



# Show Me the Money! – Avoid Rejections and Denials



April 2026

1

1

## Today's Facilitator

- Mary E. Muchow
  - Began working in Medicare in 1981
    - Claims adjudication, prepayment medical review, and training in early years
  - Spent over 20 years in Medicare Benefit Integrity
    - Investigator
    - Medicare Fraud Information Specialist, Region V
  - Joined Provider Outreach and Education in 2003



2



2

## Objective & Agenda

Objective: Know who to fix or avoid the top rejections and denials and receive correct payment

### Agenda

- Top Rejections and Denials
  - Data
- Actions to Consider
  - Ways to fix or avoid
- Resources
- Questions and Answers

3 Review the legal disclaimers at the end of the presentation.

3

## Rejections and Denials

4

4

# CMS Directives – Use of Data

- *Medicare Contractor Beneficiary and Provider Communication Manual, Chapter 6 – Provider Customer Service Program, [Section 20.3 – Data Analysis – Overall](#)*

**20.3 - Data Analysis - Overall**  
 (Rev. 10772, Issued: 04-29-21, Effective: 12-16-20, Implementation: 12-16-20)

MACs shall analyze all available data, such as CERT error rates, Recovery Auditor data, telephone, written and portal inquiries data, claims submission errors, claims payment errors, appeals data, CSR feedback, MR referral data, MR targeted probe and educate data, satisfaction survey data, as well as feedback from other areas across the MAC, as they develop their education methodology.

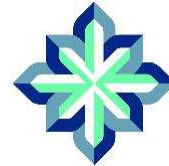
The data listed in this section shall not be construed as an all-inclusive list. MACs shall use their discretion to determine if their PCSP would benefit from analysis of data not mentioned in this section.

5

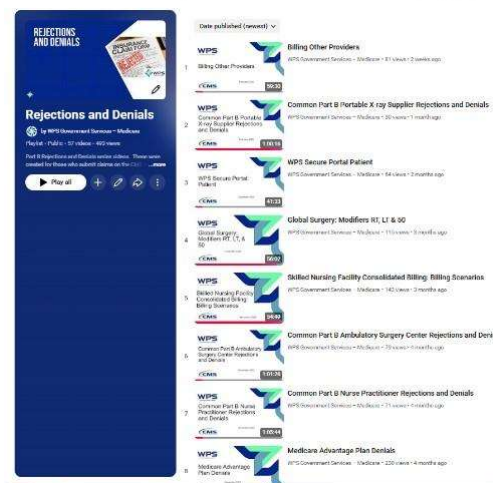


5

# Rejections and Denials Playlist

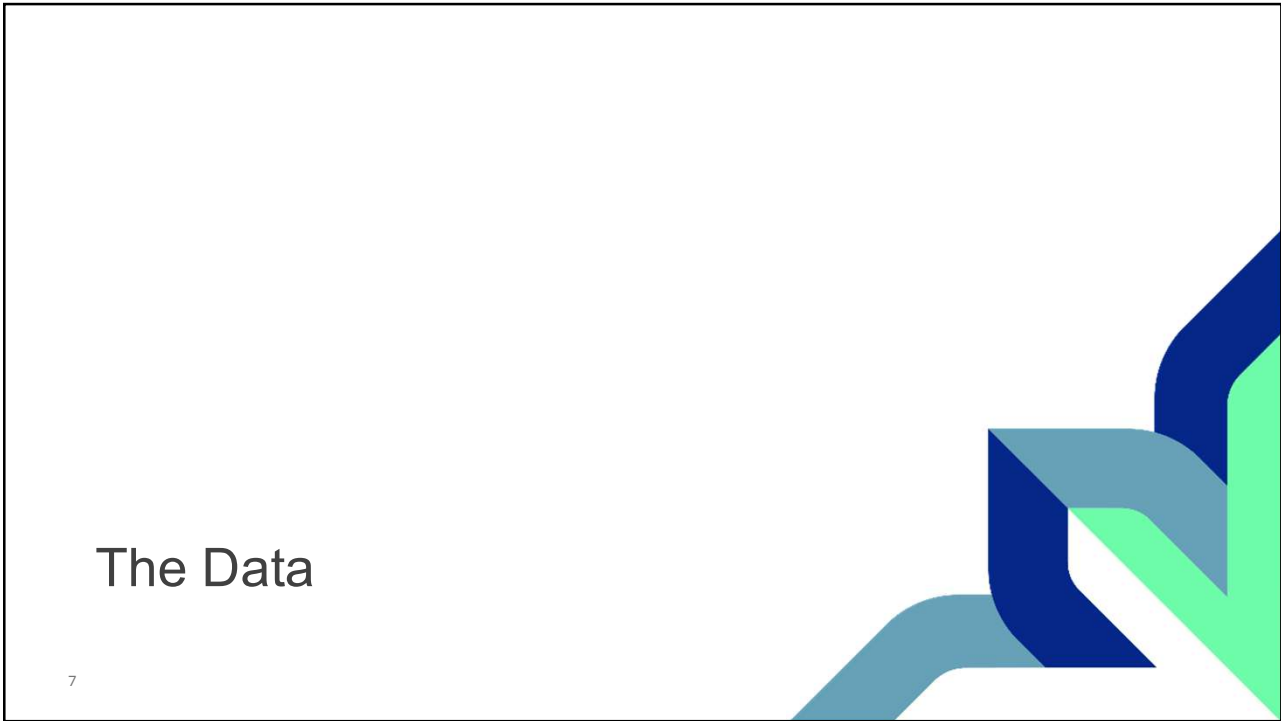


- List of YouTube videos that reveal WPS specialty specific top rejections and denials
  - Explains:
    - Purpose of RA
    - Reason and remark codes
    - Ways to fix or avoid claim submission errors
  - Provide resources



6

6




# The Data


7

7

## Dashboard – Use of Data Slicers for Data Analysis



- Kansas Part B claim submission dates 12/01/25 – 02/28/26
  - Data last refreshed 03/12/26
- All specialties
- All codes



The screenshot shows a dashboard with the following components:

- Filters:** Specialties (All), Claims Status (All), Claims Frequency (All), State (All), County (All), HCPCS Code (All), Denial Code (All).
- Denial Reason Description Table:**

Denial Code Desc	Count
141 DUPLICATE CHANGE PAID UNDER CLAIM INTEREST...	138(0)
815 OUTLIER CHANGE OF CLAIM INTEREST/ANNUAL RENEWAL...	46(0)
943 COLLECTION OF BILL FOR SERVICE IN THIS SERVICE OF...	4(0)
95 THE PROCEDURE CODE SUBMITTED IS A NON-COVERED...	36(2)
96 CLAIM NUMBER IS NOT TO BE USED...	1(0)
972 MEDICARE WILL NOT PAY FOR THIS SERVICE FOR THIS CO...	34(0)
973 THIS SERVICE IS A CONTRAINDICATION IS NOT COVERED BY...	16(17)
974 THE PHYSICIAN/PROVIDER IS NOT LICENSED TO PROVIDE...	1(10)
975 UNDESIRABLE/UNAPPROVED SERVICES ARE NOT COVERED...	36(10)
976 PROVIDER/PHYSICIAN IS NOT LICENSED TO PROVIDE...	6(10)
977 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
978 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
979 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
980 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
981 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
982 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
983 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
984 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
985 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
986 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
987 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
988 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
989 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
990 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
991 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
992 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
993 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
994 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
995 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
996 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
997 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
998 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
999 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
1000 THIS SERVICE IS NOT COVERED BY THIS PLAN...	1(0)
- HCPCS Codes Table:**

HCPCS Code	Count
93001	25(10)
93002	11(0)
93003	11(0)
93004	11(0)
93005	11(0)
93006	11(0)
93007	11(0)
93008	11(0)
93009	11(0)
93010	11(0)
93011	11(0)
93012	11(0)
93013	11(0)
93014	11(0)
93015	11(0)
93016	11(0)
93017	11(0)
93018	11(0)
93019	11(0)
93020	11(0)
93021	11(0)
93022	11(0)
93023	11(0)
93024	11(0)
93025	11(0)
93026	11(0)
93027	11(0)
93028	11(0)
93029	11(0)
93030	11(0)
93031	11(0)
93032	11(0)
93033	11(0)
93034	11(0)
93035	11(0)
93036	11(0)
93037	11(0)
93038	11(0)
93039	11(0)
93040	11(0)
93041	11(0)
93042	11(0)
93043	11(0)
93044	11(0)
93045	11(0)
93046	11(0)
93047	11(0)
93048	11(0)
93049	11(0)
93050	11(0)
93051	11(0)
93052	11(0)
93053	11(0)
93054	11(0)
93055	11(0)
93056	11(0)
93057	11(0)
93058	11(0)
93059	11(0)
93060	11(0)
93061	11(0)
93062	11(0)
93063	11(0)
93064	11(0)
93065	11(0)
93066	11(0)
93067	11(0)
93068	11(0)
93069	11(0)
93070	11(0)
93071	11(0)
93072	11(0)
93073	11(0)
93074	11(0)
93075	11(0)
93076	11(0)
93077	11(0)
93078	11(0)
93079	11(0)
93080	11(0)
93081	11(0)
93082	11(0)
93083	11(0)
93084	11(0)
93085	11(0)
93086	11(0)
93087	11(0)
93088	11(0)
93089	11(0)
93090	11(0)
93091	11(0)
93092	11(0)
93093	11(0)
93094	11(0)
93095	11(0)
93096	11(0)
93097	11(0)
93098	11(0)
93099	11(0)
93100	11(0)

8

8

## Most Common Rejections

9

9

## Top Reasons for Rejections and Number of Claim Lines

1. Claim must be submitted to RRB (10,663)
2. Rendering physician # invalid/missing (7,017)
3. Incomplete/invalid plan information for other insurance (5,631)
4. Missing/incomplete/invalid ordering primary identifier (3,440)
5. Invalid/missing modifier (3,352)

10

10

## More – Top Reasons for Rejections and Number of Claim Lines

6. Procedure inconsistent with modifier used or required (2,640)
7. Missing/incomplete/invalid billing provider primary identifier (1,837)
8. Missing/incomplete/invalid provider identifier (1,789)
9. Patient/insurance HICN and name do not match (1,643)
10. PA, NP, or CNS not internally associated with billing provider (1,075)

11

11

## Top Rejected Codes, Number of Claim Lines and Top Reasons

- 36415 (2,515)
  - Claim must be submitted to RRB
  - Missing/incomplete/invalid ordering primary identifier
  - Incomplete/invalid plan information for other insurance
- 98941 (1,973)
  - Initial date “actual” treatment began required for payment (436)
  - Rendering physician # invalid/missing (121)
  - Field 11 of claim must be completed (104)

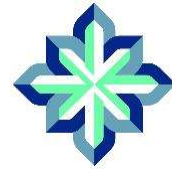
12

CPT only copyright 2025 American Medical Association. All rights reserved.



12

## More – Top Rejected Code, Number of Claim Lines and Top Reasons



- 97110 (1,960)
  - Rendering physician # invalid/missing
  - Incomplete/invalid plan information for other insurance
  - Missing/incomplete/invalid provider identifier

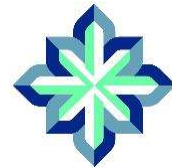


13

CPT only copyright 2025 American Medical Association. All rights reserved.

13

## Another Top Rejected Code, Number of Claim Lines and Top Reasons



- 99214 (1,914)
  - Incomplete/invalid plan information for other insurance
  - Claim must be submitted to RRB
  - PA, NP, or CNS not internally associated with billing provider

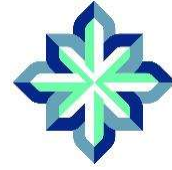


14

CPT only copyright 2025 American Medical Association. All rights reserved.

14

## One More Top Rejected Code, Number of Claim Lines, and Top Reasons



- 80053 (1,913)
  - Claim must be submitted to RRB
  - CLIA number is invalid or missing
  - Incomplete/invalid plan information for other insurance



15

CPT only copyright 2025 American Medical Association. All rights reserved.

15

## Most Common Denials

16

16

## Top Reasons for Denials and Number of Claim Lines Denied

1. Duplicate charge paid DATE on ICN (53,801)
2. Duplicate charge of claim ICN now being processed (49,781)
3. Collection of fee-for-service during periods of managed care (43,870)
4. The procedure submitted is a non-covered service (30,074)
5. Claim must be sent to EGHP first (17,000)

17

17

## More – Top Reasons for Denials

6. Medicare will not pay for this service for this condition (16,562)
7. This service by a chiropractor is not covered by Medicare (12,137)
8. This physician is not eligible to receive payment (11,982)
9. Units of service are exceeded (10,592)
10. Separate payment not made for this service (10,244)

18

18

## Top Denied Codes, Total Number of Denials and Top Reason(s)



- 92015 (25,432)
  - Procedure code submitted is a non-covered service day
- 99214 (25,195)
  - Duplicate charge paid DATE on claim ICN
  - Duplicate charge of claim ICN now being processed
  - Collection of fee-for-service during periods of managed care



19

CPT only copyright 2025 American Medical Association. All rights reserved.

19

## Top Denied Code, Total Number of Denials and Top Reasons



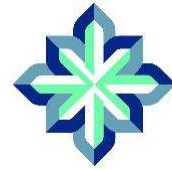
- G2211 (18,428)
  - Duplicate charge paid DATE on ICN
  - Duplicate charge of claim ICN now being processed
  - Service not payable with other services rendered
  - Procedure must be billed with primary service



20

20

## Top Denied Code, Number of Denials, and Top Reasons



- 99213 (11,784)
  - Same as 99214 on slide 20
    - Duplicate
    - Patient is enrolled in Medicare Advantage

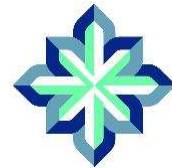


21

CPT only copyright 2025 American Medical Association. All rights reserved.

21

## Another Top Denied Code, Total Number of Denials and Top Reason



- 83036 (11,385)
  - Medicare will not pay for this service for this condition
  - Collection of fee-for-service during periods managed care
  - Not medically necessary
  - Duplicate charge paid DATE on ICN
  - Duplicate charge of claim ICN now being processed

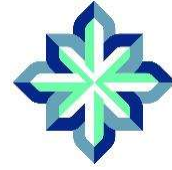


22

CPT only copyright 2025 American Medical Association. All rights reserved.

22

## Sixth Most Commonly Denied Code, Total Number of Denials and Top Reasons



- 98941 (9,706)
  - Duplicate charge paid DATE on claim ICN
  - Duplicate charge of claim ICN now being processed
  - Collection of fee-for-service during periods managed care
  - Medicare will not pay for this service for this condition



23

CPT only copyright 2025 American Medical Association. All rights reserved.

23

## Actions to Consider

24

24

## Potential Actions to Choose

- Rejection (CMS calls these “unprocessable”)
  - Fix the error, resubmit the service
- Denial
  - Fix the error, resubmit the service, if able
  - CER process
    - Use of SNAP is fastest
  - Request an appeal



25



25

## Requirements for Medicare Claims

- *Medicare Claims Processing Manual*
  - [Chapter 24 – General EDI and EDI Support Requirements, Electronic Claims, Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims](#)
  - [Chapter 25 – Completing and Processing the Form CMS-1450 Data Set](#)
  - [Chapter 26 – Completing and Processing Form CMS-1500 Data Set](#)

26

26

# CMS 1500 to ANSI 837 5010 Crosswalk

## • Crosswalks from paper claim to electronic claim

### HIPAA ELECTRONIC CLAIM SUBMISSION REQUIREMENTS: CMS 1500 TO ANSI 837 5010 CROSSWALK

The CMS-1500 (02-12) claim form is being revised to accommodate cross-walking to the 5010 version. WPS has created the following cross-reference guide to help users become compliant with this new requirement. It is to be used as a guide for providers to discuss billing requirements with their vendors. This does not replace or supersede the data requirements of the TR3 005010X222A1, which can be obtained from <http://store.x12.org/store/>

Please call us at the numbers below to discuss any questions or concerns you may have regarding this information.

J5: 866-518-3285  
J8: 866-234-7331

Item No.	Narrative	ANSI 837 version 5010	Loop	Data Element Description	Status	Requirements for version 5010
1	Type of health insurance	2-0900-SB009	2000B	Claim filing indicator code	R	Must=MB for Medicare Part B claims
1A†	Insured's ID number	2-0150-NM109	2010BA	Subscriber primary identifier	R	Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer. (For Medicare the patient is always the subscriber.) (NM101) + (IL) (NM101) + (MI)
2	Patient's name (Last Name, First Name, Middle Initial)	2-0150-NM103 2-0150-NM104 2-0150-NM105	2010BA	Subscriber last name Subscriber first name Subscriber middle name or initial	R	Enter the patient's name as shown on their Medicare card. (For Medicare, the patient is always the subscriber.)
3	Patient's birth date	2-0320-DM002	2010BA	Subscriber birth date	R	Enter the patient's birth date. Must be formatted as CCYYMMDD. Date Qualifier (DM001)=D4. Enter the patient's day, 2-7-figure. M-Male, U-Unknown.
4†	Patient's sex	2-0320-DM001		Subscriber gender code	R	
4†	Insured name (Last name, First Name, Middle Initial)	2-1250-NM103 2-1250-NM104 2-1250-NM105	2100A	Other insured last name Other insured first name Other insured middle name	S	If there is someone primary to Medicare other than the patient's or spouse's employment or any other source, list the name of the insured here. Required if any other person is known to potentially be involved in paying this claim.

**R** Required. Any data element that is needed in order to process a claim (e.g., date of service)  
**S** Situational. Any data element that must be completed if other conditions exist (e.g., if the insured differs from the patient, the insured's name must be entered on the claim)  
 † If Medicare Secondary Payer or Medicaid is involved, please refer to the 5010 TR3 for further instruction.  
 \* Use if different than information given at the claim level. Segments submitted at the claim level apply to the entire claim unless overridden by information at the service line level.

27



27

# Rejection Resources

- [How to Correct a Rejected Claim](#)
  - See Remark Codes and tips for correcting the claim
- [Rejections and Denials YouTube Playlist](#)



The screenshot shows a web page from WPS Training Center. The page title is "How to Correct a Rejected Claim". It includes a navigation bar with "GUIDES AND RESOURCES" and a search bar. The main content area contains text explaining how to identify and correct unprocessable claims, including a list of remark codes (M30, M31) and their definitions. The text mentions that M30 is for "Definition Missing Incomplete Invald HCPCS" and M31 is for "Definition Missing Incomplete Invald procedure code".

28

28

# Review Contractor Directory – Interactive Map

- Select state to view state-specific contractor contact information, including
  - MAC
  - RRB Specialty Contractor
  - CERT Contractor
  - More

## Review Contractor Directory - Interactive Map

The Review Contractor Directory - Interactive Map allows you to access state-specific CMS contractor contact information. You may receive correspondence from one or several of these contractors in your state. They may request medical records from you, as they perform business on behalf of CMS. You can use this website to access their contact information including emails, phone numbers and websites.



Select a State:

CMS Divisions Responsible for Contractors



# Provider Eligibility

- Verify
  - Provider identifiers reported on claim when required
    - Includes rendering, ordering or referring
  - Identifiers keyed correctly
  - Eligibility dates
    - Check provider enrollment records



## Provider Eligibility Help

- Call Customer Service to speak with a Provider Enrollment Specialist
- Refer to [Electronic Provider Enrollment \(Internet-Based PECOS\)](#) for help and to determine provider status
- [Medicare Provider Enrollment](#) Guides and Resources

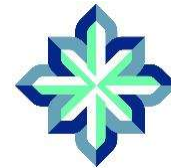


31

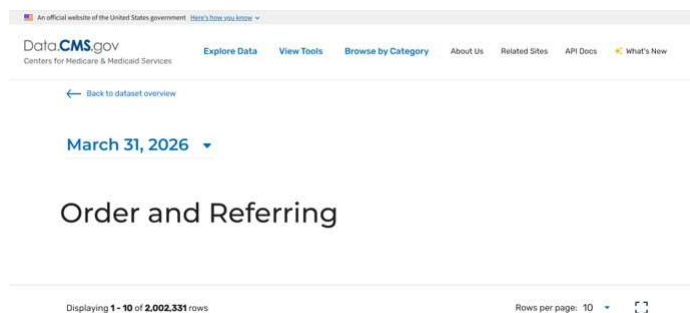


31

## Order and Referring List



- CMS maintains a searchable list of all physicians and non-physician practitioners legally eligible to order and refer in the Medicare program and who have current enrollment records in Medicare

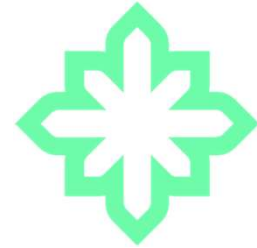


32

32

## Patient Eligibility

- Verify
  - Patient name and MBI exact match
  - If patient enrolled in hospice
  - Submit to correct payer
    - Railroad Retirement Board
    - Managed Care Plan if patient has elected Part C (Medicare Advantage)

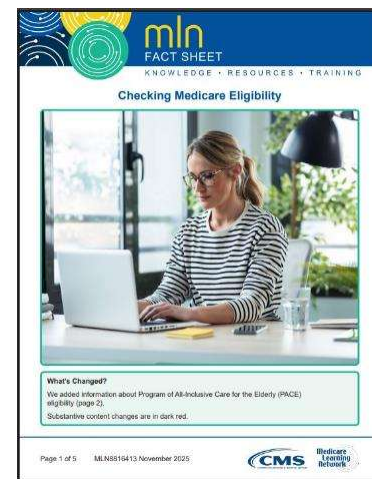


33

33

## Patient Eligibility Help

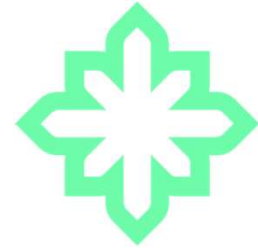
- Use WPS
  - [Portal User Manual](#)
- [Checking Medicare Eligibility](#)  
MLN8816413



34

34

## Modifier Issues



- Verify
  - Required modifier present
  - Modifier matches procedure code
  - Modifier valid for date of service



35

35

## Modifier Help

- WPS [Modifiers](#) webpage includes links to Modifier Fact Sheets
- WPS YouTube channel [Modifiers playlist](#)

The screenshot shows a YouTube playlist interface. On the left is a mobile-style view of the 'Modifiers' playlist with a 'Play all' button. On the right is a desktop-style view of the same playlist with a 'Date published (newest)' dropdown menu. The video list includes:

Video Title	Views	Time
E/M Services with Modifier 25 and Other Part B Services on the Same Date	50 views	10 days ago
Global Surgery: Modifiers RT, LT & 50	67 views	3 weeks ago
Ambulance Suppliers Using Modifier GY	66 views	3 months ago
Hospice Elections Affecting Your Claims	75 views	3 months ago

At the bottom right of the desktop view, there is a link to 'CMS Resources Medicare National Correct Coding Initiative NCCI' and a small version of the green logo seen in the first slide.

36

36

## PA/NP/CNS Not Internally Associated With Billing Provider

- A PA, NP, or CNS must associate to the billing provider
  - In the enrollment application, the PA, NP, or CNS must reassign the practitioner's benefits to the group practice or hospital that will bill for their services
- Reassigning Medicare Benefits



37



37

## Common Claim Denials

- Arranged by denial category
  - Bundling
  - Duplicate Claim/Service
  - Entitlement
  - Payer/Contractor

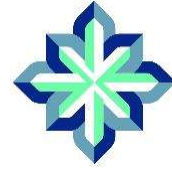
The screenshot shows a web page titled "Common Claim Denials" under the heading "GUIDES AND RESOURCES". The page is dated "Published on Aug 24, 2022. Last updated Dec 22, 2024". It lists several denial categories with brief descriptions and actions:

- Bundling Denials:** There are several scenarios in which a service or procedure does not meet its separate reimbursement because payment for it is included in Medicare's payment for another service or procedure. Some of the more common scenarios and their actions/procedures should take notice.
  - Service ID - Always Bundled:** Procedure code included in certain procedure. Medicare does not pay separately for this service.
  - Reason Code - CO 123:** Submission billing error.
  - Remark Code - NP:** Procedure code included in certain procedure. Medicare does not pay separately for this service. Some services/procedures are "invisibly bundled" for Medicare purposes and their respective separate reimbursement. Refer to the Physician Fee Schedule (PFS) Detail in Topic 2.077 to determine whether the procedure is separately reimbursable. Procedure codes with status "E" or "P" indicate the services are always bundled and will not receive Medicare reimbursement.
- Actions:** Confirm that you have billed the correct procedure code.
  - Wrong code – Submit a new claim.
  - Correct code – Verify all the charges. Do not rebill Medicare or the beneficiary.
- National Correct Coding Initiative (NCCI) Edits:**
  - Reason Code - CO 4:** Procedure code is incompatible with the modifier, or a required modifier is missing.
- Remark Code - MQ:**
  - Not covered after performed during the same session/visit as a previously covered service for the patient.
  - Incompatible procedure code/modifier combination or a required modifier is missing.
- Actions:** Refer to the NCCI Procedure to Procedure (PTP) Coding Edit.

38

38

## Avoid Duplicate Denials



- Verify
  - No auto resubmitting prior to establishing status
  - Appropriate billing
  - Appropriate modifiers
- Consider use of
  - Interactive Voice Response System (IVR)
    - [Part B IVR Operating Guide](#)
  - SNAP
    - Portal User Manual

39

39

## Avoid Medicare Advantage Denials



- Verify patient eligibility
- View [Medicare Advantage Plan Denials](#) on the [WPS YouTube channel](#)



40

40

## Billing for Non-Covered Services



- No need to submit unless beneficiary:
  - Believes a service may be covered
  - Requires Medicare denial for supplemental insurance
- See [Mandatory Claim Submission](#)
  - Claim must indicate the service is non-covered and submitted at beneficiary's request
  - Refer to [GY Modifier Fact Sheet](#)



41

41

## Avoid MSP Denials

- [Medicare Secondary Payer \(MSP\) Fact Sheet](#)
- [MSP Questionnaire](#)
- CMS [Medicare Secondary Payer](#) web page
- WPS [YouTube Channel](#)
  - [MSP Playlist](#)

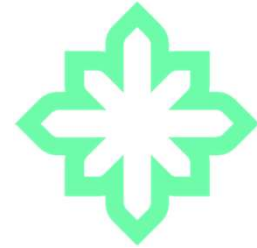


42



42

## Avoid CLIA Denials



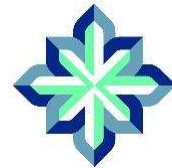
- Clinical labs are generally required to have the appropriate certificate before they can accept human samples for testing
- CMS now uses a paperless certification process, including online payment
- Report CLIA number on claim



43

43

## Coverage for 83036 (Diabetes Screening)



- Refer to [Diabetes Screening MLN](#) Educational Tool for:
  - CPT codes
  - ICD-10 codes
  - Coverage details
  - Frequency
  - More

2/19/2016 12:17 AM  
Physician Services Chart | Medicare Learning Network | MLN00208 - Medicare Payment Update

### Diabetes Screening

**CPT Codes**

**82947** — Glucose; quantitative, blood (except reagent strip)  
**82950** — Glucose; post glucose dose (includes glucose)  
**82951** — Glucose; tolerance test (GTT), 3 specimens (includes glucose)  
**83036** — Hemoglobin; glycosylated (A1C)

**ICD-10 Codes**

Z13.1  
 Note: Additional ICD-10 codes may apply. Find individual charge requests and specific ICD-10-CM services codes we cover at CMS ICD-10 ICD10Cover.com (https://www.cms.gov/medicare/icd10/cover/cover.html). Find your MAC's website steps (www.cms.gov/MACs) for more information.

**Medicare Covers**

Patients with Medicare Part B with diabetes risk factors. Patients previously diagnosed with diabetes won't qualify for this benefit.

**Frequency**

Annually, 3 screenings within the 12-month period following the date of the patient's most recent diabetes screening test.

See FAQ or [how to track eligibility \(PDF\)](#).

2/19/2016 12:17 AM  
Physician Services Chart | Medicare Learning Network | MLN00208 - Medicare Payment Update

**Payment Pays**

Medicare payment, coinsurance, or deductible.

**Other Notes**

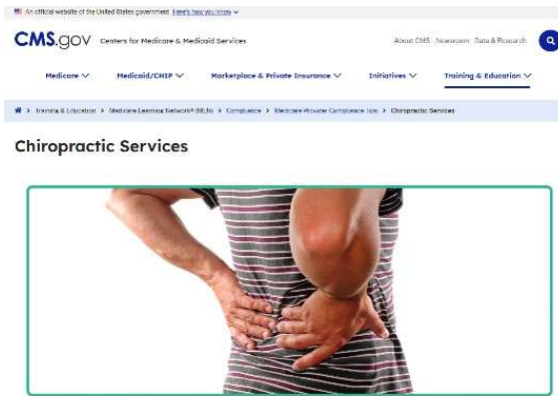
44

CPT only copyright 2025 American Medical Association. All rights reserved.

44

# Chiropractic Services

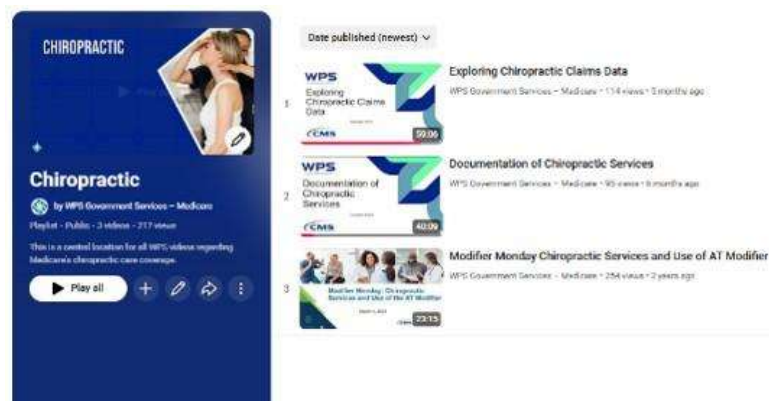
- Refer to CMS [Chiropractic Services Training & Education](#)



45

45

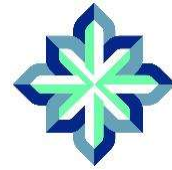
# WPS [Chiropractic Playlist](#)



46

46

## G2211 Add on Complexity Code



- Evaluation and Management (E/M) service is the primary service
  - Add-on G2211 captures inherent complexity of visit that's derived from the longitudinal nature of the practitioner and patient relationship for single, serious condition or complex condition
- G2211 not payable when the primary E/M service is reported with modifier 25, except when the service or other procedure requiring reporting of modifier 25 is on the list of allowed Part B preventive services

47

47

## G2211 Help

- MLN Matters MM13272 [Edits to Prevent Payment of G2211 with Office/Outpatient Evaluation and Management Visit and Modifier 25](#)
- MLN Matters MM13472 [How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211](#)
- [G2211 Made Easy: What You Need to Know](#) YouTube Video

48

48

## Bundling

Separate payment may not be made for items or services with a B or P status code on the [PFS Relative Value Files](#)

- Status code B = BUNDLED SERVICE
  - Payment for this service is always bundled into payment for other services not specified
- Status code P = BUNDLED / EXCLUDED CODES
  - No separate payment may be made for these services under the PFS
- Do not bill the patient for these services

49

49

## Avoid Home Health Certification Denials

- [Physician Services for Certification and Recertification of Medicare Covered Home Health Services](#)
  - Includes:
    - Coding and claim submission guidelines
    - Links to certification instructions and other resources
- For Medicare covered home health services under a home health plan of care
  - Report G0180 for physician certification
  - Report G0179 for physician recertification

50



50

## Data – Top Denial Reasons for KS Part B

- G0180
  - Missing/incomplete/invalid HHC period
  - Payment included in another service received on same day
  - Duplicate charge paid DATE on ICN
  - Collection of fee-for-service during periods of managed care
- G0179
  - Missing/incomplete/invalid HHC period
  - Duplicate charge paid DATE on ICN
  - Duplicate charge on claim ICN now being processed
  - Medicare does not pay for this service in this facility

51



51

CER and Appeals

52

52

## How to Request a Clerical Error Reopening (CER)

- Includes
  - Definition of CER
  - Corrections/situations that can/cannot be processed as a CER
  - Time limit for requesting a CER (one year from initial RA notice)
  - How to submit
    - SNAP
    - More

WPS Topic Center Tools Training Center Contact Us SEARCH

Choose Jurisdiction JS MAC Part A JS MAC Part B JS MAC Part A JS MAC Part B

GUIDES AND RESOURCES

USER LOGIN USER ID PASSWORD LOGIN

Get Help? Register! E-mail/HR Login/Support Social User Manual

### How to Request a Clerical Error Reopening (CER)

Published on Feb 21, 2016. Last Updated On 24, 2022

Jurisdiction: 03-03

Section 927 of the Medicare Modernization Act (MMA) required CMS to establish a process, separate from appeals, whereby providers, physicians and suppliers could correct minor errors or omissions. CMS created the Clerical Error Reopening process as a cost-effective way to correct these minor errors (which result in an initial claim denial or reduction) without using a level of appeal.

#### The Definition of a Clerical Error

CMS defines clerical errors as human or mechanical errors by the provider or contractor. Such errors include:

- Mathematical or computational mistakes;
- Transposed procedure or diagnostic codes;
- Insurance data entry;
- Misspelling of a file number;
- Computer error; or
- Duplicate claim denials due to a clerical error or omission (e.g., a missing modifier) that the provider believes were incorrectly identified as a duplicate
- Incorrect data items, such as provider number, use of a modifier or date of service.

Corrections That Can Be Processed as a Clerical Error Reopening :

53



53

## Appeal Levels

- Five levels in Part A and B appeals process
  1. Redetermination by a MAC
  2. Reconsideration by a Qualified Independent Contractor (QIC)
  3. Decision by the Office of Medicare Hearings and Appeals (OMHA)
    - Also known as Administrative Law Judge (ALJ) hearing
  4. Review by the Medicare Appeals Council
  5. Judicial Review in Federal District Court



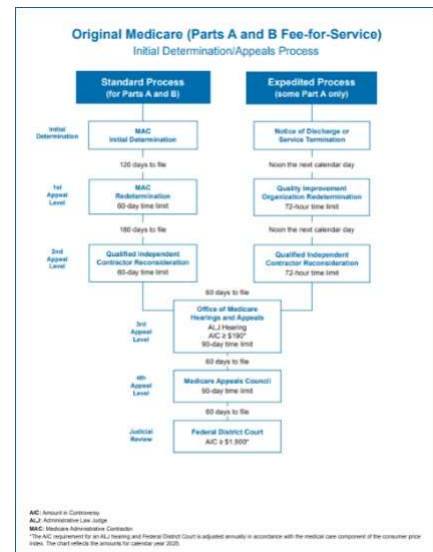
54



54

## Fee-for-Service Appeals Process Flowchart

- Includes all five appeal levels and the entity that renders each
- Days to file the request
- Time limit to render and send notice of decision, if any
  - Letter and new RA
- AIC for levels three and five



55



55

## Appeals Tips

### Be Detailed

- Claim versus overpayment
- Medical necessity
- Missing documentation
- Allowed amount

### Duplicate Requests

- Medicare can only perform each level of appeal on the same service once
  - When you disagree with the outcome of a level, sent to next level

56



56

## Submit All Supporting Documentation

Submit at the lowest level possible

- For level 3, 4, and 5, justify why it was not previously sent

Do not include documentation:

- Sent previously
- Which is unnecessary

57



57

## That's a Wrap

- What we advertised
  - Top Rejections and Denials
    - Data
  - Actions to Consider
    - Ways to fix or avoid
  - Resources
  - Questions and Answers
- Your questions answered
  - What do you want to know about rejections and denials?
    - Everything
    - The general denials guidelines
    - Most common denials and rejections and how to avoid them
    - Home health certification denials
    - What specific codes are getting denied the most

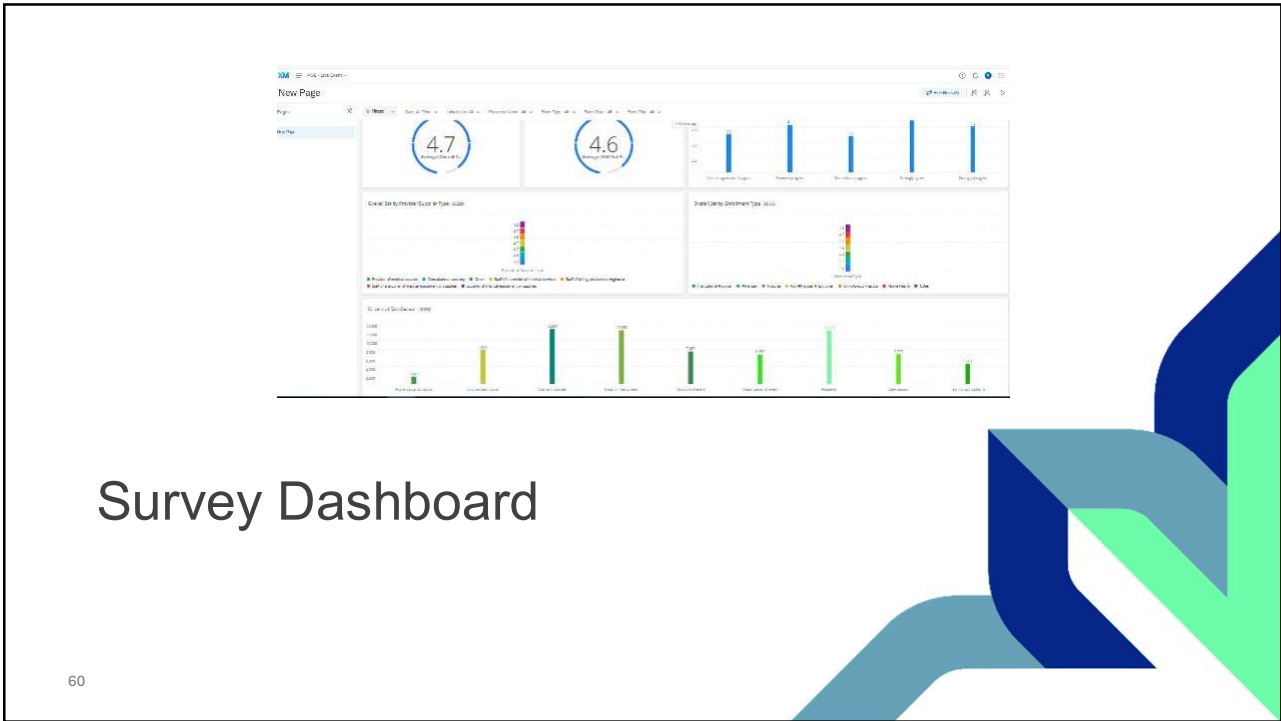
58



58



59



60

## Follow-up Questions



Send your questions for up to seven days following the training

- Email [wps.gha.education@wpsic.com](mailto:wps.gha.education@wpsic.com)
  - Subject Line: AAPC of KC MM
- Send claim specific questions to Customer Service

61

61

Up next...



62

62

## Disclaimers

This material is a tool to assist the provider community. Medicare rules change often. Access [CMS' website](#) for current coverage, regulations and rulings.

The basis for answers given today rely on facts given in the question. Medicare rules determine final coverage.

Do not record the event as CMS does not allow this for profit making purposes.

63



63

## CPT Copyright Notice

CPT codes, descriptions, and other data only are copyright 2025 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

64



64