Medicare 2018 - National Government Services, the Jurisdiction K (JK) Medicare Administrative Contractor

Reducing Provider Burden

Today's Presenter

- Jeanine Gombos LPN, CPC
  - Provider Outreach and Education Consultant

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  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- Review top reasons for claim rejection, RTP and denial
  - JK Part A claims processed December 2017
- Introduce provider job aids and self-service options to resolve/avoid claim errors
- Review Targeted Probe and Educate Strategy and the NGS Medical Review Process

Agenda

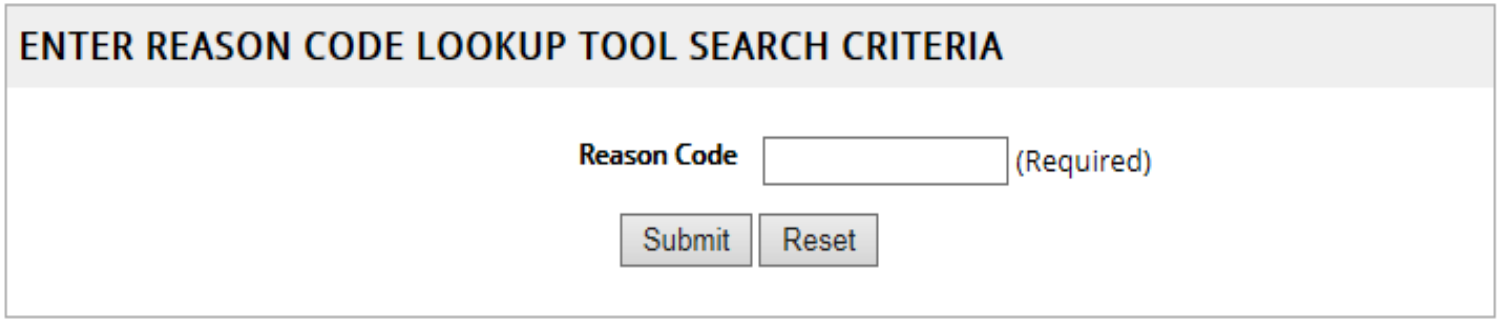
- Top five claim rejection, RTP and denial reason codes
  - Reason code look up tool
  - Provider job aids
- Targeted Probe and Educate
  - History
  - Changes in medical review process
- Provider notification
- Phases of medical review process
  - Data analysis
  - Validation
  - Calculations
  - Detailed provider results letter

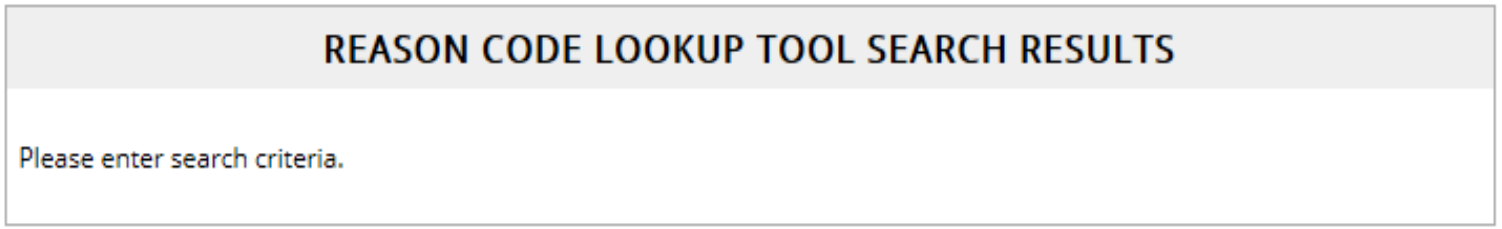
New Reason Code Look Up Tool

- Providers can now look up the top claim errors using the new reason code look up tool
  - https://www.NGSMedicare.com > Provider Resources > Calculators & Tools > Reason Code Look Up Tool for Top Claim Errors

REASON CODE LOOK UP TOOL FOR TOP CLAIM ERRORS

The Reason Code Look Up Tool for the Top Claim Errors is available for our providers to search for common claim error reason codes including denials, rejections, and RTPs. To use this tool simply key the five digit claim/line level reason code in the search box below and press **Submit**. If the reason code is part of our top claim errors, you will see the description of the reason code, tips to correct the error, tips to avoid this error in the future, and any related resources to assist you with avoiding this error, as applicable.

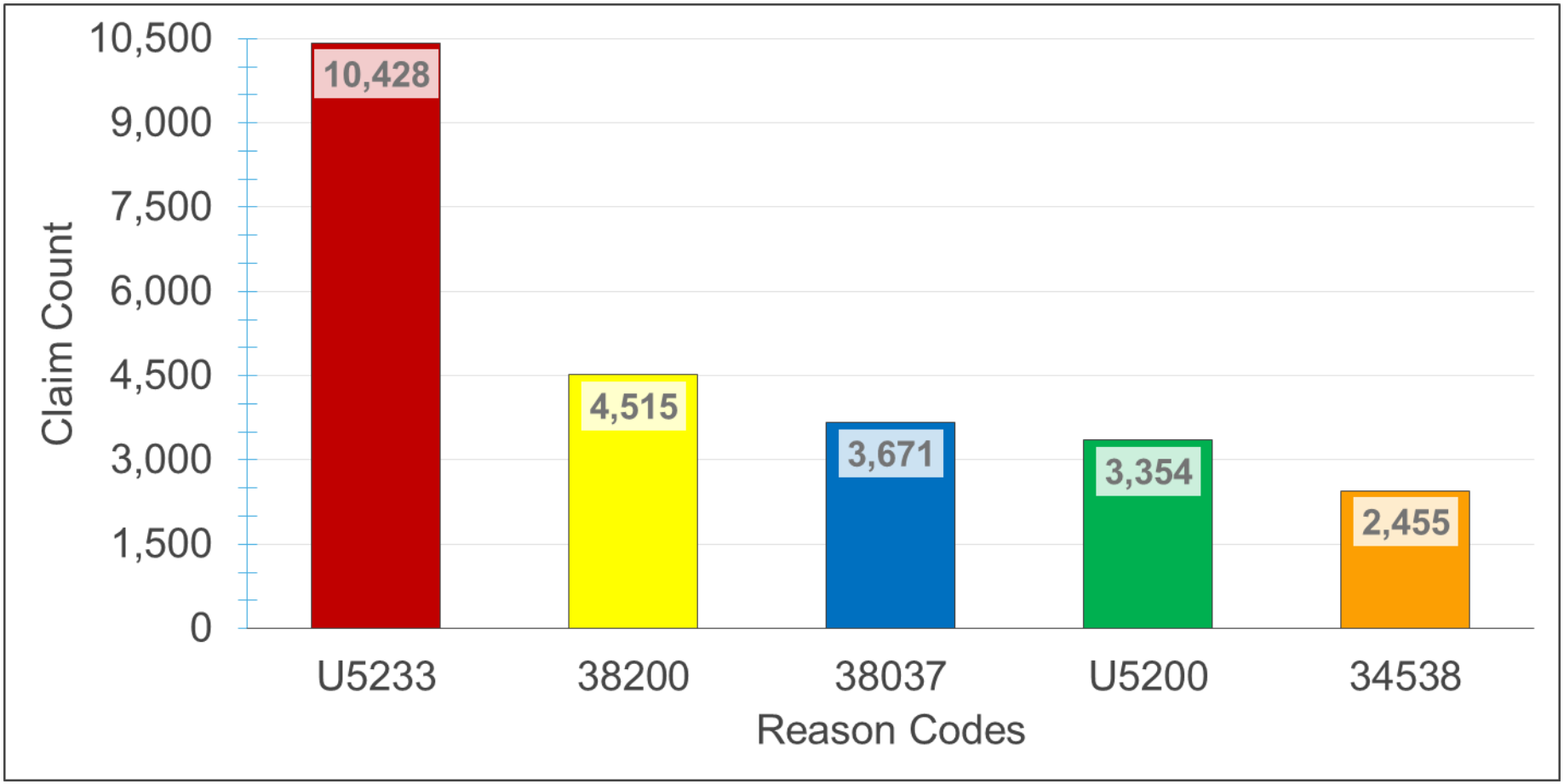




Provider Outreach and Education Reason Code Reduction Initiative

- Initiative to assist providers with reducing claim denials, rejections and RTPs
- Data on top 10 reason codes compiled and top providers identified for each on ongoing basis
  - Monthly – Compliance officers contacted with information about reason code(s)
  - Every six months – Individual education offered for providers with high occurrences of identified reason code(s)

Top Five Rejection Reason Codes December 2017



Rejection U5233

- Services on this claim fall within or overlap a Medicare Advantage (MA) health maintenance organization (HMO) enrollment period
- For inpatient Prospective Payment System (PPS) claims, the admission date falls within the HMO enrollment period

Avoiding U5233

- Verify HMO/MAO enrollment prior to claim submission by reviewing CWF, IVR system and FISS/DDE or NGSConnex
- Outpatient facilities billing services within an HMO enrollment period should submit services to appropriate HMO only, not to the MAC
- IPPS hospitals, IPFs, IRFs and LTCHs billing inpatient services within an HMO enrollment period before billing the MAC

Rejection 38200

- This claim is an exact duplicate of a previously submitted claim
- The following fields on the history and processing claim are the same:
  - Health Insurance Claim number (HICN), type of bill, provider number, statement from and to date of service, total charges, revenue code, HCPCS and modifiers

Avoiding 38200

- Verify the status of a submitted claim before submitting another claim by using the IVR system, FISS/DDE or NGSConnex online portal
  - If duplicate submitted in error and one claim paid, no additional action required
  - If duplicate submitted in error and both claims rejected, resubmit one claim
  - If duplicate submitted to provide additional information or to change original claim, adjust original finalized claim. (must appear on your remittance)

Rejection 38037

- This outpatient claim contains service dates that equal or overlap a previously submitted outpatient claim for your facility
- At least one of revenue codes or the HCPCS codes match

Avoiding 38037

- All charges for a DOS should be submitted on one claim. Prior to submitting, ensure you have received charges from all departments so you can submit one claim with all services rendered
  - If duplicate claim submitted in error and one of the claims paid, no additional action required
  - If both claims rejected: If appropriate, make corrections and resubmit the claim or file the appropriate adjustment claim

Rejection U5200

- CMS records indicate that the beneficiary is not entitled to Medicare coverage for the type of services billed on the claim. Therefore, no Medicare payment can be made.

Avoiding U5200

- Use the IVR system or FISS/DDE Provider Online System or NGSConnex to verify beneficiary eligibility prior to claim submission
  - Providers should not call NGS Customer Care to obtain eligibility information

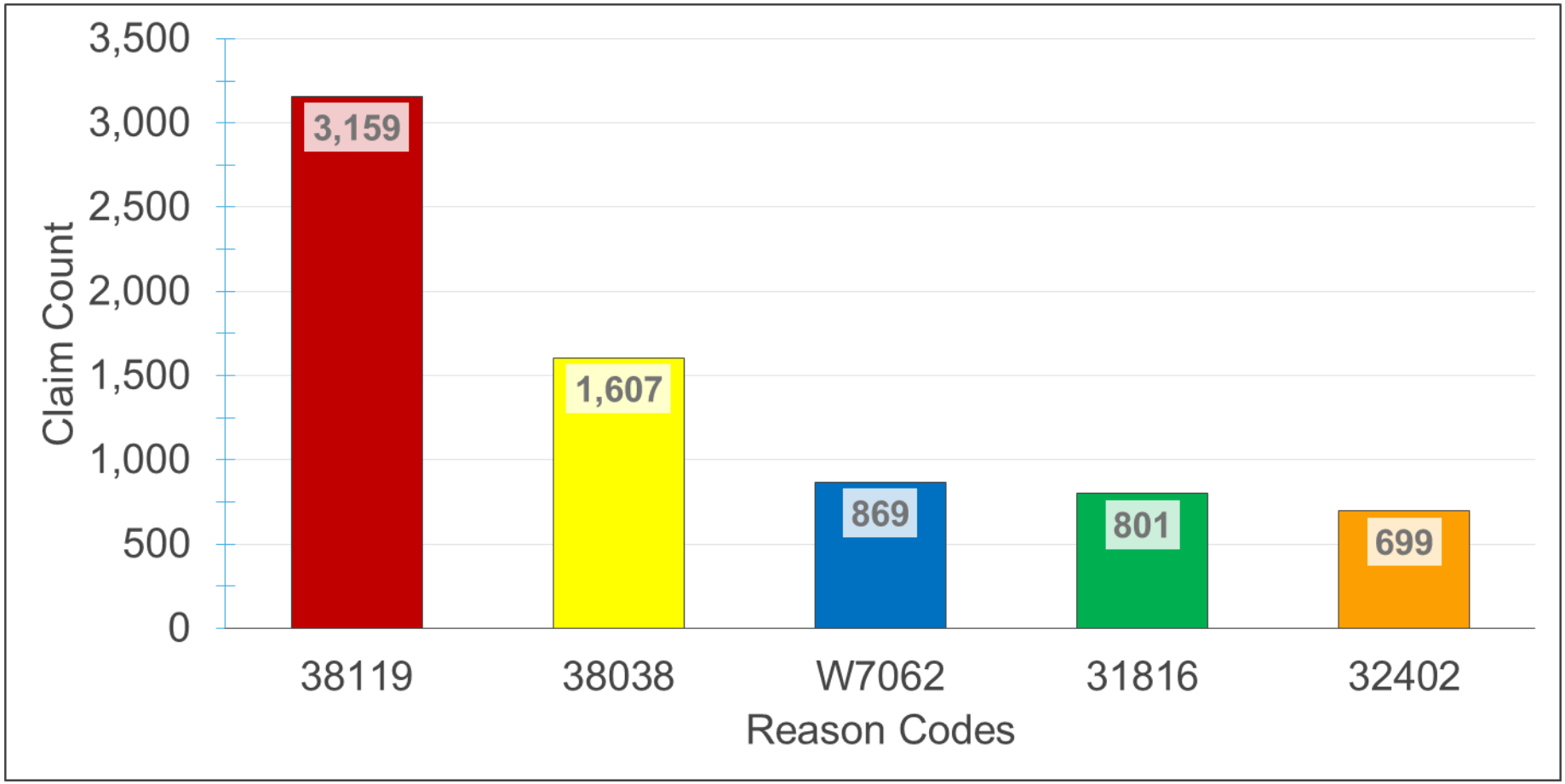
Rejection 34538

- The claim was submitted as Medicare primary and a positive MSP working aged record exists at CWF (MSP Value Code= 12/Primary Payer Code = A)

Avoiding 34538

- Determine appropriate primary payer for services prior to billing the claim
- If you determine another payer is primary to Medicare, bill that plan as primary before billing Medicare as secondary
- If you determine Medicare is primary but there is a MSP Working Aged record in CWF, contact the BCRC to have that record corrected
  - Follow guidelines in MLN Matters article #SE1416 for contacting the BCRC.
  - You may need to fax the BCRC documentation at 405-869-3307

Top Five RTP Reason Codes December 2017



RTP 38119

- Effective with admissions on and after 4/1/1995, all inpatient SNF and non-PPS bills must be processed in sequence

Avoiding 38119

- SNF claims must be submitted in date of service order
  - Verify HICN prior to claim submission
  - Compare the beneficiary's Medicare card to information on file
  - Use the IVR system or the FISS/DDE Provider Online System or NGSConnex to verify beneficiary name, HICN, and eligibility prior to claim submission

RTP 38038

- For dates of service on or after 7/31/2000, whether any revenue code lines are equal or not, OPPS bill types (12X, 13X, 14X, 76X, 75X, 34X, or any bill containing condition code 07) cannot have overlapping dates when the provider numbers are equal, unless condition code G0 or 20 or 21 is present on the claim

Avoiding 38038

- Check OPPS claims for potential overlapping dates of service prior to claim submission and bill accordingly by submitting an adjustment bill

RTP W7062

- This **c**ode is not recognized by OPPS; an alternate code for the same service may be available.

Avoiding W7062

- Medicare has assigned each HCPCS/CPT code a letter that signifies whether Medicare will reimburse the service and how it will be reimbursed
  - The indicator assigned will determine what policy rules such as packaging and discounting, will apply
  - The status indicator is located on the processed claim on FISS DDE claim page 2 (f11 line item detail) under OCE flags
- Payment status indicator B indicates that a code is not recognized by the OPPS
- Verify that the code being billed is reimbursable under the OPPS.
  - Refer to the appropriate OPPS Addendum B for status indicator listings by HCPCS

RTP 31816

- Claim reports a therapy evaluation/re-evaluation code without a G-code and/or modifier

Avoiding 31816

- Verify billing, make any necessary corrections, and resubmit the claim
- Providers who submit claims for outpatient therapy services should report the current and projected goal status for each of the G-codes at:
  - Onset of a therapy episode of care
  - Every 10th treatment day
  - Discharge
    - Goal and discharge status when the patient is discharged or to end the functional limitation

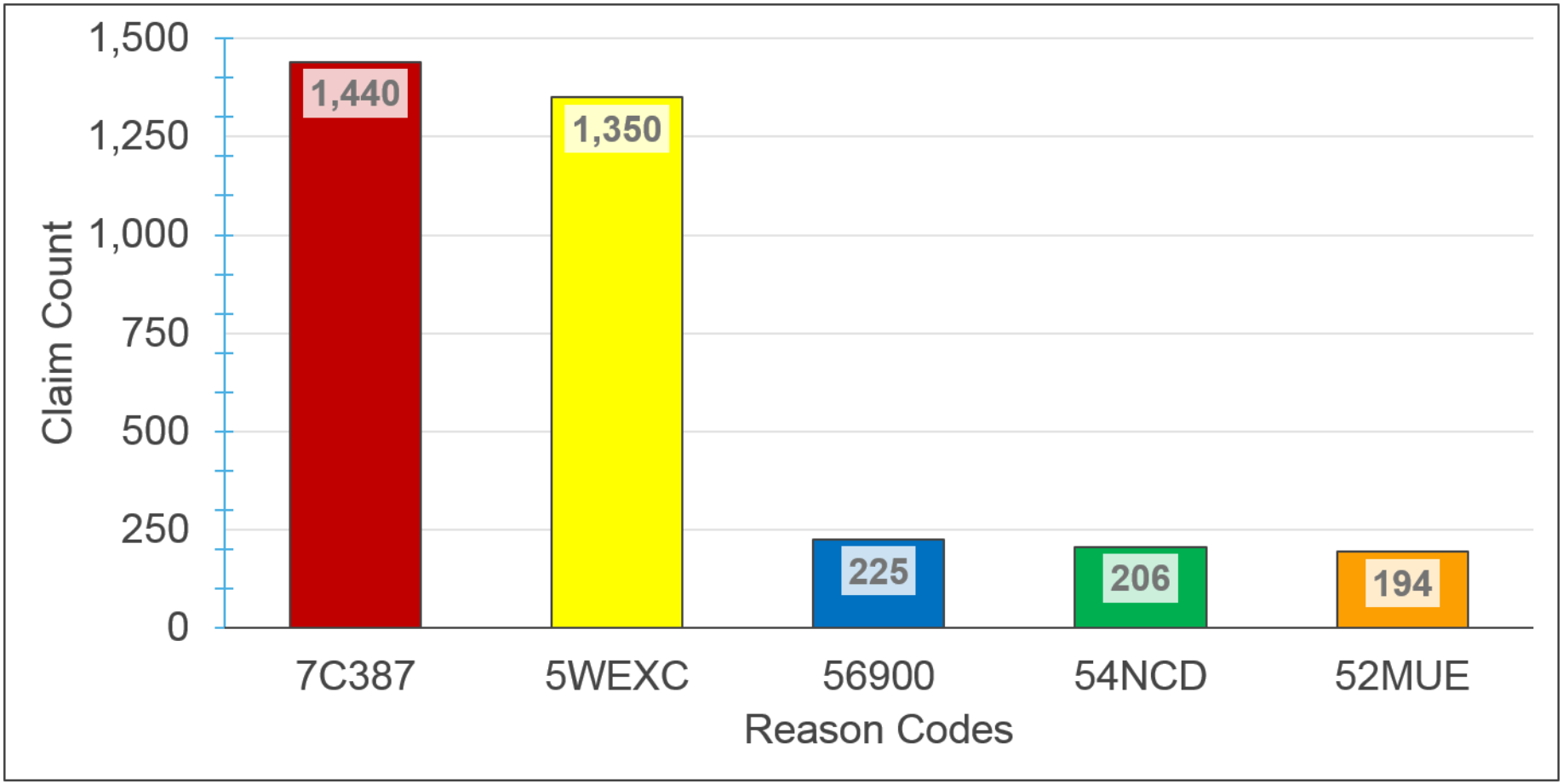
RTP 32402

- The HCPCS code(s) reported on this claim have not been billed with a valid revenue code for the dates of service

Avoiding 32402

- Provider may verify revenue codes/HCPCS code in the FISS DDE Online System by accessing menu option “01” Inquiries Menu and (13) Revenue code file and (14) HCPCS file
  - Verify the HCPCS code(s) billed
  - Verify the revenue code(s) billed
  - Verify the ‘FROM’ and ‘THROUGH’ dates

Top Five Denial Reason Codes December 2017



Denial 7C387

- Unacceptable ICD-10 principle diagnosis code for dental services

Avoiding 7C387

- Medicare coverage for dental services is very limited
- If you disagree with the denial, you have the right to appeal. If additional medical circumstances exist, or if there is a more specific diagnosis code, indicate the appropriate diagnosis code(s) for the claim(s) on appeal.

Denial 5WEXC

- As submitted, this claim does not qualify for Medicare payment due to the principal diagnosis code supplied. If additional medical circumstances exist, or if there is a more specific diagnosis code, indicate the appropriate diagnosis code(s) for the claim(s) on appeal.

Avoiding 5WEXC

- If you disagree with the denial, you have the right to appeal. If additional medical circumstances exist, or if there is a more specific diagnosis code, indicate the appropriate diagnosis code(s) for the claim(s) on appeal.

Denial 56900

- This claim is denied for payment because the provider failed to submit documentation requested by the intermediary within 45 days

Avoiding 56900

- Ensure timely and complete responses to all requests for medical records
- Providers with access to the Direct Data Entry (DDE) System should regularly access claims in status locations S B6001, S B6098, or S B6099 to obtain a listing of claims for which records have not yet been received by the Fiscal Intermediary (Medical Review Department)

Denial 54NCD

- Line level reason code to indicate that none of the diagnosis codes on the claim support the medically necessity of the services. Service denied and the provider is liable.

Avoiding 54NCD

- Ensure all Medicare coverage and medical necessity requirements are met prior to billing.
  - If the provider determines that Medicare will not cover the services, consider submitting the charges as noncovered
- Visit the CMS Medicare Coverage Database (MCD) to review the NCDs and LCDs to determine the diagnosis that are covered for the services provided
  - https://www.cms.gov/medicare-coverage-database
- Review the information on the Appeals tab for information related to submitting an adjustment to correct claims partially denied by automated LCD/NCD denials
  - https://www.ngsmedicare.com

Denial 52MUE

- Beginning with dates of service on or after 10/01/07; it has been determined that all the line items on the claim have units of service in excess of the medically reasonable daily allowable frequency
- Excess charges due to units if service greater that the maximum allowable may not be billed to the beneficiary and this provision can neither be waived nor subject to an ABN

Avoiding 52MUE

- Providers should review the information on the CMS website for Medically Unlikely prior to claim submission.
  - If the units rendered are in excess of the allowed units for that service, consider whether the excess units were actually rendered and billed correctly.

New Medical Review Strategy: Targeted Probe and Educate

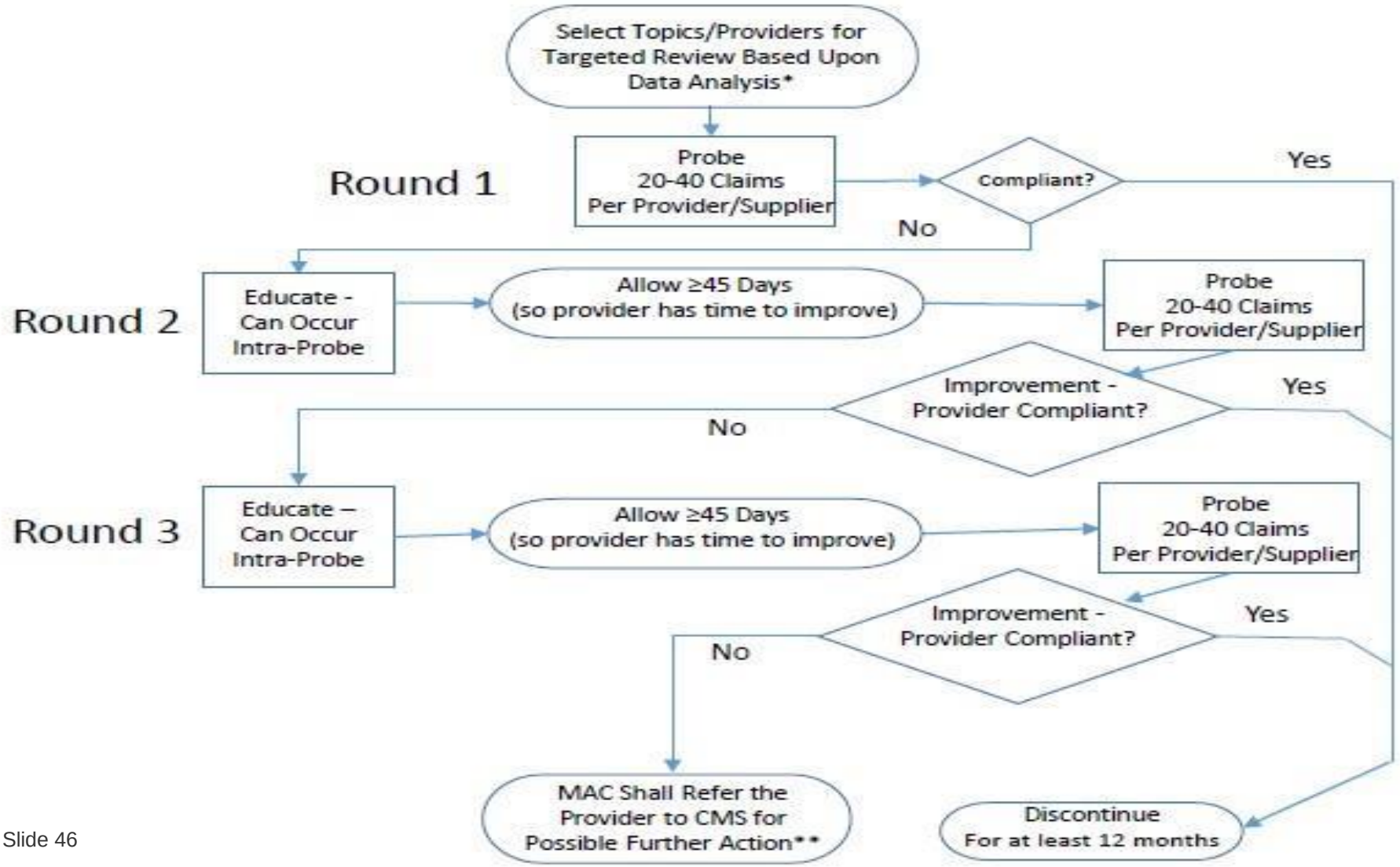
Objective for Medical Review Activities

- Objectives of a medical review is to:
  - Identify and prevent inappropriate payment
  - Identify potential risk to the Medicare trust fund
  - Educate providers
  - Appropriately pay for covered services
- Medical review meets these objectives through medical review activities

Medical Review Process Change

- The medical review process will move from a progressive corrective action (PCA) process to Targeted Probe and Educate (TPE)
  - Effective date of change is 10/1/2017
  - All lines of business
- TPE
  - History
    - Demonstration projects for inpatient services and home health
    - Proved successful in lowering providers payment error rates
    - This new model will change some of the process but not affect policy and procedures

Targeted Probe & Educate



Additional Development Requests

- Providers will continue to receive additional development requests (ADRs) in the same manner as prior to TPE
  - Part A via
    - DDE access
    - U. S. Mail
  - Part B via
    - U.S. Mail

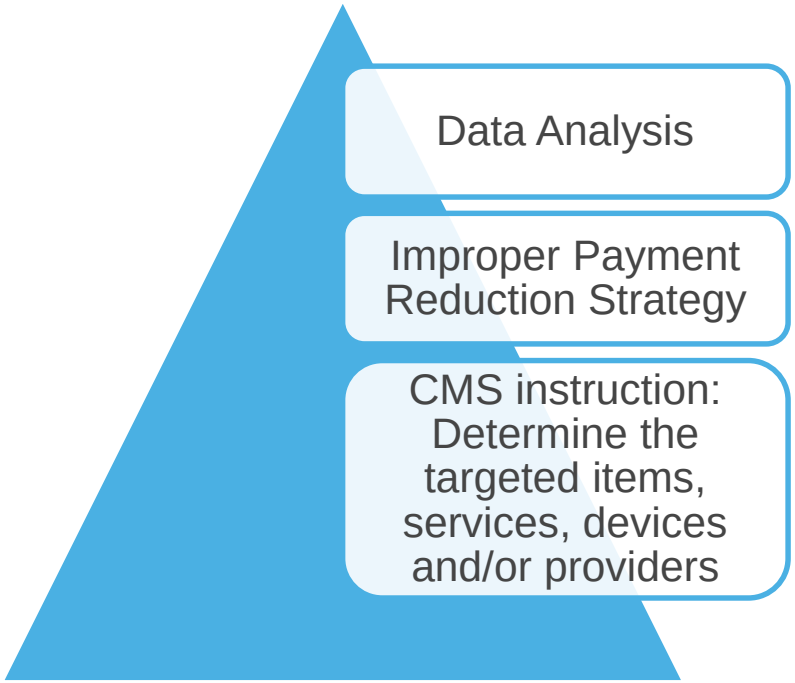
Moving from a Demonstration Project to Targed Probe and Educate

- Changes in the Probe and Educate from the Demonstration projects for HH and inpatient services
  - MACs will select the area of review based on existing data analysis procedures
    - CMS selected the area of review during the demonstration projects
  - MACs can target the providers based on data rather than perform a 100% review of all providers
    - All providers were subject to review during the demonstration project
  - MACs will perform prepay reviews
  - MACs will request between 20 -40 claims for probes and each additional round of review
  - Education between each round of review will be a primary focus
  - Education may occur during the review process when the medical team deems necessary

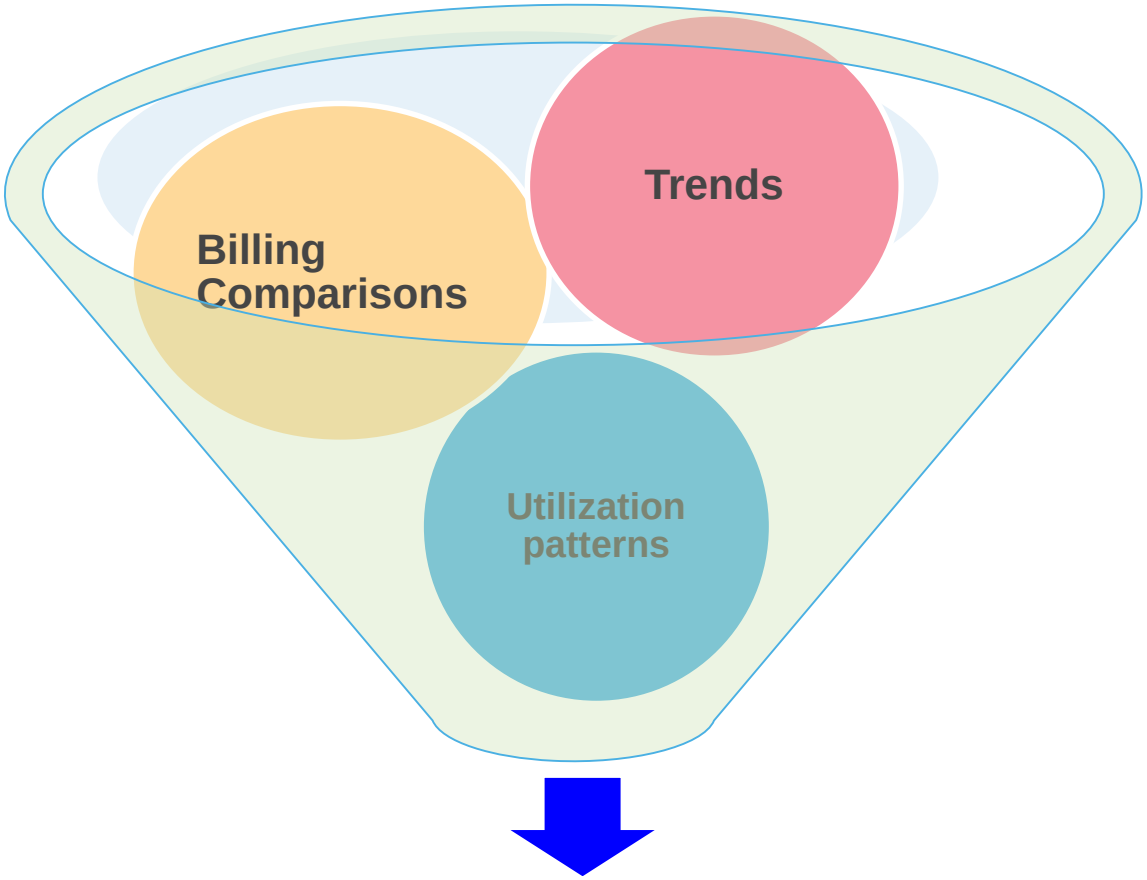
Changes in the Medical Review Process

- The process for selecting and conducting medical review has changed slightly
- Changes:
  - Set number of claims to be reviewed during each round of medical review with decision analysis and results notification at conclusion of each round
    - The previous PCA process allowed advancement of review activities to progress to percentages of all claims submitted. Education will occur prior to the 2nd and 3rd round of review
    - Opportunity for intra-round education if the nurse reviewer identifies a common theme that can easily be corrected during the review phase
    - Providers will have 45-56 days after the education before the next round of records will be requested

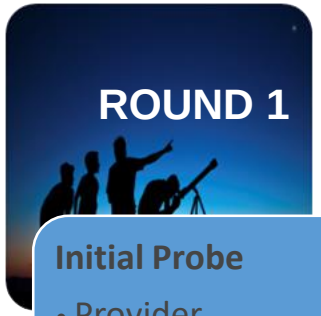
How will Review Areas Be Selected?



Data Analysis

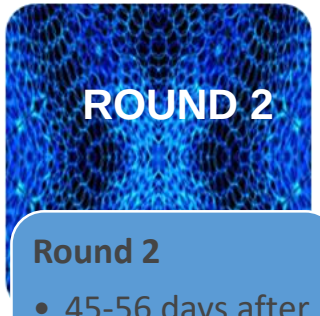


TPE Process



Initial Probe

- Provider notification
- ADR request
- Validation
- Calculation
- Results letter
- Education



Round 2

- 45-56 days after education – ADRs
- Validation
- Calculation
- Results letter
- 1:1 education

Round 3

- 45-56 days after education – ADRs
- Validation
- Calculation
- Result letter
- Referral (if applicable)

CMS

CMS Corrective Actions

- Extrapolation
- Referral to ZPIC, UPIC or RAC
- 100% prepay review
- *list not all inclusive

National Government Services

Initial Probe

- During the initial (round 1) probe providers can expect:
  - Provider Notice of Review – Targeted Probe and Education includes:
    - Reason for review
    - Request of between 20-40 claims
    - Do not send any documentation in response to this notification
    - Facility will be notified via ADR letter on each claim selected for review
      - ADRs will be generated per the usual process
    - Non-responders could be referred to the RAC, ZPIC, or UPIC
    - Medical review will review documentation within 30 days of receipt
    - Provider results letters will offer 1:1 education
      - Follow directions provided in the letter to request education
  - Automated reviews and prior authorizations are not part of the TPE program

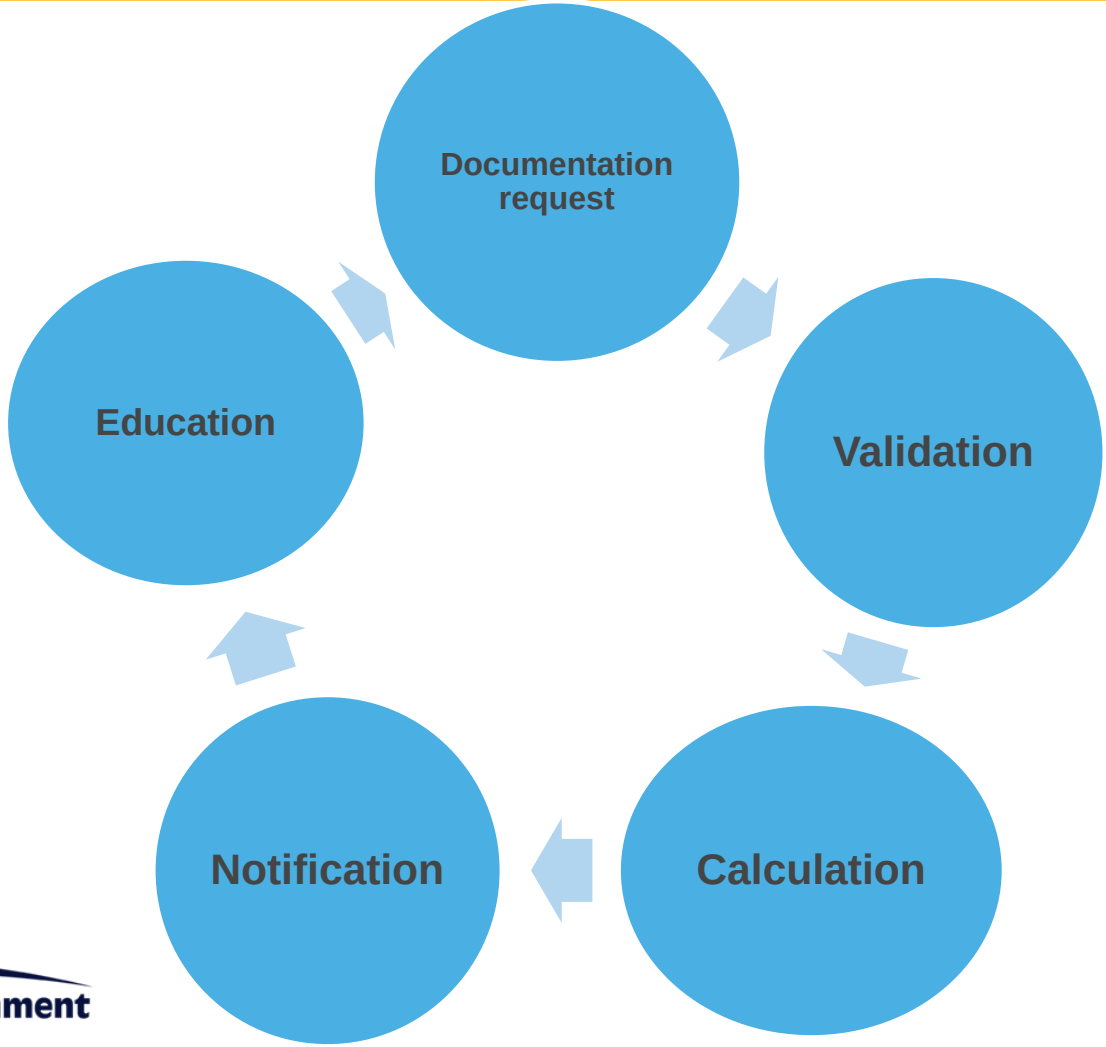
Additional Rounds of Review

- TPE consists of three rounds, if the provider continues to have a high payment error rate:
  - Round 1 (Initial Probe)
  - Round 2
  - Round 3
- Additional rounds of review will include:
  - 1:1 education with medical review after each round of review
  - Additional development request approximately 45-56 days after the education is complete
  - Detailed results letter

CMS Referral

- After three rounds of review and continued high denial rates CMS may instruct the MAC for additional action which might include:
  - Extrapolation
  - Referral to the Zone Program Integrity Contractor (ZPIC) or Unified Program Integrity Contractor (UPIC)
  - Referral to the Recovery Audit Contractor (RAC)
  - 100 % pre-pay review

Process for Each Round



Documentation Request

- Round/Probe
  - ADR between 20-40 claims from the provider
    - Provider notification letter will advise your agency of how many claims will be requested
  - Provider has 45 days to respond to the contractor with medical records
    - This includes mail time and contractor processing time to a medical review location
    - Highly recommend as an internal best practice of sending documentation **within 30 days**
  - No response counts as an error

Validation Phase

- Medical review of records for:
  - Technical components
    - Physician Certifications
    - Physician orders
    - Beneficiary election statements
  - Eligibility
    - Medicare coverage guidelines
    - Medical necessity
    - Documentation supports the services billed

Calculations

Payment Error Rate

- Payment / payment denied
- 1,000 /500 = 50% PER

Claims Error Rate

- # of claims/ claims in error
- 10 claims/ 5 claims denied = 50% CER

Calculations

- Medical review will calculate the providers payment error rate based on the payment determination made in medical review
- Payment error rates will not be adjusted based on the outcomes of the appeals process
  - Additional documentation is often received at the time of appeal that was not available at the initial medical review level
  - *This is not a change from current medical review process

Detailed Provider Results Letter

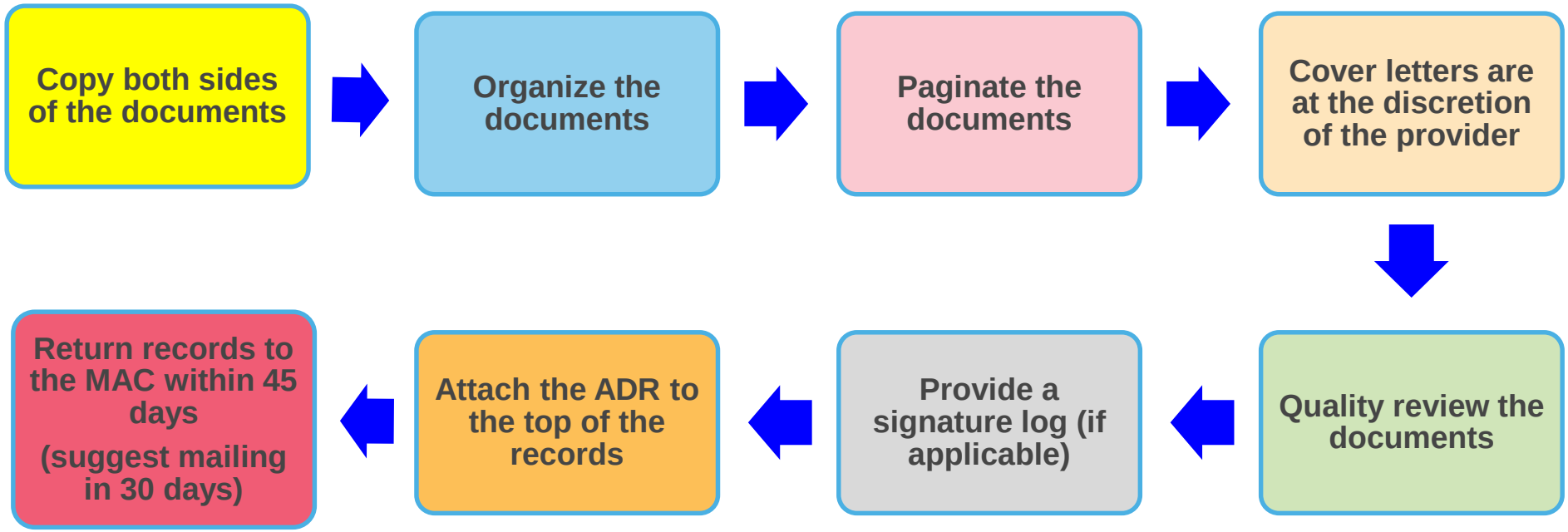
- Detailed results letter at the conclusion of each round will include:
  - Outline the targeted probe & educate process
  - Reason for denials including the Medicare regulations
  - Denial rates (PER)
  - Release or retention from medical review
    - PER of less than 15% in order to be released from additional rounds of review
  - 1:1 education information
- Read the letter in its entirety for important information regarding additional rounds of review

Record Preparation

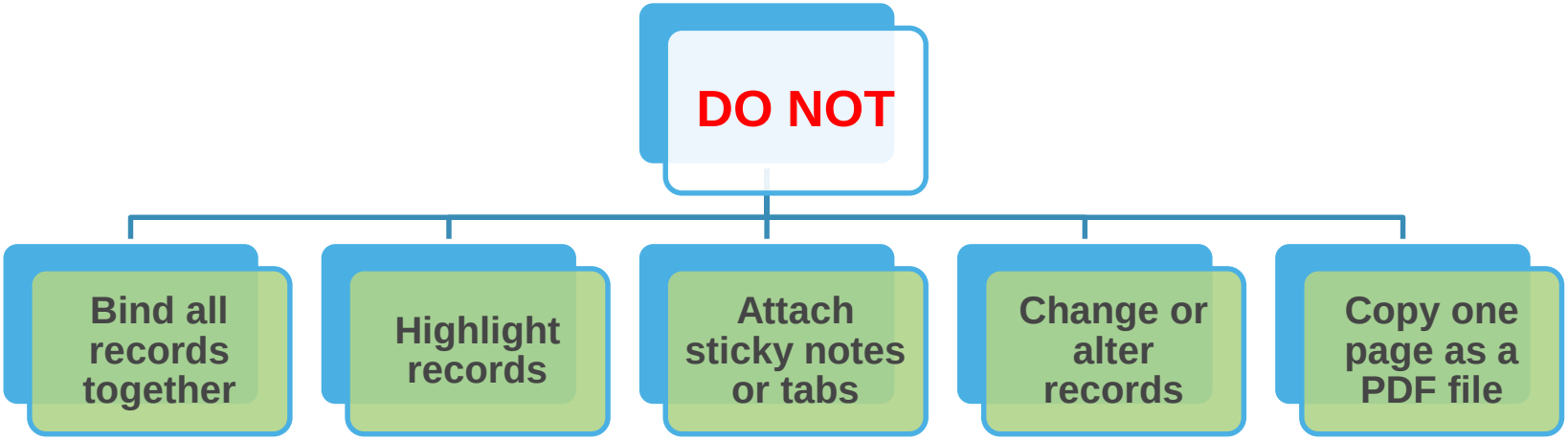
Additional Documentation Request (ADR)

System issues an ADR	• Claims suspends to status location SB 6001 • ADR is sent to provider • Provider has 45 days to return records to the MAC
Records are NOT received by day 45	• On day 46 the system will deny the claim moving it to a status location of DB 9997 • Reason code 56900
Wait one week and recheck status location	• If the records were received the claim will move to status location SM 5REC • Denied after one week, call customer care for assistance

Preparing your Documentation



Preparing Your Documentation



How to Submit Your Records to J6 NGS

J6 Part A:

National Government Services Inc.

P.O. Box 6474
Indianapolis, IN 46206-6474

J6 Part B:

National Government Services Inc.

**P.O. Box 6475
Indianapolis, IN 46206-6475**

J6 Part A & Part B:

National Government Service Inc.

8115 Knue Road
Indianapolis, IN 46250

ATT: Mail and Distribution

*Add/insert the operational area to be scanned

J6 Part A & Part B:

NGSConnex

J6 Part A:

FAX #: 315-442-4154

J6 Part B:

FAX#: 315-595-4364

Always Check **www.NGSMedicare.com** for the most current information

How to Submit Your Records to JK NGS

JK Part A:

National Government Services Inc.

P.O. Box 7108
Indianapolis, IN 46207-7108

JK Part B:

National Government Services Inc.

P.O. Box 7108 Indianapolis, IN 46207-7108

JK Part A & Part B:

National Government Service Inc.

8115 Knue Road
Indianapolis, IN 46250

ATT: Mail and Distribution

*Add/insert the operational area to be scanned

JK Part A & Part B:

NGSConnex

JK Part A:

FAX #: 315-442-4390

JK Part B:

FAX#: 315-442-4231

Always check **www.NGSMedicare.com** for the most current information

Appealing a Medical Review Decision

- With the implementation of targeted probe and educate, the process for appeal has not changed
  - First level of appeal is the redetermination level
  - 120 days from date of receipt of the initial determination notice
  - May file an appeal via:
    - NGSConnex
    - Mail
- Reminder: To ensure a timely request for an appeal, do not wait for the results letter to submit the appeal request!

You Tube Video

- NGS YouTube Video: *Targeted Probe and Educate (TPE) Medical Review Strategy*
  - Six-minute YouTube video to learn about the new Targeted Probe and Educate (TPE) Medical Review Strategy
- Did you know that NGS has created many helpful videos on a variety of topics?
  - NGS YouTube home page
  - NGS You Tube video list

References and Resources

- https://www.NGSMedicare.com
  - Provider Resources > Calculators & Tools > Reason Code Look Up Tool for Top Claim Errors
  - Education > Job Aids & Manuals
    - Manuals > Fiscal Intermediary Standard System Direct Data Entry Provider Online Guide
    - Claims, Billing and Payment
    - Preventing Reason Codes
  - Claims & Appeals > Medicare Secondary Payer

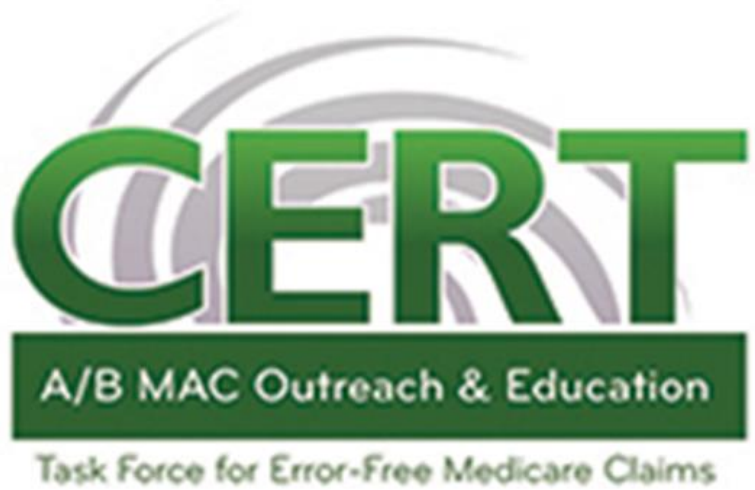
Resources

- Part A Medical Review article: "Important Information and Instructions for Responding to Additional Development Requests"
- Part B NGSConnex User Guide: "View/Search for MR ADR Submission Documents"
- NGSMedicare.com > choose contract > Medical Policy & Review tab > Medical Review > Targeted Probe and Educate
- Change Request 10249, "Targeted Probe and Educate," effective 10/1/2017

Resources

- CMS website:
  - Targeted Probe and Educate (TPE)
  - "Reducing Provider Burden"
  - CMS TPE Flow Chart

CERT A/B MAC Outreach & Education Task Force



CERT A/B MAC Outreach & Education Task Force

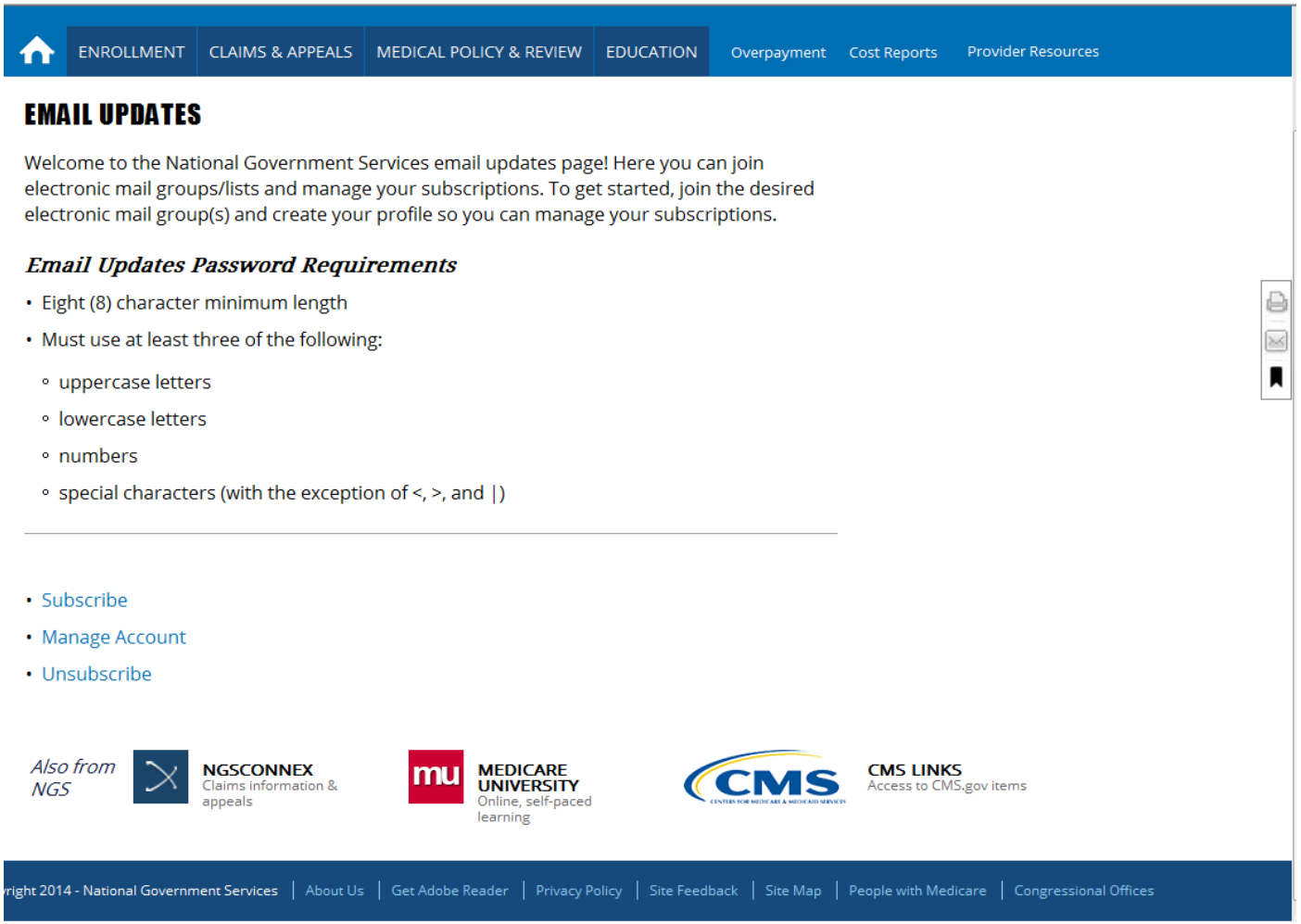
- The goal of the A/B MAC Outreach & Education Task Force is to ensure consistent communication and education to reduce the Medicare Part A and Part B error rates.
  - A joint collaboration of the A/B MACs to communicate national issues of concern regarding improper payments to the Medicare Program.
  - Partnership to educate Medicare providers on widespread topics affecting most providers and complement ongoing efforts of CMS, the MLN and the MACs individual error-reduction activities within its jurisdictions
- **Disclaimer:** The CERT A/B MAC Outreach & Education Task Force is independent from the CMS CERT team and CERT contractors, which are responsible for calculation of the Medicare fee-for-service improper payment rate.

CERT A/B MAC Outreach & Education Task Force

- CMS works closely with the CERT A/B MAC Task Force and the CERT DME MAC Outreach & Education Task Force
  - CMS has a web page dedicated to education developed by the CERT A/B MAC Outreach & Education Task Force
    - https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/CERT-Outreach-and-Education-Task-Force.html
- NGS CERT Task Force Web Page
  - Go to our website, https://www.NGSMedicare.com; in the **About Me** drop down box, select your provider type and applicable state, click on **Next, accept** the **Attestation.** Choose the **Medical Policy & Review** tab, then choose **CERT**, the **CERT Task Force** link is located to the right of the web page.

Email Updates

- Subscribe to receive the latest Medicare information.



Website and Portal Satisfaction – We Value Your Feedback

Medicare University

- Interactive online system available 24/7
- Educational opportunities available
  - Computer-based training courses
  - Teleconferences, webinars, live seminars/face-to-face training
- Self-report attendance
- Website
  - http://www.MedicareUniversity.com

Thank You!

- Questions?