Internal Medicine Coding Alert

ICD-10 Claims Processing: Denials for Immunization Encounters To Be Readjusted Soon

Good news: You now stand better chance for winning appeals.

If you have been recently facing denials when your internal medicine specialist is performing pneumococcal or hepatitis immunizations, you are not alone. Here's the latest from National Government Services (NGS) about what you need to do. Also, recent guidelines changes from CMS is all set to bring cheer as you now have an improved probability of winning an appeal for a claim that has been denied after being paid.

Scenario: Your internist performed administration of pneumococcal vaccine. You submitted the administration code, G0009 (Administration of pneumococcal vaccine) along with 90669 (Pneumococcal conjugate vaccine, 7 valent, for intramuscular use) or 90670 (...13 valent [PCV13], for intramuscular use). Since the service was provided after Oct.1, 2015, you submitted the ICD-10 code, Z23 (Encounter for immunization). You get a denial for your claim.

In another scenario, your internist performed immunization against hepatitis. You reported G0010 (Administration of hepatitis B vaccine) along with the code, 90746 (Hepatitis B vaccine [HepB], adult dosage, 3 dose schedule, for intramuscular use) and Z23. You receive a denial for this claim also. What are you doing wrong?

The problem: National Government Services (NGS) has identified a claims processing issue in which claims for immunization and administration procedures codes (for pneumococcal and hepatitis vaccines) are being incorrectly denied. According to NGS, a system error impacted providers who submitted claims for these services in which they reported ICD-10-CM diagnosis code Z23.

What you need to do: According to NGS, you need not resubmit the claim nor will you need to request an appeal. The good news is that you will not need to do anything but wait. Soon, a mass adjustment will be done to these claims denied in error.

Watch Out For New CMS Guidelines to Help Win Appeals

In a refreshing move from the **Centers for Medicare & Medicaid Services** (CMS), newly released guidance limits the scope of review for some redeterminations and reconsiderations. Now you'll have a greater chance of winning appeals on Medicare claims denials.

Scenario: Medicare paid your claim, but a Zone Program Integrity Contractor (ZPIC), Recovery Audit Contractor (RAC), Medicare Administrative Contractor (MAC), or Comprehensive Error Rate Testing (CERT) contractor reopened and reviewed the claim in a post-payment review or audit. The contractor decides to deny coverage of your claim.

You appeal a denied claim following a post-payment review or audit by a MAC or a Qualified Independent Contractor (QIC). Your appeal is solid, and the MAC or QIC should provide you with a favorable redetermination or reconsideration. But instead, the contractor gives you an unfavorable appeal decision for a different reason after performing an expanded review of other issues or additional evidence.

Contractors Must Keep Their Focus

New way: In MLN Matters SE1521, "Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims," CMS has instructed contractors to reign in their scope of review when it comes to redeterminations and reconsiderations of claims after a post-payment review or audit. According to the recent CMS guidance, MACs and QICs must now limit their review to the reason(s) directly associated with the initial denial of the claim or line item.

Although federal regulations allow contractors discretion to consider new issues during an appeal, this has led to providers receiving inconsistent or varying reasons for denials while navigating through the Medicare appeals process, laments a coding expert.

Impact: "This change will likely result in fewer denials at redetermination and reconsideration, thereby relieving some of the ongoing backlog at the Administrative Law Judge review level," stated a recent analysis by the law firm **Polsinelli PC.**

"Previously, MACs and QICs had discretion to develop new issues and review all aspects of coverage related to a denied claim or line item," Polsinelli explained. "Providers and suppliers were often frustrated because the original reason for denial had been cured (e.g., lack of documentation), but the claims were then denied for new reasons without any ability to explain or even know the issue prior to the denial."

But Don't Get Too Excited

Beware that this new limitation for the scope of review applies only to certain claims, an expert says. For instance, the guidance applies to claims denied in a post-payment review or audit only.

Caveat: Unfortunately, this limited scope doesn't extend to appeals involving a claim or line item that a contractor denied on a pre-payment basis. In this case, "MACs and QICs may continue to develop new issues and evidence at their discretion and may issue unfavorable decisions for reasons other than those specified in the initial determination," CMS says.

Also, CMS is still instructing contractors to follow existing procedures regarding claim adjustments following favorable appeal decisions. This means that these adjustments will continue to process through CMS systems and could suspend due to system edits. For claims adjustments that don't process to payment due to additional system-imposed payment limitations, conditions, or restrictions, you'll receive new denials with full appeal rights.

Another stipulation: Also, if a MAC or QIC denied your claim on post-payment review because you failed to submit requested documentation, "the contractor will review all applicable coverage and payment requirements for the item or service at issue, including whether the item or service was medically reasonable and necessary," CMS notes.

What this means: If a contractor initially denied your claim for insufficient documentation, the contractor could deny your appeal if you submit additional documentation but it doesn't support medical necessity.

No Retroactive Remedies

The new instructions to contractors in SE1521 are effective for redeterminations and reconsideration requests that a MAC or QIC received on or after Aug. 1, 2015. CMS is not applying the instruction retroactively, so you cannot request a reopening of a previously issued redetermination or reconsideration specifically to apply this scope of review limitation.

Bottom line: Despite the myriad of caveats, this CMS guidance is a boon for providers. "Ideally, this change in the review process will improve the potential ability of providers to avoid being mired in the growing backlog of appeals at the Administrative Law Judge level by increasing the chances of gaining a favorable decision at the lower levels of appeal," a law firm notes.

Link: To read "Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims" (SE1521), go to www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1521.pdf. For more on the Polsinelli PC analysis, see https://sites-polsinelli.vuturevx.com/33/350/september-2015/cms-limits-scope-of-review-burris-9.10.15.asp?sid=912283a6-83c4-4763-8f02-3dd71f38afdb.