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# Lilly Oncology

## Reimbursement Update

Previous updates found on  
[www.LillyOncology.com](http://www.LillyOncology.com)

*Lilly Oncology is pleased to offer this newsletter as part of our commitment to patient access to care. For more information about the topics discussed in this issue, please contact Doug Neely at AccessMED. Doug can be reached at (704) 995-3299.*

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This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of the written law or regulations or local payer guidelines. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

MG46256

### Medicare Identifies Common Billing Errors

Medicare Part B contractors have identified a number of billing errors that are frequently encountered as they process CMS-1500 claim forms, both paper and electronic. These types of errors may cause claims to be denied, rejected, or delayed. The Centers for Medicare and Medicaid Services (CMS) recently published a list of common errors and billing tips for physicians and providers billing Medicare carriers for services provided to Medicare beneficiaries.

Examples of the types of billing errors cited by CMS include:

- **Incorrect Health Insurance Claim Number (HICN).** Always use the HICN number and name as it appears on the patient's Medicare card.
- **Missing, incomplete, or invalid information about the place where the service was rendered.** Item 32 of the CMS-1500 requires the name and address (including ZIP code) of the place where the service was provided (unless the service was provided in the patient's home). This information is often nearly the same information required in Item 33, which asks for the billing provider's address and phone number. Both fields must be fully completed, however. Using the word "SAME" in Item 32 is not acceptable to CMS.
- **Failure to include the referring/ordering physician's name and provider number when diagnostic services, including consultations, are provided.** This information is required in Items 17, 17a, and/or 17b. Note that the National Provider Identifier (NPI), which is placed in Item 17b, is replacing the Unique Provider Identifier Number (UPIN). More information about NPIs and their implementation timeline can be found on the CMS website at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>.
- **Invalid or truncated ICD-9 diagnosis codes.** ICD-9 codes should be reported to the highest level of specificity. This means that if a 5-digit code is available, all 5 digits should be used. However, not every ICD-9 code has a fifth digit. Four-digit codes are acceptable if a 5-digit code is not available. An extra digit should not be added at the front or back of a 4-digit code to make it 5 digits. Codes should be reported as they appear in the ICD-9-CM coding book.
- **Invalid procedure code or modifier.** There is no grace period for the use of CPT/HCPCS codes or modifiers that have been discontinued. Medicare typically publishes lists of new, modified, and discontinued codes, with their effective dates, in advance.

To read the complete discussion of common coding errors and CMS tips for accurately completing claims, go to *MLN Matters*, number SE0712 on the CMS website at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0712.pdf>. ♦