


## Top Denials

Denial	Description	Tip/Resources
CO-18	Duplicate claims/service.	<p>Do not resubmit the entire claim when partial payment has been made; resubmit denied lines only (when appropriate).</p> <p>Ensure appropriate modifier(s) are on claim lines.</p> <p>To prevent unnecessary duplicate claim filings: Allow at least 30 days from the date a claim was received by Medicare to process the claim for payment.</p> <p>Check status of claim via IVR at 1-877-847-4992</p> <p>FCSO offers a free Web-based training (WBT) course titled "Duplicate Claims – Part B" at <a href="http://www.fcsomedicaretraining.com">www.fcsomedicaretraining.com</a>.</p>
CO-97	Payment adjusted because these procedure/services are not paid separately. DENIED/REDUCED SERVICE/PROCEDURE NOT PAID SEPARATELY.	<p>This denial indicates the services billed have already been paid as part of another service billed on the same date of service. Please make note of the quarterly updates to the Correct Coding Initiative (CCI) edits which are available at <a href="http://www.cms.hhs.gov/NationalCorrectcodInitED/">http://www.cms.hhs.gov/NationalCorrectcodInitED/</a>.</p> <p>The purpose of the CCI edits is to ensure the most comprehensive groups of codes are billed, rather than the component parts.</p>
CO-B9	Services not covered because the patient is enrolled in a hospice.	<p>There are specific guidelines pertaining to Medicare hospice benefits. Certain Medicare coverage does not apply to a beneficiary enrolled in a hospice program. This link will produce a document titled "Medicare Hospice Benefits", which details the guidelines applying to hospice cases:</p> <p><a href="http://www.hospiceelpaso.org/files/cms_medicare.pdf">http://www.hospiceelpaso.org/files/cms_medicare.pdf</a></p> 

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		<p>To determine if a patient is enrolled in a hospice program, contact the Interactive Voice Response Unit (IVR), from which the following data pertaining to the beneficiary can be obtained:</p> <ul style="list-style-type: none"> <li>• Hospice effective date</li> <li>• Hospice termination date (if applicable)</li> <li>• Servicing contractor number</li> <li>• The Servicing provider ID information is located at <a href="http://www.floridamedicare.com/Reference/IVR/index.asp">http://www.floridamedicare.com/Reference/IVR/index.asp</a>. Select “Hospice Provider ID Information” for the directory.</li> </ul> <p>Certain modifiers apply when services/providers are not related to hospice:</p> <ul style="list-style-type: none"> <li>• GV: Attending physician not employed or paid under agreement by the patient’s hospice provider</li> <li>• GW: Services not related to the hospice patient’s terminal condition</li> </ul>
CO-11	Diagnosis is inconsistent with the procedure; This procedure/item not payable for the diagnosis as reported.	<p>This denial indicates the procedure code billed is incompatible with the diagnosis. You may access the Procedure to Diagnosis Look-Up/Service Indication Tool located at:</p> <p><a href="http://www.cms.hhs.gov/mcd/serviceindication_criteria.asp?from2=serviceindication_criteria.asp&amp;">http://www.cms.hhs.gov/mcd/serviceindication_criteria.asp?from2=serviceindication_criteria.asp&amp;</a></p> <p>to determine if the procedure code to be billed is payable under the specific diagnosis. You may also refer to “Final LCDs” on the FCSO Medicare provider Web site for a list of HCPCS codes that spell out which services the LCD applies to, the diagnosis for which a service is covered, and the diagnosis for which the service is not considered reasonable and necessary.</p>
CO-15	Claim/service denied because the related or qualifying claim/service	<p>Medicare does not pay for services or items related to a procedure that has not been approved or billed.</p> <p>This denial is related to billing a Secondary or “Add-</p>

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	<p>was not previously paid or submitted or identified on this claim; Procedure must be billed with primary service.</p>	<p>on” code, before the primary procedure has been billed and paid.</p> <ul style="list-style-type: none"> <li>• Ensure to submit Secondary or “Add-on” codes on the same claim as the primary procedure code, to avoid these types of denials.</li> <li>• If you are unable to bill the codes at the same time, ensure the primary code has been paid before filing a claim for the Secondary code.</li> <li>• Claim status can be obtained by contacting the Part B IVR at 1-877-847-4992.</li> </ul>
CO-22	<p>Payment adjusted because this care may be covered by another payer per coordination of benefits. Claim must be sent to the Employee Group Health Plan (EGHP).</p>	<p>This denial indicates Medicare has information that the patient has another insurance primary to Medicare (called Medicare Secondary Payer, or MSP).</p> <ul style="list-style-type: none"> <li>• Submit the claim to the primary payer;</li> <li>• Once it is processed, a claim can be submitted to Medicare for possible secondary payment.</li> </ul> <p>If the provider has information the MSP file is incorrect, the beneficiary and/or the provider need to contact the Coordination of Benefits Contractor (COBC) at 1-800-999-1118 (Monday - Friday from 8:00 a.m. to 8:00 p.m. Eastern Time) to have the file updated. Once the file is updated, the claim can be submitted to Medicare as primary.</p> <p>To learn more about MSP, check out our free Web-based training (WBT) course at: <a href="http://www.fcsomedicaretraining.com">www.fcsomedicaretraining.com</a>.</p>
CO-24	<p>Payment for charges adjusted. Charges are covered under a capitation agreement/ managed care</p>	<p>This usually means a patient has a Medicare Advantage (MA) Plan (formerly an HMO). Below are points relating to this:</p> <ul style="list-style-type: none"> <li>• MA enrollment information can be obtained via the</li> </ul>

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	plan. Provider must submit claim to HMO.	<p>IVR (at 1-877-847-4992)</p> <ul style="list-style-type: none"> <li>• Claims must be submitted to the MA plan before Medicare</li> </ul> <p>Prior to a patient being seen for ESRD related dialysis; ensure they are not already covered under a capitation agreement with another provider. If they are, contact the provider before rendering services.</p>
CO-109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor. A Skilled Nursing Facility (SNF) Episode of Care Notice has been filed for this patient.	<p>Medicare Part B may not pay for certain items/services when the patient is in a Skilled Nursing Facility (SNF). The SNF is responsible for payment of these services to outside providers who furnish these services/supplies to residents, through consolidated billing (CB).</p> <p>Contact the IVR at 1-877-847-4992 to determine the patient's eligibility. The IVR provides the following SNF information if applicable:</p> <ul style="list-style-type: none"> <li>• SNF Effective Date</li> <li>• Termination Date (If Applicable)</li> <li>• Servicing Provider Number</li> </ul> <p>The Servicing provider ID information is located at <a href="http://www.floridamedicare.com/Reference/IVR/index.asp">http://www.floridamedicare.com/Reference/IVR/index.asp</a>. Select "Skilled Nursing Facility ID Information" for the directory.</p>
CO-27	Expenses incurred after coverage terminated. Charges incurred during non entitled period.	<p>Services were denied because the patient did not have Medicare Part B coverage at the time the services were performed.</p> <ul style="list-style-type: none"> <li>• Ensure you have a copy of the patient's most recently issued Medicare card in order to compare</li> </ul>

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		<p>the number with the one you are submitting</p> <ul style="list-style-type: none"> <li>• Via the Medicare card, verify for which part(s) of Medicare the patient is eligible</li> <li>• Check current and previous dates of service eligibility for beneficiaries using the IVR. Call (877) 847-4992; from the main menu, press “3,” then “1” (current eligibility).</li> </ul>
CO-50	<p>These are non-covered services because this is not deemed a medical necessity by the payer. Medicare will not pay for this service for this condition.</p>	<p>This decision was based on a Local Coverage Determination (LCD). Utilization and/or documentation requirements, as outlined in the LCD, have not been met to determine medical necessity for the services or procedures submitted to Medicare.</p> <ul style="list-style-type: none"> <li>• Review the documentation and utilization requirements for the code you are billing.</li> <li>• Ensure medical necessity for the procedure/service is clearly documented in the patient’s medical record.</li> <li>• If medical records are requested, ensure all relevant information and/or documentation is delivered complete and in a timely manner.</li> </ul>