Tips and Tricks for Submitting Claims to Optimize Your Cash Flow

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Agenda

Learning Objectives

- Participants will identify the steps to submit a clean claim
- Participants will identify what information goes in what box on the CMS 1500 claim form
- Participants will identify necessary modifiers for specific CPT codes when NCCI edits apply.

Clean Claims

- The vehicle to timely payment
- Must have all the required boxes checked or populated
- CMS 1500 (formerly the HCFA 1500) is a standardized “form” Version 02/12
  - https://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2021_07-v9.pdf
- Revised form went into effect April 1, 2014
- To order the least amount of 100 if you are filing hard copy claims:
  - https://bookstore.gpo.gov/products/health-insurance-claims-forms-cms-1500-single-sheets-revised-2012

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HEALTH INSURANCE CLAIM FORM

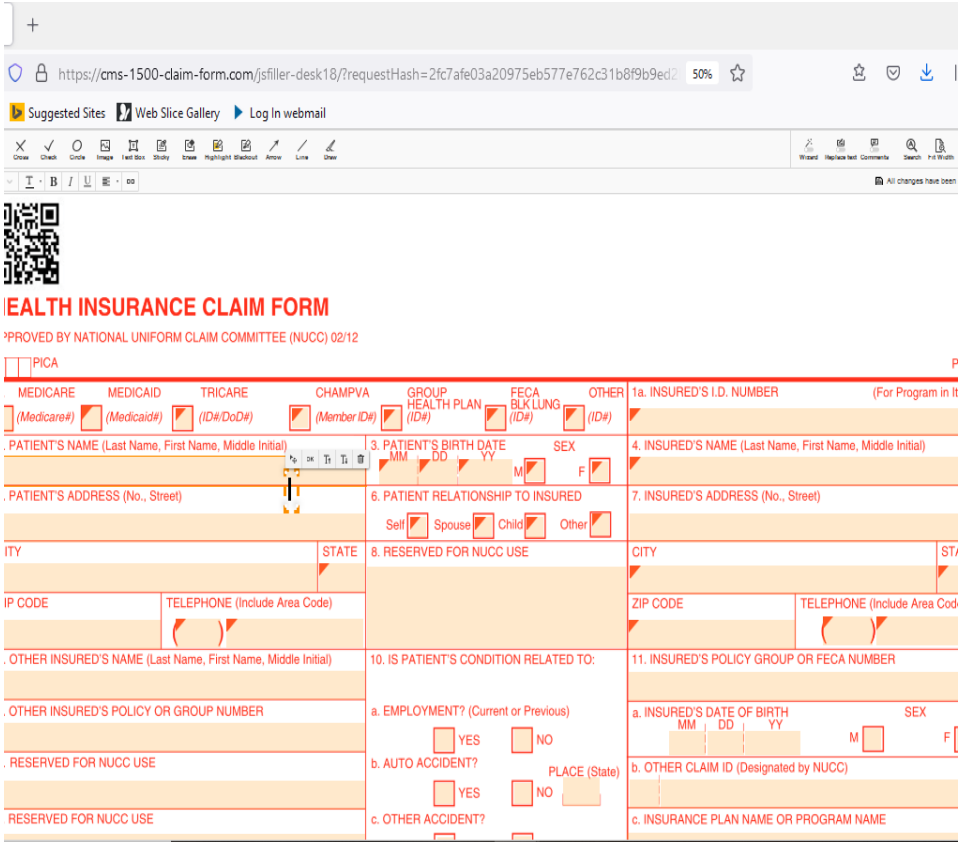
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CMS 1500 Fillable Form



- https://cms-1500-claim-form.com/jsfiller-desk18/?requestHash=2fc7afe03a20975eb577e762c31b8f9b9ed2bf76a8109408fd7ab68ae72fce91&ref=https://cms-1500-claim-form.com&projectId=832574254&loader=tips#8e554e02406f4b3aa59045a86fe1ce0d

Tips:

- https://med.noridianmedicare.com/web/jddme/claims-appeals/claim-submission/guidelines

Tips for Submitting Clean Paper Claims

Noridian uses optical character recognition (OCR) to process paper CMS-1500 claim forms. OCR is a means of inputting text into a computer. It involves scanning a paper document to create a digital image of the text and then using software to store knowledge about that digital image. With OCR, it is very important suppliers follow proper paper claim submission guidelines.

Font and Printing

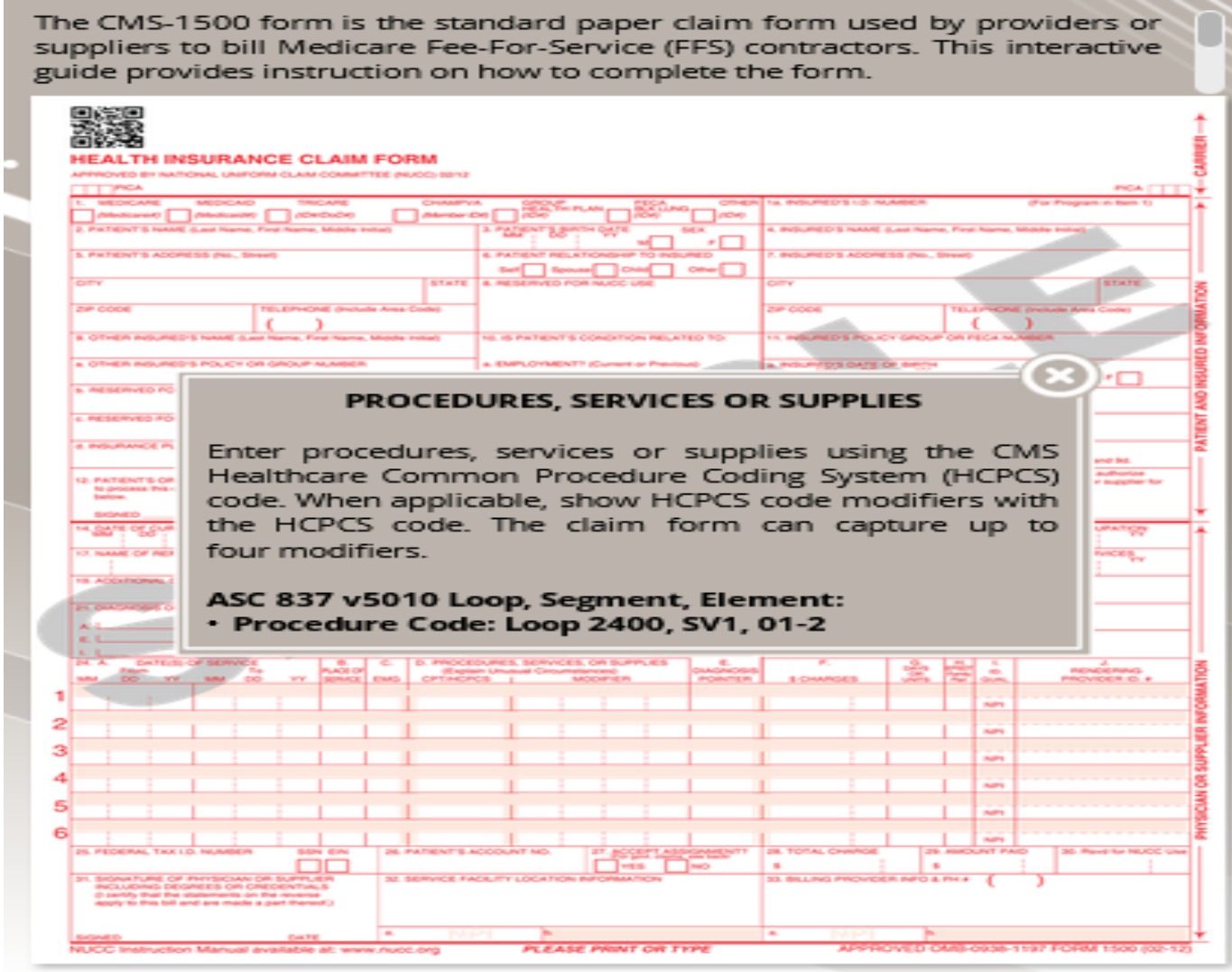
- Use Courier New font for computer-generated claims. Do not print in italics, bold or script. Do not mix fonts.
- Use Pica 10 or 12-point typeface for claims typed on a typewriter.
- Do not type in italics or script.
- Use upper case letters for all claim data.
- Ensure none of the characters touch.
- Ensure no lines from the printer cartridge are anywhere on the claim.
- Do not use special characters, (dollar signs, decimals, dashes, asterisk, or backslashes) unless otherwise specified.
- Use an ink jet or laser printer to complete the CMS-1500 claim form. Because claims submitted with dot matrix printers have breaks in the letters and numbers, OCR equipment is unable to properly read these claims. Suppliers using dot matrix printers risk slow or incorrect processing of their claims.

Ink Color

The OCR equipment is sensitive to ink color. Follow these guidelines on ink color:

- Submit the scannable, red-ink version of the CMS-1500 claim form.
- Do not use red ink to *complete* a CMS-1500 claim form. OCR scanners "drop out" any red that is on the paper.
- Use true black ink. Do not use any other color ink such as blue, purple, or red.

▶https://www.palmettogba.com/internet/eLearn4.nsf/interactivecms1500/story.html



THE CODE(S) YOU CHOOSE SHOULD NOT BE DRIVEN BY WHAT YOU WILL BE REIMBURSED

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CMS 1500 form

- The National Uniform Claim Committee (NUCC)
  - Voluntary organization, chaired by the AMA
  - The Centers for Medicare and Medicaid (CMS) partners with NUCC
- Revision due to:
  - Transition to ICD-10-CM changes
    - Needed more room for longer codes
    - Added 8 additional lines (total of 12 diagnosis codes)
    - Changed from numeric to alphabetic (A-L)
    - Removed the period within the code lines
    - Need to indicate referring (DN), ordering (DK) or supervising (DQ) provider in box 17

CMS 1500 form (cont.)

- Changed form from version 08/05 to 02/12
- Has a QR (Quick Response Code)
- Other form changes:
  - TRICARE CHAMPUS changed to TRICARE
  - Social Security Number changed to ID# for Medicare Part B
  - Box 19 changed to “additional claim information”

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Claim Form

- Lists the CPT©(s), ICD-10-CM(s) and HCPCS codes
  - What you performed (CPT©)
  - Diagnosis results (ICD-10-CM)
  - Resulting recommendations if product or a few procedures (HCPCS)
  - Must have a minimum of 1 CPT© AND/OR HCPCS code and 1 ICD-10-CM code
- Ties the coding systems together and must be appropriate for an audiologist to bill
  - Must meet medical necessity

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What Goes Where?

- Boxes 1-16 Patient information
- Box 17 Referring Provider
  - Include their NPI
  - Include DN (referring provider) or DK (ordering provider) for Medicare Part B and other payers who require it
- Box 19 Can include “need denial from Medicare for secondary to pay”
- Box 21 ICD-10-CM codes

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What Goes Where (cont.)

- Box 24 (A-J)
- A: Date of service
- B: Place of service
  - 11 Office
  - 12 Home
  - 31 Skilled Nursing Facility
  - 32 Nursing Facility
  - 34 Hospice

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What Goes Where (cont.)

- 24D: CPT©/HCPCS/modifiers and G codes for MIPS
- 24E: Diagnosis pointers
  - Corresponds to A-L in the ICD-10-CM boxes
- 24F: Fees
- 24G: Units (most will be “1” with the exception of the time-based codes, earmolds, earmold impressions)
- 24J: Your National Provider Identifier (NPI)

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What Goes Where (cont.)

- Box 25: Federal Tax Identification Number (TIN)
- Box 26: Patient account number, if one is assigned
- Box 27: Accept assignment
  - Yes or no
- Box 28: Total charge
- Box 29: Amount patient paid
- Box 32: Facility name, location, NPI number
- Box 33: Provider name, address, phone, NPI

Modifiers

- Requires documentation to be submitted attesting to why additional time and/or work was necessary
- An audit and/or a delay in payment may occur

Modifiers

- **-22 Unusual Procedural Services**
  - Utilized when procedure is greater than what is typically required
    - Involves increase in provider work, time and complexity of what is typically performed
      - Many insurance carriers state that if it is less than 25% more work, should not append
      - May yield a 20-50% increase of the allowable rate
    - Example: 92557-22

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Modifiers (cont.)

- **-26 Professional component**
  - Utilized with:
    - ENG/VNG (CPT© 92537-92546, 92458-92549)
    - OAE (CPT© 92587, 92588)
  - Utilized:
    - When another professional performed the procedure
    - You do the interpretation and prepare the report
  - Example: 92588-26

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Modifiers (cont.)

- **TC Technical component**
  - Utilized with:
    - ENG/VNG (CPT© 92537-92546, 92548-92549)
    - OAE (CPT© 92587, 92588)
  - Utilized:
    - When you only performed the test
      - Bill TC
    - Another provider does the interpretation and report
      - They bill –26
    - This equals the same reimbursement as the global fee
    - Example: 92588-TC

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Technician Services

- TC may be performed by a technician under a physician's supervision
  - May need to demonstrate tech's qualifications
  - Must be filed by a physician who provided direct supervision (must be in the facility and available)
- TC services can not be filed by an audiologist when performed by another provider, including an audiologist

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Modifiers (cont.)

- **-33 Preventative Service**
  - Use with newborn hearing screening code(s)
    - 92558 (OAE screening)
    - 92650 (ABR screening)
  - No co-pay or deductible is to be applied

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Modifiers (cont.)

- **-50 Bilateral procedure**
  - May be applicable for bilateral cerumen management CPT© codes (69209 and 69210)
- **69209** Removal impacted cerumen using irrigation/lavage, unilateral

OR

- **69210** Removal impacted cerumen requiring instrumentation, unilateral

- Impaction defined as “cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition” and “obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills.”

- May be applicable for cochlear implant CPT© codes 92601-92604 with other procedures

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Modifiers (cont.)

- **-52 Reduced services**
  - Procedure is partially reduced or eliminated
    - Discontinued at provider's discretion after the procedure commenced
    - Can be used to indicate monaural vs binaural testing
    - Not recognized by all carriers
      - Medicare suggests in box 19 add "why reduction was necessary." You may need to send chart notes separately with claim.
    - Example: 92557-52

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Modifiers (cont.)

- **-53 Discontinued procedure**
  - Procedure started, patient's well being becomes jeopardized during the procedure, provider discontinues
  - Example: Patient having ototoxicity monitoring, becomes ill during procedure
    - Reimbursed at 25% of the allowed amount
    - Example: 92557-53

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Modifiers (cont.)

- **-59 Distinct procedural service**
  - Will need to append to CPT© codes 92541, 92542, 92544 or 92545…
    - **ONLY** if performing 1-3 tests of the four-code bundle
    - Documentation should include why you performed the tests you did and not all of the tests in the bundled code

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National Correct Coding Initiative Edits

- -59 if more than two services are performed on the same date of service
- NCCI: “The purpose of the NCCI PTP (Procedure to Procedure) edits is to prevent improper payment when incorrect code combinations are reported. The NCCI contains one table of edits for physicians/practitioners and one table of edits for outpatient hospital services. The purpose of the NCCI MUE program is to prevent improper payments when services are reported with incorrect units of service. Refer to the How to Use NCCI Tools booklet (in the Downloads section below) for more information.”
- Includes codes that cannot be paired on the same date of service and codes that can be
- https://www.cms.gov/Medicare/Coding/PTP-Coding-Edits

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Most Common NCCI Edits

https://www.cms.gov/medicare/coding/ptp-coding-edits

Primary CPT© Code	CPT© Code to Add	Same DOS?	Modifier?
92540	92541, 92542, 92544, 92545	No	
92541	92542, 92544, 92545	Yes	-59
92542	92544, 92545	Yes	-59
92544	92545	Yes	-59
92550	92567, 92568	No	No
92557	92552, 92553, 92555, 92556	No	No
92570	92550, 92567, 92568	No	No

NCCI Edits (cont.)

Primary CPT © Code	CPT© Code to Add	Same DOS?	Modifier?
92588	92587	Yes	-59
92625	92652	Yes	-59

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Primary CPT© Code	CPT© Code to Add	Same DOS?	Modifier?
92601	92521, 92522, 92523, 92524, 92550, 92567, 92568, 92570, 92602, 92626, 92650, 92651, 92652, 92653	Yes	-59
92601	92552, 92553, 92555, 92556, 92557, 92558, 92561, 92562, 92563, 92564, 92565, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92583, 92584, 92587, 92588, 92596, 92597, 92603, 92604	No	

Primary CPT© Code	CPT © Code to Add	Same DOS?	Modifier?
92602	92521, 92522, 92523, 92524, 92550, 92567, 92568, 92570, 92626, 92650, 92651, 92652, 92653	Yes	-59
92602	92552, 92553, 92555, 92556, 92557, 92558, 92561, 92562, 92563, 92564, 92565, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92583, 92584, 92587, 92588, 92596, 92597, 92603, 92604	No	

Primary CPT Code	CPT Code to Add	Same DOS?	Modifier?
92603	92521, 92522, 92523, 92524, 92550, 92567, 92568, 92570, 92604, 92626, 92650, 92651, 92652, 92653	Yes	-59
92603	92552, 92553, 92555, 92556, 92557, 92558, 92561, 92562, 92563, 92564, 92565, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92583, 92584, 92587, 92588, 92596, 92597, 92602	No	

Primary CPT Code	CPT Code to Add	Same DOS?	Modifier?
92604	92521, 92522, 92523, 92524, 92550, 92567, 92568, 92570, 92626, 92650, 92651, 92652, 92653	Yes	-59
92604	92552, 92553, 92555, 92556, 92557, 92558, 92561, 92562, 92563, 92564, 92565, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92583, 92584, 92587, 92588, 92596, 92597	No	

Modifiers (cont.)

- **-76 Procedure was performed more than one time on the same date of service**
  - Glycerol or urea test
  - Ototoxicity monitoring

Medicare Modifiers

- **GY**-Item or service is statutorily excluded or does not meet the definition of any Medicare benefit
  - Often used when a secondary insurance has a hearing aid benefit
  - On the Office of the Inspector General's list for 2009
- **GA**-Waiver of liability on file
  - To be used when a denial is expected and an ABN is on file
    - No ABN, no billing the patient
- **GX-** "Notice of Liability Issued, Voluntary Under Payer Policy"
    - For services that are non-covered, statutorily excluded
- **GZ- "**Must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an Advance Beneficiary Notification (ABN) signed by the beneficiary."

Interactive CMS 1500 Instructions

https://www.palmettogba.com/internet/eLearn.nsf/cms1500/story_html5.html

https://hmsa.com/portal/provider/zav_pel.aa.CMS.400.htm

https://hmsa.com/portal/provider/cms1500_interactive_02_12.pdf

Image: http://freemancontingent.ie

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Medicare Claims Submission

- Claims must be submitted electronically
  - Submit an Electronic Data Interchange (EDI) form
  - A few exceptions include:
    - A physician, practitioner, or supplier that has fewer than 10 Full-Time Equivalent (FTE) employees.
- Claims filed later than one calendar year after date of service will be denied
  - No appeal process
  - Patient cannot be billed

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Medicare Claims Submission (cont.)

- “When you furnish covered services to Medicare beneficiaries, you are required to submit claims for your services and cannot charge beneficiaries for completing or filing Medicare claim.”

- -https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareClaimSubmissionGuidelines-ICN906764.pdf

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Claim instructions for several boxes on new form-to avoid denials

- https://med.noridianmedicare.com/web/jeb/topics/claim-submission/cms-1500-claim-form-completion-tips

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What should be included?

- Demographic information
  - Patient's name
  - Address
  - Date of birth
  - Insurance card information
    - Photocopy front and back (need address)
      - Chart retention only

And?

- Reason for the visit
  - Include other diseases that may impact hearing and balance----co-morbidities
- Case history
  - Family history of ear disease, hearing loss and other hereditary diseases/syndromes
  - Surgeries
  - Medications, past and present
    - Prescriptions, herbals, over-the-counter meds, cochleo and vestibulotoxic agents
  - Occupational noise exposure
  - Recreational noise exposure

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More…

- Pediatric:
  - History:
    - Prenatal
    - Delivery
    - Family

Critical Claim Information:

- Documentation must reflect the codes chosen for:
  - The reason for the visit AND/OR
  - Signs/symptoms AND/OR
  - Outcome of the test result

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What else?

- Who is the ordering/referring professional if required by a third- party payer?
- Medicare physician referrals:
  - On the physician's letterhead or prescription pad
    - Chart retention
  - Not to have the appearance that it was solicited by you
    - Want to avoid referral pads with your practice name
    - Contact your Medicare Administrative Contractor (MAC) for guidance
      - Get it in writing

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Questions?

Thank you!

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