Anthem Blue Cross

Avoid Needless Claims Denials with These Tips

Please review the information below to help avoid these unnecessary claims denials:

**Services disallowed by utilization management**

Inpatient hospital services are payable under Medicare Part B when Medicare Part A admission is denied not medically necessary.

Payment may be made under Medicare Part B for physician and non-physician medical and other health services when furnished by a Medicare participating hospital and payment for the inpatient services cannot be made under Medicare Part A. If an inpatient admission is denied as not reasonable and necessary, or if a hospital determines after the member is discharged that the inpatient admission was not reasonable and necessary, the hospital may be paid for the Medicare Part B inpatient services that would have been considered reasonable and necessary if the member had been treated as a hospital outpatient.

The services that are billed to Medicare Part B must be reasonable and necessary and must meet all applicable Medicare Part B coverage and payment conditions. Claims for Medicare Part B services following a Medicare Part A inpatient denial as not reasonable and necessary or if the member has exhausted his or her Medicare Part A benefits must be filed no later than 1 calendar year after the date of service.

**When to use claim TOB 12X or TOB 13X to bill for Part B services related to a denied inpatient stay:**

CMS guidelines state Medicare pays the hospital under Medicare Part B for physician services and non-physician medical and other health services when the inpatient stay is denied as not reasonable and necessary or member has exhausted his or her Medicare Part A benefits.

**Hospital should submit TOB 13x, 14x or 85x for services deemed outpatient that were rendered prior to the time of admission. For example:**

- revenue code 0450 Emergency room visit
- revenue code 051x or 052x Clinic visit
- revenue code 068x Trauma Response
- revenue code 0762 Observation room
- any preadmission diagnostic tests rendered in the 1-3 day window prior to admission.

**Hospital should submit TOB 12x for Medicare Part B services. For example:**

- revenue code 025x Pharmacy
- revenue code 026x IV therapy
- revenue code 028x Oncology
- revenue code 030x or 031x Laboratory
- revenue codes 032x or 33x Radiology
- revenue code 036x Surgery
- revenue code 040x Imaging
• revenue codes 042x, 043x or 044x PT/OT/ST
• revenue code 048x Cardiology
• revenue code 61x MRI

Room and Board and other revenue codes that cannot be billed on a TOB 12X claim:

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*revenue code 0964 is used by hospitals that have anesthesia by a Certified Registered Nurse Anesthetist exception.

(Information from CMS Publication 100-04 Chapter 4 Sections 240 & 241)
Valid Clinical Laboratory Improvement Amendments number must be submitted

Medicare Advantage individual claims are denied if the Centers for Medicare & Medicaid Services required CLIA (Clinical Laboratory Improvement Amendments) certification is missing or invalid. The CLIA number must be present in Box 23 of the HCFA 1500 claim.

For additional information, please see:
CLIA FAQs found at anthem.com/medicareprovider
CMS Claims processing manual 100-04, Chapter 16, section 70.1 (Laboratory Services) The CLIA number must be included on each claim billed on the ASC X12 837 professional format or Form CMS-1500 claim for laboratory services by any laboratory performing tests covered by CLIA. See §70.2 and 70.10 for more information.

CMS Claims Processing Manual 100-04, Chapter 26 (Completing & Processing Form CMS-1500 Data Set):

Item 23
Procedure not covered by diagnosis
A claim for a clinical diagnostic laboratory service for Medicare Advantage individual and group-sponsored members must include a valid ICD-10-CM diagnosis code. Additional information is available in the
Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report (ICD-10-CM) found at this URL:

Inappropriate or missing modifier
Therapy related services require therapy modifiers, functional measurement codes (G-codes) and corresponding therapy and severity modifiers for individual and group-sponsored Medicare Advantage claims. CMS provides detailed billing requirements for therapy modifiers at the Medicare Learning Network publication number SE1307 found at this URL:
Duplicate claim
To reduce the claims processing time, please ensure the same claims are not submitted multiple times. When submitting corrected claims for individual and group-sponsored Medicare Advantage members, please remember:

- **Medical Claims** – When submitting a corrected claim, clearly identify the claim as corrected. Please note that the claim is a “corrected claim” anywhere on the face of the claim.
- **Facility Claims** – When submitting a corrected claim, ensure the correct type of bill frequency code is used.

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