

Medicare Part B Top Claim Denials

8/6/2025

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Objective

By utilizing internal claim reporting information, we'll help identify the top ten Part B claim denials and provide solutions to prevent them in the future.

Today's Presenters

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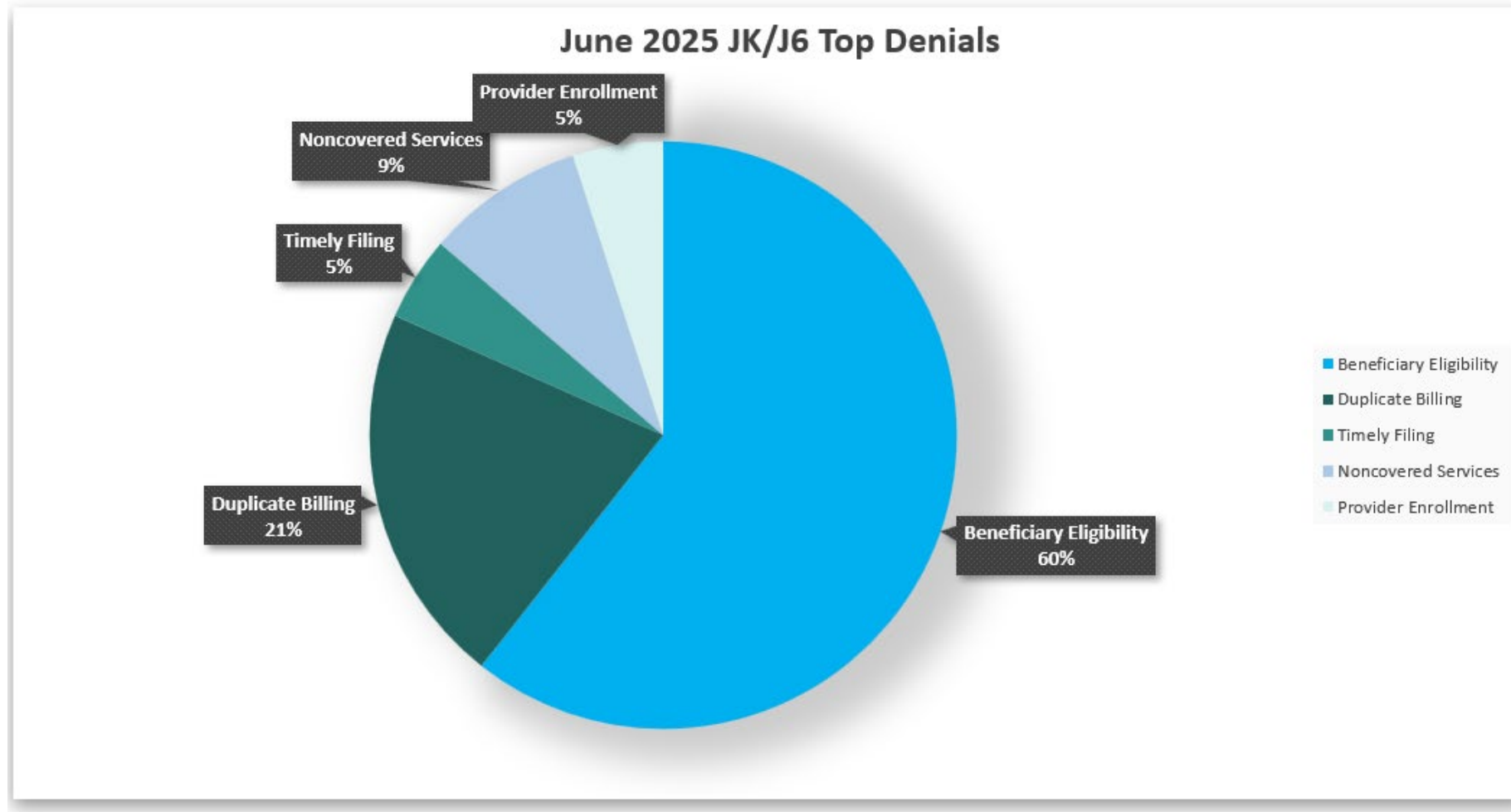


Agenda

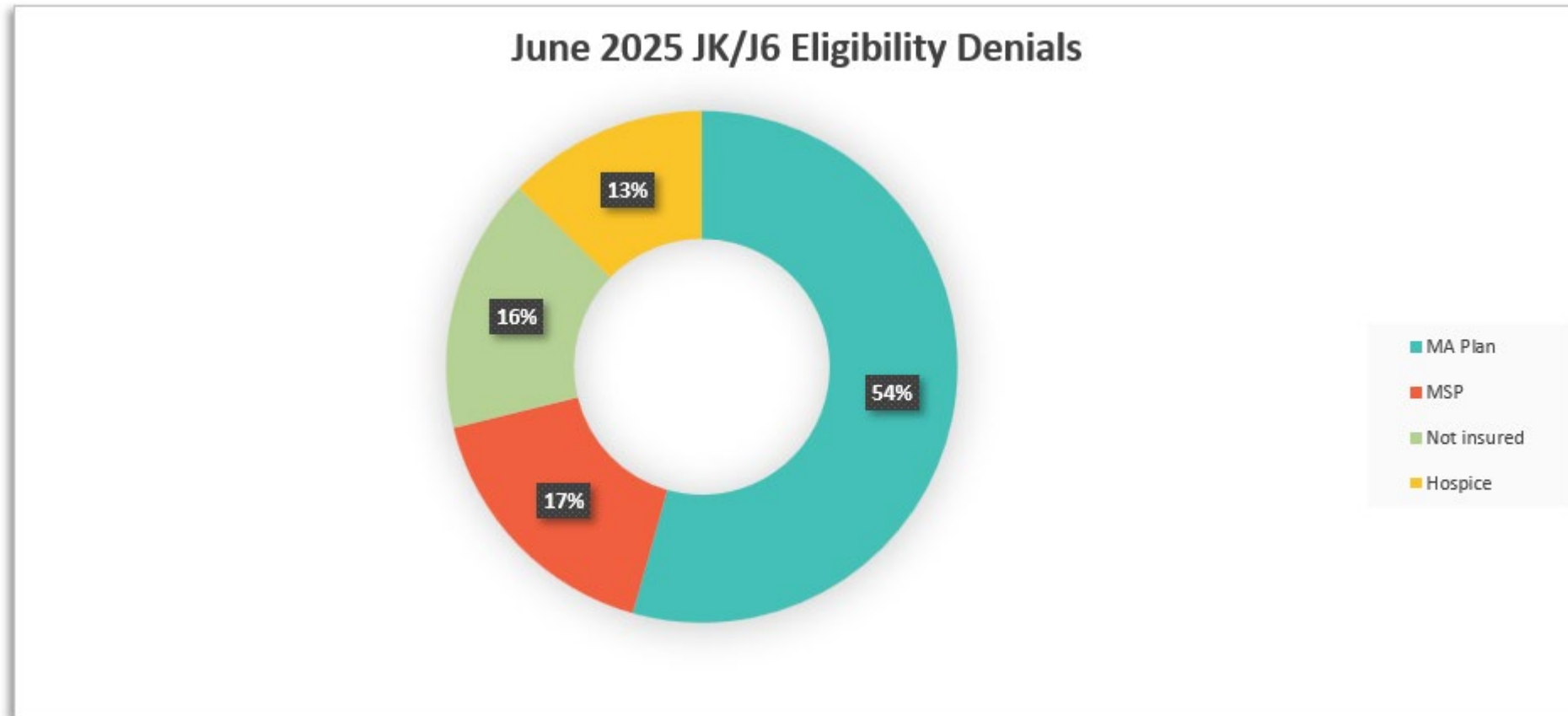
- [June 2025 Top Denials](#)
- [Beneficiary Eligibility](#)
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- [Provider Enrollment](#)
- [Duplicate Billing](#)
- [Reopening and Redeterminations](#)

June 2025 Top Denials

June 2025 JK/J6 Top Denials



Eligibility Denials



Beneficiary Eligibility

Medicare Advantage Plan

- Message code **OA-109**
 - Claim/service not covered by this payer/contractor, you must send the claim/service to the correct payer/contractor
 - Most commonly identifies that the patient is an MA plan enrollee
- **Resolution**
 - Check eligibility file for MA plan information
 - Submit claim to MA plan

Medicare Advantage Plan NGSConnex

- Location: Eligibility Lookup > Medicare Advantage

Medicare Advantage

Effective Dt	Termination Dt	Administering Insurance Company	Plan Name	Contract Number	Plan Number	Plan Option Code Description
01/01/2025		ANTHEM INSURANCE COMPANIES, INC.	Anthem Medicare Preferred	H4036	801	C - Submit claims to the MA plan. Except

1 to 1 of 1 items

Plan Name

Anthem Medicare Preferred

<https://shop.anthem.com/medicare>
Phone Number: 8882307338

Plan Option Code Description

C - Submit claims to the MA plan. Exception: If an MA plan enrolled beneficiary elects the Medicare hospice benefit, submit claims to NGS.

Close

Medicare Secondary Payer

- Message code **CO-22**
 - This care may be covered by another payer per COB
 - The patient has insurance that is primary to Medicare
- **Resolution**
 - Check eligibility file for the primary insurer
 - Submit claim to primary payer
 - You may submit an MSP claim once the primary has finalized the claim
- [Medicare Secondary Payer \(MSP\)](#)
- [Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P](#)

MSP NGSConnex

- Location: Eligibility Lookup > Medicare Secondary Payer

Medicare Secondary Payer								
Note: If the 'Related Diagnosis Codes' field is blank there are no related diagnosis codes available. To obtain additional information, contact the primary insurer.								
Effective Dt	Termination Dt	Last Maintenance Dt	Indicator	Type	ORM Indicator	Policy Number	Group Number	Relationship Code/Description
01/01/2023		05/03/2023	Primary Payer to Medicare	12 - Working aged	N/A	XXXXXX		01-Patient is insured
12/01/2019	12/31/2022	02/01/2023	Primary Payer to Medicare	12 - Working aged	N/A	XXXXXX		01-Patient is insured

MSP NGSConnex

- Location: Eligibility Lookup > Medicare Secondary Payer

Medicare Secondary Payer							
Note: If the 'Related Diagnosis Codes' field is blank there are no related diagnosis codes available. To obtain additional information, contact the primary insurer.							
Type	ORM Indicator	Policy Number	Group Number	Relationship Code/Description	Source Code/Description	Related Diagnosis Codes	Insurer Name
I2 - Working aged	N/A	XXXXXX		01-Patient is insured	21-11121-MIR Group Health Plan		HIGHMARK BLUE SHIELD ^ 1800 CENTER ST PO BOX 890089 CAMP HILL, PA 170111741
I2 - Working aged	N/A	XXXXXX		01-Patient is insured	21-11121-MIR Group Health Plan		HIGHMARK BLUE SHIELD v

Patient Does Not Have Medicare Part B

- Message code **PR-31**
 - Patient cannot be identified as our insured
 - Not entitled to Medicare on DOS
 - DOS prior to entitlement date
 - Not enrolled
 - Lapse to premium payment
 - Terminated
- **Resolution**
 - Verify eligibility in self-service tools
 - If no coverage, discuss options with patient

Part B Entitlement Date in NGSConnex

- Location: Eligibility Lookup > Beneficiary Eligibility Information Panel


Entitlement Information		
Part A Entitlement Reason	Part A Entitlement Date	Part A Termination Date
0-Beneficiary insured due to a	04/01/2006	
Prior Part A Entitlement Date	Prior Part A Termination Date	
Part B Entitlement Reason	Part B Entitlement Date	Part B Termination Date
0-Beneficiary insured due to a	04/01/2006	
Prior Part B Entitlement Date	Prior Part B Termination Date	
Medicare Inactive Begin Date	Medicare Inactive End Date	Inactive Reason

Hospice

- Message code **CO-B9**
 - Patient is enrolled in a hospice
- Remark code **N90**
 - Covered only when performed by the attending physician
- **Resolution**
 - Contact the hospice provider, or
 - File Clerical Reopening
 - **Modifier GV** – Attending physician is not employed/under arrangement by hospice provider
 - **Modifier GW** – Services provided are not related to terminal condition


Hospice NGSConnex

- Location: Eligibility Lookup > Hospice Notice of Election
 - NOE Revocation Indicator
 - 0 – Hospice benefits being used
 - 1 – Hospice benefits revoked, no longer being used

Hospice Notice Of Elections				
<input type="text" value="Search String"/>		<button>Search</button> Reset Search		
Notice of Election (NOE) ▾	NOE Receipt Date ▾	NOE Revocation Date ▾	NOE Revocation Indicator	NPI
11/05/2024	11/08/2024		0 - Not Revoked	
1 to 1 of 1 items				

Hospice NGSConnex

- Locations: Eligibility Lookup > Hospice Benefit Periods
- Benefit Period will always include
 - Start and End Date
 - DOEBA and DOLBA

Hospice Benefit Periods						
<input type="text" value="Search String"/>		<button>Search</button>		Reset Search		
Start Dt	End Dt	DOEBA	DOLBA	Days Used	NPI	Benefit Period
11/05/2024	12/18/2024	11/05/2024	12/18/2024	44		1
1 to 1 of 1 items						

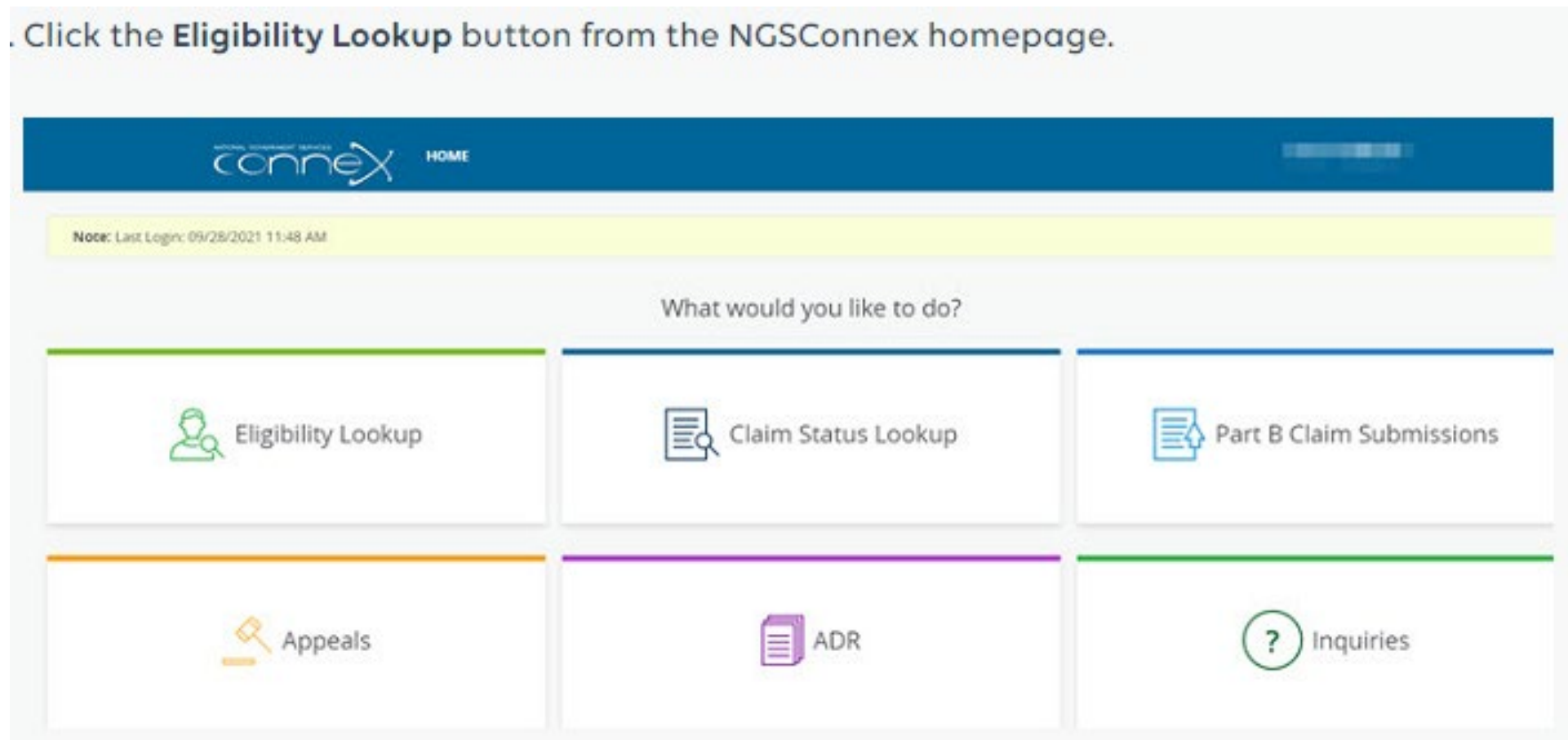
Beneficiary Eligibility Verification

- Prior to claim submission, verify your patient's eligibility using
 - [NGSConnex](#)



NGSConnex Eligibility Sample

Click the **Eligibility Lookup** button from the NGSConnex homepage.



NGSConnex Eligibility Sample

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Beneficiary Eligibility

Beneficiary Information

Medicare Number

Last Name

First Name

MBI Term Date

Date of Birth

Date of Death

Sex

Address Line 1

Address Line 2

City

State

Zip

Entitlement Information

Part A Entitlement Reason

Part A Entitlement Date

Part A Termination Date

Prior Part A Entitlement Date

Prior Part A Termination Date

Part B Entitlement Reason

Part B Entitlement Date

Part B Termination Date

Prior Part B Entitlement Date

Prior Part B Termination Date


Medicare Inactive Begin Date

Medicare Inactive End Date


Beneficiary Eligibility

- Part B Deductibles
- Medicare Advantage ☒
- Medicare Secondary Payer ☒
- Crossover
- Qualified Medicare Beneficiary ☒
- Home Health Plan ☒
- Hospice ☒
- Inpatient/SNF Spell History ☒
- End Stage Renal Disease ☒
- Preventive Services
- COVID-19 Vaccine
- Rui Vaccine
- Pneumococcal Vaccine
- Medicare Diabetes Prevention Program ☒
- Cardiac Rehabilitation
- Intensive Cardiac Rehabilitation
- Pulmonary Rehabilitation
- Acupuncture Benefits
- Smoking Cessation Counseling
- Cognitive Assessment & Care Plan ☒
- Therapy

NGSConnex Preventive Services


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Beneficiary Eligibility


Part B Deductibles


Medicare Advantage 


Medicare Secondary Payer 


Crossover


Qualified Medicare Beneficiary 

Home Health Plan 

Hospice Notice Of Elections 


Hospice Benefit Periods 

Inpatient/SNF Spell History 

End Stage Renal Disease 


Preventive Services


Audiology Screening

Hepatitis Screening 

COVID-19 Vaccine

Flu Vaccine


Pneumococcal Vaccine 

Medicare Diabetes Prevention Program 

Preventive Services

Search

Reset Search

Procedure	Modifier	Next Eligibility Dt 	Deductible Applies	Co-Insurance Applies
G0101 - CERVICAL OR VAGINAL CA	26	07/01/2025	No	No
77067 - SCREENING MAMMOGRAPHY		09/01/2024	No	No
G0438 - ANNUAL WELLNESS VISIT,	26	07/01/2024	No	No
G0439 - ANNUAL WELLNESS VISIT,	26	07/01/2024	No	No
92550 - TYMPANOMETRY AND REPLE	26	07/01/2023	No	No
92552 - PURE TONE AUDIOMETRY (26	07/01/2023	No	No
92553 - PURE TONE AUDIOMETRY (26	07/01/2023	No	No
92555 - SPEECH AUDIOMETRY THRE	26	07/01/2023	No	No
92556 - SPEECH AUDIOMETRY THRE	26	07/01/2023	No	No
92557 - COMPREHENSIVE AUDIOMET	26	07/01/2023	No	No

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Eligibility Resources

- [Checking Eligibility and Knowing your Point of Contact](#)
- [CMS IOM Publication 100-09, Medicare Administrative Contractor \(MAC\) Beneficiary and Provider Communications Manual, Chapter 6, Section 50.1](#)
- [NGSConnex User Guide](#)

Noncovered Services

Noncovered Service or Procedure

- Message Code **PR 50**
 - These are noncovered services because this is not deemed a 'medical necessity' by the payer
- Remark Code **N180**
 - This item or service does not meet the criteria for the category under which it was billed
- **Resolution**
 - The CPT/HCPCS code reported is not covered for the beneficiary, and the beneficiary is liable for these charges.
 - If an incorrect code was reported, or a modifier was excluded the claim will need to be reviewed as a reopening or a redetermination

Timely Filing Denial

Timely Filing

- Message code **CO-29** *for assigned claims*
 - The time limit for filing has expired
 - **PR 29** *for unassigned claims*
- Remark code **N211**
 - You may not appeal this decision
- **Resolution**
 - Filing limit is 12 months of the “From” date of service
 - Medicare splits the Part B claim when “From” date is not timely and the “To” date is timely
 - [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 1, Section 70.1](#)

Timely Filing Exceptions

- Eligible exception circumstances
 - Administrative error
 - Retroactive Medicare entitlement
 - Retroactive MA plan disenrollment
 - Retroactive entitlement involving Medicaid
 - [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 1, Section 70.7](#)
- Exceptions are **mailed** to NGS
 - **Preclaim:** Completed 1500 claim form, a letter explaining reason claim is being filed late, documentation
 - **Post Claim:** Part B Reopening form with documentation
 - [Requesting an Exception to Timely Filing](#)

Provider Enrollment

Provider Not Eligible

- Message code **CO-B7**
 - This provider was not certified/eligible to be paid for this procedure/service on this date of service
- **Resolution**
 - Rendering NPI is not reassigned to group NPI
 - Verify the provider information in [PECOS](#)/submit application
 - The billing and/or rendering provider NPI is not active on the DOS
 - Examples: enrollment date later than DOS, deactivated for revalidation error
 - The provider specialty not permitted payment for service/procedure
 - Examples: NPP at surgery, chiropractor billing an office visit, service cannot be performed in ASC

Duplicate Billing



Duplicate Billing

- Message Code **OA-18**
 - Exact duplicate claim/service
- **Duplicate Claim Denial Criteria**
 - MBI
 - PTAN/NPI
 - From and To date of service
 - Type of service
 - Place of service
 - Procedure codes
 - Billed amount

Eliminating Duplicate Claims

1. Verify claim status in NGSConnex or the IVR
 - Denied/rejected
 - Pending
 - Approved to pay
 2. Review the EDI validation report to verify claims accepted
 3. Review the remittance advice for denial/rejection reason
 4. Do not set claims for automatic rebill every 30 days
 5. Do not resubmit a claim to correct an original denial
 - Confirm if reopening or appeal is required
- [YouTube Video: Tips for Avoiding Duplicate Billing Denials](#)

EDI – Duplicate Claims

- Duplicate electronic claims will not be accepted into the Part B claims processing system
- Unaccepted claims appear on the EDI 277 CA report identified with the following reason codes
 - CSCC: A3 – Return as unprocessable
 - CSC: 78 – Duplicate of an existing claim/line
- Unaccepted claims are not included on the remittance advice

Provider Impacts from 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



Reopening and Redeterminations

Reopening Versus Redetermination

- **Reopening**

- Claim correction of minor clerical errors
 - Not a formal appeal
- Use for
 - Mathematical or computational mistake
 - Transposed procedure or diagnostic codes
 - Inaccurate data entry
 - Computer errors
 - Incorrect data
 - Medicare Part B provider-initiated overpayments

- **Redetermination**

- First level of the Medicare appeal process for partially or fully denied claims for complex issues that require documentation review
- Disputing Medicare Part B overpayments
- Medical necessity denials
- Determination on limitation of liability provision

Methods to Initiate a Reopening

- NGSConnex
 - Preferred method
 - [NGSConnex Part B User Guide](#)
- Telephone Reopening Unit
 - For limited request types
 - JK: 888-812-8905
 - J6: 877-867-3418
- Written Reopening
 - Complete the [Part B Reopening Request Form](#) and mail to the address on the form
 - [Large Various Adjustment Macro \(LVAM\)](#) is used when there are several reopening requests for the same reason

Reopenings Handled by Telephone Reopening Unit or Written Reopening

- Assignment of claims (carrier errors only)
- CLIA certification denials
- Adding or changing order/referring/supervising physician
- Duplicate denials
- MA plan denials (clinical trial or hospice related only)
- Modifier GV and GW
- Updated fee schedule allowance
- HIC/MBI corrections (carrier error only)
- MSP – Medicare now primary
- Patient paid amount (carrier error only)
- Add/change rendering provider
- Place of service changes

Methods to Initiate a Redetermination

- NGSConnex
 - Preferred method
 - [NGSConnex Part B User Guide](#)
- Electronic Submission of Medical Documentation (EsMD)
 - [Submit an Appeal Electronically via esMD](#)
- Written Appeal
 - Complete the [Part B Redetermination Request Form](#) and submit the form along with documentation proving medical necessity to the address on the form

Redetermination Facts

- Must be received within 120 days of the claim determination date on the remittance advice
 - Late submissions are dismissed
- NGS appeals department is responsible for reviewing and finalizing redeterminations
 - 60 days to finalize all redeterminations
- Do not send duplicate requests
 - Use NGSConnex to verify status
- Include all documentation at the time of submission
- Resources

Appeal Levels

- Level One – Redetermination
 - 120 days from date of receipt of the initial determination notice
 - No minimum
- Level Two – Reconsideration (QIC)
 - 180 days from date of receipt of the redetermination decision
 - No minimum
- Level Three – Administrative Law Judge (ALJ)
 - 60 days from the date of receipt of the reconsideration (QIC decision)
 - For requests filed on or after 1/1/2025, at least \$180 remains in controversy
- Level Four – Medicare Appeals Council (MAC)
 - 60 days from date of receipt of the ALJ decision
 - No minimum (none)
- Level Five – Federal Court Review
 - 60 days from date of receipt of the MAC decision
 - For requests filed on or after 1/1/2025, at least \$1,900 remains in controversy

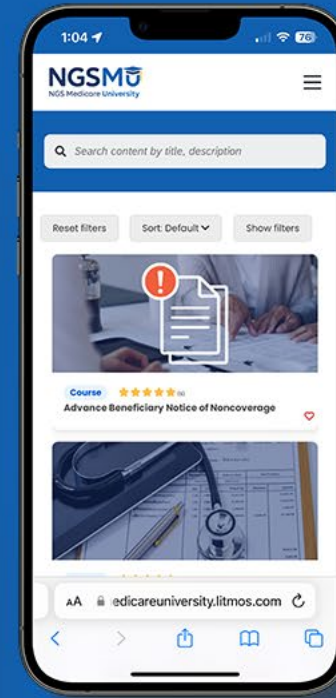
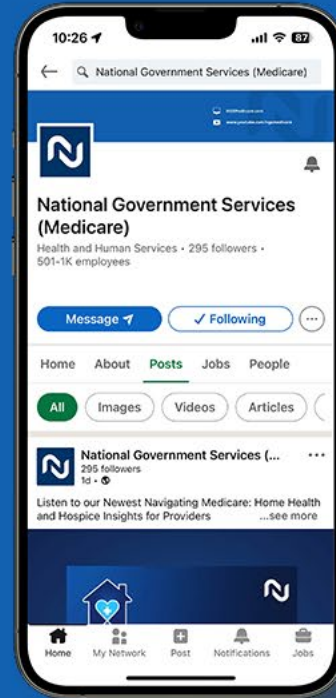
Reopening and Redetermination Resources

- [Tip Sheet for Medicare Providers on First Level of Appeals \(Redeterminations\)](#)
- [Medical Records to Support an Appeal](#)
- [How to Avoid Costly Appeals](#)
- [Reopenings for Minor Errors and Omissions](#)



Questions?

Thank you!



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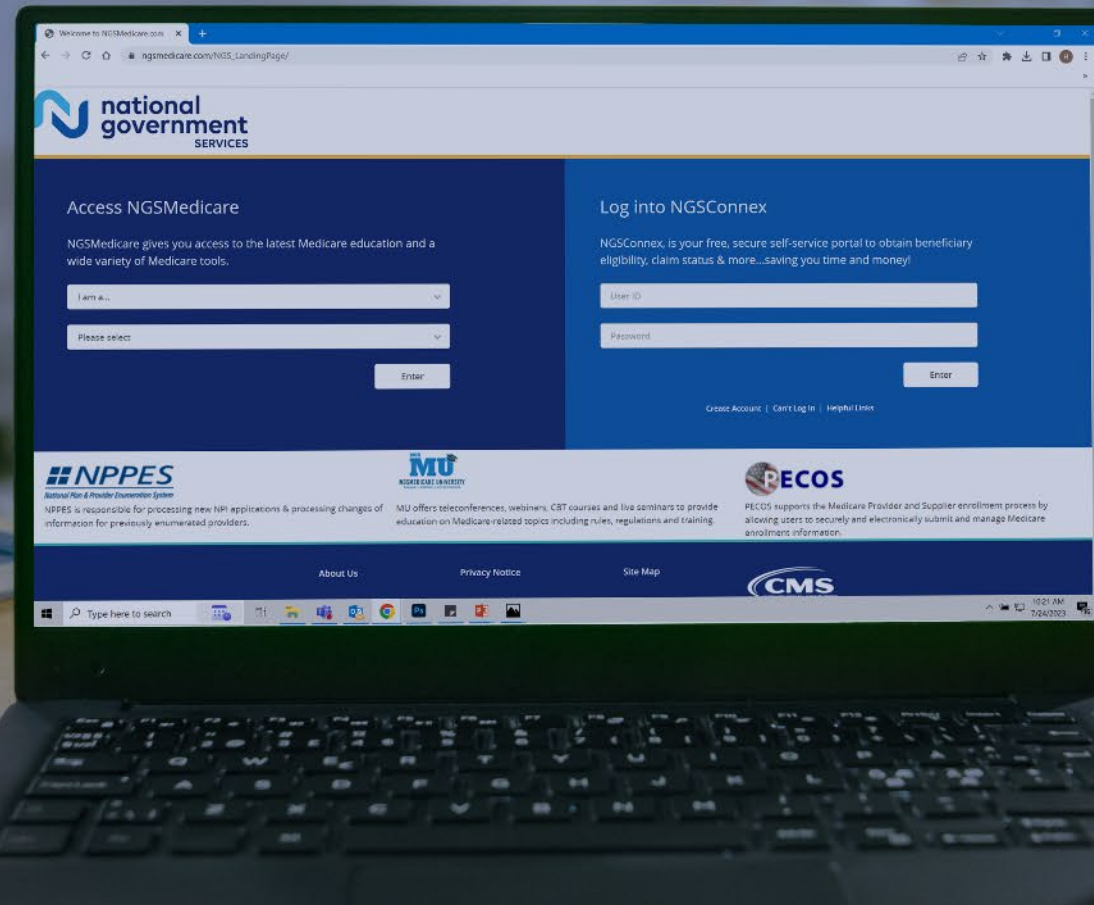


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days a week to answer general inquiries



[NGSConnex](#)

Web portal for claim information



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