MNT and DSMES REIMBURSEMENT TRACKING REPORT

IT Run Time: _____ IT Run Date: _____

Billing Activity Date: From:_____ Through:_____ Categories: 1) MNT 2) DSMES 3) _____

----------Patient----------	----------Billing Activity Details----------	----------Initial Claims Status----------	---Re-Submitted Claims Status---

Account or Referral No.	Pt Name and Address	Date of Service	Procedure Name	User Code or Cost Center	Procedure Code	No. Code Units Billed	ICD-10 Code	Payer	Amt Billed	Insurer (Ins) Discount	Insurer Adjus'd Allow'd Amt	Ins Amt Rec'd	Pt Pay Amt Due	Pt Pay Amt Rec'd	Bal Due: P = Pt Ins = Insurer	ANSI* Denial Reason or Code*
V0001	Doe, Jane 708 Main St Joliet, Il 60435	2/11/17	MNT	FNS 0007	97802	4	E10.3211	BC/BS	$160	$20	$140	$100	$40	$40	$0	
V0002	Brown, David 226 Berry St Chicago, Il 60605	2/11/17	MNT	FNS 0007	97804	4	E10.22	United Health Care	$160	$40	$120	0	$30	$0	$120 Ins $30 Pt	
V0003	Smith, Sue 222 Clare Lane Burbank, Il 60467	2/11/17	MNT	FNS 0007	97802	4	E11.64	Medicare	$160	$0	$100	$100	$0	$0	$0	
V0004	King, Carl 234 Elk Lisle, Il 60387	2/11/17	DSME	FNS 0008	G0108	1	E11.22	Cigna	$90	$30	$60	$45	$15	$0	$15 Pt	PR31

Suppliers are required to submit completed CMS-1500 claim forms, or the most current version of **American National Standards Institute (ANSI)*** and/or National Council for Prescription Drug Programs (NCPDP) electronic formats, for items provided to Medicare beneficiaries. Claims lacking beneficiary information, diagnosis coding (where necessary), procedure coding, ordering physician's name and Unique Physician Identification Number (UPIN) or billing supplier information will be denied as incomplete claims. However, these claims will be considered for payment when the missing information is supplied. The following chart identifies the most common claim submission errors, as well as helpful tips on how to decrease the number of errors. Note that suppliers should always refer to their remittance advice to determine the ANSI code assigned to the service line. ANSI codes are used to convey appeals information and other claim-specific information, providing additional explanation for claim-level adjustments.

*ANSI Code	Category	Denial Type
CO-18	Duplicate Claim	Duplicate
OA-109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	Jurisdiction
CO-57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply	Same/similar
CO-16	Claim/service lacks information which is needed for adjudication	Return/Reject
CO-176	Payment denied because the prescription is not current.	Return/Reject
CO-173	Payment adjusted because this service was not prescribed by a physician.	Return/Reject
CO-22	Payment adjusted because this care may be covered by another payer per coordination of benefits	MSP
PR-13	The date of death precedes the date of service.	Eligibility
PR-31	Claim denied as patient cannot be identified as our insured.	Eligibility
PR-27	Expenses incurred after coverage terminated.	Eligibility

*** ANSI (American National Standards Institute) Claim Adjustment Reason Codes**