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How to Avoid Duplicate Claims

4/4/2024

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

Provider Outreach and Education Consultants

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Agenda

How to Avoid Duplicate Submissions

Proper Use of Repeat Modifiers

Reopening versus Redetermination

Additional Documentation Request

Resources

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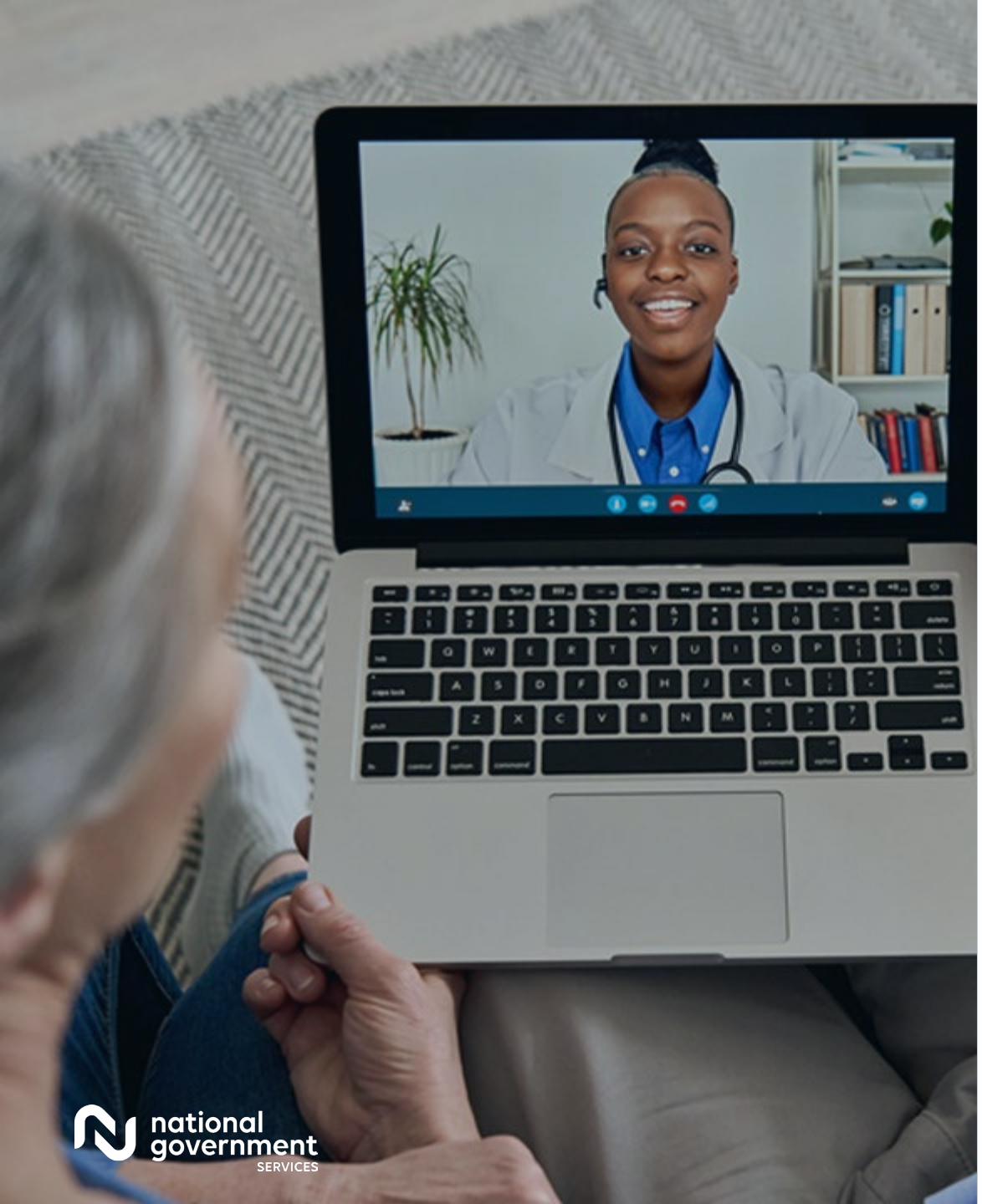

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Objective

Reduce duplicate claim submissions by utilizing the appropriate modifiers

Duplicate Elements

Elements Compared to Identify an Exact Duplicate

- MBI and provider number
- From date of service
- Through date of service
- Type of service
- Procedure code
- Place of service
- Billed amount

Submitting Duplicate Claims

- May delay payment
- Increases administrative costs to the Medicare Program
- Could be identified as an abusive biller; or
- May result in an investigation for fraud if a pattern of duplicate billing is identified

Tip to Avoiding Denials

- Check your remittance advice for previously posted claim
- Verify reason initial claim was denied
- Don’t just resubmit to correct a denial
- Use the IVR or NGSConnex to check on current claim status
- Allow 30 days from the receipt date
- Make sure your billing service/clearinghouse is waiting the appropriate time frame

Correct Process for Unpaid Claims

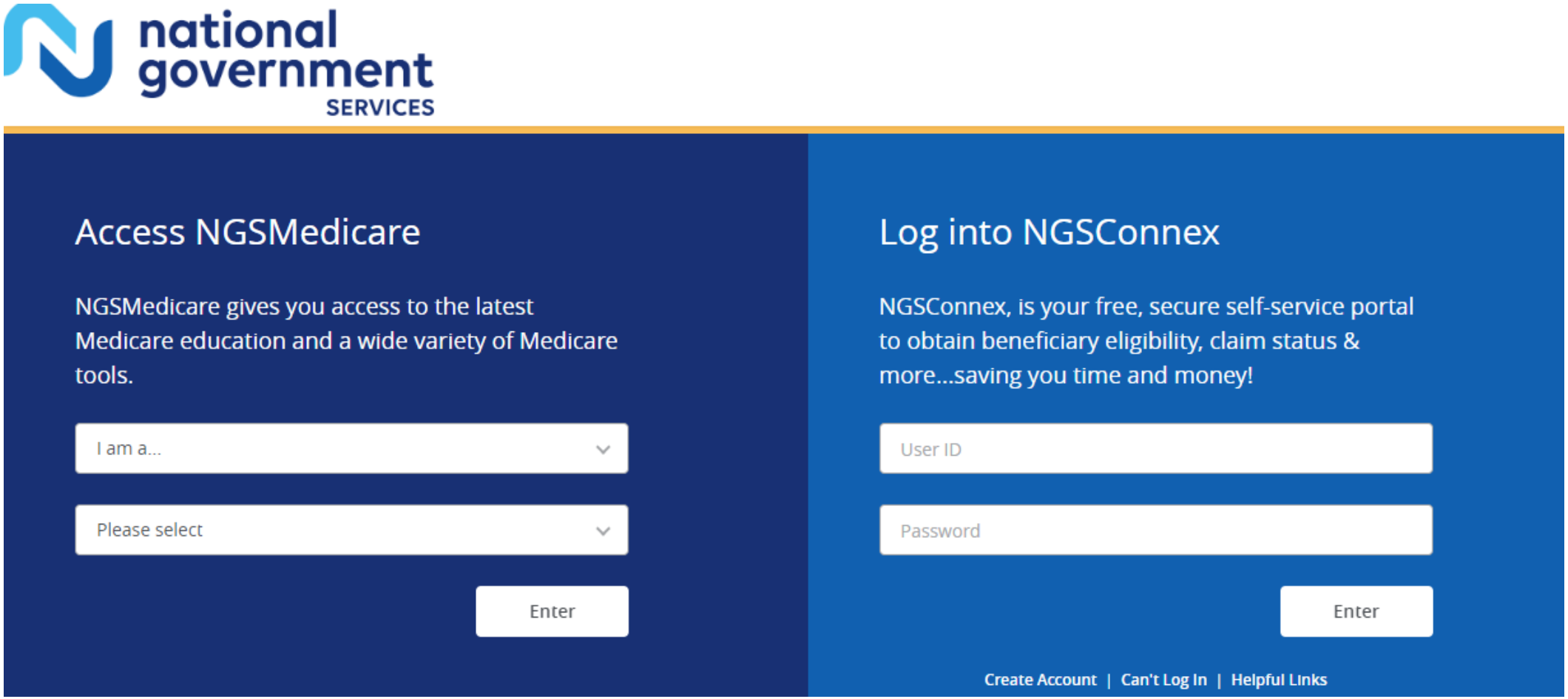
- Payment that has not been received after 30 days and there is concern follow the below steps
  - Verify claim status
    - ✓ Call the IVR system
    - ✓ Access NGSConnex
  - If IVR or NGSConnex cannot find the claim, call the PCC
  - Electronic submitters should check their EDI reports to verify which claims were received and accepted or rejected, contact
    - ✓ JK EDI: 888-379-9132
    - ✓ J6 EDI: 877-273-4334

Contact Information

- Accessing our NGSConnex provider portal
  - NGSConnex is available 24/7
  - Information obtained from the local system is only available
    - ✓ Monday–Friday: 6:00 a.m.–7:00 p.m. ET
    - ✓ Saturday: 7:00 a.m.–3:00 p.m. ET
- Accessing the IVR
  - JK: 877-869-6504 J6: 877-908-9499
  - Hours of operation
    - ✓ Monday–Friday: 6:00 a.m.–7:00 p.m. ET
    - ✓ Saturday: 7:00 a.m.–3:00 p.m. ET

NGSConnex

NGS Medicare Homepage



NGSConnex

- Free, secure, web-based application
  - Submit claims
  - Obtain beneficiary eligibility information
  - Submit documents for ADRs including medical review
  - Initiate and check status of redeterminations, reopenings and reconsideration requests
  - View claim overlap/duplicate claims

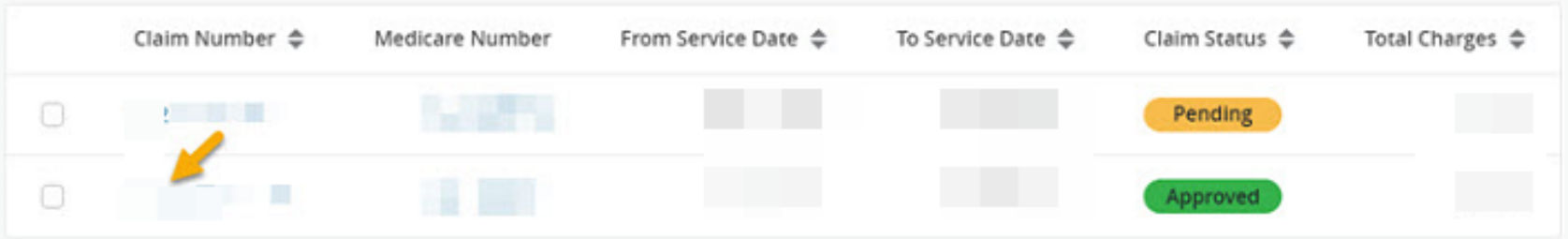
Part B IVR Releases Details On Overlapping Claims

- Claim Details Option 2 will provide overlapping claim details when your claim denies due to an overlapping Medicare Part A claim
- This functionality will inform you the claim denied due to an overlapping inpatient claim, SNF stay, home health episode of care or hospice claim and you can obtain additional details without contacting the Provider Contact Center
- Obtain this additional information by selecting “Claim Status” option then say “Claim Details.” The IVR will provide the from and to date of service for the overlapping claim and NPI of facility associated with overlapping claim
- For further details, please refer to the *Part B Provider Interactive Voice Response User Guide*

NGSConnex View Claim Details

View Claim Details

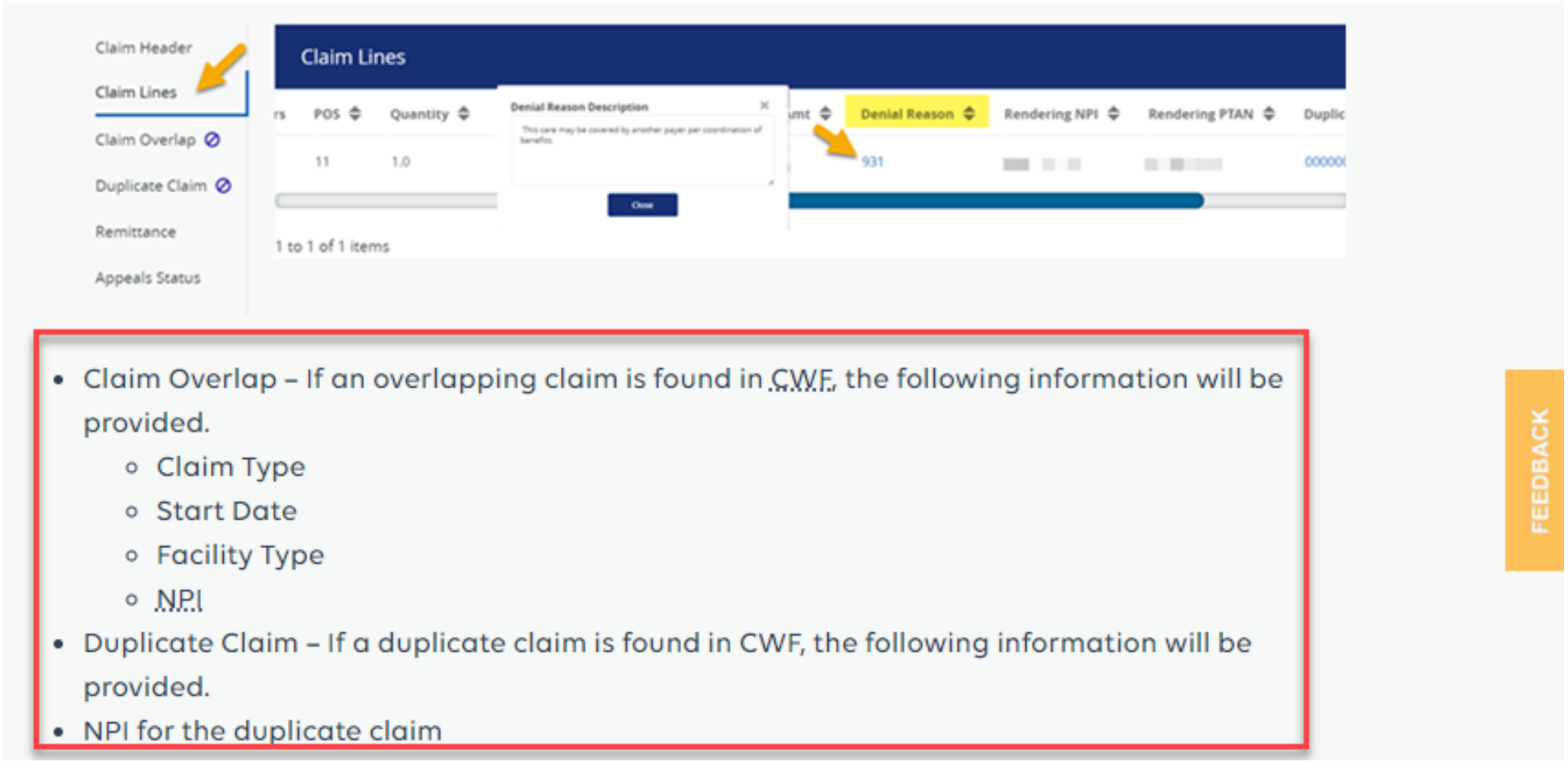
1. Select the **Claim Number** hyperlink to view additional claim details.



If the claim was denied, you can view the reason for denial. You can view the following claim details from the **Left-Side** navigation.

- Claim Header
- Claim Lines – If the claim was denied, you can view the reason for denial. The 'Denial Reason' column will include a hyperlink and provide a 'Denial Reason Description'

NGSConnex View Claim Overlap/Duplicate

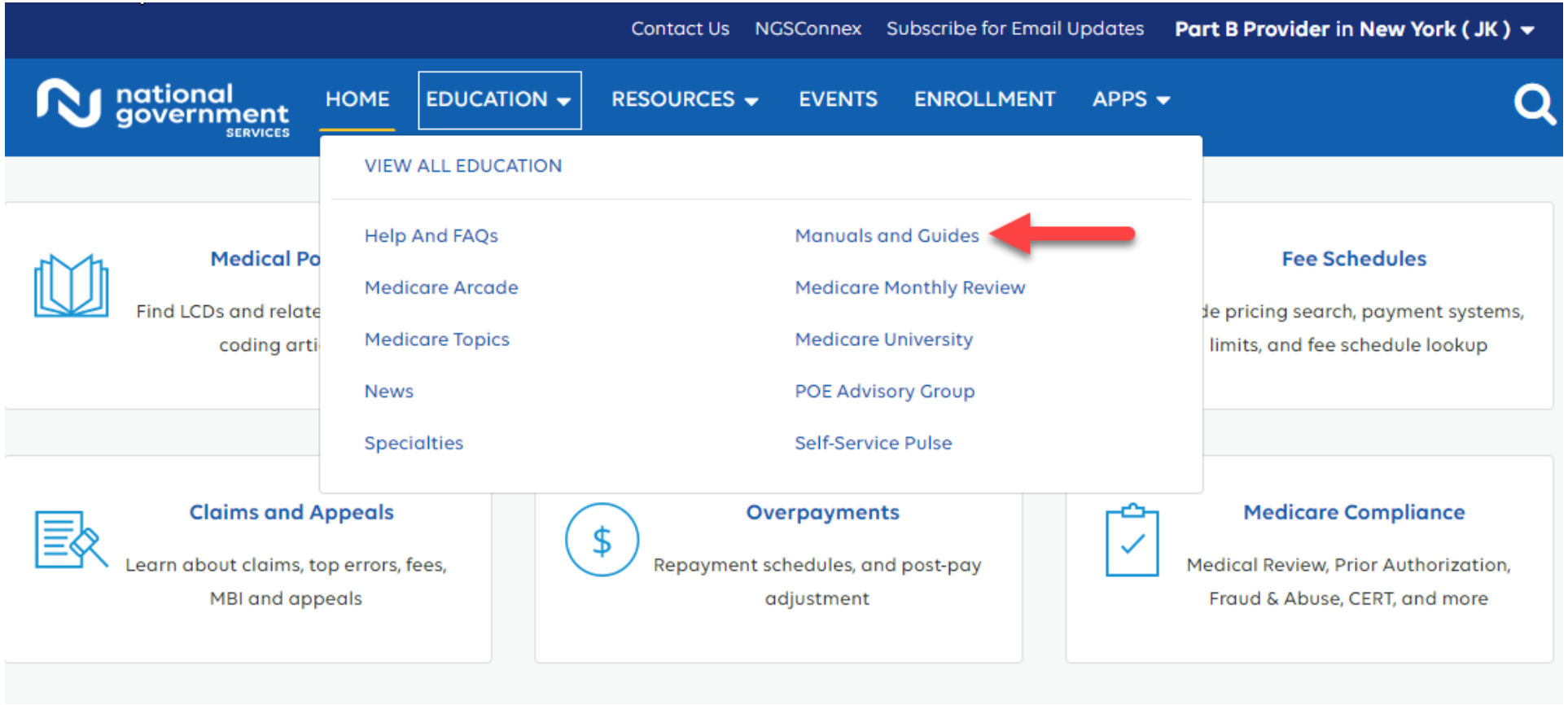


- Claim Overlap – If an overlapping claim is found in CWF, the following information will be provided.
  - Claim Type
  - Start Date
  - Facility Type
  - NPI
- Duplicate Claim – If a duplicate claim is found in CWF, the following information will be provided.
- NPI for the duplicate claim

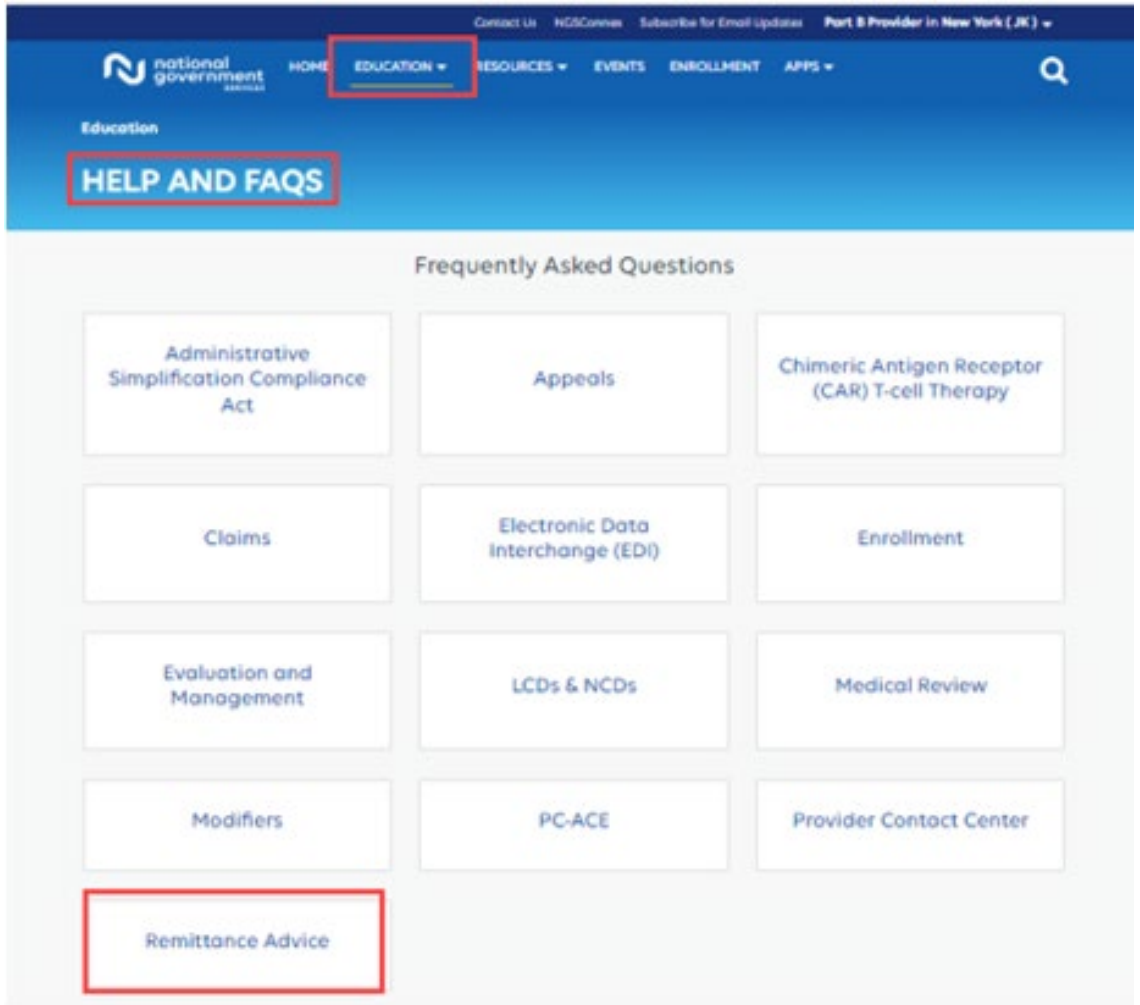
FEEDBACK

Remittance Remark Codes

Remittance Remark Codes



Remittance Remark Codes (cont.)



Duplicate Error Messages

- OA 18 – Duplicate claim/service
  - N20
    - ✓ Service not payable with other service rendered on the same date
  - N347
    - ✓ Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer
  - M86
    - ✓ Service denied because payment already made for same/similar procedure within set time frame

RARC Error Message N20

RARC	Description	Resolution
N20	Service not payable with other service rendered on the same date.	Service not payable with other service rendered on the same date. The cost of care before and after the surgery or procedure is included in the approved amount for that service. An evaluation and management service has been billed during the global period. For a “major surgery” the global period is 90 days. Consult our Global Surgery article to determine which (if any) of the situations described fits your scenario. If appropriate, request a reopening of your claim to append a modifier and/or correcting your procedure code or other details on the claim.

RARC Error Message N347

RARC	Description	Resolution
N347	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.	Modifier 91 is used to indicate a repeat laboratory procedural service on the same day to obtain subsequent reportable test values. The physician may need to indicate that a lab procedure or service was distinct or separate from other lab services performed on the same day. This may indicate that a repeat clinical diagnostic laboratory test was distinct or separate from a lab panel or other lab services performed on the same day and was performed to obtain subsequent reportable test values. Multiple laboratory services provided to a patient on one day by the same provider may appear to be incorrectly coded, when in fact the services may have been performed as reported. Because these circumstances cannot be easily identified, modifier 91 was established to permit claims of such a nature to bypass correct coding edits. The addition of this modifier to a laboratory procedure code indicates a repeat test or procedure on the same day.

RARC Error Message M86

RARC	Description	Resolution
M86	Service denied because payment already made for same/similar procedure within set time frame.	Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. When more than one E/M service is provided to the same patient on the same date by more than one physician in the same specialty in the same group, only one E/M service may be reported unless the E/M services are for unrelated problems. Physicians in the same group practice but who are in different specialties or subspecialties may bill and be paid without regard to their membership in the same group. Evaluation and Management

Proper Use of Repeat Modifiers

Repeat Modifiers 76

- Modifier 76
  - Repeat procedure by the same physician
- Appropriate use
  - Same procedure or service performed on the same day
  - On a procedure code in which quantity or number of units cannot be billed
  - List procedure code on the first line, and then again with modifier 76 (second line item)
  - Second line item will have the appropriate quantity billed amount
- Inappropriate usage
  - Do not add to each line of service
  - Do not use for repeat services due to equipment or other technical failure
  - Do not use for services repeated for quality control purposes
  - Modifier 76 cannot be used with an E/M code

Repeat Modifiers 77

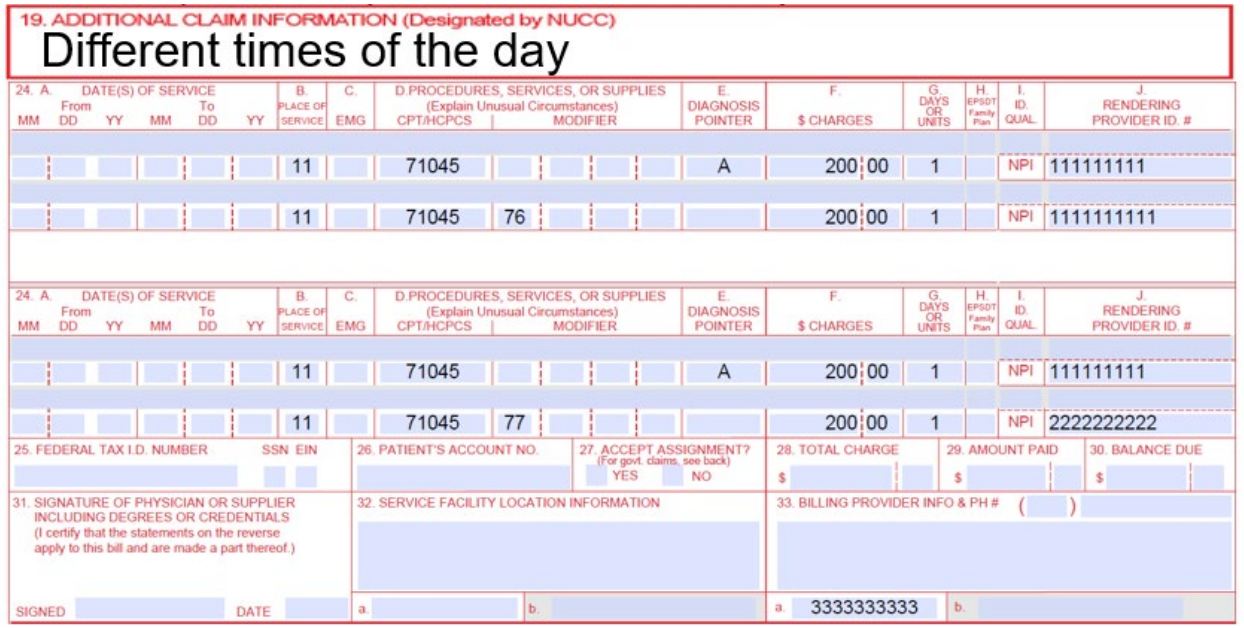
- Modifier 77
  - Repeat procedure by another physician
- Appropriate use
  - Add to the professional component of an X-ray or EKG procedure when
    - ✓ A different physician repeats the reading because another physician's expertise is needed
    - ✓ When the patient has two or more tests and more than one physician provides the interpretation and report
  - Add when billing for multiple services on a single day and the service cannot be quantity billed
- Inappropriate usage
  - Do not add when billing for multiple services considered bundled based on NCCI edits
  - Modifier 77 cannot be used with an E/M code

Example Modifier 76

- Example
  - A provider received a duplicate denial on 3/22/2024 and on 3/25/2024 for CPT 71045 (chest X-ray) with billed date of service of 2/23/2024
  - Both claims were billed for same patient, same provider, and same date of service, same charge, same CPT code, and same units, without a modifier

76/77 Modifier Example

- Billing of Modifier
  - 76 – repeat procedure or service by the same physician or other qualified health care professional
  - 77 – repeat procedure or service by another physician or other qualified health care professional



19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
Different times of the day

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
		11		71045		A	200 00	1		NPI	111111111
		11		71045	76		200 00	1		NPI	1111111111

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
		11		71045		A	200 00	1		NPI	111111111
		11		71045	77		200 00	1		NPI	2222222222

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $

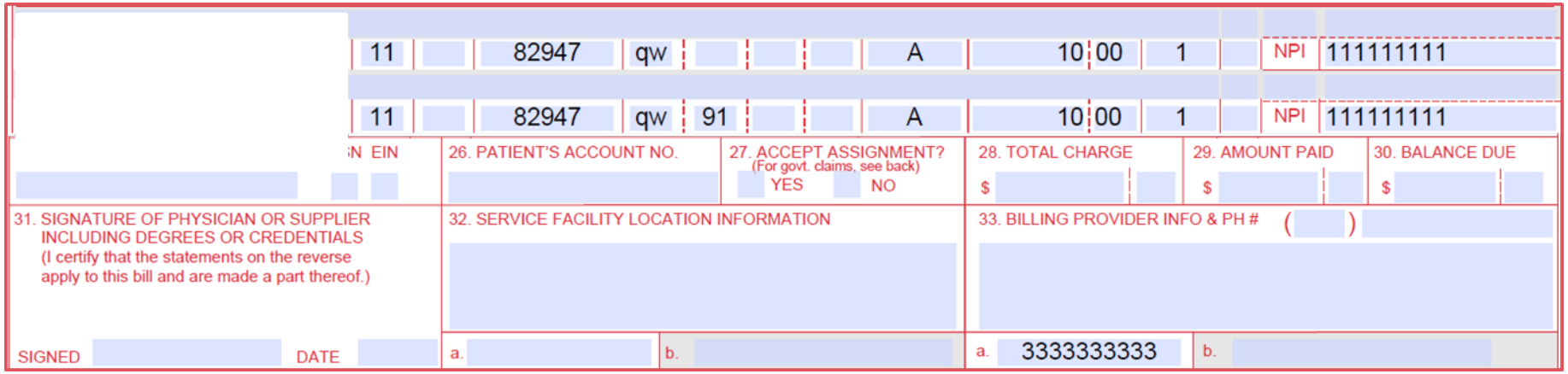
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a. b.	a. 3333333333 b.

Repeat Modifiers

- Modifier 91
  - Repeat clinical diagnostic laboratory test to obtain multiple results
- Appropriate use
  - A subsequent medically necessary laboratory test on the same day of the same laboratory test
- Inappropriate usage
  - Due to testing problems for the specimen or testing problems of the equipment
  - Rerun of a laboratory test to confirm results
  - When the procedure code describes a series of test

Modifier 91

- CPT 82947 is performed twice on the same day



	11		82947	qw				A	10	00	1	NPI 111111111
	11		82947	qw	91			A	10	00	1	NPI 111111111

N EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # ( ) a. 3333333333 b.		

Billing Reminders

- Use the most appropriate modifier
- In some cases an anatomical modifier may be the most appropriate modifier
  - FA, F1–F9
  - TA, T1–T9
  - E1–E4
- Submit all services on the same claim
- Enter the number of services on the second line item (Units field or the electronic equivalent)
- Indicate different times of the day or total number of services performed in Item 19 or the electronic equivalent

Modifiers 59/XE/XS/XP/XU: Distinct Procedural Service

- Procedure or service is distinct or separate from other services performed on same day, such as
  - Different session or patient encounter
  - Different procedure or surgery
  - Different anatomic site
  - Separate lesion
  - Separate injury

Modifiers 59/XE/XS/XP/XU

- Appropriate usage
  - Different session or patient encounter, different procedure or surgery, different anatomical site, or separate injury or area of injury
  - Medical record documentation indicates two separate distinct procedures performed on the same day by the same physician
  - Only when there is no other appropriate modifier to use
- Inappropriate usage
  - Not be appended to an E/M service performed on the same date, see modifier 25
  - NCCI modifier table with a modifier indicator of “0”
  - Medical record documentation does not support the separate and distinct status
  - Exact same procedure code was performed twice on the same day, see modifier 76 or 77
  - A more appropriate modifier exists to identify the services

Modifiers 59/XE/XS/XP/XU

- Modifiers should NOT be used unless the proper criteria for use is met
- Documentation in the medical record must satisfy the criteria required by any NCCI PTP-associated modifier
- Modifiers XE, XS, XP and XU were developed to provide greater reporting specificity
- CMS allows modifier 59 or one of the X (ESPU) modifiers on a Column One or Column Two code

Modifiers XE/XS/XP/XU

- XE: Separate Encounter
- XS: Separate Structure
- XP: Separate Practitioner
- XU: Unusual Non-Overlapping Service
- MLN® Fact Sheet: *Proper Use of Modifiers 59, XE, XP, XS, and XU*

Modifier Example

- A lesion was removed from the right hand (CPT 17000) and a simple repair of a superficial wound was performed on the right arm (CPT 12001)
- NCCI modifier indicator of 1
- Modifier 59 or X(EPSU) can be appended to either code (MM11168)

Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *= no data	Modifier 0= not allowed 1= allowed 9= not applicable
17000	12001		20121001	*	1

Modifier Example

- Patient had an arthroscopy of the shoulder with rotator cuff repair, (CPT code 29827) bundled on the same day is CPT code 29820, arthroscopy, shoulder, surgical; synovectomy, partial
- If both of these services were performed on the same shoulder during the same operative session, CPT 29820 would not be reported
- If CPT 29820 was performed on a different shoulder, use modifiers RT and LT, not modifier 59 or X(EPSU)

Specific Modifiers for Distinct Procedural Services – Helpful Links

- MLN Matters® *MM11168 Revised: Modification of the MCS Claims Processing System Logic for Modifier 59, XE, XS, XP, and XU Involving the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Column One and Column Two Codes*

Medically Unlikely Edits

- MUEs are developed based on HCPCS/CPT code descriptors, CPT coding instructions, anatomic considerations, established CMS policies, nature of service/procedure, nature of analyte, nature of equipment, prescribing information and clinical judgment
- Established to reduce the paid claims error rate
- Automated prepayment edits

Medically Unlikely Edits

- Do not exist for all HCPCS/CPT codes
- Majority of the edits are publicly available
  - Some are confidential
- Edits are updated quarterly
- An MUE is the maximum units of service that a provider would report under most circumstances
  - Single beneficiary
  - Single date of service

Redetermination/Reopening

- Redetermination
  - Analysis of documentation
    - ✓ Coverage of furnished items and service
    - ✓ Medical necessity claim denials
    - ✓ Determination on limitation of liability provisions
    - ✓ Overpayment determinations
- Reopening
  - Correct claim determination; minor errors
    - ✓ Transposed procedure or diagnosis codes
    - ✓ Inaccurate data entry
    - ✓ Computer errors
    - ✓ Incorrect data items

Redetermination/Reopening

- Redetermination – First level of an appeal
  - Written
  - NGSConnex
- Reopening – Correction to minor, uncomplicated, provider or contractor clerical errors or omissions
  - Telephone
  - Written
  - NGSConnex

Telephone Reopening/Part B Reopening Request Form

- TRU Reopenings/Part B Reopening Request Form
  - Assignment of claims (carrier errors only)
  - Adding/changing ordering/referring/supervising physician
  - Add/change rendering provider
  - POS Changes
  - CLIA certification denials
  - Duplicate denials
  - Medicare Advantage plan denials (clinical trial or hospice only)
  - Modifier GV and GW
  - Fee schedule corrections (carrier error only)
  - MBI corrections (carrier error only)
  - Patient paid amount (carrier error only)
  - MSP (Medicare now primary)
- These scenarios cannot be handled through NGSConnex

Contacting Telephone Reopening Unit

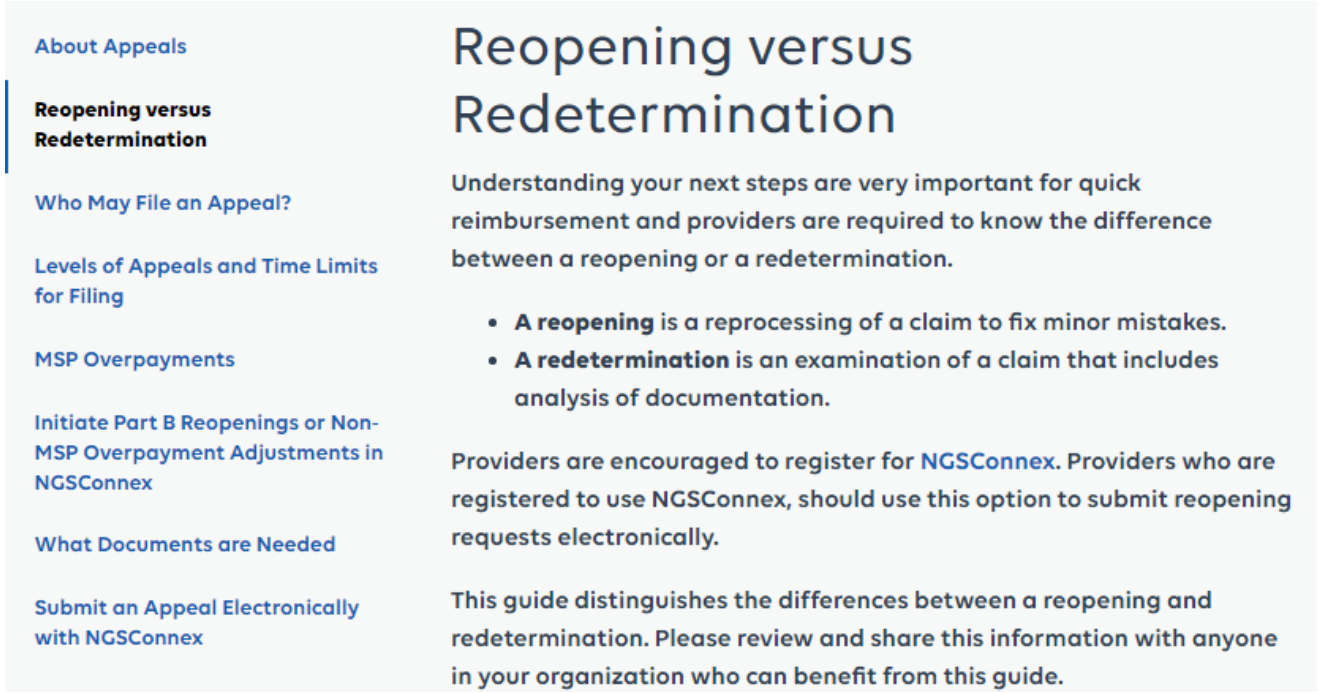
- Please provide
  - Beneficiary's name
  - Medicare MBI
  - Your name and phone number
  - Provider's full name/PTAN
  - Item or service in question
  - Date(s) of service in question
  - Reason for request

Large Various Adjustment Macro (LVAM)

- Requests for correction of 25 or more of the same or similar situations
- Complete a Part B Reopening Request Form and attach the LVAM Request Form
  - This will help ensure that the correct claims are identified for the adjustments
- Examples of like services that can be corrected through our LVAM process are
  - Changing modifiers or procedure codes
  - Adding diagnosis codes
  - Increasing billed amount
  - Changing the place of service
  - Changing the quantity billed

Reopening versus Redetermination

- Submitting appropriate reopenings and redeterminations is key to faster resolutions
- Reopening versus Redetermination



About Appeals

Reopening versus Redetermination

Who May File an Appeal?

Levels of Appeals and Time Limits for Filing

MSP Overpayments

Initiate Part B Reopenings or Non-MSP Overpayment Adjustments in NGSConnex

What Documents are Needed

Submit an Appeal Electronically with NGSConnex

Reopening versus Redetermination

Understanding your next steps are very important for quick reimbursement and providers are required to know the difference between a reopening or a redetermination.

- **A reopening** is a reprocessing of a claim to fix minor mistakes.
- **A redetermination** is an examination of a claim that includes analysis of documentation.

Providers are encouraged to register for NGSConnex. Providers who are registered to use NGSConnex, should use this option to submit reopening requests electronically.

This guide distinguishes the differences between a reopening and redetermination. Please review and share this information with anyone in your organization who can benefit from this guide.

Resubmissions

- Inappropriate to resubmit claims
  - Must submit a reopening or redetermination (depending on the modifier and denial) – do not resubmit claim
  - Duplicate denial
    - ✓ Find original denial message and correct billing
- Resubmission overwhelms payment systems
  - Do not set up auto rebills, work with vendor to reset

Additional Documentation Request Reminders

- ADR letters will include detailed instructions
  - Specific time frame to respond
  - Options for submission
    - ✓ Mailing
      - Mail the original (includes bar code) and retain a copy for your records
    - ✓ Fax
      - Some ADR letters will contain exact fax number
      - Fax to the exact number on the ADR
      - Faxing to an incorrect number will delay processing

Additional Documentation Request Reminders

- NGSConnex
  - Under My Claims tab
    - ✓ Review the list of all claims an ADR was issued
    - ✓ Check the status of an ADR
- Documentation will be reviewed from 30 to 45 days from the date the documentation is received
- Only send the documentation that is requested (unnecessary documentation will cause delays)
- Claims ADR – 30 days
- MR ADR – 45 days
- Additional Development/Documentation Request Timeline Calculator

Resources

- Medicare Topics
  - Repeat Procedures - Modifiers 76 and 77
- MLN® Educational Tool: *How to Use the Medicare National Correct Coding Initiative (NCCI) Tools*
- How to Avoid Duplicate Claim Denials
- Ambulance Duplicate Claim Denials

Resources

- *Part B Provider Interactive Voice Response User Guide*
- Part B Interactive Voice Response Touch-Tone Instructions
- NGSConnex Resources
- Reopening versus Redetermination

Questions?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course Code.

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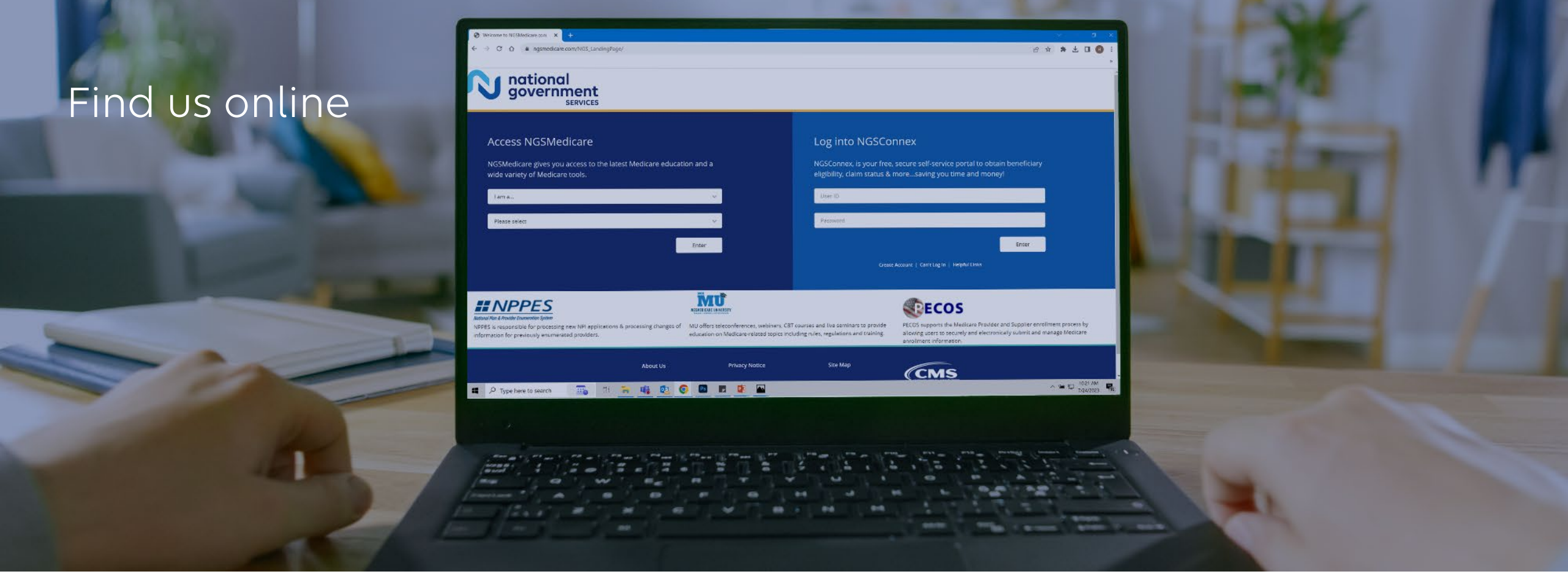

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IVR System
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NGSConnex
Web portal for claim information

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