CGS DME MAC Jurisdiction C

ANSI Denial Guide

This tool has been developed to provide the supplier community guidance on how to address claim denials in the most efficient manner. This tool does not capture all scenarios, but rather the most common. Suppliers are strongly encouraged to review all aspects of a claim denial and to respond accordingly. CGS developed the table that follows to assist suppliers in making this determination.

One question frequently asked by suppliers is "How do I determine whether to send claim denials to Reopenings or Redeterminations?" Below is an overview of the Reopenings and Redeterminations process and when it is appropriate to file a request to each.

REOPENINGS

When only a minor error or omission is involved, the supplier should request that Medicare "reopen" the claim to correct the error or omission, avoiding the need to go through the appeal process. Suppliers can request a reopening for minor errors or omissions by telephone, in writing, or by fax. Suppliers have one year from the date on the remittance advice to request a reopening. Examples of minor errors or omissions include:

- Mathematical or computational mistakes;
- Transposed procedure or diagnostic codes;
- Inaccurate data entry, such as missing modifier, number of services, etc;
- Misapplication of a fee schedule;
- Computer errors;
- Denial of claims as duplicates which the party believes were incorrectly identified as a duplicate.
- Incorrect data items, such as provider number, use of a modifier or date of service.

If a supplier or beneficiary requests a redetermination and the request involves only a minor error or omission (i.e., a clerical error), irrespective of the request for a redetermination the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) will treat the request as a request for a clerical error reopening.

To file a Reopening request please complete and send the Reopenings Request Form located at: http://www.cgsmedicare.com/jc/forms/pdf/JC_reopenings_form.pdf

Please fax to 615.782.4649 or mail to: CGS
DME MAC Jurisdiction C
PO Box 20010
Nashville, TN 37202

Or call: 1.866.813.7878

REDETERMINATIONS

A Redetermination, which is the first level of the Appeals process, is an independent review of the initial claim determination. Redeterminations are commonly requested when the initial determination was denied for medical necessity or over-utilization; however a redetermination may be requested whenever an independent re-examination of an initial claim determination is desired.

Originated June 23, 2008 • Updated February 15, 2016.
© 2016 Copyright, CGS Administrators, LLC.

Requests for Redetermination must be submitted in writing. Please fill out the Redetermination Request Form located at: http://www.cgsmedicare.com/jc/forms/pdf/JC_redetermination_form.pdf and mail to: CGS
DME MAC Jurisdiction C
PO Box 20009
Nashville, TN 37202

ANSI Reason	Remark	Explanation of Denial	Things to look for	Next Step
4		The procedure code is inconsistent with the modifier used, or a required modifier is missing.	– Review what modifiers to use for the different payment categories. – If billing for capped rental items beginning prior to 1/1/06 or enteral/parenteral pumps, is the rental/purchase option modifier needed? – If billing with an EY modifier, are there any line items that do not contain the EY modifier?	– Correct and resubmit as a new claim. – For capped rental items beginning prior to 1/1/06 or enteral/parenteral pumps, payment cannot be made past the 11th month without indicating whether the beneficiary has decided to rent or purchase the equipment. Resubmit the claim with the appropriate modifier to indicate what the beneficiary has decided to do. – If a claim line contains the EY modifier, all other claim lines must also contain the EY. If you need to bill for some items with the EY and some without, then submit two separate claims.
13		The date of death is before the date of service.	Verify the date of service billed.	– Correct and resubmit as a new claim. – If the record on file is incorrect, the patient's family/estate must contact Social Security to have records corrected.
16	M51	Missing/incomplete/invalid procedure code.	– Check effective date of procedure code being billed. – Does procedure code being billed require a modifier? Check the appropriate LCD (http://www.cgsmedicare.com/jc/coverage/LCDinfo.html).	Correct and resubmit as new claim.
16	MA130	Claim returned as unprocessable.	The claim is missing or contains invalid information to process. Refer to the Remittance Advice Remark Codes (RARCs) below to find out what specifically is missing or invalid. – Remark MA75 - Block 12 of CMS 1500 form, beneficiary signature missing. – Remark MA81 - Block 31 provider signature missing. – Remark MA83 - Block 11 is blank.	Correct and resubmit as a new claim.
16	N4	Insufficient primary EOB received.	– Does the provided EOB information match the claim? – Is the reason for the primary insurer's denial or adjustment provided?	Resubmit with sufficient primary EOB information.
16	N51	Electronic interchange agreement not on file for provider/submitter.	Our records show there is no EDI agreement on file to bill Jurisdiction C claims.	Contact the CEDI Helpdesk at 1.866.311.9184.
16	N64	Claim returned as unprocessable.	This item must be billed with spanned dates.	Correct and resubmit as new claim.
16	N280	Missing/incomplete/invalid pay-to provider identifier.	Verify physician's name is listed in block 17 and physician's NPI number is complete and valid in block 17b of CMS-1500 claim form.	Correct and resubmit as new claim.
16	N366	Information required to make payment was missing.	– Claim or Certificate of Medical Necessity (CMN) is missing or contains invalid information. – Miscellaneous procedure code was not submitted with appropriate information (i.e., MSRP, product information, make/model/serial number, narrative for medical necessity).	Verify information on the claim and/or CMN is accurate and complete. Correct and resubmit as new claim.
17	N366	Lack of response to development letter.	We sent a letter requesting addition information about your claim and received no response.	The claim can be reopened if the information previously requested is submitted within one year after the date of this denial notice.
18	N111	Duplicate claim/service	Our records show we have already processed a claim for this HCPCS code for this date of service. Call the Interactive Voice Response (IVR) system, at 1.866.238.9650, to receive information about how your claim was previously processed. The IVR will skip the duplicate denial and give the status of the original claim on file.	If you feel the claim denied as a duplicate in error, contact Telephone Reopenings at 1.866.813.7878

ANSI Reason	Remark	Explanation of Denial	Things to look for	Next Step
18	M3	Equipment is same or similar to equipment already being used.	We show the beneficiary has already received the equipment/service you are billing for. For capped rental equipment, call our Interactive Voice Response (IVR) system at 1.866.238.9650 to see what equipment we have on file and information on the supplier that provided it.	– If you disagree with the decision, submit a redetermination request with appropriate documentation. – If you feel your claim denied same or similar in error, call our Customer Service line at 1.866.270.4909. – You may also pick up your equipment from the beneficiary rather than pursue payment.
19		Claim denied because this is a work-related injury and thus the liability of the worker's compensation carrier.	Our records show the diagnosis on the claim matches the diagnosis on a worker's compensation record.	– Bill the claim to the worker compensation carrier. – If the worker's compensation carrier will not pay or pay promptly, resubmit the claim with documentation. – If the record on file is incorrect, instruct the beneficiary to contact the coordination of benefits contractor at 1.800.999.1118 for correction.
20		Claim denied due to a liability situation.	Our records show the diagnosis on the claim matches the diagnosis on a liability record.	– Bill the claim to the liability insurer. – If the liability insurer will not pay or pay promptly, resubmit the claim with documentation. – If the record on file is incorrect, instruct the beneficiary to contact the coordination of benefits contractor at 1.800.999.1118 for correction.
21		Claim denied due to payment by an auto medical/no-fault insurer.	Our records show the diagnosis on the claim matches the diagnosis on an auto medical/no-fault record.	– Bill the claim to the auto medical/no-fault insurer. – If the auto medical/no-fault insurer will not pay or pay promptly, resubmit the claim with documentation. – If the record on file is incorrect, instruct the beneficiary to contact the coordination of benefits contractor at 1.800.999.1118 for correction.
22		No primary insurance explanation of benefits (EOB) information submitted with claim. The EOB information is required for Medicare to make a secondary payment.	Determine if the patient has Group Health Plan coverage that is primary to Medicare.	– If the patient has Group Health Plan coverage, resubmit the claim with the primary insurer's EOB information. – If the record on file is incorrect, instruct the beneficiary to contact the coordination of benefits contractor at 1.800.999.1118 for correction.
22	MA16	This claim may be covered by someone other than Medicare per coordination of benefits.	Our records show the beneficiary is covered by the Black Lung Program.	Send the claim to: Department of Labor Federal Black Lung Program PO Box 828 Lanham-Seabrook MD 20703
24		Charges are covered under a capitation agreement/ managed care plan.	– Is the beneficiary enrolled in a Medicare Advantage Plan? – If claim is for dialysis equipment or supplies, what method of dialysis did the beneficiary choose?	Submit claim to correct contractor.
29		The claim was filed after the time limit.	– Verify correct date(s) of service have been billed. – Check IVR to determine if claim was processed timely.	– If incorrect date(s) of service was billed, correct and resubmit as a new claim. – If the claim was filed timely or good cause is shown, submit a request to Reopenings.
31		Patient cannot be identified as our insured.	– Verify correct beneficiary's Medicare number was submitted on claim. – Check IVR for beneficiary's eligibility with Medicare.	– Correct and resubmit as a new claim. – If record on file is incorrect, the beneficiary must contact the Social Security Administration.
35	N370	Lifetime benefit maximum has been reached. The billing exceeds the rental months covered.	– How many rental months have been paid? – Verify same equipment has not been provided by another provider. – Has there been a break in medical need?	For capped rental items beginning prior to 1/1/06, the equipment will cap out after 15 months have been paid. For capped rental items beginning on or after 1/1/06, the equipment will cap out after 13 rental months. If the equipment has capped, no more rental months can be paid. If you believe a new capped rental period is merited you, submit a reopening request with the appropriate documentation.
35	M7	Payment cannot be made after the reasonable purchase price has been met.	– Are you billing an Inexpensive/routinely purchased (IRP) item as a rental? – What is the fee schedule amount for the item? – How much reimbursement have you received so far?	Rental payments on IRP items are only paid until the purchase price is reached. You may continue to bill the beneficiary for further rental payments. If you supplied the beneficiary with a new item due to a change in medical need or due to the original equipment being lost, irreparably damaged, or stolen, submit to Redeterminations.

© 2016 Copyright, CGS Administrators, LLC.

ANSI Reason	Remark	Explanation of Denial	Things to look for	Next Step
50		Medical Necessity denial.	Check Local Coverage Determination (LCD) and Policy article: – Does item require CMN or DIF? – Does item require KX modifier? – According to the LCD is a specific ICD9 required? – Was an ADS letter received?	– If CMN/DIF was submitted with claim, send a request with supporting documentation to Redeterminations. – If the KX modifier was omitted by mistake, request a redetermination to add, change, or remove the KX (the same is true for GA, GZ, and GY modifiers). Be sure to include all the appropriate documentation. – If clerical error/minor omission (such as billing the incorrect ICD9 code), request a reopening. – Submit requested documentation to Redeterminations.
50	N115	Medical Necessity denial based on Local Coverage Determination (LCD).	Check Local Coverage Determination (LCD) and Policy article: – Does item require CMN or DIF? – Does item require KX modifier? – According to the LCD is a specific ICD-9 required? – Was a development letter received?	– If CMN/DIF is required, send a request to Redeterminations along with the CMN/DIF. – If the KX modifier was omitted by mistake, request a redetermination to add, change, or remove the KX (the same is true for GA, GZ, and GY modifiers). Be sure to include all the appropriate documentation. – If clerical error/minor omission (such as incorrect diagnosis code), request a reopening. – If a development letter was received but not responded to, submit requested documentation to Redeterminations.
50	N102	Lack of response to Development letter.	Additional documentation letter sent requesting specific documentation.	Submit the requested documentation as requested on your letter. If over 120 days, submit a redetermination request IF you have just-cause for submitting a late request (be sure to include your justification for late filing in your request).
60	M2	This service is not covered since our records show that the beneficiary was in the hospital on the date of service billed.	– Verify correct date of service and place of service was billed. – Was the item delivered within 2 days prior to discharge for training purposes?	– If the incorrect date of service was billed, correct and resubmit as a new claim. – Payment cannot be made by the DME MAC for items received while a beneficiary is in a hospital stay unless the equipment was delivered no more than 2 days prior to discharge.
96	N103	Social Security records indicate that this patient was a prisoner when the service was rendered.	– Was patient incarcerated on date of service? – Where is equipment being used?	– Send to Redeterminations with copy of incarceration release documents – If institution is not responsible for medical needs of prisoners, send documentation to Redeterminations.
96	N108	Upgrade information was invalid.	– What equipment was ordered and what equipment was provided? – Were correct modifiers appended to both lines?	Correct claim and resubmit as a new claim. For information on how to bill an upgrade, refer to the DME MAC Jurisdiction C Supplier Manual, Chapter 6 (http://www.cgsmedicare.com/jc/pubs/pdf/Chpt6.pdf).
96	N115	Item non covered based on LCD.	Check LCD (http://www.cgsmedicare.com/jc/coverage/LCDinfo.html)documentation requirements for coverage and use of modifiers.	If billed incorrectly (such as inadvertently omitting a required modifier), request a reopening (unless if is for the KX, GA, GZ, or GY modifiers, in which case you must request a redetermination request).
96	N372	Medicare will pay for medically necessary maintenance and/or servicing as needed after the end of the 13th rental month.	Capped rental item received on or after January 1, 2006 and 13 months have been paid.	Only medically necessary repairs may be billed to Medicare.
96	M124	No record of required base equipment on file for the item/ accessory/replacement part that you are billing.	Was base equipment information included with claim?	Resubmit the claim with a narrative description of the patient owned equipment including HCPCS code, make and model, and date of purchase (at least month and year).
96	M6	Servicing and repair are not billable with rented equipment, or maintenance and servicing (MS) is billed too soon.	– Is equipment currently being rented? – Does the patient own the equipment that is being serviced? – Have 15 months been billed and paid? Have 6 months passed from the end of the rental period?	– If being rented, no additional payment allowed. – If patient owns equipment send purchase documentation and request a reopening. – Verify billing date for Maintenance and Service claims. If incorrect Maintenance and Service date billed, correct and resubmit as a new claim. Call our IVR at 1.866.238.9650 to get CMN status on the equipment in question. The IVR can give you how many months have been paid and the last paid date.

© 2016 Copyright, CGS Administrators, LLC.

ANSI Reason	Remark	Explanation of Denial	Things to look for	Next Step
96	M117, MA44	Not covered unless submitted via electronic claim. No appeal rights.	Our records show that you either did not respond to a letter we sent regarding the Administrative Simplification Compliance Act (ASCA) or were denied a waiver from ASCA granting you the ability to bill paper claims. Please refer to the DME MAC Jurisdiction C Supplier Manual, Chapter 6 (http://www.cgsmedicare.com/jc/pubs/pdf/Chpt6.pdf), for more information about ASCA.	– If you have been granted a waiver, submit your paper claims after that waiver effective date. – If you did not obtain a waiver, submit your claims electronically. – If you believe your company meets one of the ASCA exceptions and believe a waiver is merited, submit proof of the exception(s) via mail to: CGS PO Box 20010 Nashville, TN 37202
107		Supplies and/or accessories are not covered if the equipment is denied.	Was main piece of equipment denied or returned as unprocessable?	Determine why main equipment was denied and correct as needed. Once the main equipment is corrected, resubmit supplies/accessories as a new claim.
109		Claim is not covered by this payor or contractor.	– Check IVR for Medicare Advantage Plan enrollment – Is code processed by another Medicare contractor? – Is the claim submitted to the correct Jurisdiction for beneficiary residence?	– If the denial is for Medicare Advantage Plan enrollment, submit your claim to the Medicare Advantage Plan. – Check to see if the HCPCS code you are billing should be billed to your local carrier or A/B MAC by looking in the most current Jurisdiction List on the CMS website (http://www.cms.hhs.gov/center/dme.asp). – Verify the beneficiary lives in Jurisdiction C. Remember that claims should be filed to the jurisdiction the beneficiary resides at the time of claim submission, not date of service. – For more information about the 109 denial regarding the beneficiary's residence (snowbirds), see our General FAQs (http://www.cgsmedicare.com/jc/help/faqs/current/general.html#Q10).
109	MA101	Our records show that the beneficiary was in a skilled nursing facility (SNF) on the date of service billed.	– Call our IVR to see if your date of service falls in-between any admittance and discharge dates of a SNF stay. – Refer to the DME MAC Jurisdiction C Supplier Manual Chapter 6 (http://www.cgsmedicare.com/jc/pubs/pdf/Chpt6.pdf), for more information about billing when the beneficiary is in a covered Part A stay.	– If patient is in a covered Part A stay, item must be billed to SNF. – If patient is not in a covered Part A stay, send to Redeterminations.
125	MA67	Corrections to a previous claim.	Was a refund or corrected claim submitted?	Review records for accuracy.
129	MA130	The claim was submitted with conflicting MSP Claim Adjustment Reason Codes (CARC).	– More than one CARC code was submitted and the definitions of the CARC codes are conflicting. – Review the CARC codes and determine if the correct CARC codes were provided.	Resubmit with the correct CARC codes.
150	N115	Information does not support the level of service. This decision was based on an LCD.	– Check to see if the HCPCS code you billed was downcoded to the least costly medically necessary alternative. – Is a specific modifier required to justify the higher equipment? – Did you submit appropriate documentation/narrative information that supports the level of service billed?	If documentation supports the level of service billed, submit to Redeterminations.
150	M3	Same or similar equipment.	– Has beneficiary previously had this equipment or does the beneficiary have similar equipment? – If beneficiary has had similar equipment, has there been a break in medical need? – Has patient had equipment for less than 5 years? – Was the beneficiary's previous equipment lost, stolen, or irrevocably damaged?	– Submit to Redeterminations with documentation that supports a break in medical need. – If equipment is less than 5 years old, no more can be allowed. – Submit to Redeterminations with documentation of loss, theft, or irrevocable damage.
151		Documentation does not support the level of service.	Check LCD for maximum allowed.	Submit to Redeterminations with documentation that supports additional units of services.
151	N362	Medically unlikely edits.	– Check date span. – Check units billed.	If the number of units or date span was a billing/clerical error, submit a reopening request. Otherwise, submit to Redeterminations with documentation to support the medical justification of the number of units dispensed. For more information about Medically Unlikely Edits (MUEs), visit the CMS website at http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

© 2016 Copyright, CGS Administrators, LLC.

ANSI Reason	Remark	Explanation of Denial	Things to look for	Next Step
172		Requires certification/ licensure specialty be on file with the National Supplier Clearinghouse (NSC).	Verify licensure information on file with the NSC.	If licensure information is incorrect, submit a "Change of Information" on the Medicare enrollment application (CMS-855S) to the NSC along with any applicable licenses and/or certifications. Once the licensure information is updated with the NSC, resubmit any denied claims as new claims.
173	M60	No Certificate of Medical Necessity received.	Was CMN/DIF submitted with claim?	Resubmit as a new claim with a new initial CMN.
176		The prescription/Certificate of Medical Necessity was not current or in effect for the date of service billed.	– Has beneficiary previously had this equipment? – Has there been a break in medical need? – Have 13/15 months been billed and paid? For more information about the 176 denial see our see our General FAQs (http://www.cgsmedicare.com/jc/help/faqs/current/general.html#Q5).	– Resubmit as a new claim asking for extension of CMN. – If documentation supports a break in medical need, resubmit with information in claim narrative. – If 13/15 months have not been billed and paid, resubmit as a new claim asking for extension of CMN.
176	M60	No recert/revision Certificate of Medical Necessity received.	– Check to see if you submitted a paper or electronic CMN with your claim. – Verify the CMN submitted is valid and also valid for the dates of service in question.	Resubmit as a new claim with the appropriate recertification/ revision CMN.
179	M6	Maintenance and/or servicing (MS) of this item is not covered until 6 months after the end of the paid rental period.	– MS is not allowed on capped rental items with initial dates on or after 1/1/06. – For capped rental items beginning prior to 1/1/06 or enteral/parenteral pumps, verify 15 rental months have been billed and paid. – If 15 rental months have been billed and paid, have 6 months passed from the end of the rental period?	– For capped rental items with initial dates on or after 01/01/06, thirteen rental months will be paid and then the beneficiary owns the equipment. – For capped rental items beginning prior to 1/1/06 or enteral/ parenteral pumps, if rental months have not been paid, you must reach the rental cap prior to billing MS. Submit claims for the remaining rental months with a narrative requesting to extend the capped rental period. – If 6 months have not passed from the end of the rental period, resubmit the claim for the correct date of service.
182	N56	The modifier that indicates what rental month you are billing does not match what we have on file.	Check to see what rental month is being billed. Does the HCPCS code have the correct modifier? – **KH** – First rental month – **KI** – Second or third rental month – **KJ** – Fourth through the 13th rental month	Resubmit the claim with the correct modifier to indicate what rental month is being billed.
185		Provider is not eligible to perform/provide this service.	– Our records show that your PTAN was not effective for the date of service billed. – Check to see if you billed with the correct NPI. – Check to see if your PTAN has termed.	– If the NPI is correct, contact NSC. – If NPI is incorrect, correct claims and resubmit as new claim. – Contact the NSC at 1.866.238.9652 to discuss your PTAN effective dates.
201		Beneficiary has Worker's Compensation Set Aside Fund.	Our records show the diagnosis on the claim matches the diagnosis on a Worker's Compensation Set Aside Fund Record.	– If so, look to the Worker's Compensation Set Aside Fund for payment. – If the record on file is incorrect or funds have been exhausted, instruct the beneficiary to contact the coordination of benefits contractor at 1.800.999.1118 for correction.
204		Medicare does not pay for this item or service.	– Is there an LCD for the item provided? – Is the item provided a covered benefit?	– Check LCD documentation requirements for coverage and modifier usage. If additional documentation is required, send to Redeterminations. – If no benefit, the denial is correct.
204	N171	Payment for repair or replacement is not covered or has exceeded the purchase price.	Have repairs exceeded the purchase price of the item?	If payment for repairs has reached the purchase price for the equipment, benefit maximum has been reached. No more can be allowed.
A1	N370	Claim/Service denied. Billing exceeds the rental months covered/approved by the payer.	– How many rental months have been paid? – Verify same equipment has not been provided by another provider. – Has there been a break in medical need?	For oxygen rentals beginning 01/01/06, the equipment will cap out after 36 months have been paid. If the equipment has capped, no more rental months can be paid. If you believe a new capped rental period is merited, resubmit the claim with a narrative explaining the situation.
B9		Medicare records indicate Hospice coverage.	Check for Hospice care enrollment.	If not entitled for Hospice care, contact the local Social Security Office for corrections. Once data is corrected, resubmit as a new claim.
B15	N70	Date of service is within a Home Health episode.	Check IVR for Home Health Episode dates.	Reimbursement is included in home health prospective payment amount.
B15	M80	Payment is included in the allowance for another item or service provided at the same time.	Verify item billed is not included in the allowance for another procedure code.	If the item is not included in the allowance for another procedure code, resubmit as a new claim.

© 2016 Copyright, CGS Administrators, LLC.