Claim Process

When providers submit claims to Medicare through electronic billing software, the staff in the Claims Department is responsible for ensuring the claims are processed. In some cases, the claims will be automatically processed through the system without any manual intervention. Other claims will need to be manually processed by a member of the Claims Department. These claims are placed in an “S” (suspense) status and a special location other than B9000 or B9099 for manual processing.

The Process of a Claim

All claims after entering into the claims processing system are subject to adjudication via automated resolution and/or processor intervention:

- System adjudication – resolution based upon system applied logic
- Manual adjudication – resolution based upon guideline requirements
- Pricing – allowable amounts applied via the system pricing files or manual pricing
- Medicare Secondary Payer – review and payment based upon Medicare as the secondary insurer type

Quality measures are implemented for claims processing to ensure all CMS requirements are met. These include daily measures to meet claims processing timeliness through the monitoring of aged claims, accuracy and to ensure all CMS directives are implemented in a timely manner.

Example:

A provider submits an electronic media claim (EMC). There are no front end edits and it is accepted through Electronic Data Interchange (EDI) Gateway. Within two to three days it is converted and visible on the Fiscal Intermediary Shared System (FISS). This particular claim begins processing in Status/ Location (S/L) S B9000. The claim processing moves the claim to the Common Working File (CWF) and the S/L is now S B9099. The CWF verifies the patient's eligibility and applies the information to the beneficiary records.

The claim is returned to FISS and it passes through the Medicare Code Editor (MCE). The MCE edits claims to detect incorrect billing data. To determine the appropriate Diagnosis-Related Group (DRG) for a Medicare patient, the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed must be reported accurately to the Grouper program.

The three basic types of edits are:

- Code Edits – Examines a record for the correct use of ICD-9-CM codes that describe a patient's diagnosis and procedures.
Coverage Edits – Examines the type of patient and procedures performed to determine if the services were covered.

Clinical Edits – Examines the clinical consistency of the diagnostic and procedural information on the medical claim to determine if they are clinically reasonable and, therefore, should be paid.

Additional information is available in the Medicare Claims Processing Manual, Chapter 3, Section 20.2.1, at: http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf. It contains program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. The following chart lists the most frequent MCE reason code errors and provides the reason code description and solutions in plain language. This tool is to be utilized as a resource that will enable you to process your claims more effectively.

<table>
<thead>
<tr>
<th>Reason Code</th>
<th>Reason Code Description</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>W0004</td>
<td>MCE or OCE has determined that a conflict exists between patient’s age &amp; the second diagnosis code.</td>
<td>Verify coding in relation to inconsistencies between a patient’s age &amp; any diagnosis on the patient’s record. Examples of age conflicts are a 5-year-old patient with a benign prostatic hypertrophy, and a 78-year-old patient with a delivery.</td>
</tr>
<tr>
<td>W0342</td>
<td>MCE has determined that the 1st procedure code is a non-covered procedure.</td>
<td>Medicare does not provide reimbursement for some procedures &amp; those procedure codes are flagged by the software. Those codes are not reportable on the Medicare claim.</td>
</tr>
<tr>
<td>W0120</td>
<td>MCE or OCE has determined that a conflict exists between the sex code and the first diagnosis code.</td>
<td>Verify inconsistencies between a patient’s sex &amp; any diagnosis or procedure on the patient’s record. Example of sex conflicts are a male patient with a cervical cancer (diagnosis) &amp; a male patient with a hysterectomy (procedure). In such cases, the diagnosis, procedure, or sex is presumed to be incorrect.</td>
</tr>
<tr>
<td>W1443</td>
<td>MCE has determined that the claims principal diagnosis is an unacceptable diagnosis.</td>
<td>There are selected codes that describe a circumstance which influences an individual’s health status but is not a current illness or injury (e.g. family history of ischemic heart disease) or codes that are not specific manifestations but may be due to an underlying cause. Such codes are considered unacceptable as a principal diagnosis. Correct the diagnosis &amp; resubmit the claim.</td>
</tr>
</tbody>
</table>

Once the claim receives an edit reason code, it is returned to the provider (RTP) for corrections. The provider is able to correct the claim via Direct Data Entry (DDE) and return back to the processing system. RTP claims that are corrected and returned will receive a new adjudication date. For further information concerning DDE
Claims Located in S Status and the Action Request Process

Listed below is an overview of the typical protocol providers should follow with claims located in a suspended location (S status) and the action request (AR) process initiated by the Provider Contact Center (PCC):

If the claim has been in a particular S status for 30 days (for example, S M1234), the provider may call the PCC and an action request can be sent to the Claims Department to have that claim processed or returned to the provider (RTPd). Note, however, that if the claim is related to MSP, an action request should only be submitted every 60 days. If the claim is affected by an issue that is on the Claims Processing Issues Log (CPIL), the provider will not need to call and report this through an action request unless the log specifies that you should do so. Bear in mind that claims in status/location S Mxxxx (i.e. where “M” is in the second placeholder) must be manually worked by the A/B MAC and no provider action is required.

After the submission of an action request, if at any point in the following 30 days (60 for MSP claims) the claim has moved to another status/location, even if it is to another suspended status, the claim is considered to be in processing. Thus, if you have seen the status/location change (for example, the claim moved from S M1234 to S M6789) another action request cannot be submitted to the Claims Department until it has been in the new status/location for 30 days (60 days for MSP). If it appears that a claim has been in a particular status/location for a long period of time (for example, 4-6 months, a year, etc.), please notify the PCC.

At times, providers may see a slower processing of claims. This may be due to situations that require a higher priority level per CMS and/or the FISS maintainers. For example, if mass adjustments are required on claims that affect a large number of providers, the same claim processors that work provider claims are also responsible for completing these mass adjustments. Therefore, depending on the priority level of the mass adjustment per CMS or the FISS maintainers, the mass adjustments may need to be completed as soon as possible, which can result in a slower processing time for regular incoming claims.

Occasionally system errors occur where claims begin to cycle. For example, in recent months, claims were cycling from status/location S B9000 to S B9099 for certain provider types. It is standard processing for claims to move into these statuses; however, it is not typical for them to cycle back and forth from one location to another. If a provider notices that this is occurring, please contact the PCC immediately.

Claims Processing Issues Log (CPIL)

The Claims Processing Issues Log (CPIL) is a tool used to notify the provider community concerning any issues that may affect claims processing. Palmetto GBA works in conjunction with CMS, other Medicare contractors and processing systems when an issue is discovered. Once an issue is verified and found to affect a percentage of claims; it is published to the CPIL and updated weekly until resolution.
Not all claim processing issues appear on the CPIL, as some issues may only relate to an individual provider. The issues are personally resolved for the provider by their PCC representative.

The Claims Processing Issues Log (CPIL) is located on the main page of the J1 Part A Home page under Top Links. This Log is updated on a weekly basis and outlines current system-related claims processing issues affecting J1 Part A providers. In addition, the Log outlines the issues’ impact to providers and status updates on the issues. Note that issues on the Log have been reported to the Centers for Medicare & Medicaid Services (CMS) and/or the Fiscal Intermediary Standard System (FISS). Please check the Log often for updates before contacting the Provider Contact Center (PCC). Once an issue has been resolved, it will remain on the CPIL for three weeks before being removed.
Top Ten Claim Submission Errors

Palmetto GBA reviews data analysis concerning the top ten claim submission errors that directly affect our providers. Our providers would like to be reimbursed for their services instead of denied for these services by Medicare! By providing education concerning these reason codes, we allow you to take steps to reduce any errors that affect your billing and reimbursement. Compliance ensures that you’re going to receive the appropriate reimbursement that you deserve to prevent unnecessary denial and reduce the need to appeal. The most prevalent claim submission errors are as follows.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Reason Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>31324</td>
</tr>
<tr>
<td>2</td>
<td>54NCD</td>
</tr>
<tr>
<td>3</td>
<td>31241</td>
</tr>
<tr>
<td>4</td>
<td>31992</td>
</tr>
<tr>
<td>5</td>
<td>38200</td>
</tr>
<tr>
<td>6</td>
<td>39934</td>
</tr>
<tr>
<td>7</td>
<td>70034</td>
</tr>
<tr>
<td>8</td>
<td>55A00</td>
</tr>
<tr>
<td>9</td>
<td>U5233</td>
</tr>
<tr>
<td>10</td>
<td>51MUE</td>
</tr>
</tbody>
</table>

1. We’re seeing **reason code 31324** as ranking in first place. Providers are to submit non-covered charges with a modifier GY or TF. For example, a patient was admitted for inpatient cosmetic surgery and Medicare doesn't cover the cosmetic surgery, it’s a statutory exclusion. Making sure that you submit your GY and TS modifiers, with those service lines as non-covered, appropriately will assign the liability to the beneficiary.

2. The second ranking reason code is **reason code 54NCD**. Reason code 54NCD is a Claim line level reason code indicating that none of the diagnosis reported on the claim supported medical necessity.

   If you are experiencing line level denials for 54NCD, remember to review the CMS National Coverage Determinations or NCDs for the coverage available for the services you’re billing. This outlines the conditions for which the service is considered reasonable and necessary. Also, visit the Palmetto GBA Web site Local Coverage Determinations or LCDs in the Medicare Policies navigational tab. LCDs outline coverage criteria on a contractor basis.

3. The third ranking **reason code 31241**. The GZ modifier indicates that an Advance Beneficiary Notice (ABN) was not issued to the beneficiary and signifies that the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy. Per Change Request 7228, dated February 4, 2011,

   Medicare automatically denies claim lines items submitted with a GZ modifier, effective for dates of service on or after July 1, 2011. Medicare does not perform complex medical review on any claim line items submitted with the GZ modifier.
In addition, line items denied due to the presence of the GZ modifier will reflect a Claim Adjustment Reason Code of 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.) and a Group Code of CO (Contractual Obligation) to show provider liability.

4. The fourth ranking reason code is 31992. Non-covered line item charges are equal to the total charges and condition code 20 or 21 is on the claim. Please ensure that ABNs are issued to the patient when you realize it is not going to be a covered stay. When you submit a claim with condition code 20, documentation will be requested for medical review. When you submit a claim with condition code 21; you are only billing for a denial to submit to the secondary insurer and these claims automatically process right through the FISS system.

5. The fifth ranking reason code is 38200. The claim is an exact duplicate of a previously submitted claim that is in the common working file (CWF) history. Providers should verify in DDE as to whether a previous claim has processed. Please note if there is an ‘X’ in the tape to tape field of the previously processed claim; a new claim may be submitted. However, if there is NO ‘X’; the initial claim has been posted to the CWF. A new claim will be considered a duplicate.

6. The sixth ranking reason code is 39934. This is a claim level reason code for claims that have all revenue lines denied/non-covered and one or more of the lines denote beneficiary liability. This reason code is denying correctly if received on claims that are being billed for demand bills. If this reason code is received for any other types of services, then it would be necessary to correct and resubmit the claim(s).

7. The seventh ranking reason code is 70034. Medicare does not cover the services for the diagnosis and/or condition. These claims suspend to a manual location SMILL. The service and diagnosis is reviewed for Medicare coverage exclusions prior to denial.

8. The eighth claim submission denial reason code is 55A00. Reason code 55A00 edits for claims denied for not having a covered diagnosis according to the LCD and/or NCD. These claims have had manual review completed by the medical review staff. Make sure that you're reviewing your NCD and your LCD policies. Check to make sure that the claims are submitted properly. If the services don't meet covered requirement, make sure that an ABN is submitted.

9. The ninth ranking reason code is a CWF utilization reason code of U5233. This is assigned when there is an overlap with the Medicare advantage health plan or HMO enrollment period. Those receiving a lot of denied claims with reason code 5233 should make sure that you’re checking the beneficiary’s eligibility prior to submitting the claim so that you can bill that to the appropriate entity. A Medicare advantage plan is the patient’s Medicare and you need to submit the claim to the MA Plan for payment. Palmetto GBA is the MAC for traditional fee for service Medicare.

You may use Direct Data Entry, the Interactive Voice Response or the Online Provider Services to check beneficiary eligibility and MA plans. These are three very good self-service tools!

10. The tenth denial reason code is 51MUE. This indicates that the service units are in excess of medically reasonable daily allowable frequency. CMS only publishes some MUE values on its Web site. There are some MUE
values that are confidential and are for the use of CMS and CMS contractors only. Confidential MUE values cannot be released since CMS does not publish them. Available MUEs that CMS publishes may be found on the National Correct Coding Initiatives Edits section of the CMS Web site.

Select claims processed between July 5 and August 7, 2011, incorrectly received service denials with reason code 51MUE/52MUE. However, a fix was installed on January 7, 2013 and all these claims have been adjusted as of January 31, 2013.

**Top Provider Contact Center (PCC) Inquiries**

The Provider Contact Center (PCC) should be utilized as the first point of contact for all provider issues and inquiries. Prior to making contact with other Palmetto GBA departments, it is imperative, per the Centers for Medicare & Medicaid Services (CMS), that the PCC be called first to assist providers. All inquiries are tracked and recorded to ensure quality and ultimately will be used in data analysis to develop training and educational materials for PCC staff and the provider community. The PCC may be contacted for issues related to coverage, claim denials and referrals.

Detailed information which is not provided through the Interactive Voice Response (IVR) unit may also be addressed to PCC, including National Provider Identifier (NPI) issues and system issues not identified on the Claims Processing Issues Log.

To ensure the best customer service to Part A providers, it is recommended that you use the Interactive Voice Response (IVR) unit to request routine claims, beneficiary eligibility and payment information. Use of the IVR allows more time for Provider Contact Center (PCC) representatives to work with providers who have complex claims issues. If you require information that cannot be accessed via the IVR, you may speak with a live representative Monday through Thursday from 7 a.m. to 5 p.m. PT. On Friday, the PCC is available from 7 a.m. to 10 a.m. and 12 p.m. to 5 p.m. The PCC is closed for training and staff development from 10 a.m. to 12 p.m. PT on Fridays.

**PCC Inquiry Reasons**

The J1 Part A Provider Contact Center (PCC) received 20,455 inquiries from December 31, 2012 to January 31, 2013. All call data is stored in the Provider Inquiry Tracking System (ITS) database by category. The ITS data is then used to analyze the number and types of inquiries in order to:

- Generate FAQs to be posted on Web site
- Identify areas for provider education
- General or specific topics
- Design additional tools and self-service resources

Palmetto GBA analyzes the ITS call data on a monthly basis. Top callers are identified with the reason for their call and may be contacted to provide further assistance if trends are identified.
The inquiry data for December 31, 2012 – January 31, 2013 is itemized as follows:

<table>
<thead>
<tr>
<th>Inquiry Reason</th>
<th>Number of Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Information</td>
<td>5,308</td>
</tr>
<tr>
<td>Denial/Reject</td>
<td>7,233</td>
</tr>
<tr>
<td>Claim Status</td>
<td>3,097</td>
</tr>
<tr>
<td>General Information</td>
<td>3,268</td>
</tr>
<tr>
<td>Eligibility</td>
<td>1,549</td>
</tr>
</tbody>
</table>
Identified Website References

Based on the inquiry data, it is recommended that the following web sites be bookmarked to conveniently locate provider specific information.

- Federal Register www.access.gpo.gov
- Palmetto GBA - J1 Part A www.PalmettoGBA.com/J1A
- Centers for Medicare & Medicaid Services (CMS) www.cms.gov
- CMS Internet-Only Manuals www.cms.gov/manuals/iom/list.asp
- National Coverage Determinations (NCDs) www.cms.gov/coverage/
- Medicare Learning Network (MLN) Matters Articles www.cms.gov/MLNMattersArticles
- Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) www.wpc-edi.com/codes
- National Provider Identifier (NPI) https://nppes.cms.hhs.gov/NPPES/Welcome.do
- Freedom of Information Act (FOIA) http://www.cms.gov/AboutWebsite/04_FOIA.asp
- Medicare www.medicare.gov/Default.asp
- Office of Inspector General (OIG) http://oig.hhs.gov/
- Department of Health and Human Services (DHHS) www.dhhs.gov/