Medicare Part B

2009 IHS Partnership

Top Rejects, Billing Errors and Resolutions

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Today's Objectives

- Response report messages, resolutions and resources.
- CMS-1500 crosswalk.
- Top billing errors, resolutions and resources.
- Professional Provider Telecommunications Network (PPTN).
- Medicare claim review programs.

Provider Outreach and Education

- **Our Goal**

- Help providers realize it is much more cost-effective for their practices to file claims correctly the first time, every time.
- Working together, we can make a difference!

GPNet

- GPNet is the Electronic Data Interchange (EDI) gateway to TrailBlazer Health Enterprises®.

- Once a file/batch has been successfully transmitted, GPNet will transmit a response report into your “Mailbox” usually within an hour; however, please allow 24 hours before contacting EDI.

Acceptance Report Messages

- All files submitted that generate an ANSI 997 Acknowledgment will receive a GPNet Claim Acceptance Response in either a report or file format. A Compliance report is generated when a claim is not syntactically correct.

- ANSI 997 ACKNOWLEDGMENT
- (99700001.RSP.ANSI_997)
- For information regarding ANSI 997 Acknowledgment response file layouts, please refer to the “ANSI 997” section of your Implementation Guide for the transaction set being used.

Response Report

- Electronic submitters will receive a response report indicating:
  - Total claims submitted
  - Total charges
  - Claim rejects
  - Dollar amount rejected

- The following message indicators are:
  - W = Warning
  - I = Informational
  - R = Reject
  - M = Message

Messages XOA and X1N

RINQ RSPR rEDI Central A70PECS
PROD MD31530 Responses - Report Format 03/17/09
F2-Top F7-Prev F8-Next F9-COLL F10-Toggle F12-Down F4-Mailbox F16-Print Queu

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PROVIDER ID: 1234567890 BATCH ID: 106936 0002 Status: ACCEPTED/PRO
Total Claims: 20 Charges: $2,000.00
Claim Rejects: 1 Charges: $100.00

PATIENT: DOE JANE PCN: JD12345 Status: REJECTE
INSURED: ID: 123456789 D
First DOS: 2009/03/10 Charges: $100.00 Payor: 04402
R MSG-XOA NPI NOT ON CROSSWALK IN 2420A LOOP > 1234567890
R MSG-X1N RENDERING PROVIDER SSN OR EIN NOT ON CROSSWALK REF-NM
** End of Report **

Messages XOA and X1N (Cont.)

- Reasons you may get these messages:
  - New provider in group has not been enrolled with Medicare.
  - Social Security number for rendering provider not matching either enrollment records or National Plan and Provider Enumeration System (NPPES).
  - Indicator “EI” used with Social Security number; should be “SY.”

Item #	Claim Description	Loop	Segment	Electronic Instructions	Status	Example	Requirements
24j+	Rendering Provider	2310B or 2420A	NM101	Rendering Identifier Code	C	82	82 = Rendering Provider
			NM108	Identification Code Qualifier		XX	XX = CMS NPI
			NM109	Identification Code		NPI #	Enter the rendering provider's NPI number.
25	Provider's Social Security or Tax ID Information	2010AA or 2010AB	REF01	Reference Identifier Qualifier		EI or SY	EI = Tax ID or SY = Social Security
			REF02	Reference Identification		###	Tax ID number or Social Security
			REF01	Reference Identifier Qualifier		EI or SY	EI = Tax ID or SY = Social Security
			REF02	Reference Identification		###	Tax ID Number or Social Security

Message C20

RINQ RSPR rEDI Central A70PECS
PROD MD31530 Responses - Report Format 03/17/09
F2-Top F7-Prev F8-Next F9-COLL F10-Toggle F12-Down F4-Mailbox F16-Print Queu

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PROVIDER ID: 1234567890 BATCH ID: 106936 0001 Status: ACCEPTED/PRO
Total Claims: 76 Charges: $8152.00
Claim Rejects: 1 Charges: $218.00

PATIENT: DOE JOHN PCN: 1074631A-SH Status: REJECTE
INSURED: ID: 123456789 A
First DOS: 2009/02/15 Charges: $218.00 Payor: 04402
R MSG-C20 PROC. REQUIRES REF PROV NPI
** End of Report **

Message C20 (Cont.)

- Reasons you may get this message:
  - Submitting X-ray or laboratory procedures without the ordering provider's National Provider Identifier (NPI).
  - Submitting consultation without the referring provider's NPI.

Item #	Claim Description	Loop	Segment	Electronic Instructions	Status	Example	Requirements
17+	Name of Referring or Ordering Physician	2310A or 2420F	NM101	Entity Identifier Code	C	DN	DN = Referring Provider
			NM102	Entity Type Qualifier		1	1 = Person
			NM103 (DN)	Referring Provider Last Name **NM101 must = DN**		Name	Enter the name of the **referring** physician if the service was **referred** by a physician.
			NM104	Referring Provider First Name			
			NM105	Referring Provider Middle Name			
		2420E	NM101	Entity Identifier Code	C	DK	DK = Ordering Provider
			NM102	Entity Type Qualifier		1	1 = Person
			NM103 (DK)	Ordering Provider Last Name **NM101 must = DK**		Name	Enter the name of the **ordering** physician if the service was **ordered** by a physician.
			NM104	Referring Provider First Name			
			NM105	Referring Provider Middle Name			
17a	UPIN Number	No Longer Used by Medicare					
17b+	NPI Number of Ordering or Referring Provider	2310A or 2420F	NM108	Identifier Code Qualifier	C	XX	XX = CMS NPI
			NM109 (DN)	Referring NPI ID **NM108 must = XX** **NM101 must = DN**		NPI #	Enter the 10-digit NPI of the **referring** provider.
		2420E	NM108	Identifier Code Qualifier	C	XX	XX = CMS NPI
			NM109 (DK)	Ordering NPI ID **NM108 must = XX** **NM101 must = DK**		NPI #	Enter the 10-digit NPI of the **ordering** provider.

Messages V3D and VBC

RINQ RSPR rEDI Central A70PECS
PROD MD31530 Responses - Report Format 03/17/09
F2-Top F7-Prev F8-Next F9-COLL F10-Toggle F12-Down F4-Mailbox F16-Print Queu

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PROVIDER ID: 1234567890 BATCH ID: 106936 0003 Status: ACCEPTED/PRO
Total Claims: 5 Charges: $500.00
Claim Rejects: 1 Charges: $100.00

PATIENT: SMITH JOHN PCN: JS24680 Status: REJECTE
INSURED: ID: 246810121A
First DOS: 2009/02/15 Charges: $100.00 Payor: 04402
R MSG-V3D DIAGNOSIS 5 INVALID > 28220 HL=17 HI-05
R MSG-VBC INVALID DX CODE > 28220 HL=17 HI-01
R MSG-J4C COMPOSITE DIAGNOSIS CODE POINTER REQUIRED-2400 SV1-07
** End of Report **

Messages V3D and VBC (Cont.)

- Reasons you may get these messages:
  - The diagnosis submitted is not valid
  - Diagnosis pointer not provided

Item #	Claim Description	Loop	Segment	Electronic Instructions	Status	Example	Requirements
21+	Diagnosis/Condition	2300	HI01-1	Diagnosis Code	C	BK	Principal Diagnosis
			HI01-2			DX Code	Primary Diagnosis Code
			HI02-1			BF	BF = Diagnosis Code
			HI02-2			DX Code	Second Diagnosis Code
			HI03-1			BF	BF = Diagnosis Code
			HI03-2			DX Code	Third Diagnosis Code
			HI04-1			BF	BF = Diagnosis Code
			HI04-2			DX Code	Fourth Diagnosis Code
			HI05-1			BF	BF = Diagnosis Code
			HI05-2			DX Code	Fifth Diagnosis Code
			HI06-1			BF	BF = Diagnosis Code
			HI06-2			DX Code	Sixth Diagnosis Code
			HI07-1			BF	BF = Diagnosis Code
			HI07-2			DX Code	Seventh Diagnosis Code
			HI08-1			BF	BF = Diagnosis Code
			HI08-2			DX Code	Eighth Diagnosis Code
24e*	Diagnosis Code Reference	2400	SV107-1	Diagnosis Code Pointer	R		A submitter must point to the primary diagnosis for each service line.
			SV107-2				
			SV107-3				
			SV107-4				

Message C3E

RINQ RSPR rEDI Central A70PECS
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F2-Top F7-Prev F8-Next F9-COLL F10-Toggle F12-Down F4-Mailbox F16-Print Queu

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PROVIDER ID: 1234567890 BATCH ID: 106936 0004 Status: ACCEPTED/PRO
Total Claims: 1 Charges: $100.00
Claim Rejects: 1 Charges: $100.00

PATIENT: SMITH JANE PCN: JS123456 Status: REJECTE
INSURED: ID: 246810121D
First DOS: 2009/02/10 Charges: $100.00 Payor: 04402
R MSG-C3E OTH PAYR REND PRV NOT = LU OR EI REF-01
** End of Report **

Message C3E (Cont.)

- Reasons you may get this message:
  - Submitting additional payer-specific provider identification number for the supplemental insurance but not furnishing valid reference identification qualifier.
- Resolution:
  - Verify the rendering provider has a different identification number for supplemental insurance. If there is a different ID, use identification qualifiers:
    - EI = Employer's identification number.
    - LU = Location number.

Message C1E

RINQ RSPR rEDI Central A70PECS
PROD MD31530 Responses - Report Format 03/17/09
F2-Top F7-Prev F8-Next F9-COLL F10-Toggle F12-Down F4-Mailbox F16-Print Queu

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PROVIDER ID: 1234567890 BATCH ID: 106936 0005 Status: ACCEPTED/PRO
Total Claims: 1 Charges: $100.00
Claim Rejects: 1 Charges: $100.00

PATIENT: SMITH JANE PCN: JS123456 Status: REJECTE
INSURED: ID: 246810121D
First DOS: 2009/02/10 Charges: $100.00 Payor: 04402
R MSG-C1E PROCEDURE CODE INVALID > 11731 SV1-01
** End of Report **

Message C1E (Cont.)

- Reason you may get this message:
  - The procedure code is invalid

Item #	Claim Description	Loop	Segment	Electronic Instructions	Status	Example	Requirements
24d	Procedure Code/Modifiers	2400	SV101-1	Service ID Qualifier	R	HC	HC = Healthcare Common Procedural Coding
			SV101-2	Procedure Code		#####	Procedure Code and Modifier
			SV101-3	Procedure Modifier 1			
			SV101-4	Procedure Modifier 2			
			SV101-5	Procedure Modifier 3			
			SV101-6	Procedure Modifier 4			

MSP Messages

RINQ RSPR rEDI Central A70PECS
PROD MD31530 Responses - Report Format 03/17/09
F2-Top F7-Prev F8-Next F9-COLL F10-Toggle F12-Down F4-Mailbox F16-Print Queu

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PROVIDER ID: 1234567890 BATCH ID: 106936 0006 Status: ACCEPTED/PRO
Total Claims: 3 Charges: $1,500.00
Claim Rejects: 1 Charges: $200.00

PATIENT: DOE JANE PCN: JD12345 Status: REJECTE
INSURED: ID: 123456789 D
First DOS: 2009/03/10 Charges: $200.00 Payor: 04402

R MSG-H63	Insurance Type Code invalid	SBR-05
R MSG-ID3	Ins Type Code invalid	SBR-05
R MSG-X21	MSP claim requires Primary Paid Amount	SBR-01
R MSG-1D4	Claim Filing Indicator code invalid	SBR-09
R MSG-C42	Other Payor ID required	NM1-09

** End of Report **

MSP Messages (Cont.)

Item #	Claim Description	Loop	Segment	Electronic Instructions	Status	Example	Requirements
11*	Insured's Policy or Group Number	2320	SBR01	Payer Responsibility	R	P	P = Primary, S = Secondary, T = Tertiary
			SBR03	Insured's Group or Policy Number		XXXXXX	Policy or Group Number
		2330A	NM109	Insured's Identifier		###	Other Subscriber's Primary Identifier
		2000B	SBR05	Insurance Type Code (Header Information)		12	Indicator must equal one of the following values: 12, 13, 14, 15, 16, 41, 42, 43 or 47 if the 2000B SBR01 is "T" or "S."
		2000B 2320	SBR09	Claim Filing Indicator Code		MB	**Indicators –** 09, 10, 11, 12, 13, 14, 15, 16, AM, BL, CH, CI, DS,HM, LI, LM, MB, MC, OF, TV, VA, WC, ZZ
11*	MSP Information for an Electronic Claim	2320	SBR05	Insurance Type Code (Detail Line Information)	C	MB	**Indicators –** AP, C1, CP, GP, HM, IP, LD, LT, MB, MC, MI, MP, OT, PP, SP
		2300	CLM01	Monetary Amount		$$$$	Total Amount of All Submitted Charges
		2320 (header)	AMT01	Amount Qualifier Code		D	D = Primary Payer **PAID** Amount
						B6	B6 = Primary Payer **ALLOWED** Amount
						F2	F2 = Patient Responsibility
			AMT02	Primary Payer Paid Amount		$$$$	Dollar Amount
				Primary Payer Allowed Amount		$$$$	Dollar Amount
		2400 (detail)	AMT01	Amount Qualifier Code		AAE	AAE = Approved Amount
			AMT02	Approved Amount		$$$	Approved Dollar Amount
		2320 (header) or 2430 (detail)	CAS01	Claim Adjustment Group Codes		CO	CO, CR, OA, PI or PR
			CAS02	Claim Adjustment Reason Codes		96	Reason Code
			CAS03	Adjustment Amount		$$$$	Monetary Amount (03, 06, 09, 12, 15 or 18)
			CAS04	Adjustment Quantity		###	Adjustment Quantity (04, 07, 10, 13, 16 or 19)
		2330B (H) or 2430 (D)	DTP01	Primary Insurance Adjudication Date		573	573 = Date Claim Paid
			DTP03	Date Paid		Date	Adjudication or Payment Date
		2300 or 2400	CN101	Contract Type Code		09	Claim OTAF Amount
			CN102	OTAF Amount		$$$	Monetary Amount
		2430	SVD02	Primary Payer Paid Amount		$$$	Service Line Paid Amount
		2330B	NM101	Entity Identifier Code		PR	PR – Payer
			NM102	Entity Type Code		2	2 = Non-Person Entity
			NM103	Last Name or Organization Name		CIGNA	Other Payer Last or Organization Name
			NM108	Identification Code Qualifier		PI	PI = Payer Identification
			NM109	Identification Code		###	Other Payer Primary Identification Number

MSP Electronic Claim Submission

- MSP claims should be submitted to Medicare electronically.

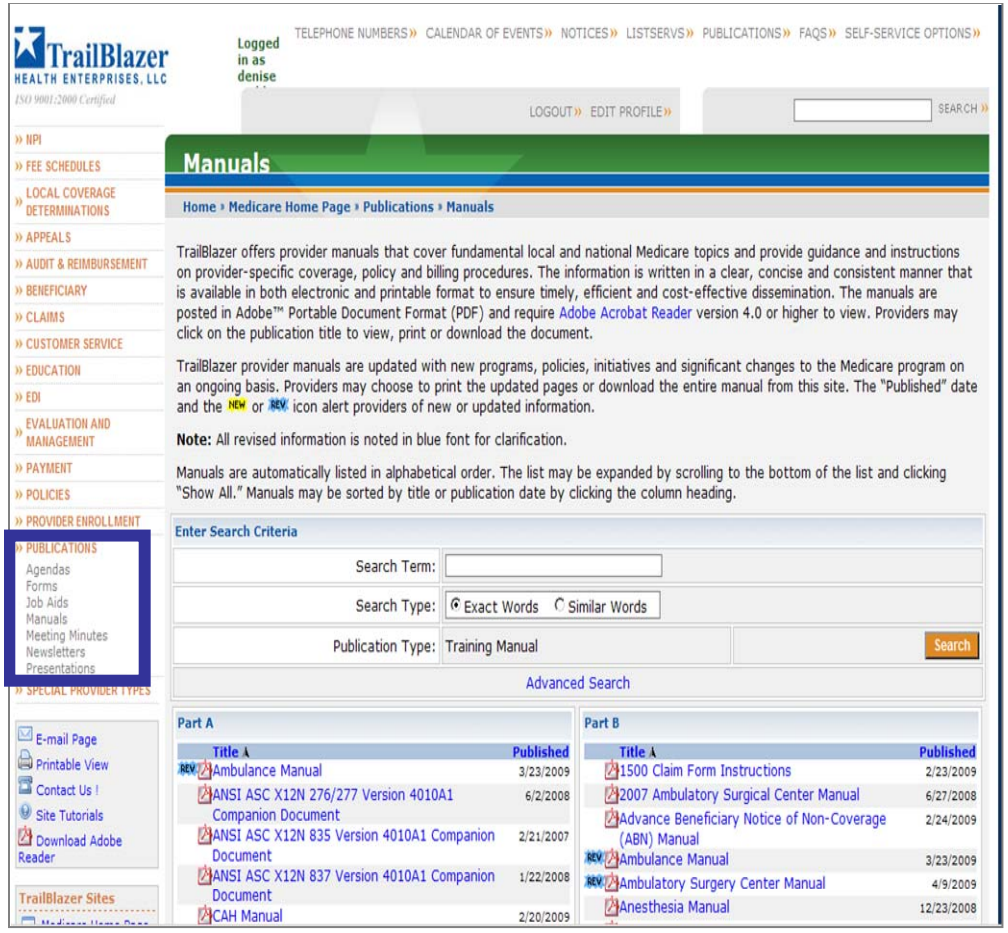
- Required information:
  - Insurer type code
  - Amount paid by primary payer
  - Amount allowed by primary payer
  - Obligation to Accept Payment in Full (OTAF) amount (if applicable)
  - Date primary insurance paid

Electronic Submission

- **Electronic Billing Reminder**

- For tribal self-funded insurance, the allowed and paid amount fields will be zero. Providers must take an extra step if the primary allowed and primary paid amounts are both “zero.”
  - Narrative field – Indicate reason for non-payment (i.e., tribal self-funded insurance).
  - CAS segment field – Indicate the appropriate Claim Adjustment Segment (CAS) reason code to the reason for non-payment.
    - 96 – Non-covered service.

MSP Manual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2007 Ambulatory Surgical Center Manual 6/27/2008
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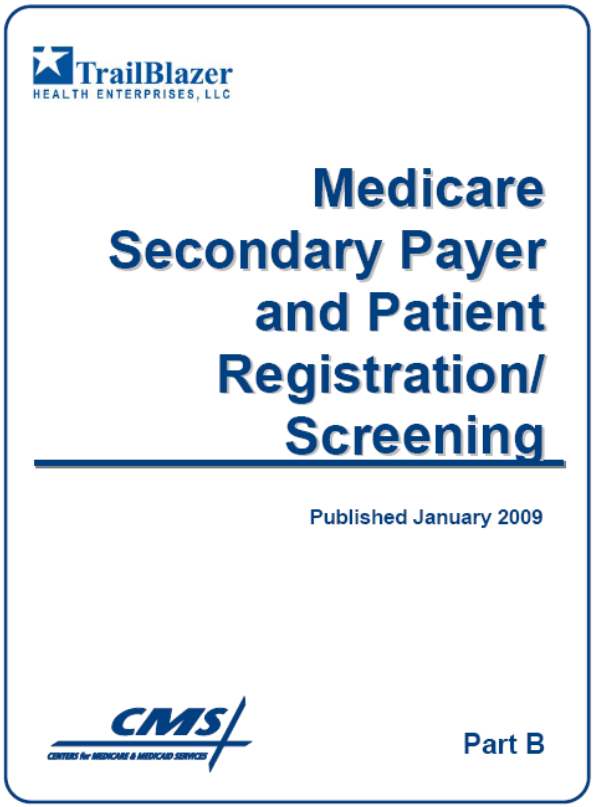
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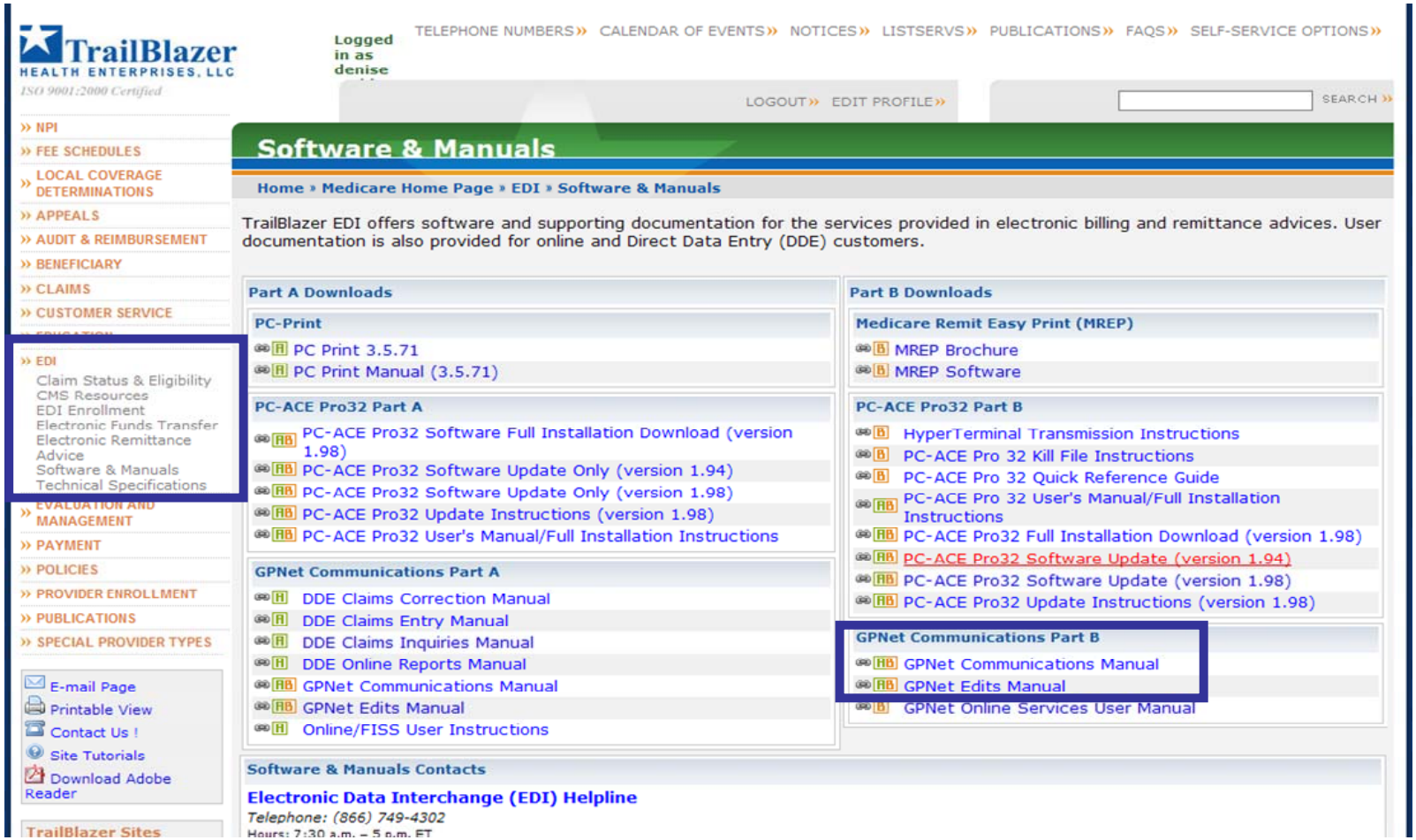
Part B

GPNet Edits Manual



GPNet Edits Manual (Cont.)

Edit #	Edit Type	Message	Segment ID	Edit Logic
X1M	C	RENDER PROV SSN OR EIN NOT ON XWALK > @FLD	REFNM	Edit is set if the 2310B is submitted and does not contain a REF01 of 1C. The 2310B REF01 does contain: - EI and the EIN from the 2310B REF02 or the EIN from the 2010AA or 2010AB REF02 where REF01 is EI is not on the PIN/NPI Crosswalk file for the NPI in the 2310B NM109.
X1N	C	RENDERING PROVIDER SSN OR EIN NOT ON CROSSWALK	REFNM	Edit is set if the 2420A is submitted and does not contain a REF01 of 1C. The 2420A REF01 does contain: - EI and the EIN from the 2420A REF02 or the EIN from the 2010AA or 2010AB REF02 where REF01 is EI is not on the PIN/NPI Crosswalk file for the NPI in the 2420A NM109 OR.

Electronic Claims Crosswalk

Item #	Claim Description	Loop	Segment	Electronic Instructions	Status	Example	Requirements
1	Type of Health Insurance	2000B	SBR01	Primary Payer Responsibility		P	P = Primary, S = Secondary, T = Tertiary
			SBR09	Primary Payer		MB	Medicare Indicator Must = MB
1a*	Patient's Medicare HIC Number	2010BA	NM101	Insured or Subscriber (IL)	R	IL	For Medicare, the patient is always the subscriber. Shown on Medicare card.
			NM102	Person		1	
			NM108	Member Identification Number		MI	
			NM109	Subscriber Primary Identifier		#	
2*	Patient's Name	2010BA	NM103	Last Name	R	Doe	Enter the patient's last name, first name and middle initial as it appears on the Medicare card.
			NM104	First Name		John	
			NM105	Middle Name		X	
			NM107	Suffix (e.g., Jr. Sr.)		JR	
3	Patient's Birth Date and Gender	2010BA	DMG02	Birth Date		19360826	Eight-digit
			DMG03	Gender		M	F = Female, M = Male, U = Unknown
4+	Insured's Name	2330A	NM103	Last Name	C	Doe	If the patient has insurance primary to Medicare, enter the insured's last name, first name and middle initial.
			NM104	First Name		John	
			NM105	Middle Name		X	
			NM107	Suffix (e.g., Jr. Sr.)		JR	
5	Patient's Address	2010BA	N301	Address Line 1		Address	Enter the patient's mailing address.
			N302	Address Line 2		Address	
			N401	City Name		Anywhere	
			N402	State Code		TX	
			N403	ZIP Code		XXXXX	
6+	Patient's Relationship to Insured	2000B	SBR02	Self Relationship	C	18	Must = Self (18) or Spouse (01) for Medicare
		2320	SBR02				

Top Denial Reasons

DENIAL REASON	OCCURRENCES
1. Provider Eligibility	4,299
2. Duplicates	2,730
3. Beneficiary Eligibility	2,391
4. Missing/Invalid Group Number	1,875
5. Late Filing/Filing Time Limit	1,212
6. Place of Service	1,048
7. Screening/Routine	1,024
8. Bundled Services	695
9. Part A Service	683
10. Provider Number Missing	512

Provider Eligibility

This is the highest billing error.

For the quarter ending March 2009, statistics reflect 4,299 claims denied as provider not eligible.

Provider Eligibility (Cont.)

- **Recommendations for improvement:**
  - Providers should verify their Medicare effective date from the letter received from the Provider Enrollment department.
  - Verify the date of service submitted is on or after the date the provider became eligible.
  - If a claim is not submitted and processed within one year of number being issued, it will be terminated and a new enrollment form will need to be submitted for reinstatement.
  - Verify the provider specialty is allowed to bill the procedure.

Duplicates

Duplicate claim denials remain one of the top Medicare Part B errors.

This quarter, 2,730 claims denied as duplicates.

Duplicates (Cont.)

- **Recommendations for improvement:**
  - Call the Provider Inquiry line if the reason for non-payment is in question:
    - (866) 448-5894
  - Verify claim status before refiling:
    - Interactive Voice Response (IVR):
      - (877) 567-9230
    - PPTN

Beneficiary Eligibility

Beneficiary eligibility is the third highest billing error.

2,391 claims denied for beneficiary eligibility.

Beneficiary Eligibility (Cont.)

- **Recommendations for improvement:**
  - Patient screening is vital:
    - Copy the Medicare card
    - Obtain essential patient information
    - Determine Medicare eligibility
    - Obtain information to allow the claim to be submitted to the appropriate insurance payer
    - Call the IVR to verify patient eligibility or,
    - Verify patient eligibility via PPTN

Missing/Incomplete Group Number

- This is a fairly new denial since NPI implementation.

- **Recommendation for improvement:**
  - If one NPI is used for multiple groups, utilize the billing and pay-to loops to identify the physical location of the group.
  - If a development letter is received from TrailBlazer℠ asking for the PTAN of group or rendering provider, respond within the given time frame.

Late Filing/Time Limit

- **This is the fifth highest billing error for this quarter with 1,212 claims denied.**

- **Recommendations for improvement:**
  - Stay informed of the claims filing deadline; it changes every January 1.

- **Claims filing deadline for 2009:**
  - Current year (2009)
  - Previous year (2008)
  - Last three months of previous year (October, November, December 2007)

Place of Service (POS)

Place of Service (POS) denials continue to be a billing error.

For this quarter 1,048 claims denied for place of service.

POS (Cont.)

- **Recommendations for improvement:**
  - Verify the procedure is valid for the POS.

- Examples of denied services:
  - Inpatient visits submitted with outpatient POS code.
  - X-ray submitted without a 26 modifier or without CPT indicating interpretation.
  - Observation codes submitted with inpatient POS code; should be outpatient.

Routine/Screening Services

This is the seventh highest billing error.

For this quarter, statistics reflect 1,024 claims denied as routine.

Routine/Screening Services (Cont.)

- **Recommendations for improvement:**
  - Providers should be familiar with the services Medicare considers screening, routine and non-covered.
  - Services/procedures performed in the absence of signs or symptoms or other evidence of illness or injury are routine in nature and are non-covered.
  - Some routine/screening services are considered by Medicare and guidelines can be found in the *Screening and Preventative* manual on the TrailBlazer Web site: http://www.trailblazerhealth.com

Bundled Services

This is the eighth highest billing error.

695 claims denied for bundled services.

Bundled Services (Cont.)

- **Recommendations for improvement:**
  - Bundled services are listed on the Medicare Physician Fee Schedule Database (MPFSDB) located on the CMS Web site.
  - Identify the most common services you provide, as well as understand those services which may be considered "bundled."

Bundled Services (Cont.)

- **Examples:**
  - CPT 99050 is a supply code not covered by Medicare.
  - Surgeries could have anywhere from 10–90 days postoperative care. Any visit billed within this period, or on the same day as surgery will deny as a bundled service unless a modifier(s) is used to indicate otherwise.
  - Some codes deny as National Correct Coding Initiative (NCCI), which indicates bundled service. Refer to the CMS Web site for a list of NCCI edits.

Part A Services

- Part A services being submitted to Part B accounted for 683 denials for this quarter.

- Services are being submitted to Part B that should be submitted to Part A.

Part A Services (Cont.)

- **Recommendations for improvement:**
  - Influenza services are being submitted to Part B when the POS is hospital outpatient. These services are submitted on the Part A claim.
  - When billing X-rays for hospital patients, use the 26 modifier to indicate interpretation service unless there is a procedure code to specifically describe physician interpretation.

Provider Number Missing

- The final top billing error is the provider number is missing.
- For this quarter, 512 claims denied for this error.
- **Recommendation for improvement:**
  - If the rendering provider has multiple PTANs linked to one NPI, utilize the billing and pay-to loops and segments to identify which location the provider is working.
  - If a development letter is received from TrailBlazer asking for the PTAN of the rendering provider, respond within the given time frame.

PPTN

- Immediate, easy access to online claim inquiry information.
- Features:
  - Individual claim display
  - Patient eligibility inquiry (entitlement, deductible, HMO and Medicare Secondary Payer {MSP})
  - Provider eligibility
  - Check status

PPTN Main Menu

- **PROFESSIONAL PROVIDER TELECOMMUNICATION NETWORK – PPTN**
- **PRODUCTION**
- **ACTION __**
- **H4 - CLAIM STATUS INQUIRY (REQUIRED FIELDS)**
- **HIC _____**
- **NPI _____**
- **SERVICE DATE RANGE (MMDDCCYY) FROM _____ TO _____**
- **OPTIONAL SECONDARY SELECTION: PROCEDURE CODE _____**
- **ICN _____**

- **SELECTION _____ (OTHER LOOK-UP ACTIONS REQUIRED FIELD)**

- **ACTION BY PROVIDER ACTION BY CODE**
- **----------**

AP - ACCOUNTS REC	**AD/ED - ADS/EOMB LOOKUP**	**DC - DIAGNOSIS LOOKUP**
PE - PROVIDER ELIG	**AI - ACCOUNTS REC INQ**	**DR - DRUG FEE SCHEDULE**
PI - PRICING INQUIRY	**AM - AMBULANCE FEE SCHEDULE**	**EI - CWF BENE ELIG LOOKUP**
PS - PROVIDER SUMMARY	**BS - BANK CHECK STATUS**	**F1 - ASC FEE SCHEDULE**
	CD - CAP FEE SCHEDULE	**HS - HPSA/SCARCITY LOOKUP**
	CF - CLINICAL LAB FEE	**MI - OTHER-INSURER LOOKUP**
	DB - MPFSDB	**PC - PROCEDURE LOOKUP**

- msg

Beneficiary Eligibility

- **PROFESSIONAL PROVIDER TELECOMMUNICATION NETWORK – PPTN PRODUCTION**
- **ACTION EI**
- **H4 - CLAIM STATUS INQUIRY (REQUIRED FIELDS)**
- **HIC _____**
- **LEGACY PROV NUM _____ NPI _____**
- **SERVICE DATE RANGE (MMDDCCYY) FROM _____ TO _____**
- **OPTIONAL SECONDARY SELECTION: PROCEDURE CODE _____**
- **ICN _____**

- **SELECTION _____ (OTHER LOOK-UP ACTIONS REQUIRED FIELD)**

- **ACTION BY PROVIDER ACTION BY CODE**
- **----------**

AP - ACCOUNTS REC	**AD/ED - ADS/EOMB LOOKUP**	**DC - DIAGNOSIS LOOKUP**
PE - PROVIDER ELIG	**AI - ACCOUNTS REC INQ**	**DR - DRUG FEE SCHEDULE**
PI - PRICING INQUIRY	**AM - AMBULANCE FEE SCHEDULE**	**EI - CWF BENE ELIG LOOKUP**
PS - PROVIDER SUMMARY	**BS - BANK CHECK STATUS**	**F1 - ASC FEE SCHEDULE**
	CD - CAP FEE SCHEDULE	**HS - HPSA/SCARCITY LOOKUP**
	CF - CLINICAL LAB FEE	**MI - OTHER-INSURER LOOKUP**
	DB - MPFSDB	**PC - PROCEDURE LOOKUP**

- msg

CWF Eligibility Detail

- ELGB CWF PART B ELIGIBILITY SYSTEM ELGBSAT1
- 02/15/2008 14:13:29 INQUIRY BY PROVIDERS
- ENTER THE FOLLOWING FIELDS:
- HIC NUMBER : **#########X**
- SURNAME : **DOE**
- INITIAL : **J**
- DATE OF BIRTH : **12121927** (MMDDCCYY)
- SEX CODE : **F**
- REQUESTOR ID :
- CARRIER NO : **04402**
- NPI INDICATOR : N N - NPI or Blank
- PROVIDER NO : **##########**
- HOST-ID : GL, GW, KS, MA, PA, NE, SE, SO, SW
- APP DATE : (MMDDCCYY)
- REASON CODE : 1
- RESPONSE CODE : P

CWF Eligibility Detail (Cont.)

- ELGB CWF PART B ELIGIBILITY SYSTEM ELGBCRO
- 02/15/2008 15:55:47 BENEFICIARY INFORMATION PAGE 01

- IP-REC CN ##########X NM Doe IT J DB 12121927 SX F CAR 04402
- PN 1234567890 REAS 1 REQ

- CORRECT CN NM IT E DB SX

- A-ENT 12121987 A-TRM B-ENT 07012002 B-TRM
- DOD LRSV 60 LPSY 190
- DAYS LEFT . FULL-HOSP . CO-HOSP FULL-SNF CO-SNF IP-DED DOEBA DOLBA
- CURRENT 59 30 20 80 0 12222007 12222007

- PHYS THER OCC THER
- PARTB YR DED-TBM PSYC TBM TBM
- 20080101 0 181000 181000

- FULL-NAME DOE.E.JANE
- HMO CURR-ID H1849 OPT C ENT 03012008 TERM
- ESRD: CODE-1 EFF DATE CODE-2 EFF DATE

- PF1=INQ SCREEN PF3/CLEAR=END PF8=NEXT

PPTN Menu Selection Claim Status

- **PROFESSIONAL PROVIDER TELECOMMUNICATION NETWORK - PPTN PRODUCTION**
- **ACTION H4**
- **H4 - CLAIM STATUS INQUIRY (REQUIRED FIELDS)**
- **HIC #########X**
- **NPI XXXXXXXXXX**
- **SERVICE DATE RANGE (MMDDCCYY) FROM 06012007 TO 06012007**
- **OPTIONAL SECONDARY SELECTION: PROCEDURE CODE _____**
- **ICN _____**

- **SELECTION _____ (OTHER LOOK-UP ACTIONS REQUIRED FIELD)**

ACTION BY PROVIDER	ACTION BY CODE	
AP - ACCOUNTS REC	AD/ED - ADS/EOMB LOOKUP	DC - DIAGNOSIS LOOKUP
PE - PROVIDER ELIG	AI - ACCOUNTS REC INQ	DR - DRUG FEE SCHEDULE
PI - PRICING INQUIRY	AM - AMBULANCE FEE SCHEDULE	EI - CWF BENE ELIG LOOKUP
PS - PROVIDER SUMMARY	BS - BANK CHECK STATUS	F1 - ASC FEE SCHEDULE
	CD - CAP FEE SCHEDULE	HS - HPSA/SCARCITY LOOKUP
	CF - CLINICAL LAB FEE	MI - OTHER-INSURER LOOKUP
	DB - MPFSDB	PC - PROCEDURE LOOKUP

- **HIC NUMBER IS A REQUIRED FIELD FOR THE H4 ACTION.**

- msg

H4 = Claim Status
Requires:
- Patient's Medicare number
- Provider NPI
- Date of service

PPTN Job Aids

Importance of Documentation

- Medical record documentation is required to record:
  - Pertinent facts, findings and observations about an individual's health history including:
    - Past and present illnesses
    - Examinations
    - Tests
    - Treatments
    - Outcomes

Coding and Documentation

- Carriers may request medical record documentation to validate:
  - Site of service.
  - Medical necessity and appropriateness of diagnostic or therapeutic services provided.
  - Services provided have been accurately reported.

Coding and Documentation (Cont.)

- The principles of documentation listed below are applicable to all types of medical and surgical services, in all settings.
  - Medical record should be complete and legible.
  - Documentation of each patient encounter should include:
    - The date
    - Reason for encounter and relevant history, findings and prior diagnostic test results
    - Assessment, clinical impression or diagnosis
    - Plan of care
    - Past and present diagnoses
    - Health risk factors identified
    - Patient's progress, response to and changes in treatment, any revision to diagnosis and any patient non-compliance should be documented
    - Thought processes and medical decision-making

Coding and Documentation (Cont.)

- Recommendations for proper claim submission:
  - Provide the services your patient needs
  - Document services rendered
  - Bill what is needed and reflected in documentation.

Coding and Documentation (Cont.)

- Helpful hints:
  - Report Evaluation and Management (E/M) services with current CPT codes.
  - Medical necessity must be met.
  - Don’t report higher level E/M when lower level is what is needed.
  - Level of service must be supported by documentation.
  - Maintain accurate medical record by documenting during or as soon as practicable after service provided.
  - Code based on documentation.
  - Time is ancillary factor unless more than 50 percent is spent providing counseling or coordination of care.
  - “Incident to” valid for office visits when performed in place of service “11” and criteria are met.

Claim Review Programs

- Since 1996, CMS has implemented several initiatives to prevent improper payments before the claim is processed and identify and recoup improper payments after the claim has been processed. The overall goal of CMS' claim review programs are to reduce payment error by identifying and addressing provider billing errors concerning coverage and coding.

Claim Review Programs (Cont.)

Prepayment Claim Review Programs	Postpayment Claim Review Programs
National Correct Coding Initiative (NCCI) Edits	Comprehensive Error Rate Testing (CERT) Program
Medically Unlikely Edits (MUE)	Recovery Audit Contractor (RAC)

MAC Medical Review (MR)

Claim Review Programs (Cont.)

- **NCCI Edits**
- Prepayment edits analyzing code pairs billed by same provider, same day, same patient.
- **MUE Edits**
- Prepayment edits analyzing units of service billed by same provider, same day, same patient.
- **CERT**
- Random selection of claims and medical records to review claims for compliance with Medicare coverage, coding and billing rules.
- **RAC**
- Tasked with detecting and correcting improper payments on Medicare claims (i.e., collecting overpayments and paying back underpayments). The RAC contacts the provider and requests a refund of any overpayment amounts and pays the provider any underpayment amounts.

Questions?

Contact Information

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Medicare Part B
2009 IHS Partnership
Top Rejects, Billing Errors and Resolutions

Thank you for attending.