



Top Claim Submission Errors: Denials – April 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 Home Health 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
55H2B	<p>Based on information provided, the beneficiary's illness or injury did not prevent the beneficiary from leaving their home unaided. Therefore, Medicare will not cover the services listed.</p> <p>Avoiding/correcting this denial: Keep in mind that Medicare guidelines indicate a beneficiary must be homebound to receive Home Health services. Homebound means leaving home is a major and taxing effort. No services should be provided to a patient that does meet the criteria for homebound status.</p>	29
55H3A	<p>Medicare requirements are that skilled observation is needed as long as the reasonable potential for change in condition is there. There was no further need for skilled observation documented.</p> <p>Avoiding/correcting this denial: If a covered level of care was required, be sure to keep accurate and specific documentation of the beneficiary's condition. Ensure that all records are submitted to Medical Review, when requested, for all services provided.</p>	24
55H20	<p>The provider's determination of non-coverage is correct: Demand Bill</p> <p>Avoiding/correcting this denial: The charges on this claim are beneficiary liable. The beneficiary may be billed for these charges.</p>	18

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, PF6 to forward to the next claim line and PF5 to go back through previous claim lines. 	15
7L003	<p>As a result of an appeal redetermination review, the claim/service was denied because the Medicare coverage guidelines were not met. A redetermination letter has been sent to the provider/beneficiary.</p> <p>Avoiding/correcting this denial: Please follow the instructions for the next level of appeal as stated in the decision letter.</p>	9
7L004	<p>As a result of an appeal redetermination review, the claim/service was denied because the Medicare coverage guidelines were not met. A redetermination letter has been sent to the provider/beneficiary.</p> <p>Avoiding/correcting this denial: Please follow the instructions for the next level of appeal as stated in the decision letter.</p>	8
55P00	<p>Service(s) have been denied based on investigation by the program safeguard contractor.</p>	7
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. 	7

55H4D	<p>The medical documentation submitted did not show that the therapy services the beneficiary received were reasonable and necessary, and at a level of complexity which requires the skills of a therapist.</p> <p>Avoiding/correcting this denial: The patient’s plan of care and documentation of therapy rendered must clearly show that therapy services provided were to treat the illness or injury or to restore or maintain function affected by the patient’s illness or injury.</p>	4
57540	<p>This claim was denied because it appeared the beneficiary did not know that this service was not covered. The beneficiary is not liable for payment.</p> <p>Avoiding/correcting this denial: When you believe services are not medically necessary, you may provide the beneficiary with the HHABN. Guidelines regarding use of the HHABN can be found in the CMS Claims Processing Manual, IOM PUB 100-4, Chapter 30, Sections 60 - 60.8.</p>	4