

Part B J4 Top Claim Denials February – April 2010

Medicare contractors receive more than 2 billion claims per year. To protect the Medicare Trust Fund and keep the Medicare program viable, CMS implemented the Comprehensive Error Rate Testing (CERT) program to measure the accuracy of Medicare Fee-for-Service (FFS) payments.

One reporting statistic of the CERT program is the Provider Compliance Error Rate (PCER), which measures the accuracy of claims upon receipt by Medicare Part B contractors before the claims are subjected to Medicare claim processing system scrutiny and edits. The PCER reflects providers' understanding of and compliance with the Medicare program's payment rules and coverage policies.

The data used for this job aid includes top claim denials, which provide a true picture of Medicare claim submission billing errors. These errors were identified for November 1, 2009, through January 31, 2010.

Top Claim Denials

The reasons for claim denials listed below reflect data from November 1, 2009, through January 31, 2010.

1. Duplicate claim/service.
2. Non-covered services.
3. Medicare Advantage plan.
4. National Correct Coding Initiative (NCCI).
5. Screening/Routine Services.
6. Patient supplies.
7. Beneficiary eligibility.
8. Medicare Secondary Payer (MSP).
9. Provider eligibility.
10. Hospice.

The denial situations are listed by the message seen on the Medicare Remittance Advice (MRA) followed by the resolution.

Payment adjustment category description:

- PR – Patient Responsibility.
- CO – Contractual Obligation.
- OA – Other Adjustment.

1. Duplicate claim/service.

Denial messages:

- **CO 18:** Duplicate claim/service.
- **N347:** Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.
- **M86:** Service denied because payment already made for same/similar procedure within set time frame.
- **N20:** Service not payable with other service rendered on the same date.

Claims submitted are exact duplicates of previous claims submitted. Claims often deny as duplicates for the following reasons:

- Claim previously processed (i.e., no payment made, allowed amount applied to deductible on the initial claim). The provider refiles the claim to correct the claim. The second claim submitted is a duplicate as the initial claim was processed correctly and applied to the patient's deductible.
- The initial claim has not paid within 30 days and the provider automatically refiles the claim to seek payment information about the initial claim.

Duplicate claim denials continue to be the top billing error for Jurisdiction 4 (Colorado, New Mexico, Oklahoma and Texas). Unnecessary duplicate filing of Medicare claims costs the provider's office valuable time and resources as well as the Medicare contractor's time and money for processing them.

Suggestions to reduce or eliminate these kinds of claim denials:

- Allow Medicare 30 days from the receipt date to process the claim for payment.
- Utilize the Interactive Voice Response (IVR) to check claim status. View the IVR Web page for assistance with calling the IVR.
<http://www.trailblazerhealth.com/Customer Service/Interactive Voice Response/Default.aspx>
- Pay special attention to "zero-pay" Remittance Advices (RAs) to determine if the claim should actually be resubmitted to Medicare.
- Follow claims filing guidelines for multiple servicing and/or use of appropriate modifiers. A detailed list of modifiers can be found in the *Modifiers* training manual and from the Modifier Code Search tool.
<http://www.trailblazerhealth.com/Publications/Training Manual/Modifiers.pdf>
<http://www.trailblazerhealth.com/Tools/ModifierCodeSearch.aspx>
- Refer to the "Duplicate Claims Submission" job aid for additional information.

<http://www.trailblazerhealth.com/Publications/Job Aid/DuplicateClaimSubmission.pdf>

A duplicate claim denial will be identified with an MRA reason code message that reads, "Duplicate claim/service." Claims often deny as duplicates for different reasons; however, providers are encouraged to review their internal processes and identify ways to reduce unnecessary duplicate claim submissions of Medicare claims.

2. Non-covered charges.

Denial messages:

- **PR 96:** Patient responsible/non-covered charge(s).
- **PR 204:** This service/equipment/drug is not covered under the patient's current benefit plan.
- **N115:** Non-covered charge(s).

Non-covered services may appear when providers bill/report services that are non-covered under the Medicare program.

Medicare exclusions include, but are not limited to: personal comfort items; self-administered drugs and biologicals (i.e., pills and other medications not administered by injection); cosmetic surgery (unless to repair an accidental injury or for improvement of a malformed body member); eye exams (for purpose of prescribing, fitting or changing eyeglasses or contact lenses in absence of disease or injury to eye); and routine immunizations.

Suggestions to reduce or eliminate these kinds of claim denials:

- Review the "Non-Covered Services" Local Coverage Determination (LCD).
<http://www.trailblazerhealth.com/Tools/LCDs.aspx>
- Statutorily excluded services do not have to be billed to Medicare. However, if the patient requests the service to be billed for supplemental insurance billing, the provider should bill the excluded service along with the GY modifier. The GY modifier should be used when physicians, practitioners or suppliers want to indicate that the item or service is statutorily non-covered or is not a Medicare benefit.

Examples of when the GY modifier could be used:

- A lab bills for blood tests that are a result of an annual exam. The lab services would be considered routine and, therefore, to be a Medicare program exclusion.
- A dentist performs an oral X-ray during a routine dental exam. Routine dental services are considered to be a Medicare program exclusion.

- A chiropractor bills for X-ray prior to spinal manipulation. X-ray services billed by a chiropractor are considered to be a Medicare program exclusion.
 - An ophthalmologist bills for refractive services. Refractive services are considered to be a Medicare program exclusion.
 - Ambulance transport when the patient could have gone by another means of transport.
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3. Medicare Advantage plan.

Denial messages:

- **OA 109:** Claim not covered by this payer/contractor. You must send the claims to the correct payer/contractor.

Many times Medicare beneficiaries are enrolled in a Medicare Advantage (MA) plan, instead of “traditional” Medicare. MA plans are health plan options that are approved by Medicare and run by private companies. They are part of the Medicare program and are sometimes called “Part C.” Medicare pays a set amount of money to these private health plans for their members’ health care and claims must be sent to the MA plan.

Suggestions to reduce or eliminate these kinds of claim denials:

- Patient screening during registration is very important to identify those patients that have joined an MA plan.
- The *Patient Registration and Screening Guide* will offer tips to establish or enhance patient screening procedures in the office.
<http://www.trailblazerhealth.com/Publications/TrainingManual/PatientRegistrationScreening.pdf>
- The IVR provides patient eligibility and benefit information (including MA information) to assist in determining if Medicare should be billed or if the patient has an MA plan that should be billed instead of Medicare. View the IVR Web page for assistance with calling the IVR.
http://www.trailblazerhealth.com/Customer_Service/Interactive_Voice_Response/Default.aspx
- Providers can also obtain MA eligibility information by using the Online Services computer inquiry system. This online application allows providers to verify claims, beneficiary eligibility and much more. Information on Online Services, along with enrollment information, can be found on the Claim Status and Eligibility Web page.
http://www.trailblazerhealth.com/Electronic_Data_Interchange/Claim_Status_-_Eligibility/Default.aspx
- CMS has a published MA plan directory that provides information regarding MA plans.
<http://www.cms.gov/MCRAdvPartDENrolData/PDMCPDO/list.asp>

During patient registration, it is important for office staff to identify whether a beneficiary's expenses should be covered by other insurance before, or in addition to, Medicare. This information helps determine who to bill and how to file claims with Medicare.

It is important to remember that people who join an MA plan:

- Are still in the Medicare program.
 - Still have Medicare rights and protections.
 - Will have a member ID card issued by the plan that should be used in place of the "traditional" Medicare red, white and blue card.
 - Will still get all their regular Medicare-covered services that are offered under Part A and Part B through the MA plan.
 - May get additional benefits offered through the plan.
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4. NCCI.

Denial messages:

- **CO 125:** Submission/billing error(s).
- **M15:** Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

CMS developed the NCCI to promote national correct coding methodologies and eliminate improper coding. NCCI edits are developed based on coding conventions defined in the American Medical Association's *CPT* book, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

Suggestions to reduce or eliminate these kinds of claim denials:

- Be familiar with the NCCI correct coding guidelines and the codes listed within the NCCI coding tables.
<http://www.cms.gov/NationalCorrectCodInitEd/NCCIEP/list.asp>
- Review the NCCI code pairs on the CMS Web site. These code pairs are updated quarterly so it is important to review the code pairs often!
- Apply the appropriate modifier for correct coding. Report appropriate anatomical, miscellaneous, global surgery and other modifiers that correspond with proper documentation in the patient's medical record.
- If the NCCI payment indicator from the table allows the additional procedure, apply the appropriate modifier to the procedure in Column 2.
- Follow claims filing guidelines for multiple servicing and/or use of appropriate modifiers.

- A detailed list of modifiers can be found in the *Modifiers* training manual and from the Modifier Code Search tool.
<http://www.trailblazerhealth.com/Publications/Training Manual/Modifiers.pdf>
<http://www.trailblazerhealth.com/Tools/ModifierCodeSearch.aspx>
 - The patient's medical record must reflect that the modifier is being used appropriately to describe the separate services. The documentation should be maintained in the patient's medical record and made available upon request.
 - Complete information regarding NCCI as well as Medically Unlikely Edits (MUEs) can be found in the *National Correct Coding Initiative and Medically Unlikely Edits* training manual.
<http://www.trailblazerhealth.com/Publications/Training Manual/NCCI.pdf>
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5. Screening/routine services.

Denial messages:

- **PR 49:** These are non-covered services because this is a routine exam or screening procedure code in conjunction with a routine exam.

Title XVIII of the Social Security Act (the Act), Section 1862(a)(7) excludes routine physical checkups (including tests that are performed in the absence of signs or symptoms) from the Medicare program. Title XVIII, Section 1862(a)(1)(A) of the Act reads: "Notwithstanding any other provision of this title, no payment can be made under Part A or Part B for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Screening is defined as examinations and/or diagnostic procedures performed in the absence of signs or symptoms. Screening is often performed based on patient age and/or family history. Most screening and preventive services are considered statutory exclusions from the Medicare program.

Suggestions to reduce or eliminate these kinds of claim denials:

- Verify the purpose of the service. If the service provided was a screening service, verify if it is a Medicare-covered service and if it was billed correctly. For example, screening Pap smears and diagnostic Pap smears have different procedure codes. Refer to the *Screening and Preventive Services* manual.
<http://www.trailblazerhealth.com/Publications/Training Manual/screening.pdf>
- The IVR will provide screening and preventive eligibility and benefit information to assist in determining if Medicare has paid or if the patient is eligible to receive the preventive service. View the IVR Web page for assistance with calling the IVR.

6. Patient supplies.

Denial messages:

- **CO B15:** This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.

Payment for “B” status code services is always bundled into payment for other adjudicated services. There are no Relative Value Units (RVUs) or payment amount established for these codes and no separate payment is ever made. Payment is subsumed into the payment for the services they are incident to (e.g., telephone call, after hours, weekend time, etc.).

Suggestions to reduce or eliminate these kinds of claim denials:

- Access the Medicare Physician Fee Schedule Database (MPFSDB) on the CMS Web site to determine if the procedure codes that are being billed are “B” status codes. The MPFSDB can be found on the CMS Web site by clicking on the subtopic PFS Relative Value Files.
<http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=4>
 - Call Customer Service at (866) 280-6520 to assist with questions regarding “B” status codes.
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7. Beneficiary eligibility.

Denial messages:

- **PR 31:** Patient cannot be identified as our insured.
- **CO 140:** Patient/insured health identification number and name do not match.
- **CO 13:** The date of death precedes the date of service.

Services were denied for one or more of the following reasons:

- Patient cannot be identified as our insured. The name or Medicare number was incorrect or missing. Please check the patient's Medicare card.
- The date of death precedes the date of service.
- Expenses were incurred prior to coverage.

- Expenses were incurred after coverage terminated.
- Expenses were incurred prior to coverage. The service was not covered by Medicare at the time the patient received it.

Suggestions to reduce or eliminate these kinds of claim denials:

- Patient screening is vital to an office's success in capturing the necessary information for correct claim submission.
- Office staff should obtain additional patient information when registering patients. Usually this is accomplished by the patient completing a medical information/history and insurance information form.
- Pay close attention to:
 - Obtaining the patient's full name directly from the card.
 - Patient address and phone number.
 - Obtaining the name and identification number of other insurance (Medicare or other type of insurance plan involved).
 - Date of birth.
- The *Patient Registration and Screening Guide* will provide ways to implement a process or improve existing patient screening processes within the office.
<http://www.trailblazerhealth.com/Publications/TrainingManual/PatientRegistrationScreening.pdf>
- The IVR will provide patient eligibility and benefit information and the Medicare effective dates. View the IVR Web page for assistance with calling the IVR.
<http://www.trailblazerhealth.com/Customervoice/InteractiveVoiceResponse/Default.aspx>
- Providers can also obtain MA eligibility information by using the Online Services computer inquiry system. This online application allows providers to verify claims, beneficiary eligibility and much more. Information on Online Services, along with enrollment information, can be found on the Claim Status and Eligibility Web page.
<http://www.trailblazerhealth.com/ElectronicDataInterchange/ClaimStatus-Eligibility/Default.aspx>

8. MSP.

Denial messages:

- **CO-22 or PR-22:** This care may be covered by another payer per coordination of benefits.
- **CO 19:** Claim not covered by this payer/contractor. You must send the claims to the correct payer/contractor:

- **N127:** This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them.

MSP claims were denied for one or more of the following reasons:

- Secondary payment cannot be considered without the identity of, or payment information from, the primary payer. The information was either not reported or was illegible.
- The patient's care should be covered by another payer per coordination of benefits.
- Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
- Claim denied because this is a work-related injury and, thus, the liability of the workers' compensation carrier.
- Claim denied because this injury/illness is the liability of the no-fault carrier.
- Payment is adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.

Suggestions to reduce or eliminate these kinds of claim denials:

- Providers must know beforehand where to file the initial claim:
 - Traditional Medicare?
 - An employer insurance plan?
 - MA plan?
- Patient screening is an excellent way for providers to obtain valuable information necessary for proper claims submission. Claim rejections and/or denials will occur if complete patient insurance information is not obtained or kept up to date. Providers are required to file claims based on information obtained from the patient prior to submitting the claim.
- Verify the patient's Medicare card and other insurance cards and retain a copy for your files.
- Verify and reverify the patient's eligibility information often to ensure the office information is up to date and accurate.
- The *Patient Registration and Screening Guide* will provide ways to implement a process or improve existing patient screening processes within the office.
<http://www.trailblazerhealth.com/Publications/TrainingManual/PatientRegistrationScreening.pdf>
- The IVR will provide patient eligibility and benefit information to assist in determining if Medicare is secondary and the effective dates. Visit the IVR Web page for assistance with calling the IVR.
<http://www.trailblazerhealth.com/CustomerService/InteractiveVoiceResponse/Default.aspx>

- Providers can also obtain MSP information by using the Online Services computer inquiry system. This online application allows providers to verify claims, beneficiary eligibility and much more. Information on Online Services, along with enrollment information, can be found on the Claim Status and Eligibility Web page. <http://www.trailblazerhealth.com/Electronic Data Interchange/Claim Status - Eligibility/Default.aspx>
 - Utilize the “Part B Crosswalk to the CMS-1500 Claim Form” job aid to view all of the necessary loops and segments needed to file an electronic claim to Medicare. <http://www.trailblazerhealth.com/Publications/Job Aid/Crosswalkto1500ClaimForm.pdf>
 - View the CMS-1500 Claim form instructions. <http://www.trailblazerhealth.com/Publications/Training Manual/claim form instructions.pdf>
 - The *Medicare Secondary Payer (MSP)* manual provides detailed MSP provision information, secondary payer type codes, the appropriate loops/segments for electronic claim submission and instructions for billing on the CMS-1500 claim form. <http://www.trailblazerhealth.com/Publications/Training Manual/MSP.pdf>
 - Be familiar with the MSP guidelines and incorporate the MSP requirements into the patient screening process to ensure the information obtained will assist with proper claim submission.
 - The Coordination of Benefits Contractor (COBC) can assist with situations where there is a conflict between the CWF and Medicare records. Providers may contact the COBC for assistance with MSP issues as well as to alert the COBC of an accident/injury. COBC information can be found in the *Medicare Secondary Payer (MSP)* manual as well as on the CMS Web site. http://www.cms.gov/COBGeneralInformation/01_Overview.asp
 - Additional MSP information can be found on the CMS Web site in Internet-Only Manual (IOM) Pub. 100-05. <http://www.cms.gov/Manuals/IOM/list.asp>
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9. Provider eligibility.

Denial messages:

- **CO B7:** This provider was not certified/eligible to be paid for this procedure/service on this date of service.
- **CO 172:** Payment is adjusted when performed/billed by a provider of this specialty.
- **CO 38 or PR 38:** Services not provided or authorized by designated (network/primary care) providers.
- **PR 170 or CO 170:** Payment is denied when performed/billed by this type of provider.

- **N121:** Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A-covered Skilled Nursing Facility (SNF) stay.

Claims for dates of service prior to the provider's Medicare effective date will be automatically denied.

Suggestions to reduce or eliminate these kinds of claim denials:

- Verify if the correct date of service appears on the RA. If the date of service on the RA is not the correct date of service, follow procedures for having errors corrected.
- If the correct date of service appears on the RA, there may be an issue with the effective date and/or termination date of the provider's Medicare billing number and it may be necessary to contact Provider Enrollment at (866) 539-5596.
- In the event changes must be made to the provider's enrollment profile, the Provider Enrollment Web page on the TrailBlazerSM Web site offers a variety of educational resources, contact information and the 855 enrollment forms necessary for updating the files.
<http://www.trailblazerhealth.com/Provider Enrollment/Default.aspx>

10. Hospice.

Denial message:

- **CO B9:** Patient is enrolled in hospice.

Suggestions to eliminate hospice denials:

- The IVR should be utilized to verify patient eligibility. The following links to a job aid that will help you navigate the IVR to obtain hospice eligibility.
http://www.trailblazerhealth.com/Publications/Job Aid/ivr_eligibility_job_aid.pdf
- The *Evaluation and Management Services* manual offers information regarding services that are billed when the patient is enrolled in hospice such as services unrelated to the terminal illness, test components and independent attending physician services.
<http://www.trailblazerhealth.com/Publications/Training Manual/EvaluationandManagementServices.pdf>
- The "Hospice Modifiers GV and GW" job aid also offers valuable information regarding the proper billing of services when the patient is enrolled in hospice.
<http://www.trailblazerhealth.com/Publications/Job Aid/HospiceModifiersGVGW.pdf>