

TOP CLAIM SUBMISSION ERRORS

Wisconsin

Top 5 Claim Submission Errors
February 1, 2004 – March 31, 2004

1. Independent Lab Billing EKG tracing or Specimen Procurement in Place-of-Service "Patient Home" (POS 12).
Missing the narrative "*homebound*," in the extra narrative field.
2. Procedure code not paid separately (always bundled), non-covered, or not valid for Medicare purposes.
Medicare Physician Fee Schedule Database (MPFSDB) lists status of B, G, I, N, or P for the procedure code billed.
3. Facility Provider Not Billed (field 32).
Facility provider's name, state, or zip code invalid or missing from field 32.
4. Individual Provider Required.
Provider number entered is not an individual provider number, or no individual provider number was entered.
5. Invalid Diagnosis Code.
Diagnosis code billed is no longer valid. (Vast majority of errors in this category are due to providers billing diagnosis code V04.8 for Influenza vaccinations. V04.8 is truncated effective 1/1/04 and after. For dates of service 1/1/04 and after, V04.81 is required for Influenza vaccinations.)

Appeals Statistics

Types of Initial Claim Determinations Appealed Most Frequently

We have identified the initial claim determinations most frequently appealed. The following chart shows the top ten initial claim determinations for the period October through December 2003.

| Top Ten Types of Initial Determinations Appealed Most Frequently |
|--|
| Diagnosis |
| Medical necessity |
| Not covered |
| Service paid on claim |
| Duplicate denial |
| Modifier |
| Frequency |
| Correct coding initiative (CCI) / Bundled |
| Insufficient documentation |
| Post Op Period |

The top three reasons are Diagnosis, Medical Necessity and Noncovered Services:

Diagnosis - All diagnosis related to the patient's condition are not always billed on the initial claim

Medical Necessity - Medical documentation is not submitted at the claim level

Noncovered services - Services that are non-covered based on the processing guidelines

Reasons for Initial Claim Determinations Reversed at the Appeal Level

We have identified the reasons for full or partial reversals of initial claim determinations within our 300 CCN sample. The following chart shows the top five reasons for full and partial reversals with focus on processing errors made by the provider, submission of documentation that should have been submitted with the initial claims, and claims denied due to medical review.

Top Five Reasons For Full and Partial Reversals

| Initial Claim Determinations |
|--------------------------------|
| Lack of documentation |
| Provider billing errors |
| Medical Review |
| System/CMS issues |
| Initial claim processing error |

We have conducted further analysis of our top three reasons for full and partial reversals.

Lack of Documentation –The following are examples of information submitted at the appeal level resulting in reversals:

Payable diagnoses codes

Modifier 59 - distinct procedural service

Modifier 76 - repeat procedure by same physician

Modifier 24 - unrelated evaluation and management service by same physician during postoperative period

Modifier 25 - significant separately identifiable evaluation and management service by same physician on the day of a procedure

Provider Billing Errors – The following are examples of corrections submitted at the appeal level resulting in reversals:

Correct quantity billed

Correct procedure code

Correct billed amount

Medical Review – The following are examples of issues submitted at the appeal level resulting in reversals:

Documentation submitted to support medical necessity for ambulance service

Documentation submitted to support medical necessity for frequency of bone mass measurement

Documentation submitted to support medical necessity of critical care same day or during post-operative period

The Data Analysis sample findings based on Medical Review determinations are referred to our Medical Review department for further analysis and ways are being sought to corroborate denials with medical review determinations. The results are used for quality improvement and educational purposes within the medical review process.

Top Five Types of Service Most Frequently Appealed

To assist in our quality improvement efforts we also identified the top five types of service, which are most frequently appealed. The chart below depicts the findings for October-December 2003.

Top Five Types of Service Most Frequently Appealed

| Types of Service |
|--|
| Evaluation and Management - 99200-99499 |
| Pathology & Laboratory – 80000-89399, G0001, P0000-P9999 |
| Radiology – 70000-79999, G0130-G0133, G0236 |
| Ambulance - A0000-A0999 |
| Chiropractic Manipulative Treatment – 98940-98943 |

Evaluation and Management, Pathology and Laboratory and Radiology services are all high volume procedures and this is one reason they account for the highest numbers of appeals. Our analysis has also shown the following contributing factors:

Required modifiers are not always billed on the initial claims

All diagnoses related to the patient's condition are not always billed on the initial claims

Pathology and laboratory services are frequently billed multiple times on the same date without appropriate modifiers causing denials

Laboratory services with frequency guidelines are questioned

Changes in the laboratory NCDs generate appeal requests when quarterly updates are made

Radiology services are often billed lacking appropriate modifiers or correct diagnoses

Ambulance providers do not usually submit run sheets or additional documentation at the initial claims level

Air ambulance

Chiropractic claims are also initially billed without appropriate documentation and although developed, often the information is not submitted timely necessitating an appeals request

Provider Medicare Telephone Numbers

WISCONSIN – Hours 7:00 a.m.– 5:00 p.m.

| | |
|--|----------------|
| Claim Status (IVR) | 1-877-567-7176 |
| Customer Service Representative Inquiry . . | 1-866-359-1599 |
| MSP Related Inquiry (8:00 a.m. – 4:30 p.m.) | 1-877-908-8475 |
| Financial Related Inq. (8:00 a.m. – 4:30 p.m.) | 1-866-463-8207 |
| Telephone Appeals | 1-877-674-5354 |
| Provider Enrollment | 1-877-908-8476 |
| General Administration | 1-877-908-8475 |



Beneficiary Inquiries or Appeals - 1-800-MEDICARE or 1-800-633-4227