

## TOP TEN

I hope that everybody is as relieved as I am that the Hollywood writers strike is over. It has been unbearable, the pain and anguish that I went through trying to find fresh material. The Late Night hosts were completely shut down and I was stuck watching the reruns of the Late Night “Top Ten” over and over again. It was like I was stuck in the Bill Murray movie “Groundhog Day”. I just kept reliving each day over and over again with no help of escaping.

I am sure some of the providers today are feeling the same way. We keep finding ways to improve our billing practices and Medicare keeps finding ways to reject them, over and over again. What is worse, it seems that it is the same thing over and over. I keep dreaming that their administrators will come in off strike, figure out what the problem is, so we can get some fresh material and start getting paid for the services that we perform.

But just like the writers had the late night show hosts over a barrel, CMS has us over a barrel when it comes to billing for and getting paid for the services that we provide. They write the “jokes” (they call them procedure codes) and we have no alternative but to accept them. Their “jokes” are just not very funny when it comes to getting the money you are owed for products and services that you have provided. Did you ever wonder if they are just sitting back laughing at us saying, “I know, next week lets make them put a modifier in front of the procedure code, but only if the patient came in on Thursday between 2 and 5 p.m.”?

So what do we do? Good question! Right now I believe the answer is monitor what they are rejecting and why, educate yourself and your staff on how to avoid getting those rejections and then I believe we will improve our businesses, reduce our accounts receivable and increase our cash flow. That is until they write some new “jokes”. So, what are the top reasons that Medicare is denying your requests for payment, what does it mean and how do you avoid?

Using the example given to us by our good friends on late night television, I have compiled a list of the Top Ten” denials that you will most likely see when billing our good friend Uncle Sam and what you should do about them.

- 1. CO18 – Duplicate Claim.** The number one cause of the CO18 is the claim was billed and denied and the claim was resubmitted without the biller paying attention to what needed to be done based on the initial denial. Prior to submitting claims, verify that the claim hasn’t already been denied. If it is a re-bill, then research why it was denied, fix the problem and then resubmit.
- 2. OA109 – Claim not covered by this payer/contractor.** You must send the claim to the correct payer/contractor. When the patient enters your store, copy their card, ask if they have another card other than Medicare, verify the patient’s eligibility via one of the online systems available such as Zirmed and send to the payer which is the payer of record.
- 3. CO57 – Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day’s supply.** To prevent this denial which pertains to receiving too any products within

a certain time period, your customer service team needs to look at the patient's history of their last purchase and verify that they can receive another bra or prosthesis prior to dispensing.

**4. CO175 – Payment denied because the prescription is incomplete.** This code indicates that Medicare has a CMN (Certificate of Medical Necessity) on file but the CMN has errors. Prior to sending in claims with a CMN to be attached, review the CMN and data entered that is to be sent electronically and verify that the CMN is compliant and meets the medical policy criteria.

**5. PR96 – Non-covered charge(s).** This denial is received when an item is simply not covered by Medicare. Some providers would bill Medicare for these items if there is a secondary payer that is requesting to see the non-covered denial from Medicare. If this is not the case, then intake personnel must verify what items are covered and non-covered prior to dispensing products to the patient. It is also advisable to get an ABN (Advanced Beneficiary Notice) signed by the patient prior to dispensing the product.

**6. CO50 – These are non-covered services because this is not deemed a “medical necessity” by the payer.** If a claim is billed to Medicare without a KX modifier, it will be denied with a CO50 denial. The KX modifier is stating that the specified medical necessity documentation is on file within the patient's medical record and that the patient meets the specified coverage criteria as outlined by the Local Coverage Determination (LCD). Check to see if the products you are billing require the KX modifier and ensure they are attached to the HCPCS code prior to billing.

**7. CO176 – Payment denied because the prescription is not current.** When this code is accompanied by an M60 remark code the CMN is missing from the claim. The missing CMN may also be attributed to the fact that the recertification CMN is not on file and needs to be obtained/sent. Once you receive your report from Medicare stating what claims have been accepted and those which have been rejected, check to see if your CMNs attached upon transmission. If not, check with your software vendor to see if there is a problem with this aspect of the program.

**8. CO16 – Claim/Service lacks information which is needed for adjudication.** Some reasons you may receive a CO16 denial include but are not limited to:

- Billing for place of service 31 (Skilled Nursing Facility) and not listing the facility's address on the claim
- Incorrect date span
- Missing the LT (left) or RT (right) modifier

Proof your claims prior to sending to verify that the modifiers are attached, the addresses are inserted. Basically, be sure every “i” is dotted and “t” is crossed prior to claim submission.

**9. CO13 – The date of death precedes the date of service.** For purchase items, this is not usually a concern. It comes into play when rental equipment is at a patient's home and it hasn't been returned after the patient has expired.

**10. CO35 – Lifetime benefit maximum has been reached.** This code is stating that Medicare has paid for the maximum 13 rental months for the patient’s capped rental equipment and you cannot bill for any more rentals. If you are dispensing capped rental equipment, ask the patient prior to dispensing if they have received this equipment previously or make a 3-way call to Medicare with the patient on the line. This will help obtain the information necessary to determine if the patient has received the equipment before and have them sign an ABN so that you can receive payment in the event of a denial.

So now we know what some of the common objections are to sending you your money and what you can do to prevent having those issues. I hope this will help you navigate some of the billing pitfalls that Medicare’s comedy writing crew has put in place for you. I know it seems like an uphill battle but information and knowledge are your best tools.

Remember, in “Groundhog Day” Bill Murray finally escaped February 28<sup>th</sup> after several attempts. Bill got the girl and everyone lived happily ever after. We can hope for the same with Medicare and their rejections, right? Nah, Bill Murray had a better comedy crew than Medicare does.

Be well and let’s talk soon.

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