Chapter 14

Payments (RAs/EOBs), Appeals, and Secondary Claims

CHAPTER OUTLINE

Claim Adjudication

Monitoring Claim Status

The Remittance Advice/Explanation of Benefits (RA/EOB)

Reviewing and Processing RAs/EOBs

Appeals, Postpayment Audits, Overpayments, and Grievances

Billing Secondary Payers

Learning Outcomes

After studying this chapter, you should be able to:

1. Describe the steps payers follow to adjudicate claims.
2. List ten checks that automated medical edits perform.
3. Describe the procedures for following up on claims after they are sent to payers.
4. Identify the types of codes and other information contained on an RA/EOB.
5. List the points that are reviewed on an RA/EOB.
6. Explain the process for posting payments and managing denials.
7. Describe the purpose and general steps of the appeal process.
8. Discuss how appeals, postpayment audits, and overpayments may affect claim payments.
9. Describe the procedures for filing secondary claims.
10. Discuss procedures for complying with the Medicare Secondary Payer (MSP) program.

Key Terms

adjudication
aging
appeal
appellant
autoposting
claim adjustment group codes (GRP)
claim adjustment reason codes (RC)
claimant
claim status category codes
claim status codes
claim turnaround time
concurrent care
determination
development
electronic funds transfer (EFT)
explanation of benefits (EOB)
grievance
HIPAA X12 835 Health Care Payment and Remittance Advice (HIPAA 835)
HIPAA X12 276/277 Health Care Claim Status Inquiry/Response (HIPAA 276/277)
insurance aging report
medical necessity denial
Medicare Outpatient Adjudication remark codes (MOA)
Medicare Redetermination Notice (MRN)
Medicare Secondary Payer (MSP)
overpayments
pending
prompt-pay laws
RA/EOB
reconciliation
redetermination
remittance advice (RA)
remittance advice remark codes (REM)
suspended

Claim follow-up and payment processing are important procedures in billing and reimbursement. Medical insurance specialists track claims that are due, process payments, check that claims are correctly paid, and file claims with secondary payers. These procedures help generate maximum appropriate reimbursement from payers for providers.

Claim Adjudication

When the payer receives claims, it issues an electronic response to the sender showing that the transmission has been successful. Each claim then undergoes a process known as **adjudication**, made up of steps designed to judge how it should be paid:

1. Initial processing
2. Automated review
3. Manual review
4. Determination
5. Payment

Initial Processing

Each claim's data elements are checked by the payer's front-end claims processing system. Paper claims and any paper attachments are date-stamped and entered into the payer's computer system, either by data-entry personnel or by the use of a scanning system. Initial processing might find such problems as the following:

- The patient's name, plan identification number, or place of service code is wrong.
- The diagnosis code is missing or is not valid for the date of service.
- The patient is not the correct sex for a reported gender-specific procedure code.

Claims with errors or simple mistakes are rejected, and the payer transmits instructions to the provider to correct errors and/or omissions and to re-bill the

Billing Tip

Minor Errors on Transmitted Claims
When the practice finds or is notified about a minor error—such as a data-entry mistake or an incorrect place of service—it can usually be corrected by asking the payer to reopen the claim and make the changes.

Billing Tip

Proof of Timely Filing

- Payers may reduce payment for or deny claims filed after their deadline. Different payers may have different timelines; be familiar with the rules of each payer. Usually, providers cannot bill patients if they have missed the payer's submission deadline.
- Practice management programs create a tamper-proof record of the filing date of every claim that can be used to prove timely filing.

service. The medical insurance specialist should respond to such a request as quickly as possible by supplying the correct information and, if necessary, submitting a clean claim that is accepted by the payer for processing.

Automated Review

Payers' computer systems then apply edits that reflect their payment policies. For example, a Medicare claim is subject to the Correct Coding Initiative (CCI) edits (see Chapters 7 and 10). The automated review checks for the following:

1. *Patient eligibility for benefits:* Is the patient eligible for the services that are billed?
2. *Time limits for filing claims:* Has the claim been sent within the payer's time limits for filing claims? The time limit is generally between 90 and 180 days from the date of service.
3. *Preauthorization and referral:* Are valid preauthorization or referral numbers present as required under the payer's policies? Some authorizations are for specific dates or number of service, so these data will be checked, too.
4. *Duplicate dates of service:* Is the claim billing for a service on the same date that has already been adjudicated?
5. *Noncovered services*: Are the billed services covered under the patient's policy?
6. *Valid code linkages*: Are the diagnosis and procedure codes properly linked for medical necessity?
7. *Bundled codes:* Have surgical code bundling rules and global periods been followed?
8. *Medical review:* Are the charges for services that are not medically necessary or that are over the frequency limits of the plan? The payer's medical director and other professional medical staff have a medical review program to ensure that providers give patients the most appropriate care in the most cost-effective manner. The basic medical review edits that are done at this stage are based on its guidelines.
9. *Utilization review:* Are the hospital-based health care services appropriate? Are days and services authorized consistent with services and dates billed?
10. *Concurrent care*: If concurrent care is being billed, was it medically necessary? **Concurrent care** refers to medical situations in which a patient receives extensive care from two or more providers on the same date of service. For example, both a nephrologist and a cardiologist would attend a hospitalized patient with kidney failure who has had a myocardial infarction. Instead of one provider's working under the direction of another, such as the relationship between a supervising surgeon and an anesthesiologist, in concurrent care each provider has an independent role in treating the patient. When two providers report services as attending physicians, rather than as one attending and one consulting provider, a review is done to determine whether the concurrent care makes sense given the diagnoses and the providers' specialties.

Manual Review

If problems result from the automated review, the claim is **suspended** and set aside for **development—**the term used by payers to indicate that more information is needed for claim processing. These claims are sent to the medical re-

view department, where a claims examiner reviews the claim. The examiner may ask the provider for clinical documentation to check:

- Where the service took place
- Whether the treatments were appropriate and a logical outcome of the facts and conditions shown in the medical record
- That services provided were accurately reported

Claims examiners are trained in the payer's payment policies, but they usually have little or no clinical medical background. When there is insufficient guidance on the point in question, examiners may have it reviewed by staff medical professionals—nurses or physicians—in the medical review department. This step is usually followed, for example, to review the medical necessity of an unlisted procedure.

Example

As an example, the following table shows the benefit matrix—a grid of benefits and policies—for a preferred provider organization's coverage of mammography.

BENEFIT MATRIX		
FEMALE PATIENT AGE GROUP	**IN-NETWORK**	**OUT-OF-NETWORK**
35–39 One baseline screening	No charge	20 percent per visit after deductible
40–49 One screening every two years, or more if recommended	No charge	20 percent per visit after deductible
50 and older One screening every year	No charge	10 percent per visit after deductible

- *Initial processing*: The payer's initial claim processing checks that the patient for whom a screening mammogram is reported is a female over age thirty-five.
- *Automated review*: The payer's edits reflect its payment policy for female patients in each of the three age groups. If a claim reports a single screening mammogram for a forty-five-year-old in-network patient within a twenty-four-month period, it passes the edit. If the claim contains two mammograms in fewer than twenty-four months, the edit would flag the claim for manual review by the claims examiner.
- *Manual review*: If two mammograms are reported within a two-year period for a patient in the forty- to forty-nine-year age range, the claims examiner would require documentation that the extra procedure was recommended and then review the reason for the recommendation. If an X-ray is included as a claim attachment, the claims examiner would probably ask a staff medical professional to evaluate the patient's condition and judge the medical necessity for the extra procedure.

Determination

For each service line on a claim, the payer makes a payment **determination**—a decision whether to (1) pay it, (2) deny it, or (3) pay it at a reduced level. If the service falls within normal guidelines, it will be paid. If it is not reimbursable, the item on the claim is denied. If the examiner determines that the service was at too high a level for the diagnosis, a lower-level code is assigned. When the level of service is reduced, the examiner has downcoded the service (see also Chapter 7). A **medical necessity denial** may result from a lack of clear,

Compliance Guideline

Documentation is Essential
If proper and complete documentation is not provided on time when requested during a manual review, claim denial or downcoding may result, with the risk for an investigation or audit. Supply both the date-of-service record and any applicable patient or treatment information to support the facts that the service was provided as billed, was medically necessary, and has been correctly coded.

Billing Tip

Medical Necessity Denials
Understand payers' regulations on medical necessity denials. Often, when claims are denied for lack of medical necessity, fees cannot be recovered from patients. For example, the participation contract may prohibit balance billing when a claim is denied for lack of medical necessity unless the patient agreed in advance to pay.

correct linkage between the diagnosis and procedure. A medical necessity denial can also happen when a higher level of service was provided without first trying a lower, less invasive procedure. Some payers or polices require a patient to fail less invasive or more conservative treatment before more intense services are covered.

HIPAA Tip

HIPAA 835

The HIPAA X12 835 Health Care Payment and Remittance Advice (HIPAA 835) is the HIPAA-mandated electronic transaction for payment explanation.

Payment

If payment is due, the payer sends it to the provider along with a **remittance advice (RA)** or electronic remittance advice (ERA), a transaction that explains the payment decisions to the provider. In most cases, if the claim has been sent electronically, this transaction is also electronic; but it may sometimes be paper. An older term that now usually refers to the paper document is **explanation of benefits (EOB)**. When the general term **RA/EOB** is used in this text, it means both formats.

Thinking It Through — 14.1

A payer's utilization guidelines for preventive care and medical services benefits are shown below.

SERVICE	*UTILIZATION*
Pediatric:	
Birth–1 year	Six exams
1–5 years	Six exams
6–10 years	One exam every two years
11–21 years	One exam
Adult:	
22–29 years	One exam every 5 years
30–39 years	One exam every 3 years
40–49 years	One exam every 2 years
+50 years	One exam every year
Vision Exam	Covered once every 24 months
Gynecological	Covered once every year
Medical Office Visit	No preset limit
Outpatient Therapy	60 consecutive days per condition/year
Allergy Services	Maximum benefit: 60 visits in 2 years

If a provider files claims for each of the following cases, what is the payer's likely response? (Research the CPT codes in the current CPT before answering.) Explain your answers. An example is provided.

PATIENT	AGE	CPT CODE	DOS	PAYER RESPONSE?
Case Example: Patient X	*45*	*99212*	*11/09/2008*	*Pay the claim, because unlimited medical office visits are covered.*
1. Guy Montrachez	25	92004	11/08/2008	
2. Carole Regalle	58	99385	12/04/2008	
3. Mary Hiraldo	25	99385 and 88150 88150	11/08/2008 12/10/2008	
4. George Gilbert	48	99386 99386	10/20/2007 11/02/2008	

Monitoring Claim Status

Practices closely track their accounts receivable (A/R)—the money that is owed for services rendered—using the practice management program (PMP). The accounts receivable is made up of payments due from payers and from patients. For this reason, after claims have been accepted for processing by payers, medical insurance specialists monitor their status.

Claim Status

Monitoring claims during adjudication requires two types of information. The first is the amount of time the payer is allowed to take to respond to the claim, and the second is how long the claim has been in process.

Claim Turnaround Time

Just as providers have to file claims within a certain number of days after the date of service, payers also have to process clean claims within the **claim turnaround time**. The participation contract often specifies a time period of thirty to sixty days from claim submission. States have **prompt-pay laws** that obligate state-licensed carriers to pay clean claims for both participating and nonparticipating providers within a certain time period, or incur interest penalties, fines, and lawyers' fees. ERISA (self-funded) plans' claims are under federal prompt-pay rules.

Billing Tip

Prompt-Pay Laws for States
The websites of states' insurance commissions or departments cover their prompt-pay laws. Research the law in the state where claims are being sent to determine the payment time frames and the penalty for late payers.

Aging

The other factor in claim follow-up is **aging—**how long a payer has had the claim. The practice management program is used to generate an **insurance aging report** that lists the claims transmitted on each day and shows how long they have been in process with the payer. A typical report, shown in Figure 14.1 on page 454, lists claims that were sent fewer than thirty days ago, between thirty and sixty days ago, and so on.

HIPAA Health Care Claim Status Inquiry/Response

The medical insurance specialist examines the insurance aging report and selects claims for follow-up. Most practices follow up on claims that are aged less that thirty days in seven to fourteen days. The **HIPAA X12 276/277 Health Care Claim Status Inquiry/Response** is the standard electronic transaction to obtain information on the current status of a claim during the adjudication process. The inquiry is the **HIPAA 276**, and the response returned by the payer is the **HIPAA 277**. Figure 14.2 shows how this exchange is sent between provider and payer.

The HIPAA 277 transaction from the payer uses **claim status category codes** for the main types of responses:

- *A* codes indicate an acknowledgment that the claim has been received.
- *P* codes indicate that a claim is **pending**; that is, the payer is waiting for information before making a payment decision.
- *F* codes indicate that a claim has been finalized.
- *R* codes indicate that a request for more information has been sent.
- *E* codes indicate that an error has occurred in transmission; usually these claims need to be re-sent.

These codes are further detailed in **claim status codes**, as shown in Table 14.1.

HIPAA Tip

HIPAA Claim Status

The HIPAA Claim Status transaction is the 276/277 Health Care Claim Status Inquiry/Response.

Valley Associates, P.C.

Primary Insurance Aging

As of 11/30/2008

Date of Service	Procedure	-- Past -- 0 - 30	-- Past -- 31 - 60	-- Past -- 61 - 90	-- Past -- 91 - 120	-- Past -- 121 ----->	Total Balance
Aetna Choice (AET00)							**(555)777-1000**
WILLIWA0 Walter Williams			SS: 401-26-9939	Policy: ABC103562239		Group: BDC1001	
Birthdate: 9/4/1936							
Claim: 53	Initial Billing Date: 10/8/2008		Last Billing Date: 10/8/2008				
10/1/2008	99212		46.00				46.00
10/1/2008	93000		70.00				70.00
		0.00	116.00	0.00	0.00	0.00	116.00
	Insurance Totals	$0.00	$116.00	$0.00	$0.00	$0.00	$116.00
Anthem BCBS PPO (ANT01)							**(555)888-1000**
CARUTRO0 Robin Caruthers			SS: 331-24-0789	Policy: GH331240789		Group: OH4071	
Birthdate: 3/29/1979							
Claim: 49	Initial Billing Date: 10/6/2008		Last Billing Date: 10/6/2008				
10/6/2008	99212		46.00				46.00
		0.00	46.00	0.00	0.00	0.00	46.00
	Insurance Totals	$0.00	$46.00	$0.00	$0.00	$0.00	$46.00
Cigna HMO Plus (CIG00)							**(555)666-3001**
PEREZCA0 Carmen Perez			SS: 140-24-6113	Policy: 140603312X			
Birthdate: 5/15/1934							
Claim: 52	Initial Billing Date: 10/8/2008		Last Billing Date: 10/8/2008				
10/1/2008	99213		62.00				62.00
		0.00	62.00	0.00	0.00	0.00	62.00
	Insurance Totals	$0.00	$62.00	$0.00	$0.00	$0.00	$62.00

FIGURE 14.1 Example of an Insurance Aging Report

> **Billing Tip**
>
> **Automated Claim Status Requests**
> Some medical billing programs can be set up to automatically track how many days claims have been unpaid and to send a claim status inquiry after a certain number of days. For example, if a particular payer pays claims on the twentieth day, the program transmits a 276 for unpaid claims aged day twenty-one.

Working with Payers

In order to have claims processed as quickly as possible, medical insurance specialists must be familiar with the payers' claim-processing procedures, including:

- The timetables for submitting corrected claims and for filing secondary claims. The latter is usually a period of time from the date of payment by the primary payer.
- How to resubmit corrected claims that are denied for missing or incorrect data. Some payers have online or automated telephone procedures that can be used to resubmit claims after missing information has been supplied.
- How to handle requests for additional documentation if required by the payer.

Requests for information should be answered as quickly as possible, and the answers should be courteous and complete. Medical insurance specialists use correct terms to show that they understand what the payer is asking. For example, a payer often questions an office visit (E/M) service that is reported on the same date of service as a procedure or a preventive physical examination on the grounds that the E/M should not be reimbursed separately. Saying "well, the doctor did do both" is less persuasive than saying "the patient's presenting problems required both the level of E/M as indicated as well as the reported procedure; note that we attached the modifier–25 to indicate the necessity for this separate service."

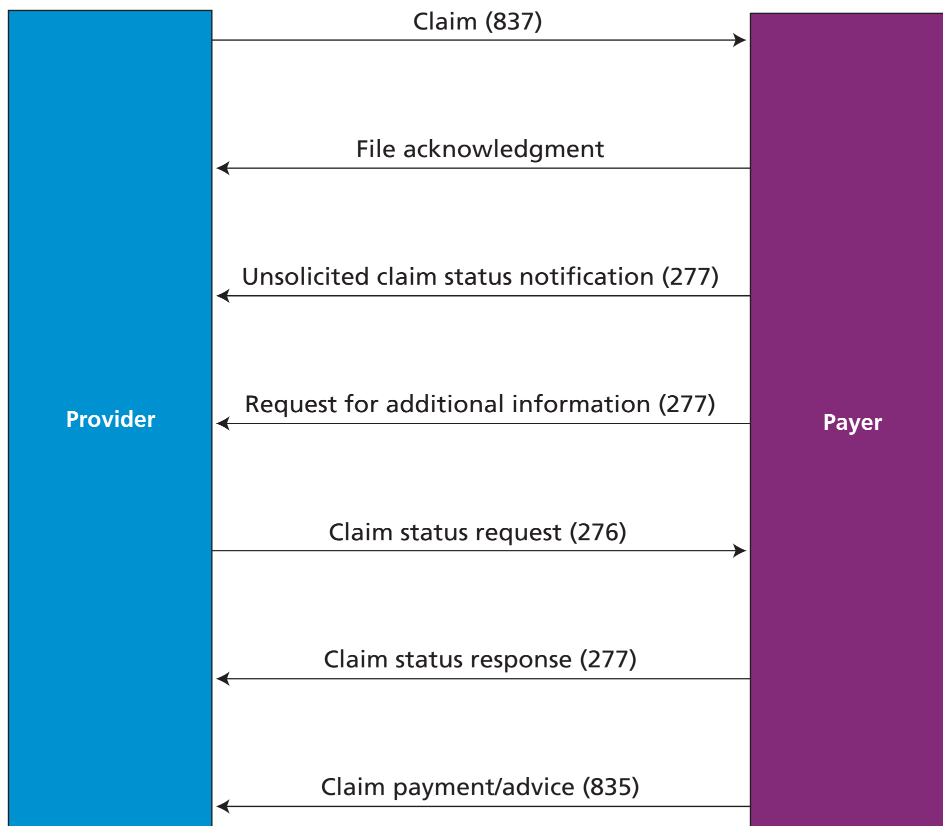

FIGURE 14.2 General Claim Status Request/Response Information Flow

Table 14.1 Selected Claim Status Codes

Code	Description
1	For more detailed information, see remittance advice.
2	More detailed information in letter.
3	Claim has been adjudicated and is awaiting payment cycle.
4	This is a subsequent request for information from the original request.
5	This is a final request for information.
6	Balance due from the subscriber.
7	Claim may be reconsidered at a future date.
9	No payment will be made for this claim.
12	One or more originally submitted procedure codes have been combined.
15	One or more originally submitted procedure codes have been modified.
16	Claim/encounter has been forwarded to entity.
29	Subscriber and policy number/contract number mismatched.
30	Subscriber and subscriber ID mismatched.
31	Subscriber and policyholder name mismatched.
32	Subscriber and policy number/contract number not found.
33	Subscriber and subscriber ID not found.

Claim Status Category Codes and Claim Status Codes

http://www.wpc-edi.com

A payer may fail to pay a claim on time without providing notice that the claim has problems, or the payer may miscalculate payments due. If the problem is covered in the participation contract, the recommended procedure is to send a letter pointing this out to the payer. This notice should be sent to the plan representative identified in the contract.

The Remittance Advice/Explanation of Benefits (RA/EOB)

The remittance advice/explanation of benefits (RA/EOB) summarizes the results of the payer's adjudication process. Whether sent electronically or in a paper format, the basic information in the transaction is the same, although the appearance of the documents is often different.

Content of RAs/EOBs

An RA/EOB covers a group of claims, not just a single claim. The claims paid on a single RA/EOB are not consecutive or logically grouped; they are usually for different patients' claims and various dates of service. RAs/EOBs list claims that have been adjudicated within the payment cycle alphanumerically by the patient account number assigned by provider, alphabetically by client name, or numerically by the internal control number. A corresponding EOB sent to the patient, on the other hand, lists just the information for the recipient.

RAs/EOBs, as shown in Figure 14.3, have four types of information, often located in separate sections: header information, claim information, totals, and a glossary (list of definitions for codes used on the form).

Header Information

The header information section (see section 1 in Figure 14.3) contains payer name and address; provider name, address, and NPI; date of issue; and the check or electronic funds transfer (EFT, see page 462) transaction number. There is a place for "bulletin board" information, made up of notes to the provider.

Claim Information

For each claim, section 2 contains the patient's name, plan identification number, account number, and claim control number, and whether the provider accepts assignment (using the abbreviations ASG = Y or N) if this information applies. Under column headings, these items are shown:

COLUMN HEADING	*MEANING*
PERF PROF	Performing provider
SERV DATE	Date(s) of service
POS	Place of service code
NOS	Number of services rendered
PROC	CPT/HCPCS procedure code
MODS	Modifiers for the procedure code
BILLED	Amount provider billed for the service
ALLOWED	Amount payer allows
DEDUCT	Any deductible the beneficiary must pay to the provider
COINS	Any coinsurance the beneficiary must pay to the provider
GRP/RC	Group (GRP) and reason (RC) adjustment codes (explained below)
AMT	Amount of adjustments due to GRP/RC codes
PROV PD	Total amount provider is paid for the service
PT RESP	Total amount that the beneficiary owes the provider for the claim
CLAIM TOTALS	Total amount for each of these columns: BILLED, ALLOWED, DEDUCT, COINS, AMT, and PROV PD

Billing Tip

Medicare Professional Versus Institutional RAs
A provider that submits claims to Medicare carriers or DMERCS receives a professional RA; one that submits claims to fiscal intermediaries receives an institutional RA.

1

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EXAMPLE MEDICARE CARRIER
1000 SOMEPLACE LANE
FAIRFAX, VA 22033-0000                                              MEDICARE
1-877-555-1234                                                      REMITTANCE
                                                                    NOTICE

EXAMPLE MEDICARE PROVIDER                                           PROVIDER #:999999
200 DOCTORS DRIVE                                                   PAGE #:  1 OF 2
SUITE 200                                                           DATE:  01/28/08
SOMEWHERE, NJ   16666-0200                                          CHECK/EFT #:  000234569
******************************************************************************************
*                                                                                        *
*              WELCOME TO THE MEDICARE PART B STANDARD PAPER REMITTANCE                  *
*                                                                                        *
*                                                                                        *
*                                                                                        *
*                                                                                        *
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2

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PERF PROV   SERV DATE  POS NOS  PROC   MODS   BILLED   ALLOWED   DEDUCT   COINS  GRP/RC  AMT  PROV PD
------------------------------------------------------------------------------------------------------
NAME FISCHER, BENNY       HIC 9999999999 ACNT  FISC6123133-01  ICN 0202199306840  ASG Y       MOA MA01
123456ABC  0225 022502 11  1  99213        66.00    49.83     0.34     9.97  PR-96  16.17    39.52
PT RESP    10.31              CLAIM TOTALS  66.00    49.83     0.34     9.97         16.17
                                                                                NET   39.52
------------------------------------------------------------------------------------------------------
NAME FISCHER, BENNY       HIC 9999999999 ACNT  FISC6123133-01  ICN 0202199306850  ASG Y  MOA MA01 MA07
123456ABC  0117 011702 11  1 99213         66.00    49.83     0.00     9.97  PR-96  16.17    39.86
PT RESP     9.97              CLAIM TOTALS  66.00    49.83     0.00     9.97         16.17    39.86
CLAIM INFORMATION FORWARDED TO:  NEW JERSEY MEDICAID                            NET   39.86
------------------------------------------------------------------------------------------------------
NAME HURT, I. M.          HIC 9999999999 ACNT  HURT5-329       ICN 0202199306860  ASG Y       MOA MA01
123456ABC  0117 011702 11  1  90659        25.00     3.32     0.00     0.00  CO-42  21.68     3.32
123456ABC  0117 011702 11  1  G0008        10.00     4.46     0.00     0.00  CO-42   5.54     4.46
PT RESP     0.00              CLAIM TOTALS  35.00     7.78     0.00     0.00         27.22     7.78
                                                                                NET    7.78
------------------------------------------------------------------------------------------------------
NAME MARLOWE, PHILIP      HIC 9999999999 ACNT  MARL0861-316    ICN 0202199306870  ASG Y  MOA MA01 MA07
123456ABC  0209 020902 11  1  99213        66.00    49.83     0.00     9.97  PR-96  16.17    39.86
PT RESP     9.97              CLAIM TOTALS  66.00    49.83     0.00     9.97         16.17    39.86
ADJ TO TOTALS:  PREV PD  10.00   INT  0.00      LATE FILING CHARGE  0.00
CLAIM INFORMATION FORWARDED TO:  NEW JERSEY MEDICAID                            NET   29.86
------------------------------------------------------------------------------------------------------
NAME RAP, JACK            HIC 9999999999 ACNT  RAP33-721       ICN 0202199306880  ASG Y  MOA MA01 MA07
123456ABC  0314 031402 11  1  99213        66.00    49.83     0.00     9.97  PR-96  16.17    39.86
123456ABC  0314 031402 11  1  82962        10.00     4.37     0.00     0.00  CO-42   5.63     4.37
123456ABC  0314 031402 11  1  94760        12.00     0.00     0.00     0.00  CO-B15 12.00     0.00
REM: M80
PT RESP     9.97              CLAIM TOTALS  88.00    54.20     0.00     9.97         33.80    44.23
                                                                                NET   44.23
```

3

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TOTALS:   # of    BILLED   ALLOWED   DEDUCT     COINS    TOTAL      PROV PD      PROV      CHECK
          CLAIMS     AMT      AMT       AMT       AMT   RC AMT          AMT    ADJ AMT       AMT
            5     321.00   211.47      0.34     39.88   109.53       161.25      31.25    108.75
  PROVIDER ADJ DETAILS:     PLB REASON CODE       FCN              HIC         AMOUNT
                                  50                                            15.44
                                  FB         0202199306770    9999999999         5.81
```

4

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GROUP CODES:
PR      Patient Responsibility
CO      Contractual Obligation
OA      Other Adjustment

GLOSSARY:  Group, Reason, MOA, Remark and Adjustment Codes
CO      Contractual Obligation.  Amount for which the provider is financially liable.  The patient may
        not be billed for this amount.
PR      Patient Responsibility.  Amount that may be billed to a patient or another payer.
42      Charges exceed our fee schedule or maximum allowable amount.
96      Non-covered charge(s)
B15     Claim/service denied/reduced because this procedure/service is not paid separately.
        Charges exceed our fee schedule or maximum allowable amount.
M80     We cannot pay for this when performed during the same session as another approved procedure for
        this beneficiary
MA01    (Initial Part B determination, carrier or intermediary)  If you do not agree with what we
        approved for these services, you may appeal our decision.  To make sure that we are fair to you,
        we require another individual that did not process your initial claim to conduct the review.
        However, in order to be eligible for a review, you must write to us within 6 months of the date
        of this notice, unless you have a good reason for being late.  (An institutional provider, e.g.,
        hospital, SNF, HHA may appeal only if the claim involves a medical necessity denial, a SNF
        recertified bed denial, or a home health denial because the patient was not homebound or was not
        in need of intermittent skilled nursing services, and either the patient or the provider is
        liable under 1879 of the Social Security Act, and the patient chooses not to appeal.)  NOTE:  If
        you are a member of the telephone review demonstration, or if telephone reviews are expanded,
        add the following to the end of the description for MA01.  If you meet the criteria for a
        telephone review, you may phone to request a telephone review.
MA07    The claim information has also been forwarded to Medicaid for review.
MA28    Receipt of this notice by a physician who did not accept assignment is for information only and
        does not make the physician a party to the determination.  No additional rights to appeal this
        decision, above those rights already provided for by regulation/instruction, are conferred by
        receipt of this notice
50      Late Filing Reduction
FB      Forwarding Balance
```

FIGURE 14.3 Sections of the RA/EOB

Totals

The third part (see section 3 in Figure 14.3) shows the totals for all the claims on the RA/EOB. At the end, the CHECK AMT field contains the amount of the check or EFT payment that the provider receives.

Glossary

The glossary section is the fourth area (see section 4 in Figure 14.3) of an RA/EOB. It lists the adjustment codes shown on the transaction with their meanings.

Adjustments

An adjustment on the RA/EOB means that the payer is paying a claim or a service line differently than billed. The adjustment may be that the item is:

- Denied
- Zero pay (if accepted as billed but no payment is due)
- Reduced amount paid (most likely paid according to the allowed amount)
- Less because a penalty is subtracted from the payment

To explain the determination to the provider, payers use a combination of codes: (1) claim adjustment group code, (2) claim adjustment reason code, and (3) remittance advice remark code. Each of these is a HIPAA administrative code set, like place of service (POS) codes and taxonomy codes.

Billing Tip

Code Updates
Claim adjustment reason codes and remark codes are updated three times each year. Access the website (http:www.wpc-edi.com/codes) for updated lists.

Claim Adjustment Group Codes

Claim adjustment group codes (group codes, abbreviated **GRP**) are:

- *PR—Patient Responsibility:* Appears next to an amount that can be billed to the patient or insured. This group code typically applies to deductible and coinsurance/copayment adjustments.
- *CO—Contractual Obligations:* Appears when a contract between the payer and the provider resulted in an adjustment. This group code usually applies to allowed amounts. CO adjustments are not billable to patients under the contract.
- *CR—Corrections and Reversals:* Appears to correct a previous claim.
- *OA—Other Adjustments*: Used only when neither PR nor CO applies, as when another insurance is primary.
- *PI—Payer Initiated Reduction:* Appears when the payer thinks the patient is not responsible for the charge but there is no contract between the payer and the provider that states this. It might be used for medical review denials.

Billing Tip

Patient Balance Billing
A group code PR with an associate reason code indicates whether a provider may or may not bill a beneficiary for the unpaid balance of the furnished services.

Claim Adjustment Reason Codes

Payers use **claim adjustment reason codes** (reason codes, abbreviated **RC**) to provide details about adjustments. Examples of these codes and their meanings are provided in Table 14.2.

Claim Adjustment Reason Codes
http://www.wpc-edi.com/codes/claimadjustment

Remittance Advice Remark Codes

Payers may also use **remittance advice remark codes** (remark codes, **REM**) for more explanation. Remark codes are maintained by CMS but can be used by all payers. Codes that start with *M* are from a Medicare code set that was in place before HIPAA but that is still used, including **Medicare Outpatient Adjudication remark codes (MOA)**. Codes that begin with *N* are new. Table 14.3 on page 461 shows selected remark codes.

Remittance Advice Remark Codes
http://www.wpc-edi.com/codes/remittanceadvice

Table 14.2 Selected Claim Adjustment Reason Codes

Code	Description
1	Deductible amount
2	Coinsurance amount
3	Copayment amount
4	The procedure code is inconsistent with the modifier used, or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Payment adjusted because the submitted authorization number is missing, is invalid, or does not apply to the billed services or provider.
16	Claim/service lacks information that is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury/illness and thus the liability of the workers' compensation carrier.
20	Claim denied because this injury/illness is covered by the liability carrier.
21	Claim denied because this injury/illness is the liability of the no-fault carrier.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
25	Payment denied. Your stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
29	The time limit for filing has expired.
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Claim denied. Insured has no dependent coverage.
36	Balance does not exceed copayment amount.
37	Balance does not exceed deductible.
38	Services not provided or authorized by designated (network/primary care) providers.
39	Services denied at the time authorization/precertification was requested.
40	Charges do not meet qualifications for emergency/urgent care.
41	Discount agreed to in preferred provider contract.
42	Charges exceed our fee schedule or maximum allowable amount.
45	Charges exceed your contracted/legislated fee arrangement.
49	These are noncovered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50	These are noncovered services because this is not deemed a medical necessity by the payer.

(continued on next page)

Table 14.2 Selected Claim Adjustment Reason Codes *(continued)*

Code	Description
51	These are noncovered services because this is a preexisting condition.
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56	Claim/service denied because procedure/treatment has not been deemed "proven to be effective" by the payer.
57	Payment denied/reduced because the payer deems that the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.
63	Correction to a prior claim.
65	Procedure code was incorrect. This payment reflects the correct code.
96	Noncovered charge(s).
97	Payment is included in the allowance for another service/procedure.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Payment adjusted as not furnished directly to the patient and/or not documented.
114	Procedure/product not approved by the Food and Drug Administration.
115	Payment adjusted as procedure postponed or canceled.
123	Payer refund due to overpayment.
124	Payer refund amount—not our patient.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.
138	Claim/service denied. Appeal procedures not followed or time limits not met.
140	Patient/insured health identification number and name do not match.
145	Premium payment withholding.
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
150	Payment adjusted because the payer deems that the information submitted does not support this level of service.
151	Payment adjusted because the payer deems that the information submitted does not support this many services.
152	Payment adjusted because the payer deems that the information submitted does not support this length of service.
155	This claim is denied because the patient refused the service/procedure.
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion.
A0	Patient refund amount.
A1	Claim denied charges.
B5	Claim/service denied/reduced because coverage guidelines were not met.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Payment denied because only one visit or consultation per physician per day is covered.
B15	Payment adjusted because this procedure/service is not paid separately.
B16	Payment adjusted because "new patient" qualifications were not met.
B18	Payment denied because this procedure code and modifier were invalid on the date of service.
B22	This payment is adjusted based on the diagnosis.
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit.
D8	Claim/service denied. Claim lacks indicator that "X-ray is available for review."
D21	This (these) diagnosis(es) is (are) missing or invalid.
W1	Workers' Compensation State Fee Schedule adjustment.

Table 14.3 Selected Remark Codes

Code	Description
M11	DME, orthotics, and prosthetics must be billed to the DME carrier who services the patient's ZIP code.
M12	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.
M37	Service not covered when the patient is under age 35.
M38	The patient is liable for the charges for this service, as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.
M39	The patient is not liable for payment for this service, as the advance notice of noncoverage you provided the patient did not comply with program requirements.
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
N15	Services for a newborn must be billed separately.
N16	Family/member out-of-pocket maximum has been met. Payment based on a higher percentage.
N210	You may appeal this decision.
N211	You may not appeal this decision.

Thinking It Through — 14.2

Review the RA/EOB from Medicare for assigned claims shown in Figure 14.4, locating the highlighted claims that contain these data:

A. GRP/RC AMT CO-42 $18.04

B. GRP/RC AMT PR-96 $162.13

1. What do the adjustment codes mean in the first claim?
2. What do the adjustment codes mean in the second claim?
3. In the second claim, the modifier –GY is appended to the E/M code 99397. What does this modifier mean? Check Chapter 10, Medicare, if necessary to interpret this information. Who is responsible for payment?

```
MEDICARE PART B                                    600000162                100554462
PROVIDER #:
CHECK/EFT #:100554462          12/27/04            PAGE #:  2 OF 3

PERF PROV  SERV DATE  POS NOS   PROC   MODS      BILLED    ALLOWED  DEDUCT    COINS      GRP/RC-AMT     PROV PD

NAME                        HIC             ACNT                    ICN 2204350383560  ASG Y  MOA MA01
110008957  1210 121004 11    1 99214                130.00     90.19    0.00     18.04 CO-42     39.81      72.15
PT RESP    18.04               CLAIM TOTALS         130.00     90.19    0.00     18.04           39.81      72.15
                                                                                                    72.15 NET

NAME                        HIC             ACNT                    ICN 2204350383450  ASG Y  MOA MA01  MA18
110005232  1213 121304 11    1 99212                 60.00     41.65    0.00      8.33 CO-42     18.35      33.32
PT RESP     8.33               CLAIM TOTALS          60.00     41.65    0.00      8.33           18.35      33.32
CLAIM INFORMATION FORWARDED TO: WORLDNET SERVICES CORPORATI                                         33.32 NET

NAME                        HIC             ACNT                    ICN 2204350383510  ASG Y  MOA MA01  MA18
110008957  1210 121004 11    1 99213                 85.00     57.87    0.00     11.57 CO-42     27.13      46.30
PT RESP    11.57               CLAIM TOTALS          85.00     57.87    0.00     11.57           27.13      46.30
CLAIM INFORMATION FORWARDED TO: ANTHEM BCBS/CT STATE RETIRE                                         46.30 NET

NAME                        HIC             ACNT                    ICN 2204350383500  ASG Y  MOA MA01  MA18
110005232  1213 121304 11    1 99397 GY             162.13      0.00    0.00      0.00 PR-96    162.13       0.00
110005232  1213 121304 11    1 93000                 70.00      0.00    0.00      0.00 PR-49     70.00       0.00
110005232  1213 121304 11    1 99213 25              57.87     57.87    0.00     11.57                      46.30
PT RESP   243.70               CLAIM TOTALS         290.00     57.87    0.00     11.57          232.13      46.30
CLAIM INFORMATION FORWARDED TO: BENEFIT PLANNERS                                                    46.30 NET

NAME                        HIC             ACNT                    ICN 2204350383550  ASG Y  MOA MA01  MA18
110008957  1210 121004 11    1 99214                130.00     90.19    0.00     18.04 CO-42     39.81      72.15
PT RESP    18.04               CLAIM TOTALS         130.00     90.19    0.00     18.04           39.81      72.15
CLAIM INFORMATION FORWARDED TO: ANTHEM BCBS/CT STATE RETIRE                                         72.15 NET
```

FIGURE 14.4 Medicare RA

Reviewing and Processing RAs/EOBs

An RA/EOB repeats the unique claim control number that the provider assigned to the claim when sending it. This number is the resource needed to match the payment to a claim. To process the RA/EOB, each claim is located in the practice management program—either manually or automatically by the computer system. The remittance data are reviewed and then posted to the PMP.

Reviewing RAs/EOBs

This procedure is followed to double-check the remittance data:

1. Check the patient's name, account number, insurance number, and date of service against the claim.
2. Verify that all billed CPT codes are listed.
3. Check the payment for each CPT against the expected amount, which may be an allowed amount or a percentage of the usual fee. Many practice management programs build records of the amount each payer has paid for each CPT code as the data are entered. When another RA/EOB payment for the same CPT is posted, the program highlights any discrepancy for review.
4. Analyze the payer's adjustment codes to locate all unpaid, downcoded, or denied claims for closer review.
5. Decide whether any items on the RA/EOB need clarifying with the payer, and follow up as necessary.

Billing Tips

Paper Check Processing

- Because payments may be mailed, the practice's mail should be opened daily and checks deposited according to the office's guidelines.
- All checks that come into the practice should be routed through the staff member who processes claims.

Procedures for Posting

Many practices that receive RAs/EOBs authorize the payer to provide an **electronic funds transfer (EFT)** of the payment. Payments are deposited directly into the practice's bank account. Otherwise, the payer sends a check to the practice, and the check is taken to the practice's bank for deposit.

Posting and Applying Payments and Adjustments

Payment and adjustment transactions are entered in the practice management program. The data entry includes:

- Date of deposit.
- Payer name and type.
- Check or EFT number.
- Total payment amount.
- Amount to be applied to each patient's account, including type of payment. Codes are used for payments, adjustments, deductibles, and the like.

Some PMPs have an **autoposting** feature. Instead of posting payments manually, this feature automatically posts the payment data in the RA/EOB to the correct account. The software allows the user to establish posting rules, such as "post a payment automatically only if the claim is paid at 100 percent," so that the medical insurance specialist can examine claims that are not paid as expected.

Reconciling Payments

The process of **reconciliation** means making sure that the totals on the RA/EOB check out mathematically. The total amount billed minus the adjustments

(such as for allowed amounts and patient responsibility to pay) should equal the total amount paid. For example, study this report for an assigned claim:

POS	PROC MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
11	99213	85.00	57.87	0.00	11.57	CO-42 27.13	46.30

RECONCILIATION

Amount Billed	$85.00
(Coinsurance)	–11.57
(GRP/RC Amount)	–27.13
Payment	$46.30

In this case, the allowed amount (ALLOWED) of $57.87 is made up of the coinsurance (COINs) to be collected from the patient of $11.57 plus the amount the payer pays to the provider (PROV PD) of $46.30. The difference between the billed amount (BILLED) of $85.00 and the allowed amount of $57.87 is $27.13. This amount is written off unless it can be billed to the patient under the payer's rules.

Billing Tip

Auditing Payments per Contract Terms
Verify that payments are correct according to payers' participation contracts. This double-check is particularly important if payments are autoposted. In this case, periodically post a representative number of RAs/EOBs manually as an audit to uncover any payment problems.

Denial Management

Typical problems and solutions are:

- *Rejected claims:* A claim that is not paid due to incorrect information must be corrected and sent to the payer according to its procedures.
- *Procedures not paid*: If a procedure that should have been paid on a claim was overlooked, another claim is sent for that procedure.
- *Partially paid, denied, or downcoded claims*: If the payer has denied payment, the first step is to study the adjustment codes to determine why. If a procedure is not a covered benefit or if the patient was not eligible for that benefit, typically the next step will be to bill the patient for the noncovered amount. If the claim is denied or downcoded for lack of medical necessity, a decision about the next action must be made. The options are to bill the patient, write off the amount, or challenge the determination with an appeal, as discussed on page 464. Some provider contracts prohibit billing the patient if an appeal or necessary documentation has not been submitted to the payer.

Billing Tip

Organize Before Calling
Before calling a payer to question a claim determination, prepare by gathering the RA/EOB, the patient's medical record, and the claim data. Be ready to explain the situation and to politely ask to speak to a supervisor if necessary.

To improve the rate of paid claims over time, medical insurance specialists track and analyze each payer's reasons for denying claims. This record may be kept in a denial log or by assigning specific denial-reason codes for the practice management program to store and report on. Denials should be grouped into categories, such as:

- Coding errors (incorrect unbundling, procedure codes not payable by plan with the reported diagnosis codes)
- Registration mistakes, such as incorrect patient ID numbers
- Billing errors, such as failure to get required preauthorizations or referral numbers
- Payer requests for more information or general delays in claims processing

The types of denials should be analyzed to find out what procedures can be implemented to fix the problems. For example, educating the staff members responsible for getting preauthorizations about each payer's requirements may be necessary.

Thinking It Through — 14.3

Based on the following RA/EOB:

1. What is the total amount paid by check? (Fill in the "amount paid provider" column before calculating the total.)
2. Were any procedures paid at a rate lower than the claim charge? If so, which?
3. Why do you think there is no insurance payment for services for Gloria Vanderhilt?
4. Was payment denied for any claim? For what reason?

Date prepared: 6/22/2008 **Claim number:** 0347914

Patient's name	Dates of service from - thru	POS	Proc	Qty	Charge amount	Eligible amount	Patient liability	Amt paid provider
Kavan, Gregory	04/15/04 - 04/15/04	11	99213	1	$48.00	$48.00	$4.80	______
Ferrara, Grace	05/11/04 - 05/11/04	11	99212	1	$35.00	$35.00	$3.50	______
Cornprost, Harry	05/12/04 - 05/12/04	11	99214	1	$64.00	$54.00	-0-	______
Vanderhilt, Gloria	05/12/04 - 05/12/04	11	99212	1	$35.00	$35.00	$35.00	-0-
Dallez, Juan	05/13/04 - 05/13/04	11	99212	1	$35.00	*	*	-0-

* * * * * * * * *Check #1039242 is attached in the amount of ________* * * * * * * * *

*** Procedure not covered under Medicaid**

Appeals, Postpayment Audits, Overpayments, and Grievances

After RAs/EOBs are reviewed and processed, events that may follow can alter the amount of payment. When a claim has been denied or payment reduced, an appeal may be filed with the payer for reconsideration, possibly reversing the nonpayment. Postpayment audits by payers may change the initial determination. Under certain conditions, refunds may be due to either the payer or the patient. In some cases, the practice may elect to file a complaint with the state insurance commissioner.

The General Appeal Process

An **appeal** is a process that can be used to challenge a payer's decision to deny, reduce, or otherwise downcode a claim. A provider may begin the appeal process by asking for a review of the payer's decision. Patients, too, have the right to request appeals. The person filing the appeal is the **claimant** or the **appellant**, whether that individual is a provider or a patient.

Basic Steps

Each payer has consistent procedures for handling appeals. These procedures are based on the nature of the appeal. The practice staff reviews the appropriate

procedure before starting an appeal and plans its actions according to the rules. Appeals must be filed within a specified time after the claim determination. Most payers have an escalating structure of appeals, such as (1) a complaint, (2) an appeal, and (3) a grievance. The claimant must move through the three levels in pursuing an appeal, starting at the lowest and continuing to the highest, final level. Some payers also set a minimum amount that must be involved in an appeal process, so that a lot of time is not spent on a small dispute.

Options After Appeal Rejection

A claimant can take another step if the payer has rejected all the appeal levels on a claim. Because they license most types of payers, state insurance commissions have the authority to review appeals that payers reject. If a claimant decides to pursue an appeal with the state insurance commission, copies of the complete case file—all documents that relate to the initial claim determination and the appeal process—are sent, along with a letter of explanation.

Medicare Appeals

Medicare participating providers have appeal rights. Note, though, that there is no need to appeal a claim if it has been denied for minor errors or omissions. The provider can instead ask the Medicare carrier to reopen the claim so the error can be fixed, rather than going through the appeals process. However, if a claim is denied because of untimely submission (it was submitted after the timely filing deadline), it cannot be appealed.

The current Medicare appeals process is the result of changes in the law; the Medicare, Medicaid, and SCHIP Benefits and Improvement Act of 2000, known as BIPA, and the Medicare Modernization Act significantly changed these procedures. The Medicare appeal process involves five steps:

1. *Redetermination*: The first step, called **redetermination**, is a claim review by an employee of the Medicare carrier who was not involved in the initial claim determination. The request, which must be made within 120 days of receiving the initial claim determination, is made by completing a form (Figure 14.5 on page 466) or writing a letter and attaching supporting medical documentation. If the decision is favorable, payment is sent. If the redetermination is either partially favorable or unfavorable, the answer comes as a letter (see Figure 14.6 on page 467) called the **Medicare Redetermination Notice (MRN)**. The decision must be made within 60 days; and the letter is sent to both the provider and the patient.
2. *Reconsideration*: The next step is a reconsideration request. This request must be made within 180 days of receiving the redetermination notice. At this level, the claim is reviewed by qualified independent contractors (QIC).
3. *Administrative law judge*: The third level is a hearing by an administrative law judge. The amount in question must be over $110, and the hearing must be requested within 60 days of receiving the reconsideration notice.
4. *Department appeals board*: The fourth level must be requested within 60 days of receiving the response from the hearing by the administrative law judge. No monetary amount is specified.
5. *Federal court (judicial) review:* The fifth and final Medicare appeal level is a hearing in federal court. The amount in dispute must be at least $1,090, and the hearing must be requested within 60 days of receiving the department appeals board decision.

Billing Tip

Late Claims Not Appealable
A claim that is denied because it was not timely filed is not subject to appeal.

Billing Tip

Calendar Days, Not Working Days
Note that the timelines for each appeal level are calendar days (including weekends), not working days.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM

1. Beneficiary's Name: ____________________
2. Medicare Number: ____________________
3. Description of Item or Service in Question: ____________________
4. Date the Service or Item was Received: ____________________
5. I do not agree with the determination of my claim. MY REASONS ARE:
6. Date of the initial determination notice ____________________
   (If you received your initial determination notice more than 120 days ago, include your reason for not making this request earlier.)
7. Additional Information Medicare Should Consider: ____________________
8. Requester's Name: ____________________
9. Requester's Relationship to the Beneficiary: ____________________
10. Requester's Address: ____________________
11. Requester's Telephone Number: ____________________
12. Requester's Signature: ____________________
13. Date Signed: ____________________
14. ❑ I have evidence to submit. (Attach such evidence to this form.)
    ❑ I do not have evidence to submit.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.

Form CMS-20027 (05/05) EF 05/2005

FIGURE 14.5 Medicare Request for Redetermination Form

Compliance Guideline

Patients' Rights Under Medicare
A beneficiary may request an itemized statement from the provider. A provider who does not comply within thirty days may be fined $100 per outstanding request. The beneficiary may examine the itemized statement and request review of questionable or unclear charges. The provider is required to work with the enrollee to explain discrepancies.

Postpayment Audits

Most postpayment reviews are used to build clinical information. Payers use their audits of practices, for example, to study treatments and outcomes for patients with similar diagnoses. The patterns that are determined are used to confirm or alter best practice guidelines.

At times, however, the postpayment audit is done to verify the medical necessity of reported services or to uncover fraud and abuse. The audit may be based on the detailed records about each provider's services that are kept by payers' medical review departments. Some payers keep records that go back

MODEL

Medicare Number of Beneficiary:
111-11-1111 A

Contact Information
If you questions, write or call:
Contractor Name
Street Address
City, State Zip
Phone Number

MEDICARE APPEAL DECISION

MONTH, DATE, YEAR

APPELLANT'S NAME
ADDRESS
CITY, STATE ZIP

Dear *Appellant's Name*:

This letter is to inform you of the decision on your Medicare Appeal. An appeal is a new and independent review of a claim. You are receiving this letter because you made an appeal for *(insert: name of item or service).*

The appeal decision is
(*Insert either:* ***unfavorable.*** *Our decision is that your claim in not covered by Medicare and over/under $100 remains in controversy.*
OR ***partially favorable****. Our decision is that your claim is partially covered by Medicare. and over/under $100 remains in controversy)*

More information on the decision is provided below. You are not required to take any action. However, if you disagree with the decision, you may appeal to *(insert: an Administrative Law Judge (for Part A), a Hearing Officer (for part B)).* You must file your appeal, in writing, within (*insert: 6 months (for Part B) or 60 days (for Part A)* of receiving this letter.

A copy of this letter was also sent to *(Insert: Beneficiary Name or Provider Name). (Insert: Contractor Name)* was contracted by Medicare to review your appeal. For more information on how to appeal, see the section titled "Important Information About Your Appeal Rights."

Summary of the Facts
Instructions: You may present this information in this format, or in paragraph form.

Provider	Dates of Service	Type of Service
Insert: Provider Name	*Insert: Dates of Service*	*Insert: Type of Service*

- A claim was submitted for (*insert: kind of services and specific number)*.
- An initial determination on this claim was made on (*insert: Date)*.
- The *(insert: service(s)/item(s) were/was)* denied because (*insert: reason*).
- On (*insert: date)* we received a request for a redetermination.
- *(Insert: list of documents)* was submitted with the request.

Decision
Instructions: Insert a brief statement of the decision, for example "We have determined that the above claim is not covered by Medicare. We have also determined that you are responsible for payment for this service."

Explanation of the Decision
Instructions: This is the most important element of the redetermination. Explain the logic/reasons that led to your final determination. Explain what policy (including local medical review policy, regional medical review policy, and/or national coverage policy), regulations and/or laws were used to make this determination. Make sure that the explanation contained in this paragraph is clear and that it included an explanation of why the claim can or cannot be paid. Statements such as "not medically reasonable and necessary under Medicare guidelines" or "Medicare does not pay for X" provide conclusions instead of explanation, and are not sufficient to meet the requirement of this paragraph.

Who is Responsible for the Bill?
Instructions: Include information on limitation of liability, waiver of recovery, and physician/supplier refund requirements as applicable.

What to Include in Your Request for an Independent Appeal
Instruction: If the denial was based on insufficient documentation or if specific types of documentation are necessary to issue a favorable decision, please indicate what documentation would be necessary to pay the claim.

Sincerely,

Reviewer Name
Contractor Name
A Medicare Contractor

FIGURE 14.6 Medicare Redetermination Notice

for many months or years. The payer analyzes these records to assess patterns of care from individual providers and to flag outliers—those that differ from what other providers do. A postpayment audit might be conducted to check the documentation of the provider's cases or, in some cases, to check for fraudulent practices (see Chapters 2 and 7).

Thinking It Through 14.4

In a large practice of forty providers, the staff responsible for creating claims and billing is located in one building, and the staff members who handle RAs/EOBs work at another location. In your opinion, what difficulties might this separation present? What strategies can be used to ensure the submission of complete and compliant claims?

Billing Tip

Medicare Beneficiaries and Overpayments
Medicare beneficiaries are notified when their providers receive overpayment notices from Medicare. Patients may be given the choice of receiving refund checks from the provider or credits on their accounts.

Compliance Guideline

Finding Overpayments Proactively
Part of the practice's compliance plan is a regular procedure to self-audit and discover whether overbilling has occurred—and to send the payer a notice of the situation and a refund.

Refunds of Overpayments

From the payer's point of view, **overpayments** (also called credit balances) are improper or excessive payments resulting from billing errors for which the provider owes refunds. Examples are:

- A payer may mistakenly overpay a claim.
- A payer's postpayment audit may find that a claim that has been paid should be denied or downcoded because the documentation does not support it.
- A provider may collect a primary payment from Medicare when another payer is primary.

In such cases, reimbursement that the provider has received is considered an overpayment, and the payer will ask for a refund (with the addition of interest for Medicare). If the audit shows that the claim was for a service that was not medically necessary, the provider also must refund any payment collected from the patient.

Often, the procedure is to promptly refund the overpayment. Many states require the provider to make the refund payment unless the overpayment is contested, which it may be if the provider thinks it is erroneous. A refund request may also be challenged because:

- Many practices set a time period beyond which they will not automatically issue a refund.
- State law may also provide for a reasonable time limit during which payers can recoup overpayments. For example, Missouri gives insurance companies twelve months from the date they processed the claim to request refunds; Maryland's period is six months.

Grievances

If a medical practice believes that it has been treated unfairly by an insurance company, it has the right to file a **grievance** with the state insurance commission. The law requires the state to investigate the complaint, and the state can require the insurance company to answer. Grievances, like appeals, require a good deal of staff time and effort. They should be filed when repeated unresolved problems cannot otherwise be worked out with payers. The state insurance commission sets the requirements and steps for pursuing this option.

Billing Secondary Payers

If a patient has additional insurance coverage, after the primary payer's RA/EOB has been posted, the next step is billing the second payer. The primary claim, of course, gave that payer information about the patient's secondary insurance pol-

icy. The secondary payer now needs to know what the primary payer paid on the claim in order to coordinate benefits. The primary claim crosses over automatically to the secondary payer in many cases—Medicare-Medicaid and Medicare-Medigap claims, as well as others—and no additional claim is filed. For non-crossover claims, the medical insurance specialist prepares an additional claim for the secondary payer and sends it with a copy of the RA/EOB.

Electronic Claims

The medical insurance specialist transmits a claim to the secondary payer with the primary RA/EOB, sent either electronically or on paper, according to the payer's procedures. The secondary payer determines whether additional benefits are due under the policy's coordination of benefits (COB) provisions and sends payment with another RA/EOB to the billing provider. This flow is shown in Figure 14.7(a).

The practice does not send a claim to the secondary payer when the primary payer handles the coordination of benefits transaction. In this case, the primary payer electronically sends the COB transaction, which is the same HIPAA 837 that reports the primary claim, to the secondary payer. This flow is shown in Figure 14.7(b).

When the primary payer forwards the COB transaction, a message appears on the primary payer's RA/EOB. For example, on the Medicare RA shown in Figure 14.4 on page 461, COB is indicated by the phrase "CLAIM INFORMATION FORWARDED TO," followed by the name of the secondary payer, such as Worldnet Services Corporation, Anthem BCBS/CT State Retirement, Benefit Planners, and so forth. Medicare has a consolidated claims crossover process that is managed by a special coordination of benefits contractor (COBC). Plans that are supplemental to Medicare sign one national crossover agreement.

Billing Tip

Coordination of Benefits (COB)
Many health plans receive Medicare claims automatically when they are the secondary payer. Do not send a paper claim to the secondary payer upon receipt of the RA/EOB; it will be coded as a duplicate claim and rejected.

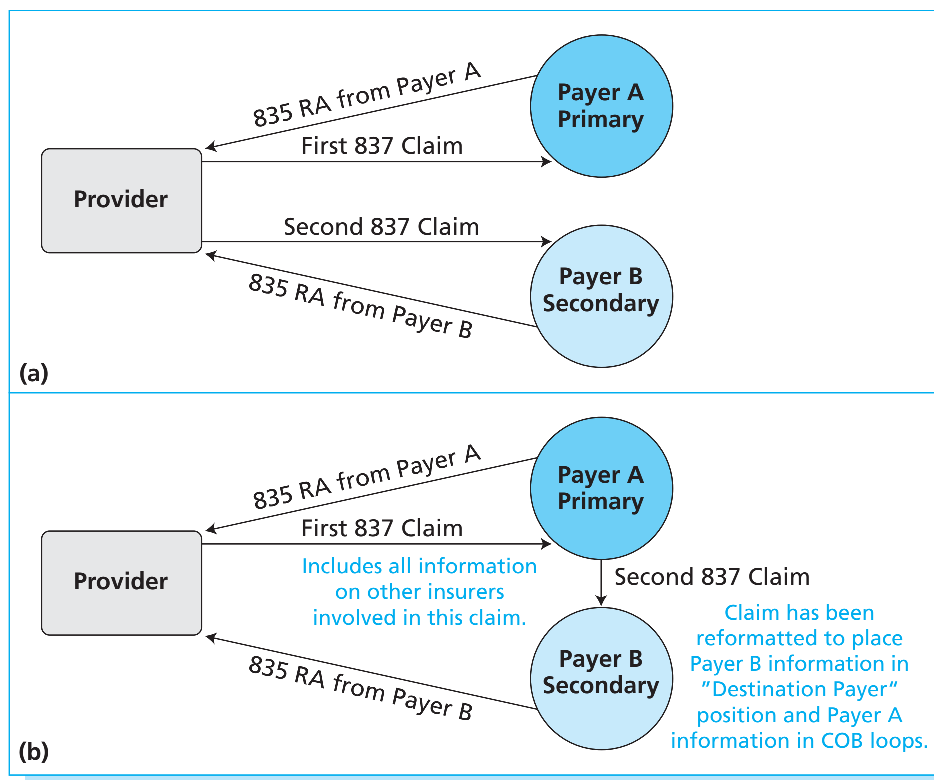

FIGURE 14.7 (a) Provider-to-Payer COB Model, (b) Provider-to-Payer-to-Payer COB Model

HIPAA Tip

PHI on RAs/EOBs

Black out other patients' protected health information (PHI) on printed RAs/EOBs being sent to secondary payers.

Paper Claims

If a paper RA/EOB is received, the procedure is to use the CMS-1500 to bill the secondary health plan that covers the beneficiary. The medical insurance specialist completes the claim form and sends it with the primary RA/EOB attached.

The Medicare Secondary Payer (MSP) Program, Claims, and Payments

Benefits for a patient who has both Medicare and other coverage are coordinated under the rules of the **Medicare Secondary Payer (MSP)** program. The Medicare Coordination of Benefits department receives inquiries regarding Medicare as second payer and has information on a beneficiary's eligibility for benefits and the availability of other health insurance that is primary to Medicare.

If Medicare is the secondary payer to one primary payer, the claim must be submitted using the HIPAA 837 transaction unless the practice is excluded from electronic transaction rules. The 837 must report the amount the primary payer paid for the claim or for a particular service line (procedure) in the Allow Amount field. Claims for which more than one plan is responsible for payment prior to Medicare, however, should be submitted using the CMS-1500 claim form. The other payers' RAs/EOBs must be attached when the claim is sent to Medicare for processing.

Billing Tip

Submit MSP Claims for Zero Balances
Send an MSP claim to Medicare even when the primary payer has fully paid the bill and the patient owes nothing so that the amount paid can be credited to the patient's Medicare Part B annual deductible.

Following MSP Rules

The medical insurance specialist is responsible for identifying the situations where Medicare is the secondary payer and for preparing appropriate primary and secondary claims. A form such as that shown in Figure 14.8 is used to gather and validate information about Medicare patients' primary plans during the patient check-in process.

Over Age Sixty-Five and Employed

When an individual is employed and is covered by the employer's group health plan, Medicare is the secondary payer. This is the case for employees who are on leaves of absence, even if they are receiving short- or long-term disability benefits. Medicare is also secondary when an individual over age sixty-five is covered by a spouse's employer (even if the spouse is younger than sixty-five). On the other hand, Medicare is the primary carrier for:

- An individual who is working for an employer with twenty employees or fewer
- An individual who is covered by another policy that is not a group policy
- An individual who is enrolled in Part B but not Part A of the Medicare program
- An individual who must pay premiums to receive Part A coverage
- An individual who is retired and receiving coverage under a previous employer's group policy

Disabled

If an individual under age sixty-five is disabled and is covered by an employer group health plan (which may be held by the individual, a spouse, or another family member), Medicare is the secondary payer. If the individual or family

Patient's Name ______________________________ Medicare # ______________________

▪ **Medicare Secondary Payer Screening Questionnaire**

1. Are you covered by the Veterans Administration, the Black Lung Program, or Workers Compensation? If so which one? - ________________ ( ) Yes ( ) No
2. Is this illness or injury due to any type of accident? ( ) Yes ( ) No
3. Are you age 65 or older? ( ) Yes ( ) No
   a. Are you currently employed? ( ) Yes ( ) No
   b. Is your spouse currently employed? ( ) Yes ( ) No
4. Are you age 65 or under? ( ) Yes ( ) No
   a. Are you covered by any employer Group Health Plan? ( ) Yes ( ) No
   b. Or another large Group Health Plan? ( ) Yes ( ) No

▪ **Authorization Statement and Payment Agreement**

I declare under penalty of perjury that I do not have another primary insurance carrier to pay for medical care rendered to me by ______________________________, and that all information with regard to residence, employment, and income is correct to the best of my knowledge.

I request that payment of authorized Medicare Benefits be made to this health center for any services furnished to me by its physicians or suppliers.

I understand that my signature requests that payment be made and that it authorizes release of medical information necessary to pay the claim(s). If a secondary insurance carrier is involved my signature also authorizes releasing information to the insurer or agency shown.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determined by the Medicare Carrier as full charge, and the patient is responsible only for the deductible (Excluding UGS/Medicare) coinsurance and noncovered services. Coinsurance and deductible are based upon charge determined by the Medicare carrier.

____ ____________________________
Signature of Patient or Authorized Representative Date

____ ____________________________
Witnessed by Date

FIGURE 14.8 Medicare Secondary Payer Screening Questionnaire

member is not actively employed, Medicare is the primary payer. Medicare is also the primary payer for:

- An individual and family members who are retired and receiving coverage under a group policy from a previous employer
- An individual and family members who are working for an employer with a hundred employees or fewer
- An individual and family members receiving coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; see Chapter 9)
- An individual who is covered by another policy that is not a group policy

End-Stage Renal Disease (ESRD)

During a coordination-of-benefits period, Medicare is the secondary payer for individuals who are covered by employer-sponsored group health plans and who fail to apply for ESRD-based Medicare coverage. The coordination-of-benefits

period begins the first month the individual is eligible for or entitled to Part A benefits based on an ESRD diagnosis. This rule is in effect regardless of whether the individual is employed or retired.

Workers' Compensation

If an individual receives treatment for a job-related injury or illness, Medicare coverage (and private insurance) is secondary to workers' compensation coverage (see Chapter 13). Included in this category is the Federal Black Lung Program, a government program that provides insurance coverage for coal miners. When an individual suffers from a lung disorder caused by working in a mine, Medicare is secondary to the Black Lung coverage. If the procedure or diagnosis is for something other than a mining-related lung condition, Medicare is the primary payer.

Automobile, No-Fault, and Liability Insurance

Medicare (and private insurance) is always the secondary payer when treatment is for an accident-related claim, whether automobile, no-fault (injuries that occur on private property, regardless of who is at fault), or liability (injuries that occur on private property when a party is held responsible).

Veterans' Benefits

If a veteran is entitled to Medicare benefits, he or she may choose whether to receive coverage through Medicare or through the Department of Veterans Affairs.

MSP Claims and Payments

Table 14.4 provides details for completing an MSP CMS-1500. Three formulas are used to calculate how much of the patient's coinsurance will be paid by Medicare under MSP. Of the three amounts, Medicare will pay the lowest. The formulas use Medicare's allowable charge, the primary insurer's allowable charge, and the actual amount paid by the primary payer. Medicare, as the secondary payer, pays 100 percent of most coinsurance payments if the patient's Part B deductible has been paid. See Figure 14.9 on page 475.

The three formulas are:

1. Primary payer's allowed charge minus payment made on claim
2. What Medicare would pay (80 percent of Medicare allowed charge)
3. Higher allowed charge (either primary payer or Medicare) minus payment made on the claim

> **Compliance Guideline**
>
> **Patient Coinsurance When Medicare Is Secondary**
> Medicare patients should not be charged for the primary insurance coinsurance until the RA is received and examined, because the patient is entitled to have Medicare pay these charges. A patient who has not met the deductible is, however, responsible for the coinsurance, and that amount is applied toward the deductible.

Example

A patient's visit allowed charge from the primary payer is \$100, and the primary payer pays \$80, with a \$20 patient coinsurance. Medicare allows \$80 for the service. The patient has met the Part B deductible. The calculations using the three formulas result in amounts of (1) \$100 - \$80 = \$20, (2) \$80 × 80 percent = \$64, and (3) \$100 - \$80 = \$20. Medicare will pay \$20, since this is the lowest dollar amount from the three calculations.

Medicare pays up to the higher of two allowable amounts when another plan is primary. But if the primary payer has already paid more than the Medicare allowed amount, no additional payment is made.

Table 14.4 Medicare Secondary Payer (MSP) CMS-1500 (08/05) Claim Completion

Item Number	Content
1	Check both Medicare and either Group Health Plan or Other as appropriate for the patient's primary insurance.
1a	Enter the Medicare health insurance claim number that appears on the patient's Medicare card.
2	Record the patient's name *exactly* as it appears on the Medicare card, entering it in last name, first name, middle initial order.
3	Enter the patient's date of birth in eight-digit format; select male or female.
4	Enter the name of the insured person who has the primary coverage. If the insured is the patient, enter SAME.
5	Enter the patient's mailing address.
6	Select the appropriate box for the relationship: Self, spouse, child, or other.
7	If the patient and the insured are the same person, leave blank. If the insured's address is the same as the patient's, enter SAME. If the insured's address is different, enter the mailing address.
8	Select the appropriate boxes for marital status and employment status.
9a-d	Leave blank.
10a–10c	Choose the appropriate box to indicate whether the patient's condition is the result of a work injury, an automobile accident, or another type of accident.
10d	Leave blank.
11	Enter the insured's policy/group number.
11a	Enter the insured's date of birth and sex if they differ from the information in IN 3.
11b	If the policy is obtained through an employer or a school, enter the name in IN 11b; otherwise leave it blank. If the patient's employment status has changed—for example, if the patient has retired— enter RETIRED followed by the retirement date.
11c	Name or plan ID of the primary insurance.
11d	Leave blank.
12	Enter "Signature on File," "SOF," or a legal signature per practice policy.
13	Enter"Signature on File," "SOF," or a legal signature to indicate that there is a signature on file assigning benefits to the provider from the primary insurance.
14	Enter the date that symptoms first began for the current illness, injury, or pregnancy.
15	Leave blank.
16	Enter the dates the patient is employed but unable to work in the current occupation.
17	Enter the name (first name, middle initial, last name) and credentials of the professional who referred or ordered the services or supplies on the claim.
17a	Enter the appropriate identifying number (either NPI or non-NPI/qualifier) for the referring physician.
18	If the services provided are needed because of a related inpatient hospitalization, the admission and discharge dates are entered. For patients still hospitalized, the admission date is listed in the From box, and the To box is left blank.
19	Complete according to the carrier's instructions.
20	Complete if billing for outside lab services.
21	Enter up to four ICD-9-CM codes in priority order. At least one code must be reported.
22	Leave blank.
23	Enter the preauthorization number assigned by the payer or a CLIA number.
24A	Enter the date(s) of service.
24B	Enter the place of service (POS) code.
24C	Check with the payer to determine whether this element (emergency indicator) is necessary. If required, enter Y (yes) or N (no) in the unshaded bottom portion of the field.
24D	Enter the CPT/HCPCS codes and applicable modifiers for services provided. Do not use hyphens.
24E	Using the numbers (1, 2, 3, 4) listed to the left of the diagnosis codes in IN 21, enter the diagnosis for the each service listed in IN 24D.

(continued on next page)

Table 14.4 **Medicare Secondary Payer (MSP) CMS-1500 (08/05) Claim Completion** ***continued***

Item Number	Content
24F	For each service listed in IN 24D, enter charges without dollar signs or decimals. If the claim reports an encounter with no charge, such as a capitated visit, a value of zero (0) may be used.
24G	Enter the number of days or units, as applicable.
24H	Leave blank.
24I–24J	Enter the NPI or non-NPI/qualifier.
25	Enter the physician's or supplier's federal tax identification number and check the appropriate box for SSN or EIN.
26	Enter the patient account number used by the practice's accounting system.
27	If the physician accepts assignment for the primary payer and Medicare, select Yes.
28	Enter the total of all charges in IN 24F.
29	Enter the amount of the payments received for the services listed on this claim from the patient. Attach the RA/EOB to show what the primary payer paid.
30	Leave blank.
31	Enter the provider's signature, the date of the signature, and credentials or SOF.
32	Enter the name, address, city, state, and ZIP code of the location where the services were rendered if other than the physician's office or the patient's home, or enter SAME.
33	Enter the provider name, address, ZIP code, telephone number, NPI, non-NPI number, and appropriate qualifier. The NPI should be placed in FL 33a. Enter the identifying non-NPI number and qualifier in FL 33b.

TRICARE CMS-1500 Secondary Claims

When TRICARE is the secondary payer, six item numbers on a paper claim are filled in differently than when TRICARE is the primary payer:

Item Number	Content
11	Policy number of the primary insurance plan
11a	Birth date and gender of the primary plan policyholder
11b	Employer of the primary plan policyholder if the plan is a group plan through an employer
11c	Name of the primary insurance plan
11d	Select Yes or No as appropriate.
29	Enter all payments made by other insurance carriers. Do not include payments made by the patient.

Medicare and Medicaid

If a patient is covered by both Medicare and Medicaid (a Medi-Medi beneficiary), Medicare is primary. The claim that is sent to Medicare is automatically crossed over to Medicaid for secondary payment. In this case, if a paper claim is completed, the Item Numbers are as indicated in Table 14.5 on pages 476–477.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

Field	Entry
1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	X Medicare; X Group Health Plan
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	123455669A
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	RAMOS CARLA D
3. PATIENT'S BIRTH DATE (MM DD YY) / SEX (M / F)	05 13 1933 / F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	SAME
5. PATIENT'S ADDRESS (No., Street)	28 PARK STREET
6. PATIENT RELATIONSHIP TO INSURED (Self / Spouse / Child / Other)	Self X
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	KANSAS CITY / MO
8. PATIENT STATUS (Single / Married / Other)	Single X
CITY / STATE (insured)	
ZIP CODE / TELEPHONE (Include Area Code)	64111 / (816) 555 2185
Employed / Full-Time Student / Part-Time Student	Employed X
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) (insured)	( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S POLICY GROUP OR FECA NUMBER	G2IX
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / NO	NO X
a. INSURED'S DATE OF BIRTH (MM DD YY) / SEX (M / F)	
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) / SEX (M / F)	
b. AUTO ACCIDENT? YES / NO / PLACE (State)	NO X
b. EMPLOYER'S NAME OR SCHOOL NAME	CORELLI INC
c. EMPLOYER'S NAME OR SCHOOL NAME	
c. OTHER ACCIDENT? YES / NO	NO X
c. INSURANCE PLAN NAME OR PROGRAM NAME	PLAINS HEALTH PLAN
d. INSURANCE PLAN NAME OR PROGRAM NAME	
10d. RESERVED FOR LOCAL USE	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SOF DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SOF

PATIENT AND INSURED INFORMATION

Field	Entry
14. DATE OF CURRENT: (MM DD YY) ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM DD YY)	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM DD YY) TO (MM DD YY)	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	
17a.	
17b. NPI	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM (MM DD YY) TO (MM DD YY)	
19. RESERVED FOR LOCAL USE	
20. OUTSIDE LAB? YES / NO / $ CHARGES	NO X
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24e by Line)	1. 388.31; 2. 477.9; 3. ___ . ___; 4. ___ . ___
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

	24. A. DATE(S) OF SERVICE From (MM DD YY)	To (MM DD YY)	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID.#
1	10 01 2008		11		99204		1,2	128 00	1		NPI	
2	10 01 2008		11		92557		1	95 00	1		NPI	
3	10 01 2008		11		92567		1	10 00	1		NPI	
4											NPI	
5											NPI	
6											NPI	

Field	Entry
25. FEDERAL TAX I.D. NUMBER / SSN EIN	016778002 / EIN X
26. PATIENT'S ACCOUNT NO.	RAM04
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO	YES X
28. TOTAL CHARGE	$ 313 00
29. AMOUNT PAID	$ 20 00
30. BALANCE DUE	$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	SIGNED SOF DATE
32. SERVICE FACILITY LOCATION INFORMATION	SAME; a. NPI; b.
33. BILLING PROVIDER INFO & PHONE # ( )	RONALD R BERGEN, 96 YORK AVE, KANSAS CITY MO 64112; a. NPI 0175328865; b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

FIGURE 14.9 CMS-1500 (08/05) Completion for Medicare Secondary Payer (MSP) Claims

Table 14.5	Medicare/Medicaid CMS-1500 (08/05) Claim Completion
Item Number	***Content***
1	Indicate Medicare and Medicaid.
1a	Enter the Medicare health insurance claim number that appears on the patient's Medicare card.
2	Record the patient's name *exactly* as it appears on the Medicare card, entering it in last name, first name, middle initial order.
3	Enter the patient's date of birth in eight-digit format; make the appropriate selection for male or female.
4	Enter the name of the insured if not the patient.
5	Enter the patient's mailing address.
6	Select the appropriate box for the relationship: Self, spouse, child, or other.
7	If the insured's address is the same as the patient's, enter SAME. If it is different, enter the mailing address.
8	Select the appropriate boxes for marital status and employment status.
9	Enter Medicaid patient's full name.
9a	Enter the Medicaid number here or in IN 10d, according to the payer.
9b	Medicaid insured's date of birth if different than patient's.
9c	Leave blank.
9d	Leave blank.
10a–10c	Choose the appropriate box to indicate whether the patient's condition is the result of a work injury, an automobile accident, or another type of accident.
10d	Varies with the insurance plan; complete if instructed.
11	Enter NONE.
11a-d	Leave blank.
12	Enter "Signature on File," "SOF," or a legal signature, per practice policy.
13	Leave blank.
14	Enter the date that symptoms first began for the current illness, injury, or pregnancy.
15	Leave blank.
16	Enter the dates the patient is employed but unable to work in the current occupation.
17	Enter the name and credentials of the professional who referred or ordered the services or supplies on the claim.
17a	Enter the appropriate identifying number (either NPI or non-NPI/qualifier) for the referring physician.
18	If the services provided are needed because of a related inpatient hospitalization, the admission and discharge dates are entered. For patients still hospitalized, the admission date is listed in the From box, and the To box is left blank.
19	Complete according to the carrier's instructions.
20	Complete if billing for outside lab services.
21	Enter up to four ICD-9-CM codes in priority order.
22	Leave blank.
23	Enter the preauthorization number assigned by the payer or a CLIA number.
24A	Enter the date(s) of service, from and to.
24B	Enter the place of service (POS) code that describes the location at which the service was provided.
24C	Check with the payer to determine whether this element (emergency indicator) is necessary. If required, enter Y (yes) or N (no) in the unshaded bottom portion of the field.
24D	Enter the CPT/HCPCS codes and applicable modifiers for services provided. Do not use hyphens.
24E	Using the numbers (1, 2, 3, 4) listed to the left of the diagnosis codes in IN 21, enter the diagnosis for the each service listed in IN 24D.
24F	For each service listed in IN 24D, enter charges without dollar signs or decimals. If the claim reports an encounter with no charge, such as a capitated visit, a value of zero (0) may be used.
24G	Enter the number of days or units, as applicable. If only one service is performed, the numeral 1 must be entered.

(continued on next page)

Table 14.5 **Medicare/Medicaid CMS-1500 (08/05) Claim Completion** *continued*

Item Number	*Content*
24H	Leave blank.
24I–24J	Enter NPI or non-NPI/qualifier.
25	Enter the physician's or supplier's federal tax identification number and check the appropriate box for SSN or EIN.
26	Enter the patient account number used by the practice's accounting system.
27	Select Yes. 28 Enter the total of all charges in IN 24F.
29	Amount of the payments received for the services listed on this claim. If no payment was made, enter "none" or "0.00."
30	Leave blank.
31	Enter the provider's or supplier's signature, the date of the signature, and the provider's credentials (such as MD).
32	Enter the name, address, city, state, and ZIP code of the location where the services were rendered if not the physician's office or the patient's home, or enter SAME. The supplier's NPI is entered in IN 32a. Enter the payer-assigned identifying non-NPI number and qualifier of the service facility in IN 32b.
33	Enter the billing provider's or supplier's name, address, ZIP code, telephone number, NPI, non-NPI number, and appropriate qualifier. The NPI should be placed in IN 33a. Enter the identifying non-NPI number and qualifier of the billing provider in IN 33b.

Thinking It Through — 14.5

Ron Polonsky is a seventy-one-year-old retired distribution manager. He and his wife Sandra live in Lincoln, Nebraska. Sandra is fifty-seven and is employed as a high-school science teacher. She has family coverage through a group health insurance plan offered by the state of Nebraska. Ron is covered as a dependent on her plan. The Medicare Part B carrier for Nebraska is Blue Cross and Blue Shield of Kansas.

Which carrier is Ron's primary insurance carrier? Why?

Review

Steps to Success

- ❒ Read this chapter and review the Key Terms and the Chapter Summary.
- ❒ Answer the Review Questions and Applying Your Knowledge in the Chapter Review.
- ❒ Access the chapter's websites and complete the Internet Activities to learn more about available professional resources.
- ❒ Complete the related chapter in the *Medical Insurance Workbook* to reinforce your understanding of processing payments from payers, handling appeals, and completing secondary claims.

Chapter Summary

1. Payers first perform initial processing checks on claims, rejecting those with missing or clearly incorrect information. During the adjudication process that follows, claims are processed through the payer's automated medical edits; a manual review is done if required; the payer makes a determination of whether to pay, deny, or reduce the claim; and payment is sent with a remittance advice/explanation of benefits (RA/EOB).
2. Automated edits check for (a) patient eligibility for benefits, (b) time limits for filing claims, (c) preauthorization and referral requirements, (d) duplicate dates of service, (e) noncovered services, (f) code linkage, (g) correct bundling, (h) medical review to confirm that services were appropriate and necessary, (i) utilization review, and (j) concurrent care.
3. Medical insurance specialists monitor claims by reviewing the insurance aging report and following up at properly timed intervals based on the payer's promised turnaround time. The HIPAA X12 276/277 Heath Care Claim Status Inquiry/Response (276/277) is used to track claim progress through the adjudication process.
4. The HIPAA X12 835 Health Care Payment and Remittance Advice (HIPAA 835) is the standard transaction payers use to transmit adjudication details and payments to providers. Electronic and paper RAs/EOBs contain the same essential data: (a) a heading with payer and provider information, (b) payment information for each claim, including adjustment codes, (c) total amounts paid for all claims, and (d) a glossary that defines the adjustment codes that appear on the document. These administrative code sets are claim adjustment group codes, claim adjustment reason codes, and remittance advice remark codes.
5. The unique claim control number reported on the RA/EOB is first used to match up claims sent and payments received. Then basic data are checked against the claim; billed procedures are verified; the payment for each CPT is checked against the expected amount; adjustment codes are reviewed to locate all unpaid, downcoded, or denied claims; and items are identified for follow up.
6. Payments are deposited in the practice's bank account, posted in the practice management program, and applied to patients' accounts. Rejected claims must be corrected and re-sent. Missed procedures are billed again. Partially paid, denied, or downcoded claims are analyzed and appealed, billed to the patient, or written off.
7. An appeal process is used to challenge a payer's decision to deny, reduce, or otherwise downcode a claim. Each payer has a graduated level of appeals, deadlines for requesting them, and medical review programs to answer them. In some cases, appeals may be taken beyond the payer to an outside authority, such as a state insurance commission.
8. Filing an appeal may result in payment of a denied or reduced claim. Postpayment audits are usually used to gather information about treat-

ment outcomes, but they may also be used to find overpayments, which must be refunded to payers. Refunds to patients may also be required.

9. Claims are sent to patients' additional insurance plans after the primary payer has adjudicated claims. Sometimes the medical office prepares and sends the claims; in other cases, the primary payer has a coordination of benefits (COB) program that automatically sends the necessary data to secondary payers.
10. Under the Medicare Secondary Payer program, Medicare is the secondary payer when (a) the patient is covered by an employer group health insurance plan or is covered through an employed spouse's plan; (b) the patient is disabled, under age sixty-five, and covered by an employee group health plan; (c) the patient is diagnosed with ESRD but is covered by an employer-sponsored group health plan; (d) the services are covered by workers' compensation insurance; (e) the services are for injuries in an automobile accident; or (f) the patient is a veteran who chooses to receive services through the Department of Veterans Affairs.

Review Questions

Match the key terms with their definitions.

A. medical necessity denial
B. adjudication
C. Medicare Redetermination Notice (MRN)
D. insurance aging report
E. adjustment
F. accounts receivable (A/R)
G. development
H. electronic funds transfer
I. concurrent care
J. determination

_____ 1. Analysis of how long a payer has held submitted claims
_____ 2. Payer paying a service at a different amount than billed
_____ 3. Medical situation in which a patient receives extensive independent care from two or more attending physicians on the same date of service
_____ 4. A payer's refusal to pay for a reported procedure that does not meet its medical necessity criteria
_____ 5. Payer process to review claims
_____ 6. Letter from Medicare to an appellant regarding a first-level appeal
_____ 7. A payer's decision regarding payment of a claim
_____ 8. A banking service for directly transmitting funds from one bank to another
_____ 9. Money that is due to the practice from payers and patients
_____ 10. Payer action to gather clinical documentation and study a claim before payment

Decide whether each statement is true or false.

_____ 1. A claim may be rejected by a payer because the patient has not paid the premium for the reported date of service.
_____ 2. The medical review program is created by the provider's practice manager to adjudicate claims.
_____ 3. A payer's claims examiners are trained medical professionals.
_____ 4. If a patient's medical record clearly documents a high level of evaluation and management service, the associated procedure code is not likely to be reduced by the payer.
_____ 5. The claim turnaround time is often specified by state regulations.
_____ 6. The insurance aging report shows when patients received their statements.
_____ 7. The EFT summarizes the results of the payer's adjudication process.

_____ 8. An appeal can be filed if the provider disagrees with the payer's determination.

_____ 9. The RA/EOB shows the patient's financial responsibility, which is subtracted from the allowed charge to calculate the amount the provider is paid.

_____ 10. The Medicare Secondary Payer program requires Medicaid to cost-share crossover claims.

Select the letter that best completes the statement or answers the question.

_____ 1. A payer's initial processing of a claim screens for
A. utilization guidelines
B. medical edits
C. basic errors in claim data or missing information
D. claims attachments

_____ 2. Some automated edits are for
A. patient eligibility, duplicate claims, and noncovered services
B. valid identification numbers
C. medical necessity reduction denials
D. clinical documentation

_____ 3. A claim may be downcoded because
A. the claim does not list a charge for every procedure code
B. the claim is for noncovered services
C. the documentation does not justify the level of service
D. the procedure code applies to a patient of the other gender

_____ 4. Payers should comply with the required
A. insurance aging report
B. claim turnaround time
C. remittance advice
D. retention schedule

_____ 5. A person filing an appeal is called a
A. guarantor
B. claims examiner
C. medical director
D. claimant

_____ 6. Appeals must always be filed
A. within a specified time
B. by the provider for the patient
C. by patients on behalf of relatives
D. with the state insurance commissioner

_____ 7. If a postpayment audit determines that a paid claim should have been denied or reduced
A. the provider is subject to civil penalties
B. the provider must refund the incorrect payment
C. the provider bills the patient for the denied amount
D. none of the above

_____ 8. If a patient has secondary insurance under a spouse's plan, what information is needed before transmitting a claim to the secondary plan?
A. RA/EOB data
B. 271 data
C. PPO data
D. none of the above

_____ 9. The HIPAA standard transaction that is used to inquire and answer about the status of a claim is
A. 837
B. 835
C. 276/277
D. 980

_____10. Which of the following appears only on secondary claims?
A. primary insurance group policy number
B. primary insurance employer name
C. primary plan name
D. primary payer payment

Define the following abbreviations.

1. RA ______________________________
2. EOB ______________________________
3. MSP ______________________________
4. EFT ______________________________

Applying Your Knowledge

Case 14.1 Auditing Claim Data

The following data elements were submitted to a third-party payer. Using the ICD-9-CM, the CPT/HCPCS, and the place of service codes in Appendix B, audit the information in each case and advise the payer about the correct action.

A. Dx 783.2
CPT 80048
POS 60

B. Dx 518.83
CPT 99241-22

C. Dx 662.30
CPT 54500

Case 14.2 Calculating Insurance Math

Patient ID	Patient Name	Plan	Date of Service	Procedure	Provider Charge	Allowed Amount	Patient Payment (Coinsurance and Deductible)	Claim Adjustment Reason Code	PROV PAY
537-88-5267	Ramirez, Gloria B.	R-1	02/13/2008–2/13/2008	99214	$105.60	$59.00	$8.85	2	$50.15
348-99-2537	Finucula, Betty R.	R-1	01/15/2008–1/15/2008	99292	$88.00	$50.00	$7.50	2	$42.50
537-88-5267	Ramirez, Gloria B.	R-1	02/14/2008–2/14/2008	90732	$38.00	0	$38.00	49	0
760-57-5372	Jugal, Kurt T.	R-1	02/16/2008–2/16/2008	93975 99204	$580.00 $178.00	$261.00 $103.00	$139.15 $15.45	12	$121.8 $87.55
875-17-0098	Quan, Mary K.	PPO-3	02/16/2008–2/16/2008	20004	$192.00	$156.00	$31.20	2	$124.80
								TOTAL	$426.85

The RA/EOB shown above has been received by a provider.

A. What is the patient coinsurance *percentage* required under plan R-1?

____

B. What is the patient coinsurance *percentage* required under plan PPO-3?

____

C. What is Gloria Ramirez's *balance due* for the two dates of service listed?

____

D. Kurt Jugal's first visit of the year is the encounter shown for DOS 2/16/2008. What is the patient *deductible* under plan R-1? (*Hint:* Since the deductible was satisfied by the patient's payment for the first charge, that payment was made up of the deductible and the coinsurance under the plan.)

____

Case 14.3 Using Insurance Terms

Read this information from a Medicare carrier and answer the questions that follow.

Noridian Administrative Services (*a Medicare Carrier)* denies Q4054 (Darbepoetin Alfa) and Q4055 (Epoetin alfa) services when coverage guidelines are not met using the adjustment reason code B5. In the past, we denied these services as beneficiary responsibility. It has now been determined that these denials are a medical necessity denial. As such, the Advance Beneficiary Notice (ABN) rules apply.

Effective for claims received on/after (*date)*, when these services are billed with a –GA modifier, the beneficiary will be held liable for noncovered services. Claims submitted without a –GA modifier will be denied as provider responsibility.

A. Based on Table 14.2 on page 459, what is the meaning of adjustment reason code B5?

B. Based on the information on ABNs in Chapter 10, what is the meaning of ABN modifier –GA?

C. If a –GA modifier is attached to HCPCS codes Q4054 and Q4055 on a claim, can the patient be billed?

D. If a –GA modifier is *not* attached to the HCPCS codes Q4050 and Q4055 on a claim, can the provider balance-bill the patient?

Internet Activities

_____ 1. The administrative (nonclinical) code sets for HIPAA transactions are available on the Washington Publishing Company website. Visit this site at http://www.wpc-edi.com/codes. Select one of the code lists for review, and locate the Change List to view recent alterations.

_____ 2. The American Health Lawyers website contains information about legal matters in health care. Visit http://www.healthlawyers.org and click *Today in Health Law*. Report on a topic related to medical billing and insurance.

_____ 3. The American Academy of Professional Coders (AAPC) has an examination for the certified professional coder—payer (CPC-P) credential. Those who pass this test are good candidates for employment by payers' customer service departments and for the claim review and adjudication process. Study the requirements for this credential at http://www.aapc.com.

_____ 4. Commercial companies offer effective appeal letters for purchase. Using a search engine such as Google or Yahoo, research two of these Web sites related to medical (or health insurance) appeals. Review the appeal letters that can be purchased.