



News Flash - Rejected Claims Reminder

Fee-for-Service Medicare claims can be rejected by Medicare contractors (carriers, intermediaries (FIs), and Medicare Administrative Contractors (MACs)) for a variety of reasons including: incorrect billing information, terminated provider, the beneficiary is not eligible for Medicare or the claim was sent to the wrong contractor. If a provider has questions about a claim rejected by an FI/carrier or MAC, the provider should contact the contractor directly. ***It is never appropriate to direct the beneficiary who received the service billed on the claim to the 1-800-Medicare toll free line to resolve a claim rejection.***

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Reasons for Provider Notification of Medicare Claims Disputed/Rejected by Supplemental Payers/Insurers

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), and durable medical equipment MACs (DME MACs))

Provider Action Needed

Effective for claims processed on or after July 1, 2007, when claims crossed over by Medicare to a supplemental payer/insurer are rejected or disputed by that insurer, Medicare will add a standardized message to the notification to the provider. That message will be in the form of a Dispute Reason Code, which will explain why the supplemental insurer disputed the claim. Be sure your billing staff is aware of these codes, as described later in this article, and is ready to take corrective action, as appropriate.

Disclaimer

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Background

In *MLN Matters* article, MM3709, the Centers for Medicare & Medicaid Services (CMS) describes the notification process to Medicare providers when Medicare claims that should automatically cross to a supplemental payer/insurer are not crossed over due to claim data errors. The notification is mailed to the correspondence address that is submitted by the provider, along with all other Medicare enrollment data, and is maintained by CMS' Medicare contractors. (MM3709 may be referenced at: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3709.pdf> on the CMS website.)

There are also situations where provider notifications are sent **after** the claim has crossed to the supplemental payer/insurer. This occurs in situations where the insurer may not be able to process the Medicare claim for supplemental payment and, therefore, rejects or disputes the claim back to CMS' Coordination of Benefits Contractor (COBC). When these situations occur, the COBC transmits a report containing the "disputed" claims to the Medicare contractor, which then notifies the provider, through a special automated correspondence, that the claim was not crossed automatically.

Beginning in July 2007, provider notifications will include standardized language for claims that have been disputed by the supplemental payer/insurer and the dispute has been accepted by the COBC. The standardized language will read: "Claim rejected by other insurer," and it will include a reason code. The following is a list of the reason codes that may be contained in the standardized language and the definition of each-:

Dispute Reason Codes:

- 000100 - Duplicate Claim
- 000110 - Duplicate Claim (within the same ISA – IEA loop)
- 000120 - Duplicate claim (within the same ST-SE loop)
- 000200 – Claim for Provider ID/State should have been excluded
- 000300 - Beneficiary not on eligibility file
- 000400 - *Reserved for future use*
- 000500 - Incorrect claim count
- 000600 - Claim does not meet selection criteria
- 000700 - HIPAA Error
- 009999 – Other

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When Medicare providers receive this notification, they may need to take appropriate action to obtain payment from the supplemental payer/insurer for all Dispute Reason Codes **except** for 000100, 000110, 000120, and 000400.

Additional Information

If you have any questions, please contact your carrier, FI, A/B MAC, or DME MAC at their toll-free number found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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