Ways to AVOID an Appeal

* Verify all data pertaining to the service is correct. Correct data allows the service to process as is intended, eliminating the need to make corrections after the claim has processed.
* Become familiar with Local Coverage Determinations (LCD).
* Become familiar with National Coverage Determinations (NCD).
* Append modifiers to services when appropriate. Failure to append a modifier when appropriate will result in a denial.
* Document a repeat or duplicate service to reflect it is a distinct and separate service. Failure to document a repeat or duplicate service will result in a denial.
* Submit supporting documentation with the claim when certain modifiers e.g. 52 or 22 are appended to the service or when a LCD or NCD indicates documentation is required. Failure to submit the documentation will result in a denial.
* Comply with requests for supporting documentation. Failure to comply with the request will result in a denial.
* The supporting documentation must include the rendering physician's signature. Failure to provide a valid signature will result in a denial.
* Enter the concise description of an unlisted procedure code (an NOC code) or a "not otherwise classified" code. Failure to describe the NOC or other scenarios listed below will result in a denial.
* When Medicare is the secondary payer (MSP) the claim must include information from the primary insurer. Failure to include this information will result in a denial.

Verify all data pertaining to the service is correct. Correct data allows the service to process as is intended, eliminating the need to make corrections after the claim has processed.

* NPI of Billing Physician
* Assignment or Non-assignment of claim
* Medicare Beneficiary ID Number
* Zip Code of the place of service
* All related diagnosis reported with the highest degree of specificity
* NPI of Referring Physician
* Date of service
* Place of service
* Procedure code
* Modifiers when applicable
* Number of service(s)
* Billed amount for each service
* NPI of Rendering Physician
* Clinical Laboratory Improvement Amendment Number (CLIA) for laboratory services
* The date last seen / X-ray date, initial treatment date for Podiatry, Physical Therapy and Chiropractic services
* Primary payer data

Become familiar with Local Coverage Determinations (LCD).

* An LCD is a decision by a Medicare contractor whether to cover a particular item or service.  LCDs contain reasonable and necessary information and are administrative and educational tools to assist you in submitting correct claims for payment.
* LCDs are located in the Medical Policy Center on the Novitas Solutions website.

Become familiar with National Coverage Determinations (NCD).

* The National Coverage Determinations Manual describes whether specific medical items, services, treatment procedures, or technologies can be paid for under Medicare. All decisions that items, services, etc. are not covered are based on Â§1862(a)(1) of the Act (the not reasonable and necessary exclusion) unless otherwise specifically noted.
* [NCDs are located on the CMS website](http://www.cms.gov/DeterminationProcess/01_Overview.asp#TopOfPage).

Append modifiers to services when appropriate. Failure to append a modifier when appropriate will result in a denial.

* Modifiers provide the means to indicate a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.
* Appropriate modifier scenarios include:
* a service or procedure has both a professional (26) and technical (TC) component
* a service or procedure was performed by more than one physician (77)
* a service or procedure has been increased (22) or reduced (52)
* only part of a service was performed (54 or 55)
* an adjunctive service was performed (59)
* a bilateral procedure was performed (50)
* a service or procedure was provided more than once unusual events occurred (76)
* A list of modifiers and definitions is located in the Claims and Billing Center on the Novitas Solutions website.

Document a repeat or duplicate service to reflect it is a distinct and separate service. Failure to document a repeat or duplicate service will result in a denial.

* Report modifier 76 to indicate a procedure or service was repeated subsequent to the original procedure or service.
* Report body site modifiers to indicate more than one of the same service is performed but on different body parts sites, e.g. LT, RT, TA, T9
* Report modifier 59 modifier to indicate a distinct procedural service.  This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries).
* Report clarifying information pertaining to repeat or duplicate services using block 19 of the CMS-1500 (02-12) claim form or in the Extra Narrative Data segment (Loop 2300/2400) of the ANSI ASC X12 837 Versions of an electronic claim.  Utilize this field to report the time of each subsequent or repeat service or the number of times this service needed to be performed.

Submit supporting documentation with the claim when certain modifiers e.g. 52 or 22 are appended to the service or when a LCD or NCD indicates documentation is required. Failure to submit the documentation will result in a denial.

* Modifier 22 represents increased procedural services and when the work required to provide a service is substantially is greater than typically required. Documentation must support the substantial additional work and the reason for the additional work (e.g. increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).
* Modifier 52 represents reduced services and when under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion.  The explanation can be submitted by entering the information block 19 of the CMS-1500 (02-12) claim form or in the Extra Narrative Data segment (Loop 2300/2400) of the ANSI ASC X12 837 Versions of an electronic claim or submitting the supporting documentation.
* Documentation can be submitted when a CMS-1500 claim is filed or if the claim is submitted electronically a Fax Cover Sheet for Submitting Medical Documentation for Electronic Claims  [[Part A Cover Sheet](https://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName%3A00004751)] [[Part B Cover Sheet](https://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName%3A00004752)] form, must be completed.

Comply with requests for supporting documentation. Failure to comply with the request will result in a denial.

* The process whereby a contractor requests additional documentation after claim receipt is known as "development". When a coverage or coding determination cannot be made based upon the information on the claim and its attachments (e.g., due to a medical review of the service/claim), contractors may solicit for more information from the provider by issuing an Additional Documentation Request (ADR). Novitas Solutions will specify in the development letter or ADR the piece(s) of documentation needed to make the coverage or coding determination.
* For responses to development that are received within the 45-day timeframe, Novitas Solutions will complete the review and notify the provider and beneficiary, if indicated, of the claim determination within 60 days of receiving all the requested documentation. For record or documentation requests where no timely response was received, Novitas Solutions will indicate that the denial was made without reviewing the medical record because the requested records were not received or were not received timely.

The supporting documentation must include the rendering physician's signature. Failure to provide a valid signature will result in a denial.

* Medicare contractors require a legible identifier for services provided or ordered.
* The only acceptable method of documenting the provider signature is by written or electronic signature or an attestation or signature log.
* Stamp signatures are not acceptable to sign an order or other medical record documentation for medical review purposes.

Enter the concise description of an unlisted procedure code (an NOC code) or a 'not otherwise classified' code. Failure to describe the NOC or other scenarios listed below will result in a denial.

* The description must be entered into block 19 of the CMS-1500 (02-12) claim form or in the Extra Narrative Data segment (Loop 2300/2400) of the ANSI ASC X12 837 Versions of an electronic claim.  This block / segment is also used to describe other billing scenarios listed below.
* Enter the drug's name and dosage.
* Enter all applicable modifiers when modifier 99 (multiple modifiers) is entered.
* Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.
* When dental examinations are billed, enter the specific surgery for which the exam is being performed.
* Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.
* Enter the date for a global surgery claim when providers share post-operative care.

When Medicare is the secondary payer (MSP) the claim must include information from the primary insurer. Failure to include this information will result in a denial.

* To submit MSP claims using the CMS-1500 (02-12) claim form, please refer to the Medicare Secondary Payer guidelines.
* To submit MSP claims electronically, please refer to the EDI (Electronic Data Interchange) Billing guide.
* Please note it is the provider's responsibility to obtain primary insurance information from the beneficiary and bill Medicare appropriately. Claim filing extensions will not be granted because of incorrect insurance information.