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1. Claim Development Procedures

When a Medicare claim requires additional information, the DME MAC will send a development letter (sometimes referred to as an “ADS” letter) requesting information for the incomplete or inaccurate claim. These are not denial letters. The claims they refer to are pending in the computer system, waiting for a response.

You may receive several letters asking the same questions if several claims submitted were lacking the same information. Each letter with the response must be returned so it can be matched to the corresponding claim. The requested information may be written directly on the development letter or documentation may be attached to the letter. Be sure to respond to each question asked.

Responses to development letters should be returned immediately to avoid processing delays. If the response is delayed and the claim is subsequently denied, the claim will either need to be refiled or an appeal requested, depending on the denial code.

2. Medicare Summary Notice (MSN)

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 21

A Medicare Summary Notice (MSN) is sent to Medicare beneficiaries for each claim that is processed. The MSN explains which claim is involved, the type of services, the supplier, and other identifying information. Statements on the MSN explain the basis for the payment and/or denial. The MSN also includes information that may affect future reimbursement, such as explaining that a Certificate of Medical Necessity (CMN) has expired. Remind your beneficiaries to review each MSN carefully and report any suspected errors as soon as possible. The information on an MSN is provided to you on your Remittance Advice.

The beneficiary will be issued an MSN on both assigned and nonassigned claims.

3. Medicare Remittance Advice (RA)

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 22

You will be notified of the claim determination on all claims that you submit, whether they are assigned or nonassigned. The notification is provided by issuance of a Remittance Advice (RA). RAs, which may also be referred to as Remits, include information on one or more claims that you have submitted to the DME MAC. The notices are mailed daily; therefore, you should receive notification shortly after your claims are processed.

All original RAs should be kept in your records, as they provide valuable facts regarding your claims. There may be occasions in the future when you will need to refer to an earlier RA.

The claims will be listed in order by the National Provider Identifier (NPI). On the same line as the beneficiary's name, you will find the HICN and internal control number (ICN), also referred to as a claim control number. The ICN will be different for every claim. These numbers are important when calling or writing regarding a claim.

Special attention should be made to the claim remarks and ANSI codes (AC). The claim remarks are listed at the end of the first line in the MOA field and an explanation of each code can be found at the bottom of the RA. The ANSI codes are listed at the end of each line item, prefaced by a group code (CO, PR or OA). Explanations for the ANSI code and the group code will be listed at the bottom of the RA. The codes will explain the basis for payment, reason(s) for denial, and other pertinent claim information.

When you look at an RA, do not just look at the "PAY PROV" column. The other information given is very important in helping you understand the way a claim was processed. As an example, the "PAY PROV" column may show "00." This does not mean the claim was denied. There may have been approved charges that were applied to the beneficiary's deductible, resulting in no payment.

RAs are also available as an electronic data file. This type of remittance is referred to as an Electronic Remittance Advice (ERA). See Chapter 8 of this manual for information about ERAs.

4. Biller Purged Claim Report

The Biller Purged Claim Report(s) represents a claim which has been deleted from our system due to an error(s) on the claim.

In most cases, the report has an error message in the bottom left-hand corner of the printout. For each claim contained within the report, you must verify all information on the claim, make any necessary changes, and submit a new claim. Please do not return the Biller Purged Claim Reports to the DME MAC. If you discover the errors were caused by your software, you must contact your software vendor or programmer for assistance.

The most common error messages fall into two categories: Beneficiary Information or Provider Information.

Beneficiary Information:

Most of the errors in this category occur when the beneficiary information (name, Medicare number, sex, etc.) submitted on the claim does not match the information we have on file for that beneficiary and/or that Medicare number. The beneficiary's name and Medicare number must be submitted on the claim exactly as they appear on the beneficiary's red, white and blue Medicare card. Do not use nicknames, abbreviations or middle names unless included on the Medicare card. It is recommended that you maintain in your records a copy of the beneficiary's Medicare card for verification purposes. If the information submitted on the claim exactly matches the beneficiary's Medicare card, contact the Jurisdiction C DME MAC by calling 866.270.4909 for further assistance.

Beneficiary information errors include:

0001 - HICN SUFFIX, SEX - The suffix used for the Medicare number does not match the sex indicated for this beneficiary, or an incorrect Medicare number was submitted.

0007 - BENE REC CLOSED - The master record for this Medicare number was closed because a previous claim was submitted with inappropriate patient information.

0047 - NAME-KEY MISMATCH - The beneficiary's name does not match the name on file for this Medicare number.

0049 - SEX-KEY MISMATCH - The sex indicated on the claim does not match the sex on file for this Medicare number.

0058 - RESPONSE REVIEW - An incorrect Medicare number was submitted for the beneficiary.

Provider information:

4076 – PROV NOT FOUND – The claim could not be processed due to an issue with your National Provider Identifier (NPI). This edit typically indicates a problem with your NPI as it relates to the supplier number assigned by the National Supplier Clearinghouse. You must correct your information with the National Plan and Provider Enumeration System (NPPES) and/or the National Supplier Clearinghouse (NSC) before submitting a new claim.

Remember—DO NOT return Biller Purged Claim Reports. Changes must be submitted as a new claim.

5. ANSI Codes

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 22, §60

ANSI (American National Standard Institute) codes are used to explain the adjudication of a claim. The following information describes the types of codes that will appear on your RA.

Claim Adjustment Reason Codes are codes developed for use by all healthcare payers. Consequently, these codes have generic messages and a number of them do not apply to Medicare. A complete list of these codes can be found at <http://www.wpc-edi.com>.

Remittance Advice Remark Codes give further explanation to reason codes. Remark codes are maintained by CMS. A complete list of remark codes can be found at <http://www.wpc-edi.com/codes/remittanceadvice>.

The definitions of the reason and remark codes which appear on an RA can be found at the bottom of the RA.

When you receive a claim denial, the reason and remark codes will help you to determine the problem. CGS has developed an ANSI Denial Guide to assist you with common denials. The ANSI Denial Guide is available on our web site at http://www.cgsmedicare.com/jc/claims/pdf/JC_ANSI_denial_guide.pdf.

Group Codes, which are entered along with all reason code(s), establish financial liability for the amount of the adjustment or to identify a post-initial-adjudication adjustment. Group codes are not used with Medicare REF or MIA/MOA remarks code entries. The definitions of the group codes used by the DME MAC can be found on the following page.

<p>PR</p>	<p>Patient responsibility. This signifies the amount that may be billed to the beneficiary or to another payer on the beneficiary's behalf. For example, PR would be used with the reason code for:</p> <ul style="list-style-type: none"> • Patient's deductible or coinsurance, • The patient assumed financial responsibility for a service not considered reasonable and necessary, • Cost of therapy or psychiatric services after the coverage limit had been reached, • A charge denied as a result of the patient's failure to supply primary payer or other information, • Where a patient is responsible for payment of excess non-assigned physician charges. <p>Charges that have not been paid by Medicare and/or are not included in a PR group are:</p> <ul style="list-style-type: none"> • Late filing penalty (reason code B4), • Excess charges on an assigned claim (reason code 42), • Excess charges attributable to rebundled services (reason code B15), • Charges denied as a result of the failure to submit necessary information by a provider who accepts assignment, • Services that are not reasonable and necessary for care (reason code 50 or 57) for which there are no indemnification agreements are the liability of the provider. <p>Providers may be subject to penalties if they bill a patient for charges not identified with the PR group code.</p>
<p>CO</p>	<p>Contractual obligations. This includes any amounts for which the provider is financially liable, such as:</p> <ul style="list-style-type: none"> • Participation agreement violations, • Assignment amount violations, • Excess charges by a managed care plan provider, • Late filing penalties, • Gramm-Rudman reductions, • Medical necessity denials/reductions. <p>The patient may not be billed for these amounts.</p>
<p>OA</p>	<p>Other adjustment. This would only be used if neither PR nor CO applied. At least one PR, CO or OA group must appear on each remittance advice. For example, OA would be used when a claim is paid in full at initial adjudication with reason code 93 and a zero amount. Neither the patient nor the provider can be held responsible for any amount classified as an OA adjustment.</p>
<p>CR</p>	<p>Correction to or reversal of a prior decision. This group applies whenever there is a change to a previously adjudicated claim. CR explains the reason for the correction; PR, CO and/or OA must always be used in tandem with CR to show the revised information. Separate reason code entries must be used in the NSF for the CR group entry and any other groups that apply to the readjudicated claim.</p> <p>At least one reason code is always used with a group code in the NSF. We always enter the reason code(s) and that amount from the initial remittance advice for the service being corrected with the CR, and include any additional reason code that may apply to the subsequent adjustment. If the change does not involve a prior denial/reduction reason code reason code 93 is used.</p>