Provider Update

Avoid Needless Claims Denials with These Tips

Please review the information below to help avoid these unnecessary claims denials:

Services disallowed by utilization management
Inpatient hospital services are payable Under Medicare Part B when Medicare Part A admission is denied not medically necessary

Payment may be made under Medicare Part B for physician and non-physician medical and other health services when furnished by a Medicare participating hospital and payment for the inpatient services cannot be made under Medicare Part A. If an inpatient admission is denied as not reasonable and necessary, or if a hospital determines after the member is discharged that the inpatient admission was not reasonable and necessary, the hospital may be paid for the Medicare Part B inpatient services that would have been considered reasonable and necessary if the member had been treated as a hospital outpatient.

The services that are billed to Medicare Part B must be reasonable and necessary and must meet all applicable Medicare Part B coverage and payment conditions. Claims for Medicare Part B services following a Medicare Part A inpatient denial as not reasonable and necessary or if the member has exhausted his or her Medicare Part A benefits must be filed no later than 1 calendar year after the date of service.

When to use claim TOB 12X or TOB 13X to bill for Part B services related to a denied inpatient stay:

CMS guidelines state Medicare pays the hospital under Medicare Part B for physician services and non-physician medical and other health services when the inpatient stay is denied as not reasonable and necessary or member has exhausted his or her Medicare Part A benefits .

Hospital <u>should submit TOB 13x, 14x or 85x</u> for services deemed outpatient that were rendered prior to the time of admission. For example:

- revenue code 0450 Emergency room visit
- revenue code 051x or 052x Clinic visit
- revenue code 068x Trauma Response
- revenue code 0762 Observation room
- any preadmission diagnostic tests rendered in the 1-3 day window prior to admission.

Hospital <u>should submit TOB 12x</u> for Medicare Part B services. For example:

- revenue code 025x Pharmacy
- revenue code 026x IV therapy
- revenue code 028x Oncology
- revenue codes 030x or 031x Laboratory
- revenue codes 032x or 33x Radiology
- revenue code 036x Surgery
- revenue code 040x Imaging
- revenue codes 042x, 043x or 044x PT/OT/ST
- revenue code 048x Cardiology
- revenue code 61x MRI

Room and Board and other <u>revenue codes that cannot be billed on a TOB 12X</u> claim:

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	024x	029x
0390	0399	045x	050x	051x	052x	054x	055x
056x	057x	058x	059x	060x	0630	0631	0632
0633	0637	064x	065x	066x	067x	068x	072x
0762	082x	083x	084x	085x	088x	089x	0905
0906	0907	0912	0913	093x	0941	0943	0944
0945	0946	0947	0948	095x	0960	0961	0962
0963	0964*	0969	097x	098x	099x	100x	210x
310x							

*revenue code 0964 is used by hospitals that have anesthesia by a Certified Registered Nurse Anesthetist exception.

(Information from CMS Publication 100-04 Chapter 4 Sections 240 & 241)
Valid Clinical Laboratory Improvement Amendments number must be submitted
Medicare Advantage individual claims are denied if the Centers for Medicare & Medicaid Services required CLIA (Clinical Laboratory Improvement Amendments) certification is missing or invalid. The CLIA number must be present in Box 23 of the HCFA 1500 claim.

For additional information, please see:
CLIA FAQs found at anthem.com/medicareprovider
CMS Claims processing manual 100-04, Chapter 16, section 70.1 (Laboratory Services)
The CLIA number must be included on each claim billed on the ASC X12 837 professional

format or Form CMS-1500 claim for laboratory services by any laboratory performing tests covered by CLIA. See §70.2 and 70.10 for more information.

CMS Claims Processing Manual 100-04, Chapter 26 (Completing & Processing Form CMS-1500 Data Set):

Item 23
Procedure not covered by diagnosis
A claim for a clinical diagnostic laboratory service for Medicare Advantage individual and group-sponsored members must include a valid ICD-10-CM diagnosis code. Additional information is available in the Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report (ICD-10-CM) found at this URL: https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/Downloads/manual201601_ICD10.pdf:

Inappropriate or missing modifier
Therapy related services require therapy modifiers, functional measurement codes (G-codes) and corresponding therapy and severity modifiers for individual and group-sponsored Medicare Advantage claims. CMS provides detailed billing requirements for therapy modifiers at the Medicare Learning Network publication number SE1307 found at this URL: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1307.pdf

Duplicate claim
To reduce the claims processing time, please ensure the same claims are not submitted multiple times. When submitting corrected claims for individual and group-sponsored Medicare Advantage members, please remember:

- **Medical Claims** – When submitting a corrected claim, clearly identify the claim as corrected. Please note that the claim is a "corrected claim" anywhere on the face of the claim.
- **Facility Claims** – When submitting a corrected claim, ensure the correct type of bill frequency code is used.

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*In New Mexico, Amerigroup Community Care of New Mexico, Inc. In Texas, Amerigroup members in the Medicaid Rural Service Area are served by Amerigroup Insurance Company; all other Amerigroup members are served by Amerigroup Texas, Inc. In Washington, Amerigroup Washington, Inc.

Amerivantage is a DSNP plan with a Medicare contract and a contract with the State Medicaid program. In New Mexico: Amerivantage is an HMO with a Medicare contract. Enrollment in Amerivantage depends on contract renewal.