

Top Claim Submission Errors: Denials – October 2009

In the chart below are the denial reason code narratives for the top claim submission errors with claim tips, as appropriate. This list contains the top reason codes for hospice claims in the following states: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

Reason Code	Reason code descriptive narrative and tips to correct and/or avoid future denials.	Total Number of Denials
55H1L	<p>According to Medicare hospice requirements, the information provided does not support that your illness is terminal.</p> <p>Avoiding/correcting this denial: Ensure that the documentation provides clear evidence that the medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course and that the documentation support hospice appropriateness for the dates of service billed.</p>	56
39928	<p>Each line of charges on this claim has been denied by medical review.</p> <p>Avoiding/correcting this denial: Providers should access MAP171D on MEDA DDE for the line item detail medical review reason code. MAP171D can be accessed thru claim option 12:</p> <ul style="list-style-type: none"> ▪ Hit PF2 once or PF11 twice from page 2 of the claim to access MAP171D. ▪ Since it is possible for each line item to have a different line item denial you will want to review the additional lines that were denied. To perform this function, press PF6 to forward to the next claim line and PF5 to go back through previous claim lines. 	7

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56900	<p>This claim is denied for payment because the provider failed to submit documentation requested by the intermediary within 45 days. Sections 1815(a) and 1833(e) of the Social Security Act state that providers must submit documentation upon request as a condition of Medicare payment. Medical review requests documentation for various reasons by sending the provider a request for additional documentation, also known as an ADR. Each ADR has a date in the left-hand corner. If we do not receive the requested information within 45 days of that date, the claim is denied.</p> <p>Avoiding/correcting this denial:</p> <ul style="list-style-type: none"> ▪ Providers are advised to regularly access claims in status location SB6001 to obtain a listing of claims for which records have not yet been received by the Fiscal Intermediary (Medical Review). ▪ The provider may wish to sign up to receive ADRs electronically. Please see our website under EDI products for further information on this option. 	5
55H1Q	<p>The Notice of Election (NOE) for this beneficiary was not received as requested.</p> <p>Avoiding/correcting this denial: Respond to all documentation requests using the correct PO Box address, and respond timely.</p>	2

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