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Part B Insider (Multispecialty) Coding Alert

Claims Errors: This MAC Denied Over 1,200 Claims for Services Administered to Deceased Patients

Avoid these top ten Medicare errors to avoid revenue drains.

What's the top tool in your arsenal to avoid claims rejections? Verify patient eligibility.

That was the word from NGS Medicare's **Michelle Coleman** during the MAC's Feb. 16 webinar, "Minimize Errors, Maximize Revenue." Coleman not only shared the top claims submission errors submitted to NGS in December 2011, but also suggested solutions for avoiding the same mistakes. Read on for the scoop on how to keep your revenue rolling in.

1. **Patients weren't covered by the MAC.** NGS saw over 49,000 claims in December alone for patients not covered by the contractor. For instance, if a patient enrolled in a Medicare Advantage plan or moved across the state line, thus changing their MAC to another contractor, they were not covered by NGS and their claims were denied.

Solution: Check the patient's eligibility information at every visit. "I know sometimes physicians do that once a year - when the new year comes up they'll check and see if a new card was issued," Coleman said. "But with Medicare patients it's really important to make sure that you check the eligibility every time you see the patient." You can check a patient's eligibility through the MAC or via CMS's interactive voice response (IVR) system at 1-800-MEDICARE.

2. Claims were missing information. NGS also saw scores of denials for claims that lacked information that the MAC needed to process the claim.

Solution: Make sure you check to see if the procedure code has a local coverage determination (LCD) or national coverage determination (NCD) that guides claims submission. "It could be that the claim is missing a diagnosis or maybe a modifier," Coleman said.

3. The time limit for filing the claim has expired. "We had 37,427 claims with this denial in December, and it's a pretty simple one to fix," Coleman said.

Solution: "You have to make sure that you submit the claim and that we receive it within one year from the date of service," Coleman said. "We do not have any appeal rights on these claims " when you receive a denial for the time limit, you cannot appeal it."

4. Patient cannot be identified as the MAC's insured. Practices submitted 17,959 claims to NGS that fell under this error in December.

Solution: "This is another error where you have to verify the patient's eligibility information," Coleman said. "To reduce these types of denials, make sure you're screening your patients in the beginning before you see them, and the office personnel should review the patient's eligibility information when registering the patient."

5. The provider was not eligible to collect for the procedure on the service date. NGS processed 13,000 claims in December with this error code. For instance, the provider's NPI was expired, or the claim was submitted under an individual's PTAN that was registered as a rendering provider but not a billing provider.

Solution: "You want to make sure that you either contact customer service or the MAC's provider enrollment line to make sure the provider's files are correct," Coleman suggested.

6. The procedure code is inconsistent with the modifier used, or a modifier is missing. NGS saw over 12,000 claims with

this denial in December.

Solution: "You need to check your LCD and NCD, or even the Correct Coding Initiative (CCI) table to see if you're even able to use a specific modifier," Coleman said. "Make sure you're using a modifier if necessary, or if the code does not allow a modifier, that you're not submitting it with one."

7. The services billed are non-covered charges. In December, NGS processed over 5,000 claims with this error.

Solution: Make sure that the CPT code you're using is accurate, and that it describes a covered service under Medicare.

8. The service is not deemed a "medical necessity" by the payer. "This usually has something to do with the diagnosis," Coleman said.

Solution: Verify that the diagnosis you reported is payable, up-to-date, and accurate. "Remember if you're using an ICD-9 code, it must be documented in the patient's record that the patient has that condition. You can't just put on an ICD-9 code because it's payable," she added.

9. The date of death precedes the service date. NGS saw 1,252 claims in December with this error.

Solution: Verify that the patient's eligibility information is correct, and that you've submitted the correct date of service. If any Social Security files were updated incorrectly with the wrong date of death, the patient's family will have to get involved to rectify the situation on the Social Security records by submitting the death certificate.

10. The claim represents a work-related injury or illness and is therefore the liability of the workers' compensation carrier.

Solution: You must verify the patient's eligibility information to ensure that you know whether a workers' compensation payer is involved in the claim.

"Keep in mind that when we look at our eligibility information for the patient, we're getting it from a common working file, which all the carriers have access to," Coleman said. "So if that information isn't sent over to the common working file, we can't update the records. What sometimes happens is that a patient maybe has a liability case open. The patient may have closed it, but if the information isn't showing in the common working file, we deny the claim."