

# How to Avoid Duplicate Claims

6/10/2025

**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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# Agenda

- [Duplicate Elements](#)
- [NGSConnex](#)
- [Remittance Remark Codes](#)
- [Proper Use of Repeat Modifiers](#)
- [Reopening versus Redetermination](#)
- [Additional Documentation Request](#)
- [Resources](#)



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# Objective

Reduce duplicate claim submissions by using 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



## Access NGS Medicare

NGSMedicare gives you access to the latest Medicare education and a wide variety of Medicare tools.

I am a...



Please select



Enter

## Log into NGSConnex

NGSConnex, is your free, secure self-service portal to obtain beneficiary eligibility, claim status & more...saving you time and money!

User ID

Password

Enter

[Create Account](#) | [Can't Log In](#) | [Helpful Links](#)



# 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.

	Claim Number ↕	Medicare Number	From Service Date ↕	To Service Date ↕	Claim Status ↕	Total Charges ↕
<input type="checkbox"/>	<a href="#">[Redacted]</a>	[Redacted]	[Redacted]	[Redacted]	Pending	[Redacted]
<input type="checkbox"/>	<a href="#">[Redacted]</a>	[Redacted]	[Redacted]	[Redacted]	Approved	[Redacted]

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 Header

Claim Lines

Claim Overlap

Duplicate Claim

Remittance

Appeals Status

Claim Lines

rs	POS	Quantity	Denial Reason Description	Amount	Denial Reason	Rendering NPI	Rendering PTAN	Duplic
11		1.0	This care may be covered by another payer per coordination of benefits.		931			000000

1 to 1 of 1 items

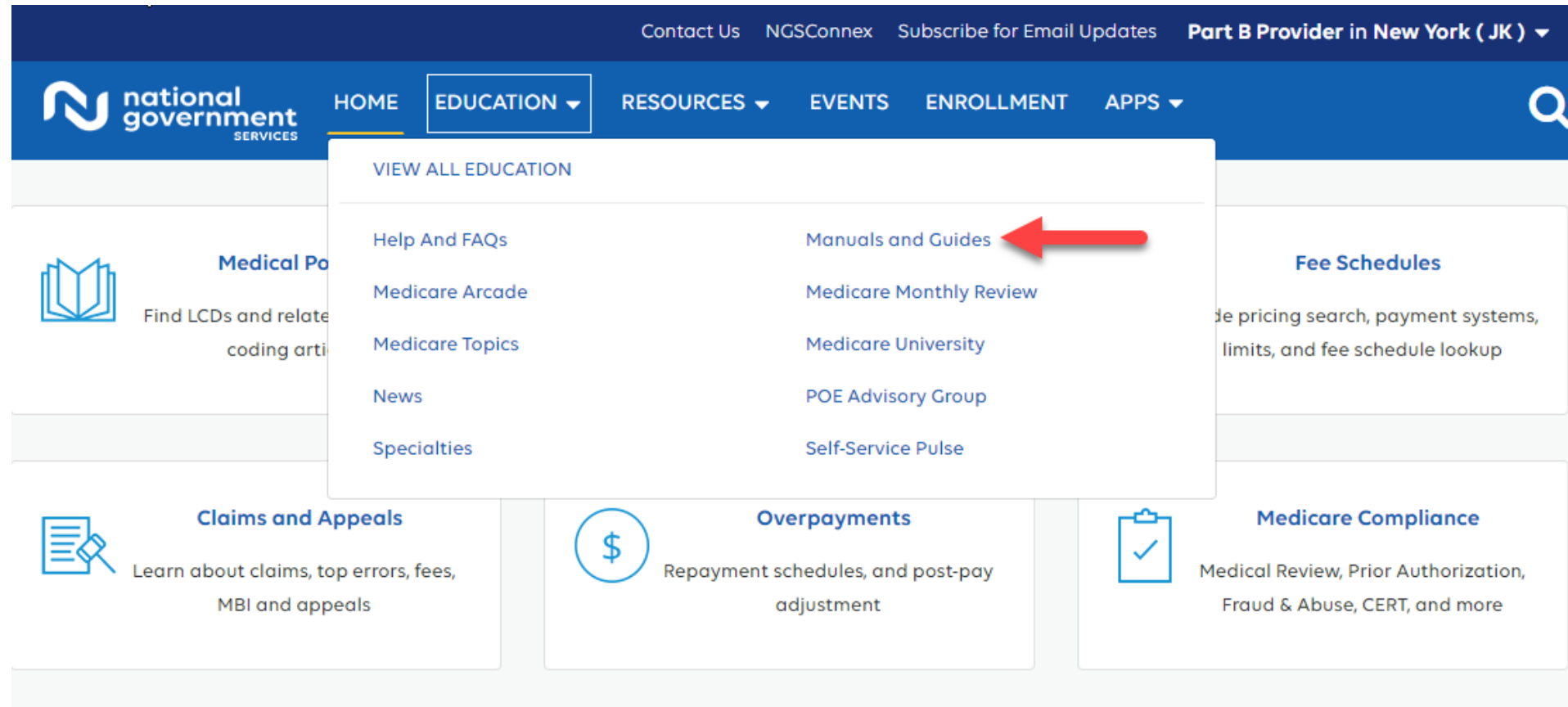
- Claim Overlap – If an overlapping claim is found in CWF, the following information will be provided.
  - Claim Type
  - Start Date
  - Facility Type
  - NPI
- Duplicate Claim – If a duplicate claim is found in CWF, the following information will be provided.
  - NPI for the duplicate claim

FEEDBACK

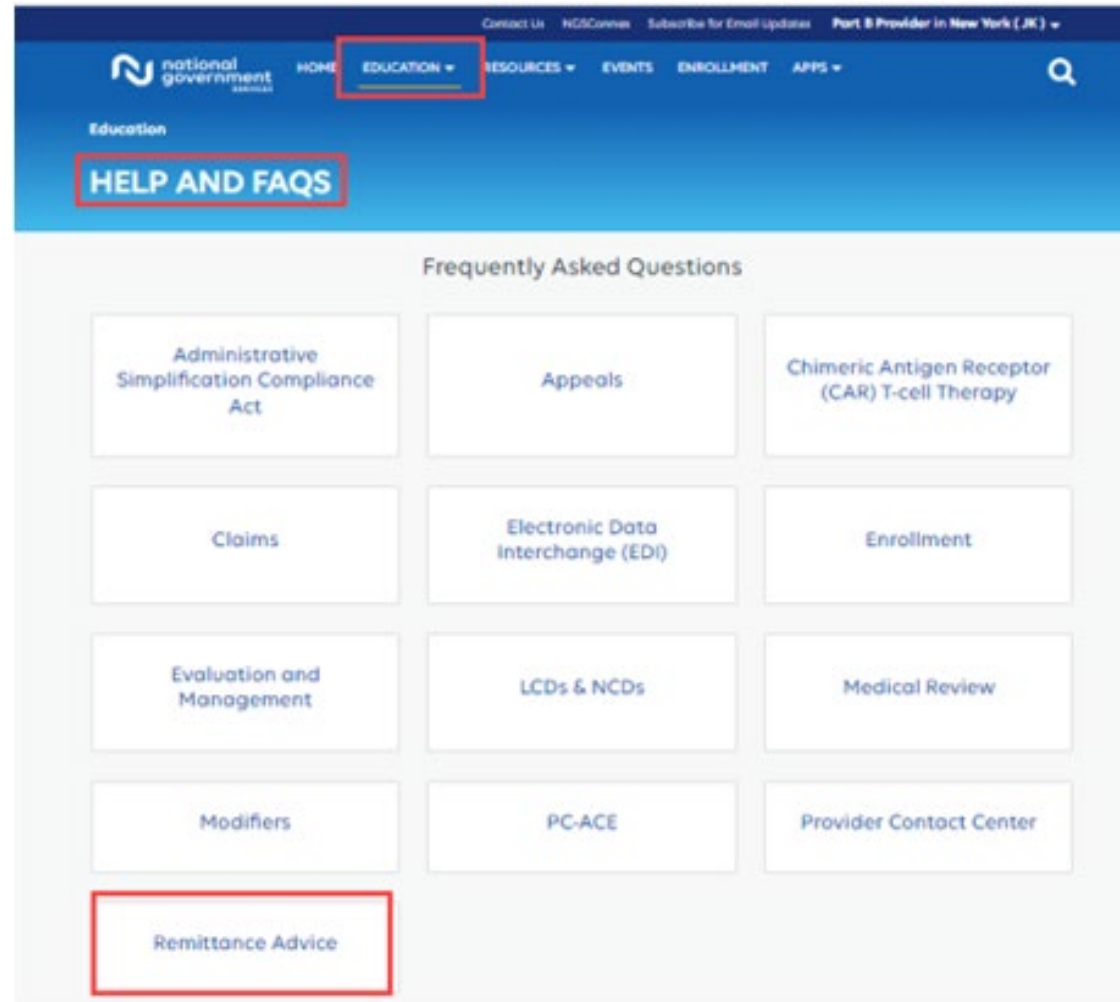
# Remittance Remark Codes



# Remittance Remark Codes



# Remittance Remark Codes



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

# 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.	<p>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.</p> <p>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.</p>



# RARC Error Message M86

RARC	Description	Resolution
M86	Service denied because payment already made for same/similar procedure within set time frame.	<p>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.</p> <p><a href="#">Evaluation and Management</a></p>

# 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 2/28/2025 and on 3/5/2025 for CPT 71045 (chest X-ray) with billed date of service of 2/3/2025
  - 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						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPST Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #			
From	To	MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER									
								11	71045			A	200.00	1	NPI	111111111			
								11	71045	76			200.00	1	NPI	111111111			
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPST Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #			
From	To	MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER									
								11	71045			A	200.00	1	NPI	111111111			
								11	71045	77			200.00	1	NPI	222222222			
25. FEDERAL TAX I.D. NUMBER						SSN EIN		26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT?		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE		
											YES NO		\$		\$		\$		
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
IN 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.				

# 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<sup>®</sup> 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

# Reopening versus Redetermination

# 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)
  - CLIA certification denials
  - Duplicate claim denials
  - Fee schedule corrections
  - Medicare Advantage plan denials (clinical trial or hospice only)
  - MSP (Medicare now primary)
  - Patient paid amount (carrier error only)
- 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

# 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

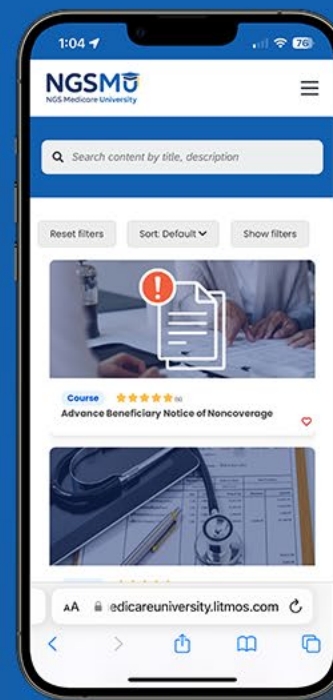
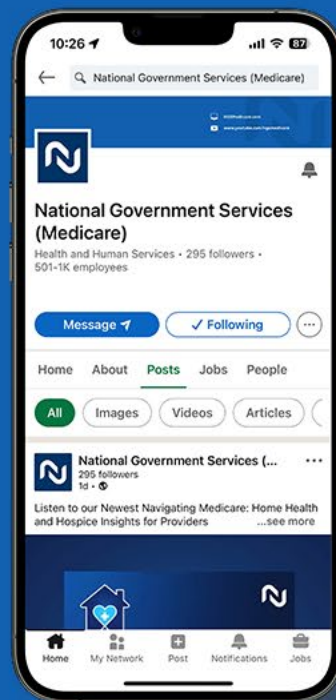
# Resources

- 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](#)



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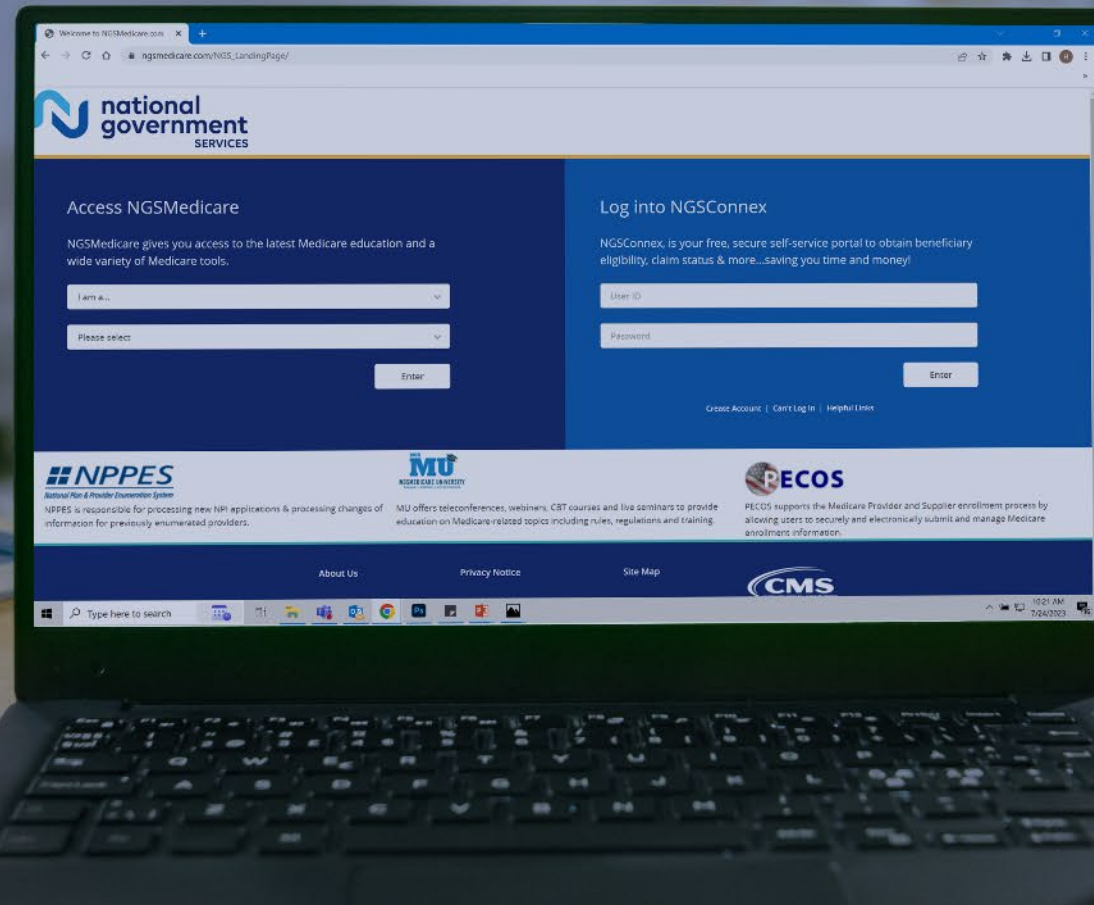


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Web portal for claim information



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# Questions?

Thank you!