

January 2010 J1 Part A Medical Review Top Denial Reason Codes

The following information has been taken from the most recent publication by Palmetto GBS, the MAC for J1 covering the West Coast. Although these results are specific to their region, they represent denials experienced by many providers.

The recommendation provided by Palmetto follow what we have been telling our seminar attendees for a long while. So many of these denials are avoidable with a little forethought and prevention. It is so important to have an audit system in place that reviews documentation before the dreaded ADR arrives. There are two provider setting identified, the SNF Part A and Part B services provided by hospitals and SNFs. We do not have any information on CORF or ORF (Rehab Agency) denials. But again, reasons for denial are not just exclusive to these two provider setting, but applicable to all.

Top Outpatient Denial Reason Codes (13x, 14x, 23x)

1. 5D164/5H164 - No Documentation of Medical Necessity ¹

Reason for Denial

This claim was fully or partially denied because the documentation submitted for review does not support the medical necessity of some of the services billed

How to Avoid a Denial

Submit all documentation related to the services billed which support the medical necessity of the services
Use the most appropriate ICD-9-CM codes to identify the beneficiary's medical diagnosis.

2. 5D161/5H161 - No Physician's Orders ²

Reason for Denial

This claim was fully or partially denied because there were no physician's orders submitted for review or all or some of the services billed

How to Avoid a Denial

A physician's order should be submitted for review with the request for copies of medical records
The copy of the order should be legible and dated.
Ensure that orders submitted for review are for the dates of service billed.

3. 56900 - Lack of Response to Medical Record Request ³

¹ Medical Necessity is the benchmark for the payment of Medicare. We recommend adding a reason for referral or medical necessity statement to your evaluation. Or, when receiving an ADR attach as supplementary information.

² This cause for denial is very appealable for therapy services. CMS has identified that although a referral from the physician identifies that the patient is under the care of a physician or non-physician practitioner (NPP – depending on the site of service) and that payment is dependent on the certification of the plan by the physician/NPP. You need to review your LCD to see if this referral is identified by your MAC. If so, we recommend including the CMS statements that can be found in the Benefit Manual; also it really is good practice to ensure the referral is present in the medical record.

³ This is a no brainer! To get a denial because you didn't respond to the ADR timely is inexcusable.

4. 5D169/5H169 - Services Not Documented ⁴

Reason for Denial

This claim was partially or fully denied because the provider billed for services/items not documented in the medical record submitted.

How to Avoid a Denial

- Submit all documentation related to the services billed
- Ensure that results submitted are for the date of service billed, the correct beneficiary and the specific service billed

5. 5D162/5H162 – No plan of care ⁵

Reason for Denial

This claim was partially or fully denied because the provider did not include a written plan of care or establish the plan of care before rendering treatment. For services to be covered by the Medicare program these services must be furnished under a written plan of care and the plan of care must be established before rendering treatment. The plan can be established by the physician or non physician practitioner (NPP), the treating physical therapist, occupational therapist, or speech-language pathologist. The NPP can be a physician assistant, nurse practitioner, or clinical nurse specialist. (Only a physician can establish a plan of care in a Comprehensive Outpatient Rehabilitation Facility.)

How to Avoid a Denial

Documentation and tips that may be helpful to avoid future denials for this reason may include, but are not limited to, the following:

- At a minimum, the plan of care should include (1) the diagnosis, (2) long term goals, and (3) type, amount, duration and frequency of the specific therapy service.
- Changes in the plan may be made in writing and must be signed by one of the following: the physician, the physical therapist who furnishes the physical therapy services, the occupational therapist who furnishes the occupational therapy services, the speech-language pathologist who furnishes the speech-language pathology services, a registered professional nurse, a nurse practitioner or a clinical nurse specialist or a physician assistant

6. 5D165/5H165 – No Physician Certification/Re-Certification ⁶

Reason for Denial

For services to be covered by the Medicare program, the plan of care must be certified by the physician or non-physician practitioner (NPP). Certification means that the physician or NPP has signed and dated the plan of care or some other document that indicates approval of the plan of care.

⁴ CMS requires that the skilled services provided are documented in the treatment encounter note. A check list of CPT codes does not meet this requirement. Remember, the CPT coding system is a billing system and uses descriptions of the codes, example therapeutic activities. This does not indicate what the provider did that justified the billing of those services.

⁵ A signed plan is a compliance requirement and must be a part of the medical record. The clinician must complete the plan and sign it before treatment can be provided by the therapist assistant and before the next treatment when the clinician is providing service. Remember, the plan must be signed and dated by the person who establishes the plan.

⁶ The certification /recertification of the plan is the technical requirement for payment, not the referral. It is an automatic denial on Medical Review. The denial is appealable by including delayed certification in the appeal, but why get that far? If you do not have the certification, prior to sending the documentation to the requestor, obtain a delayed certification / recertification and indicate the reason for the delay.

How to Avoid a Denial

Documentation and tips that may be helpful to avoid future denials for this reason may include, but are not limited to, the following:

- The certification must indicate that the beneficiary (1) needed the type of therapy provided, (2) was under the care of a physician, nurse practitioner, clinical nurse specialist, or physician assistant, and (3) was treated under a valid plan of care.
- The initial certification should be signed/dated within 30 days of the first day of treatment (including the evaluation)
- The recertification must occur at least every 90 calendar days
- The signature may be written, electronic, or stamped. If the physician fails to date his/her signature, staff can add "Received Date" in writing or with a stamp
- Clear copies of the medical records should be submitted

8. 5H500- Billing Error ⁷

Reason for Denial

The services billed were not covered. According to documentation in the medical record, the hospital has billed items and/or services in error. The hospital may not charge the beneficiary for items and/or services that were billed in error.

How to Avoid a Denial

- Check all bills for accuracy prior to submitting to Medicare
- Ensure that the documentation submitted, in response to the ADR, corresponds with the date that the service/diagnostic test was rendered, and the dates of service billed.

Top Skilled Nursing Facility (SNF) Denial Reason Codes (18x, 21x)

1. 5DOWN - Medical Review Downcode ⁸

Reason for Denial

The services billed were paid at a lower payment level. Documentation submitted for review should support the data on the MDS, paint a clear picture of the beneficiary's medical condition, and meet coverage criteria. Based on medical review, the documentation submitted for review did not meet the criteria for the RUG code(s) billed. As a result, reimbursement has been adjusted to a lower payment level.

How to Avoid a Denial

To avoid medical review downcoding of billed RUG codes, submit all documentation to support the RUG code(s) billed. The MDS assessment that established the RUG code billed must be supported by the clinical documentation. If any portion of documentation to support the RUG code billed is not submitted, a downcode may result. When therapy RUG codes are billed, the following documentation must be submitted for review:

- Orders for therapy services signed and dated by the physician,
- A written therapy plan of treatment established by the physician after consultation with the therapist,

⁷ Again, billing for services provided on the wrong day will always get denied. So include a review of the claim form in your chart audits. Although not indicated here, billing CPT codes that are not supported by the documentation will also get you a denial.

⁸ Once again, the RUG code billed must be supported by the documentation. Making sure that the minutes and days identified in the MDS are accurate and match the therapy log/grids. The documentation must also support the intensity of the services provided, or again, the claim may be downcoded to a lesser level.

- The actual minutes of therapy rendered as documented on a log/grid or in the clinical documentation to support the minutes recorded on the MDS, and;
- Progress notes and any other documentation to establish the medical necessity of the services rendered.

2. 5D507/5H50 – SNF MDS is not in the National Repository ⁹

Reason for Denial

The MDS cannot be accessed in the National Repository.

How to Avoid a Denial

Ensure that the MDS has been entered into the National Repository prior to submitting request for payment to Medicare

Check all bills for accuracy and ensure that the MDS clinical assessment includes data for all covered days associated with the billing period.

3. 56900 - Lack of Response to Medical Record Request ¹⁰

4. 5D504/5H504 - Information Provided Does Not Support the Medical Necessity for This Service ¹¹

Reason for Denial

The claim was fully or partially denied, as we were unable to determine medical necessity with the documentation submitted for review.

How to Avoid a Denial

Submit all documentation to support medical necessity of the services billed. Include documentation for the “look back period(s).” This may include up to 30-45 days prior to the dates of service under review.

5. 5D509 – No Qualifying Hospital Stay Dates Were Shown in HIMR for This Skilled Nursing Facility

Reason for Denial

The service(s) billed [was/were] not covered by Medicare, as there is no qualifying hospital dates shown in Health Insurance Maintenance Record (HIMR) for this skilled nursing facility.

How to Avoid a Denial

The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in one or more hospitals. In determining whether the requirement has been met, the day of admission, **but not the day of discharge**, is counted as a hospital inpatient day. In addition, the qualifying hospital stay must be medically necessary.

⁹ The claim cannot be billed until the MDS has been locked and transmitted to state.

¹⁰ Same comments on this one as for the Outpatient claims. Not responding timely is dumb!

¹¹ The ADR will list all of the documentation required. All of the MDSs that created a payment in the period under review must be submitted along with the information supporting that MDS.