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Top 10 Claim Submission Errors, Denials, and FAQ's Ask-the-Contractor Teleconference (ACT) Minutes

January 15, 2009

Chairperson: Serita Hammel

The Central Region, "Top 10 Claim Submission Errors, Denials, and FAQ's" Ask-the-Contractor Teleconference (ACT) was called to order by Serita Hammel, Medicare Outreach Analyst – Omaha Office, at 1:30 PM Central Time.

Serita began the teleconference by introducing herself. She was joined by other Outreach Analysts and members of the Provider Outreach and Education staff. Participants were encouraged to sign up for the WPS and CMS electronic mailing lists at that time. The introductory discussion was followed by a review of the handouts that had been e-mailed to the registered teleconference participants prior to the call. Providers were notified of the Top 10 Claim Submission Errors, Denials, and FAQ's. Providers were also notified about updates that occurred on 01-15-2009, the date of the call. Providers were advised that the FISS system was experiencing system problems with OPPS outlier calculations and as a result, CMS has instructed Fiscal Intermediaries to hold OPPS claims with reason code OPPS1 that were received on or after 01-01-2009 until the system is corrected. Also, another issues was reported on 01-15-2009 with code Q3014 for Tele Health Originating Site Facility Fee for 22X, 23X, 72X, 76X types of bills (TOB) and an issue has been identified through testing. Claims will be held with HCPCS code Q3014 until a fix to the system is received and these claims will be held until then.

I have included the questions that were asked during the seminar and provided the answers below. Providers were advised to provide any beneficiary specific questions via fax to my attention and that I will work with them individually.

Q1. Why are claims being inactivated that are in an IB9997 status? Can those inactivated claims being retrieved?

A1. There are two situations in which a claim will be inactivated:

- The first way is if you have a claim returned back to you in status location TB9997 editing for the same reason code for three times. The system will automatically inactivate the claim. Claims that have been inactivated cannot be retrieved. You can correct and resubmit the claim. You can see inactivated claims in DDE.
- The second way is if a claim sits in a TB9997 for longer than 60 days and has no activity the system will automatically inactivate the claim. The claim cannot be retrieved once the claim has been inactivated. You can resubmit a new claim. You can see inactivated claims in DDE.

Q2. If a patient comes to the emergency room twice on the same day once in the morning for chest pain and once in the afternoon for abdominal pain, should the G0 modifier be appended to the second claim?

A2. Yes, these procedures are distinct and separate.

Q3. If a patient came in for chest pains twice in the same day, would the G0 modifier be appropriate?

A3. In this circumstance, the claims must be combined because the patient came in for the same reason G0 modifier would not be applicable in this situation.



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Q4. If a Patient Discharges and then readmits during the same month, do I have to wait until the 214 type of bill processes to send my 212 type of bill?

A4. No, if the admit date on the 212 type of bill is different from the 214 type of bill.

Q5. A question was asked in regards to high dollar benefit exhaust claims.

A5. Provider was advised to submit examples of claims outside of the call. We will work individually with this provider outside of the call.

Q6. When do I have to submit my no pay bill?

A6. You should submit the no pay monthly if a denial is needed for another insurer or you may submit the no pay upon discharge.

Q7. If you have two visits in one day that were distinct visits, but both had labs, is the only way to bill this claim is by combining the claim?

A7. Provider was advised to submit examples of claims outside of the call. We will work individually with this provider outside of the call.

Q8. How do I process my claims if there are three ER visits on the same day?

A8. This is correct if there are three distinct and separate ER visits on the same day, you will need to combine two of the visits on one claim. Have this claim process, then send the third visit on a separate claim with the G0 condition code.

Q9. My facility was coming off a ban and billing some days as covered and some days as non-covered. I would go to update the claims, but the claim would be in a TB9997 status. The system was stating that covered days and non-covered days didn't add up, but the system was plugging in the non-covered days as covered. The correction line tried to fix it, but it will not process. What should we do?

A9. If you are on a ban, you have to split your claim from your payable days.

Q10. We are doing an adjustment because our claim is in a TB9997 and the system states that there are no remarks, but there clearly are remarks.

A10. An adjustment should not be submitted on a claim that is in a T B9997 status location. This claim can be corrected by the provider. Provider was advised to submit examples of claims outside of the call. We will work individually with this provider outside of the call.

Q11. Do you have any helpful hints for date of death issues?

A11. Yes, you will need to provide a death certificate to the Social Security Administration.

Q12. I am billing a 121 and 131 type of bill for benefits exhaust and the 131 type of bills are denying as duplicates because the ER charge has to be billed separate.

A12. You need to send the 131 type of bill and let it completely process then submit the 121 type of bill.

Q13. We have an issue with 30905 there are a lot of claim that are billed with adjustments the DCN numbers are correct if you go on the corrections side of the system and F9 the claims will process. Why are these claims being hung up?

A13. You must put the seven spaces along with the site id (01, 02, 03 or 04, depending on the region). The best way to bypass this problem is to do the adjustments through the FISS system because the DCN number is already locked in for you.



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Q14. With reason code 31715 is it denying for the same date of service or for units.

A14. If you receive reason code 31715 it is denying because of the units of service billed for specific services because you can only bill for the maximum amount for that HCPCS code which is on the list. You can find the list on the [CMS Website](#).

Q15. Does WPS look at system enhancements so providers won't encounter the same problem?

A15. Absolutely, if there is a problem on our side or if a provider reports a problem, we do try to correct our systems, but remember we do need a valid claim example to address the issues.

Q16. When receiving reason code N5052 can providers correct the Medicare number on the first page if it was returned?

A16. You can correct the number by going into claim correction screen, then go to the field that states "process new HIC," hit the "Y" then tab and put in the correct HIC number and press F9 and it will generate the new HIC number that you entered.

Q17. What is reason code SM3240?

A17. SM3240 is a status location and not a reason code and it is an internal error. These errors are being worked, but we don't have a fix date.

Q18. On the denials for the antiemetic drugs does WPS have a list of the antiemetic drugs are?

A18. Provider was advised to email request – *request not received as of 01-23-2009*.

The teleconference was ended at approximately 2:40 PM Central Time.

The references included in this presentation are for informational purposes only. The current Medicare regulations will prevail.

There were 75 participants on 52 lines for the teleconference.