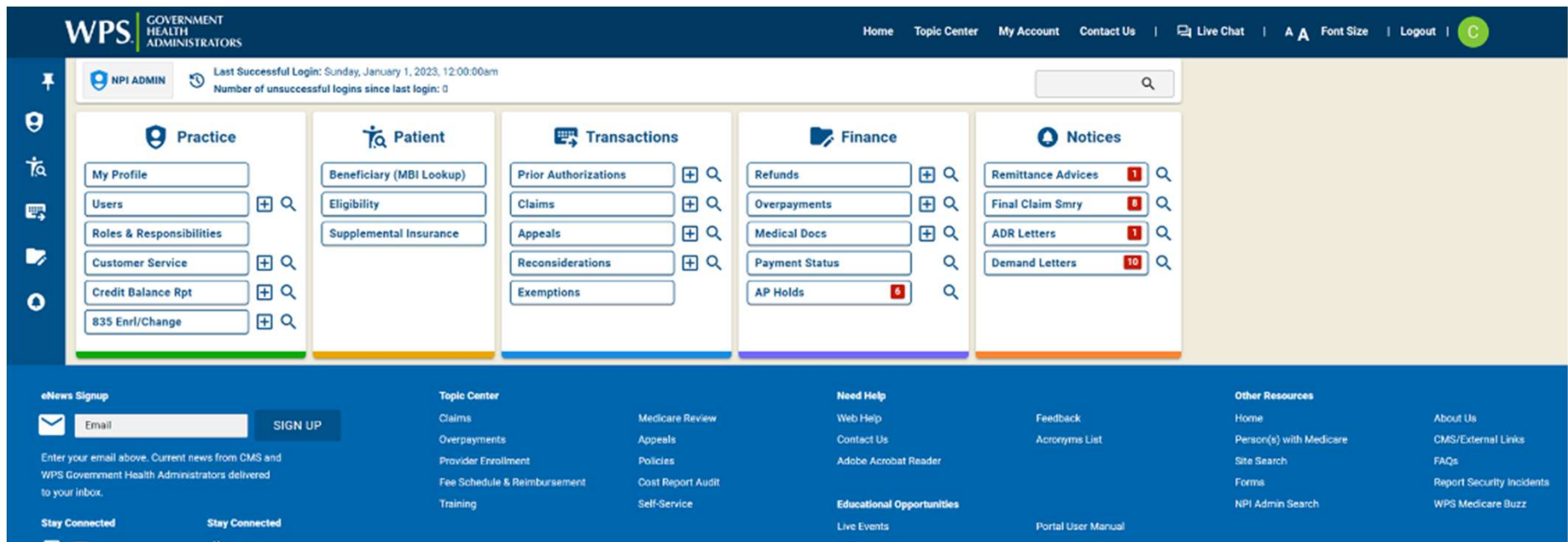


Wrap Up Recent Medicare Updates



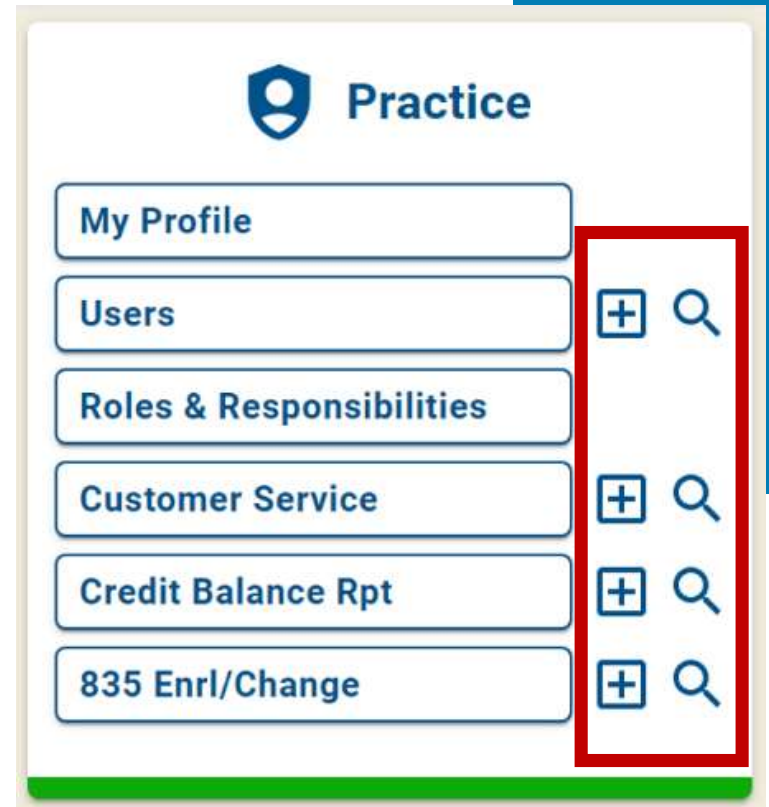
Provider Portal Redesign

- Exciting updates coming mid-October



Indicators

- Plus sign - enter a new item
- Magnifying glass - search for an existing item

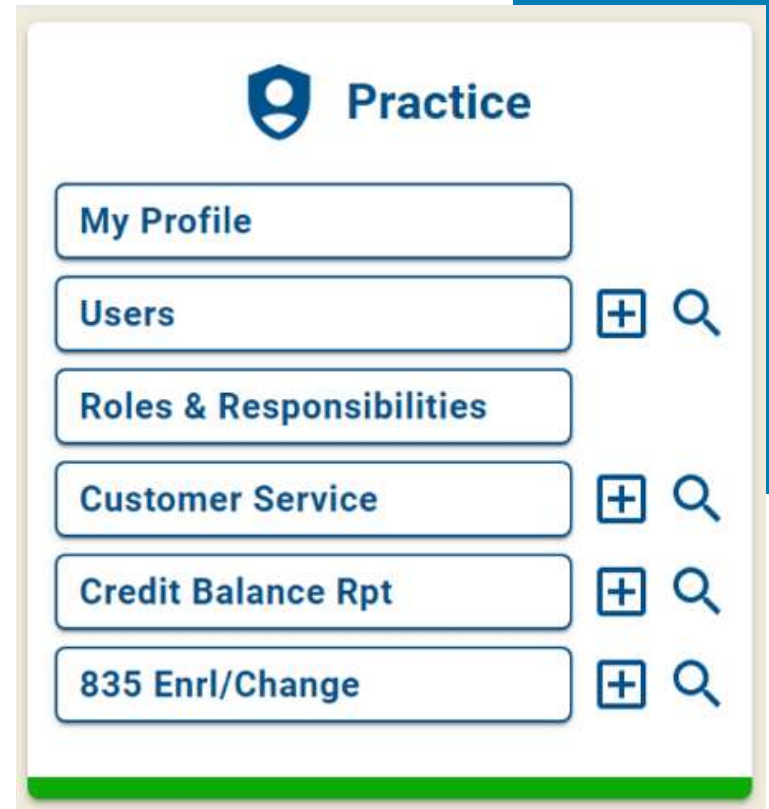


The screenshot shows a web interface titled "Practice" with a user icon. Below the title is a list of items: "My Profile", "Users", "Roles & Responsibilities", "Customer Service", "Credit Balance Rpt", and "835 Enrl/Change". To the right of the last four items are plus (+) and magnifying glass (Q) icons. A red rectangular box highlights these icons for "Users", "Customer Service", "Credit Balance Rpt", and "835 Enrl/Change".

Item	Plus Sign (+)	Magnifying Glass (Q)
My Profile		
Users	+	Q
Roles & Responsibilities		
Customer Service	+	Q
Credit Balance Rpt	+	Q
835 Enrl/Change	+	Q

Practice

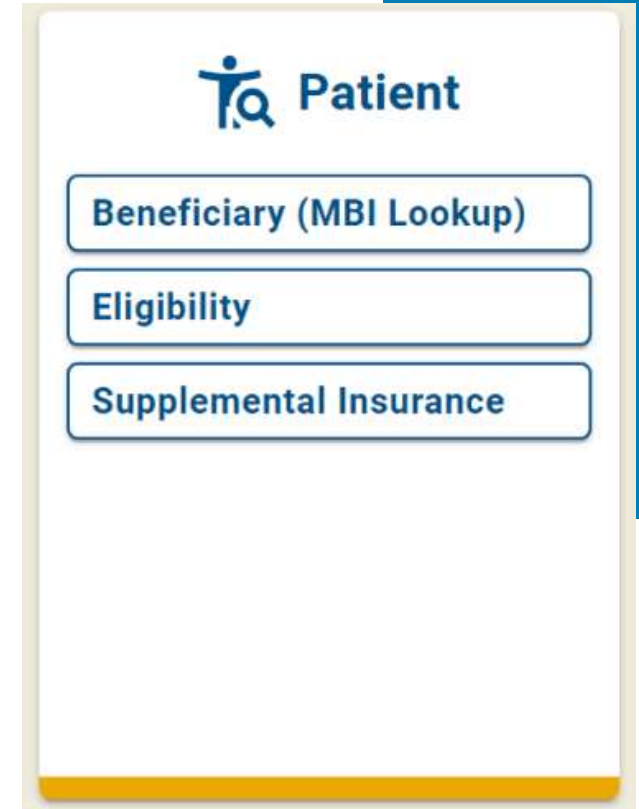
- User's information
 - Profile
 - Contact Customer Service
- Credit Balance
 - Fiscal Intermediary Standard System (FISS)
- 835 transactions
 - Electronic Remittance Advice (ERA)




Patient

Transactions for the patient information

- Medicare Beneficiary Identifier (MBI)
 - CMS required elements
- Eligibility
 - Part A and B
 - Deductible
 - Payer information
- Supplemental insurance

A screenshot of a web application interface for patient information. At the top, there is a blue icon of a person with a magnifying glass and the word "Patient" in blue. Below this, there are three rounded rectangular buttons stacked vertically: "Beneficiary (MBI Lookup)", "Eligibility", and "Supplemental Insurance". The buttons have a light blue border and a subtle shadow. The entire interface is set against a white background with a blue header bar at the top right.

 Patient

Beneficiary (MBI Lookup)

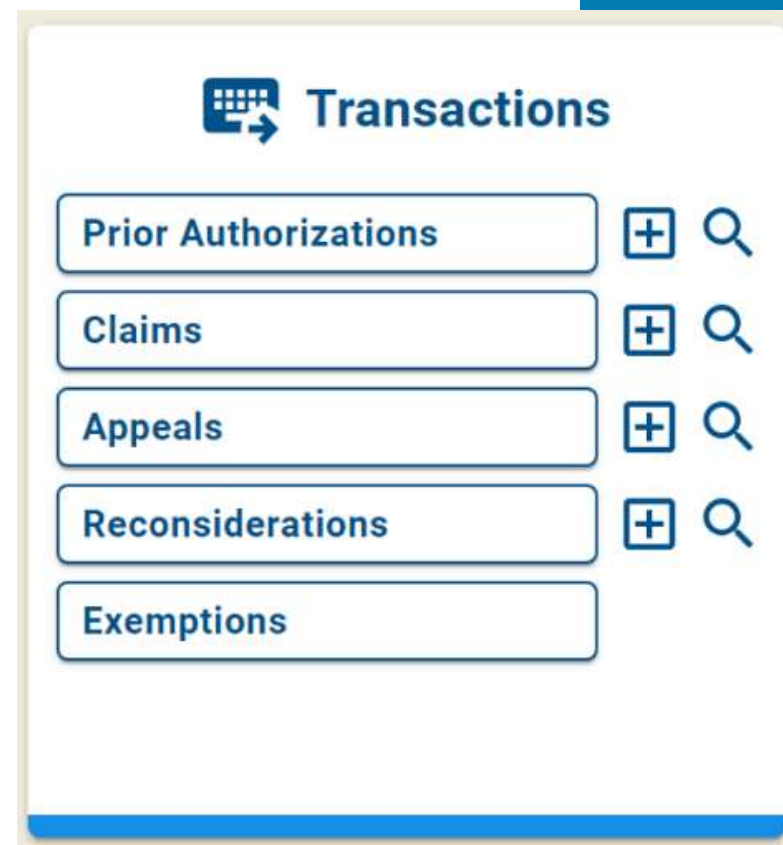
Eligibility

Supplemental Insurance

Transactions

Actions for a provider

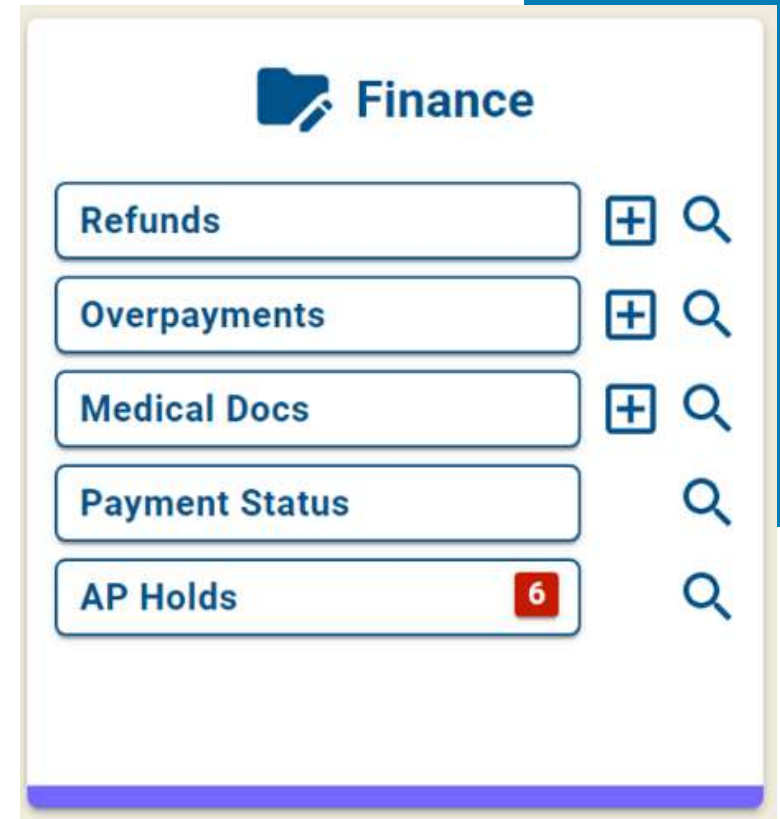
- Prior authorizations
- Claims
- Appeals
- Reconsiderations
- Exemptions



Finance

Items affecting your payment or ways to provide us money

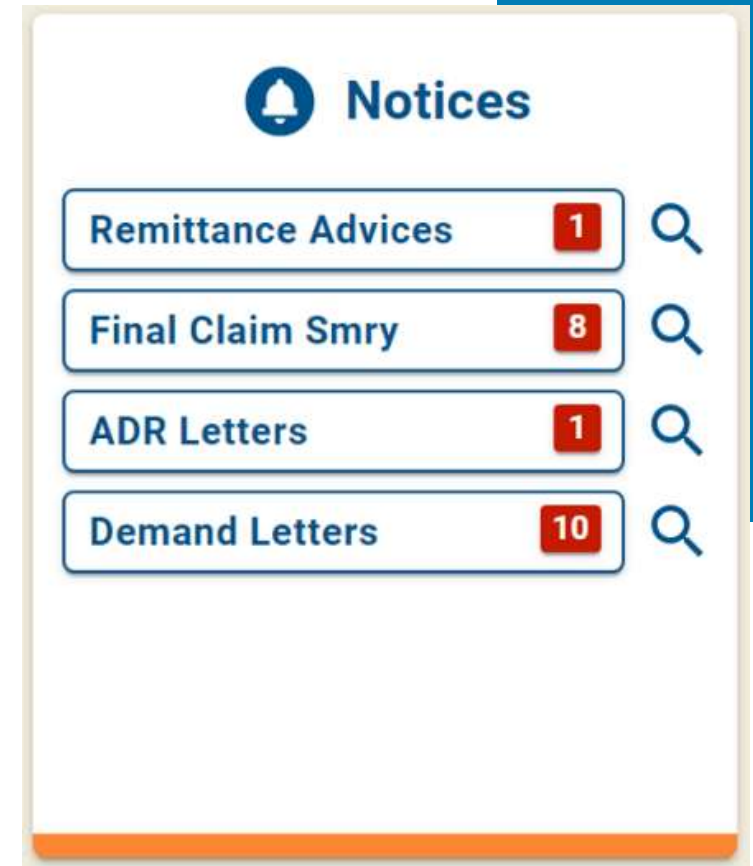
- Refunds
- Overpayments
- Medical docs
- Payment status
- Accounts payable (AP) holds



Notices

Correspondence from us

- Remittance notices
- Final claim summary (smry)
- Additional documentation requests (ADR)
- Demand letters



Brand Refresh



Learn More - Resources

- [Medicare Secondary Payer](#) booklet
- SE21002 - [Billing for Services when Medicare is a Secondary Payer](#)
- [Medicare Advance Written Notices of Non-coverage](#) booklet
- CMS [SNF Consolidated Billing](#) web page
- *Medicare Claims Processing Manual*, [Chapter 5 – Part B Outpatient Rehabilitation and CORF/OPT Services](#), Section 10.3.3
- [Reason/Remark Code Lookup](#)
- MLN901346 - [How to Use the Medicare NCCI Tools](#)



Learn More - Additional Resources

- [Medicare NCCI Edits](#)
 - [Procedure to Procedure Edits](#)
 - [Medically Unlikely Edits](#)
- [Medicare Coverage Database](#)
- [Responding to a Medical Review Additional Documentation Request \(ADR\)](#)
- *Medicare Claims Processing Manual*, [Chapter 4 - Part B Hospital](#), Section 240.1



Follow-up Questions

october
2024

SUN	MON	TUE	WED	THU	FRI	SAT
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Review Our Performance



The background of the slide features a series of concentric circles in various shades of gray, creating a tunnel-like effect that draws the eye towards the center.

The End

That's a wrap!
