Part B Insider (Multispecialty) Coding Alert

Billing: This MAC's Top 5 Most Common Denial Reasons May Surprise You

Trying to reconcile why you're facing denials? This list might help.

Sometimes you might feel like you're shooting in the dark when it comes to whether a claim will be paid or denied but one MAC has tried to illuminate that darkness by revealing the top five reasons for denial among Part B claims.

Palmetto GBA released this list of common denials in September, and it could help you determine how to straighten out your claims and start collecting for your services. Read on to access the denial list.

1. Patient is enrolled in hospice care. If your doctor is the patient's attending physician in the hospice, then his services are typically bundled into the hospice care payment. The exception to this rule is when the doctor administers services unrelated to the patient's terminal condition. For these services, you can get paid if you use modifier GW (Service not related to the hospice patient's terminal condition).

Example: Your physician is seeing a hospice patient for a kidney stone when the patient's terminal illness is lung cancer. For this service, you would attach modifier GW to the codes you report for the kidney stone treatment.

2. You reported a noncovered service. These are never paid, and "they include eye refraction, 'well person' exams and hot/cold packs used in physical therapy," Palmetto says.

Although it may seem obvious that noncovered services will face denials, you may not be aware of which services aren't covered. These fall into four categories, according to the Medicare publication Items and Services That Are Not Covered Under the Medicare Program, which are as follows:

- Services and supplies that are not medically reasonable and necessary. These include screening tests for which the beneficiary has no symptoms.
- Non-covered items and services. These include personal comfort items such as radios and televisions, eyeglasses, hearing aid exams, or cosmetic surgery.
- Services and supplies that have been denied as bundled or included in the basic allowance of another service. For example, these include physician standby services or telephone calls to and from the beneficiary.
- Items and services reimbursable by other organizations and furnished without charge. This includes services that should be covered under automobile or workers' compensation insurance, among other insurers.

3. Your claim fell victim to NCCI edits. The most common denial reasons when National Correct Coding Initiative (NCCI) edits are involved are

"pulse oximetry, heparin, creatinine (blood) and some supplies," Palmetto says.

CMS issues NCCI edits on a quarterly basis, and many other payers besides Medicare use them to determine which services to bundle. The edits are listed on CMS's website so you can identify pairs of codes that carriers will flag as unallowable when billed together.

The edits bundle services in two instances: pairs in which one code describes a component of a more comprehensive code, and pairs that describe mutually exclusive procedures.

To view the NCCI edits, visit www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html. The files are in zipped Microsoft Excel format, so users will need the appropriate software to examine them.

4. You billed Medicare as the primary payer, even though it should have been secondary. "The MSP Lookup Tool can help guide you as to whether another insurer may be involved," Palmetto says. This allows you to verify whether Medicare is the primary or secondary payer.

In addition, make sure you ask patients about all of their insurers when they first present to your practice. You'll bill the primary payer first and wait for the remittance advice from that insurer before you can submit the remaining balance to the Medicare secondary payer. In addition, if the claim involves an automobile accident or workers' compensation claim, bill the appropriate entity before billing Medicare.

5. You separately billed pre- and post-op visits that were actually included in the global surgery package. As most practices are aware, payment for services typically associated with the surgical procedure is bundled into the surgery payment. These services include all pre-, intra- and post-procedure care for the full global period (0, 10, or 90 days) related to the surgery.

You can use CMS's Medicare Physician Fee Schedule to look up the global period for any CPT® code, and that will show you how many days of postoperative care are included in the fee for the surgery.

Resource: To read Palmetto's list of top five denial reasons, visit www.palmettogba.com/palmetto/providers.nsf/DocsCat/Jurisdiction-11-Part-B~8EELKQ7002.