Avoiding Outpatient Prospective Payment System (OPPS) Claim Errors

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Agenda

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PART I
COMMON SUBMISSION ERRORS

- 32402 – Invalid HCPCS code and revenue combination
- 32404 – The HCPCS is invalid
- 38031 – Duplicate outpatient claim
- 38038 – Overlapping outpatient claim
- 39012 – Timely filing
- 70007 – Validate units
- N5052 – Beneficiary identification information

32402
Invalid HCPCS code and revenue combination.

To verify and correct the claim:
1. Go to main menu, select “01” and press enter.
2. On the Inquiry Menu select “14” and press enter.
3. Enter the locality code and HCPCS code and press enter.
4. Default to the “main” carrier. Please use the CMS website for pricing information.
5. The appropriate revenue code and/or range will be listed next to the effective date that matches the date of service on your claim. F6 forward for more entries.

32404
The HCPCS code billed is invalid.
Verify the HCPCS code. If a provider feels the code is correct, contact the customer service department with documentation from CMS showing that the HCPCS code is valid.

38031

This outpatient claim is a duplicate to a previously processed outpatient claim. If a claim is receiving this error, the following elements are the same:

- Statement from and through date
- Provider numbers
- Revenue codes
- At least one HCPCS code OR at least one revenue code service date

Verify that claim dates and coding are correct.

If the second claim is a separate and distinct service:

- Report G0 (zero) condition code on the second claim
- Claim will bypass OCE edit

If the second medical visit is not a separate and distinct service:

- Combine with first medical visit claim
- Except services subject to the 3-day payment window

38038

This OPPS claim's date of service is overlapping or on the same day as another processed OPPS claim.

Verify dates and coding are correct. If unable to find the duplicated claim, call customer service for assistance.

- If the second claim is a separate and distinct visit, add a G0 condition code and F9
- If the second claim is not a separate and distinct visit, adjust the paid claim and add the late charges
- If the second claim is a demand bill, add condition code 20 and F9
- If billing for a denial notice for another insurance, add a condition code 21 and F9

39012

The override message for justification reason code 39011, is not formatted correctly or is missing. On page 4 of the claim, enter one of the following messages verbatim:

- Justify: MSP Involvement
- Justify: SSA Involvement
- Justify: PRO Involvement
- Justify: Other Involvement

Remember, the “Justify” message needs to be formatted exactly as above, with no extra spaces, indentions or punctuations, and must start in the very first space, of the first line, of the remarks page.
Effective January 1, 2013, the narrative for 39012 will be changed. The “Justify” messages will be changed as follow:
“MS” instead of Justify: MSP Involvement
“SS” instead of Justify: SSA Involvement
“PR” instead of Justify: PRO Review Involvement
“OT” instead of Justify: Other involvement

70007

Please validate the number of units billed.

When units billed are equal to or greater than 100 or when units for HCPCS J0878/J0583 are equal to or greater than 1000.

- If units are incorrect, correct the units. On the first line of the remarks section, enter verbatim: Units audited and verified, your name and phone number
- If units are correct, update the first line of the remarks section, enter verbatim: Units audited and verified, your name and phone number.
- For providers without access, call the correction line and validate the number of units billed.

N5052

CWF records indicate the beneficiary’s name and health insurance claim number do not match.

Verify the beneficiary information, correct and resubmit if appropriate.

PART II
STRAATEGIES FOR BILLING CORRECTLY

Admission Procedures

When admitting a beneficiary to an inpatient stay:

Verify beneficiary identification.
- Check name against Medicare card – does it match?

Check beneficiary eligibility.
- Part A and/or Part B

Verify if beneficiary has Traditional Medicare or Medicare Advantage Policy.
- Check CWF; check start and termination dates of Medicare Advantage policies

Collect MSP information.
- Administer MSP Questionnaire
- Check CWF for primary insurance information
- COBC with any changes

Coordinate communication between various staff members and departments.
- Admission and billing
• Billing and clinical
• Management

### MSP and COBC

To ensure correct claim submissions and timely payment:
- Collect health insurance information upon each office visit, outpatient visit, and inpatient hospital admission.
- Identify primary payer and bill responsible payer.
- Use specific and correct diagnosis codes, especially for accident related claims.

Report directly to the COBC any changes in MSP related information.
- Work with beneficiary or representative to contact COBC.
- Update with beneficiary in the office. COBC will update information via a telephone call only on the **first** call. No update will be made on subsequent calls.
- Can fax or mail proof of information on the insurer or employer’s letterhead.

### Billing Procedures

Although Part B claims are not required to be billed if no payment is expected from Medicare, it is highly recommended so a timely filed claim is on record in case beneficiary insurance status changes.

Bill claims for repetitive services monthly.

To avoid duplicate errors, verify the claim was entered into the FISS system before resubmitting a new claim.

If a claim was assigned an error code, make the appropriate correction(s). If you are unsure about why the claim received an error, contact Customer Service. Providers without access to DDE can call the Correction Line to have a claim error worked.

When adjusting a claim, make sure to adjust the correct claim. Remember, each adjustment cancels the previous claim on CWF. If unsure of which claim to adjust, contact Customer Service.

### PART III

#### TOP TECHNICAL REJECTION CODES

- **39011** – Claim not submitted timely
- **79994** – Timely filing, no information received from beneficiary
- **7538M** – Diabetes self management training

### 39011

Claim was not submitted timely. Claims with date of service (DOS) on or after 01/01/10 which are received more than 1 year beyond the DOS will be denied as being past the timely filing deadline. Timely filing is counted from the through date on of the claim.
- Most frequent error code
• Cannot be overridden
• Limited exceptions found in IOM

79994

Claim has failed the timeliness of submission edit because Medicare information was not received from the beneficiary.
• Not one of the timeliness exception as outlined in CMS IOM 100-04; Chapter1; Section 70.7

7538M

More than 2 hours of follow-up diabetes self management training paid.
• No advance beneficiary notice given, provider liable.

PART IV
WHAT TO DO WHEN A CLAIM REJECTS OR DENIES

Technical Rejections

A technical rejection is the result of incorrect coding or failing to adhere to Medicare billing regulations. If a claim rejection is received, determine if the claim posted to CWF.
• X in “Tape to Tape” field indicates claim did not post.
• Claim is not recorded in CWF history and cannot be adjusted.
• If claim has not posted to CWF a new claim can be sent with corrections.
• If a rejected claim posted to CWF, to correct the claim, submit an adjustment.
• When adjusting a claim, always use the last DCN processed.
• Bill type changes to a 117
• Use appropriate condition code D0 – D9, or E0
• Use appropriate adjustment reason code.
• Remarks when needed to clarify reason for adjustment

Denials

A denial is a rejection for a medical necessity reason. Denials for medical necessity can be appealed. The appeals process consists of five levels. Each level must be completed for each claim at issue prior to proceeding to the next level of appeal.

A provider may appeal an initial determination only if:
• Items or services are not covered because they are not reasonable and necessary or constitute custodial care.
• Neither the beneficiary nor the provider knew or could reasonably have been expected to know that the services were not covered; and
• The beneficiary has been found not liable for the cost of the service(s) under limitation of liability or indicates in writing that he/she does not intend to request reconsideration of the A/B MAC’s initial determination.
• If the beneficiary appeals the A/B MAC’s initial determination, the provider is made a party to the appeal.
ACRONYMS

• CMS – Centers for Medicare & Medicaid Services
• COBC – Coordination of Benefits Contractor
• CWF – Common Working File
• FISS – Fiscal Intermediary Standard System
• HCPCS – Healthcare Common Procedure Coding System
• MSP – Medicare Secondary Payer
• OCE – Outpatient Code Editor
• OPPS – Outpatient Prospective Payment System
• PRO – Peer Review Organization

RESOURCES & REFERENCES

CMS Website:
http://www.cms.gov/

WPS Medicare Website:
http://www.wpsmedicare.com/index.shtml

To sign up for eNews:

Direct Data Entry (DDE)

Direct online access to Medicare claims. Features claim entry, claim status, eligibility inquiries through Common Working File (CWF), as well as other functions.

J5/J5 National:
http://www.wpsmedicare.com/j5macparta/resources/claims_elig_tools/direct_data_entry/index.shtml

J8
http://www.wpsmedicare.com/j8macparta/resources/claims_elig_tools/direct_data_entry/index.shtml

Interactive Voice Response Unit (IVR)

Quick and easy access to Medicare information 24 hours a day.

J5/J5 National:

J8:
# CMS Secure Net Access Portal (C – SNAP)

Self-service source for patient eligibility, claim status and more.

**J5/J5 National:**
http://www.wpsmedicare.com/j5macparta/resources/claims_elig_tools/csnap/index.shtml

**J8**
http://www.wpsmedicare.com/j8macparta/resources/claims_elig_tools/csnap/index.shtml

## Customer Service

Available for complex claim inquiries regarding Medicare coverage, billing and claim processing.

**J5/J5 National:**

**J8:**

## OPSS Billing

CMS Internet – Only Manual  
Publication 100 – 04, Claims Processing Manual, Chapter 4  

## Timely Filing

CMS Internet – Only Manual  
Publication 100 – 04, Claims Processing Manual, Chapter 1, Section 70  

## Diabetes Self-management

CMS Internet – Only Manual (IOM)  
Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 300  

## Medicare Secondary Payer Billing

CMS Internet – Only Manual (IOM)  
Publication 100 – 05 Medicare Secondary Payer Manual, Chapter 3  
• Section 40 – Completing the Form CMS – 1450 in MSP Situations by Provider of Service
• Section 50 – Summary of MSP Data Elements for Form CMS – 1450

MLN Matters Number SE1205 – Updating Beneficiary Information with the Coordination of Benefits Contractor

MLN Matters Number SE1217 – Guidance for Correct Claims Submission When Secondary Payers are Involved

This program is presented for informational purposes only.

Current Medicare regulations will always prevail