

Medicare Part B 2024
Spring/Summer Virtual Conference
Mastering Medicare: Tuesday Tutorials

Top Claim Errors

6/11/2024

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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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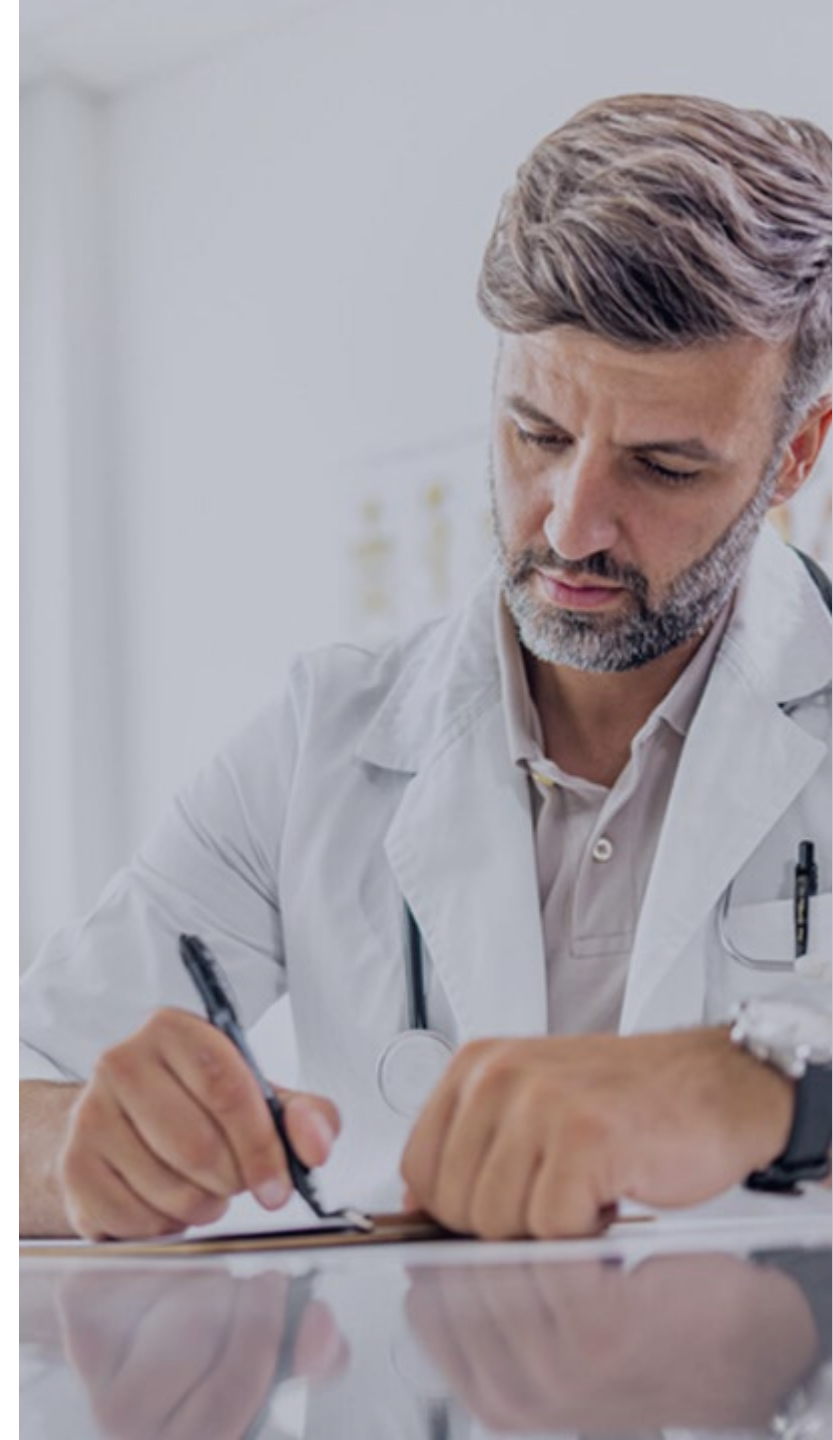
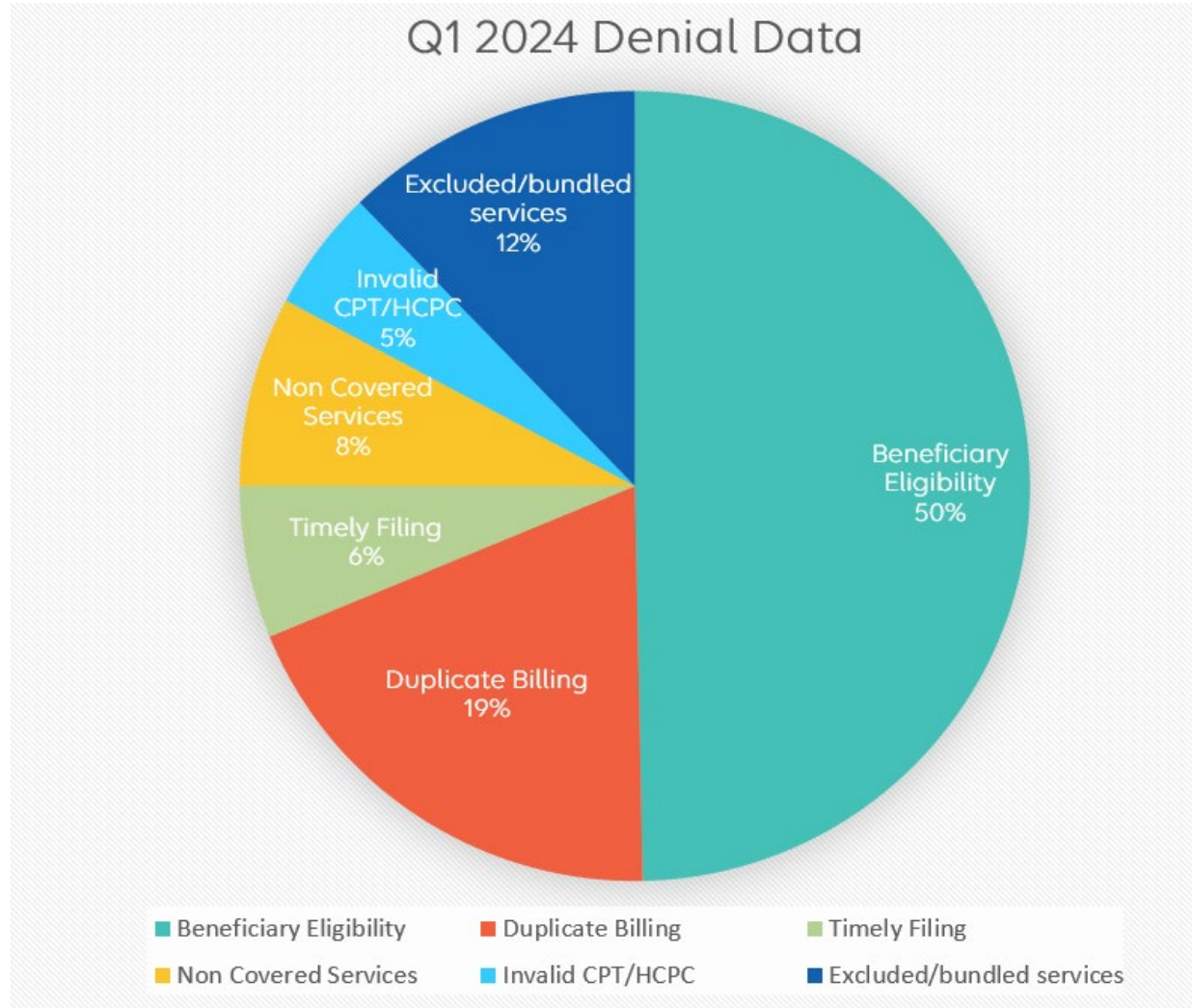


Agenda

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Q1 2024 Claim Denial Data

Q1 2024 Claims Denial Chart



Duplicate Billing

Duplicate Billing

- Message Code OA-18
 - Exact duplicate claim/service
- Issues caused by duplicate billing
 - 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

Duplicate Elements

- Patient's Medicare number
- PTAN/NPI
- From and through date of service
- Type of service
- Place of service
- Procedure codes
- Billed amount

Tips to Avoid Duplicate Claims

- Use NGSConnex or the IVR to verify the status of the original claim
 - Denied/rejected
 - Pending
 - Approved to pay
- Electronic claim submitters
 - Check your EDI validation report to verify claims were received and accepted
 - Check your software system to verify claims are not set up for automatic rebill every 30 days
 - Review your remittances
- Review your remittance advice for denial/rejection reason
- Do not resubmit a claim to correct an original denial
 - May need to submit a reopening or appeal
- [Tips for Avoiding Duplicate Billing Denials](#)

EDI - Duplicate Claims

- Electronic claims that are duplicates to already received electronic claims will not be accepted into the Part B claims processing system
 - JK only
 - Will not appear on the remittance advice
- 277 CA report rejection codes
 - CSCC: A3 – Return as unprocessable
 - CSC: 78 – Duplicate of an existing claim/line

Beneficiary Eligibility

Beneficiary Eligibility

- Message code PR-31
 - Patient cannot be identified as our insured
 - Common reasons for denial
 - MBI invalid/incorrect
 - No Part B entitlement on date of service
- Resolution
 - Ensure MBI is valid, submit claim again
 - Verify eligibility in self-service tools, if no entitlement, check with patient

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 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
- If patient is retired, no longer has that insurance
 - Contact BCRC
 - MSP file must be closed in order to process a primary claim

NGSConnex Eligibility Verification

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






The screenshot displays the NGSConnex homepage interface. At the top, there is a dark blue header with the 'connex' logo and the word 'HOME'. Below the header, a yellow notification bar states 'Note: Last Login: 09/29/2021 11:48 AM'. The main content area is titled 'What would you like to do?' and features a grid of six interactive buttons. The first button in the top row is 'Eligibility Lookup', which is highlighted with a green border and contains an icon of a person. Other buttons include 'Claim Status Lookup' (document with magnifying glass), 'Part B Claim Submissions' (document with arrow), 'Appeals' (gavel), 'ADR' (document), and 'Inquiries' (question mark).

NGSConnex Eligibility Verification

 [HOME](#)

[Printable View](#)

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
- IRVIAH 18 Month Line

Beneficiary Eligibility

Beneficiary Information

Medicare Number	Last Name	First Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
MBI Term Date	Date of Birth	Date of Death
<input type="text"/>	<input type="text"/>	<input type="text"/>
Sex	Address Line 1	Address Line 2
<input type="text" value="Female"/>	<input type="text"/>	<input type="text"/>
City	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>

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 Services

- Message Code PR-204
 - This service/equipment/drug is not covered under the patient's current benefit plan
 - Medicare Fee-for-Service does not cover the service that has been billed for the condition
 - The CPT/HCPC on the claim is not a covered Medicare service/equipment or drug
- There are multiple reasons for denial including but not limited to
 - Status A Code
 - Status R Code
 - Status X Code
 - Hearing Aid/Hearing Aid Related
 - Wheelchair only Transports
 - Medical Therapy Management Services by a Pharmacist
 - Removal of Intrauterine Device (without complication)

Noncovered Services

- Resolution
 - Utilize the following resources, as well as the most current CPT/HCPCS coding books, to verify if the code you want to bill to Medicare is a covered service
 - Medicare Physician Fee Schedule Database
 - CMS Internet Only Manuals
 - Medicare Coverage Data Base

Invalid CPT/HCPC

Invalid CPT/HCPC

- Message Code CO-16
 - Claim/service lacks information or has submission/billing error(s)
- Remark Code M51
 - Missing/incomplete/invalid procedure code(s)
- Resolution
 - Utilize the following resources, as well as the most current CPT/HCPCS coding books, to verify if the code you want to bill to Medicare is a covered service
 - Medicare Physician Fee Schedule Database
 - CMS Internet Only Manuals
 - Medicare Coverage Data Base

Timely Filing

Timely Filing

- Message code CO-29/PR 29 (unassigned claims)
 - The time limit for filing has expired
- Remark code N211
 - You may not appeal this decision
 - The time limit for filing has expired
- All claims must be submitted within one year from the date of service
 - Span date claims use the “To” date

Timely Filing Exceptions

- CMS indicates Medicare contractors may determine certain situations allowing extension of the time limit
 - Administrative error
 - Retroactive Medicare entitlement
 - Retroactive MA plan disenrollment
 - Retroactive entitlement involving Medicaid
- Exceptions may be mailed to NGS before or after the claim is submitted
 - Preclaim: Completed 1500 claim form, a letter explaining reason claim is being filed late, documentation
 - Postclaim: Part B Reopening form with documentation
- [Requesting an Exception to Timely Filing](#)

Excluded/Bundled Services

Excluded Services

- Message Code PR-204
 - This service is not covered under patient's current benefit plan
 - Statutory exclusion
- Examples
 - Cosmetic surgery, custodial care, hearing aids and auditory implants
- [CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 16, General Exclusions From Coverage](#)

Bundled Services

- Message Code CO-97
 - Payment is included in another service on the same day
- Remark Code N20
 - Service not payable with other service rendered on the same date
- This includes multiple scenarios
 - MPFSDB Status B
 - MSFSDB Status E drug codes
 - MSFSDB Status X drug codes
 - MPFSDB Status T when billed with Status A, C, or D codes on the same date by the same rendering provider when a rendering provider performs both the surgical procedure and anesthesia on the same DOS
 - Some DME codes
- [Fee Schedule Assistance](#) > Procedure Status Indicators

Reopening Versus Redetermination

Reopening Versus Redetermination

- Reopening

- To correct a claim(s) determination resulting from minor errors
- Mathematical or computational mistake
- Inaccurate data entry
- Computer errors
- Incorrect data items
- Transposed procedure or diagnostic codes

- Redetermination

- First level of the Medicare appeal process
- For partially paid or denied claim(s) resulting from more complex issues that require analysis of documentation
- Coverage of furnished items and service
- Overpayment determinations
- Medical necessity claim denials
- Determination on limitation of liability provision

Reopening

Methods to Initiate a Reopening

- NGSConnex
 - Preferred method
 - [NGSConnex Part B User Guide](#)
- Telephone Reopening Unit
 - JK: 888-812-8905
 - J6: 877-867-3418
- Written Reopening
 - J6
 - National Government Services, Inc.
 - P.O. Box 6475
 - Indianapolis, IN 46206-6475
 - JK
 - National Government Services, Inc.
 - P.O. Box 7111
 - Indianapolis, IN 46207-7111
 - [Reopenings for Minor Errors and Omissions](#)

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

Appeals

Methods to Initiate a First Level Appeal

- NGSConnex
 - Preferred method
 - [NGSConnex Part B User Guide](#)
- Electronic Submission of Medical Documentation (EsMD)
 - [Submit an Appeal Electronically via esMD](#)
- Written Appeal
 - JK
 - National Government Services, Inc.
 - P.O. Box 7111 Indianapolis, IN 46207-7111
 - J6
 - National Government Services, Inc.
 - P.O. Box 6475 Indianapolis, IN 46206-6475
- [Part B Redetermination Request Form](#)

The Five Levels of Appeal

- 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 1/1/2024, 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 1/1/2024, at least \$1,840 remains in controversy.
 - For requests filed on or after 1/1/2023, at least \$1,850 remains in controversy
- [How to Avoid Costly Appeals](#)

Appeal Documentation

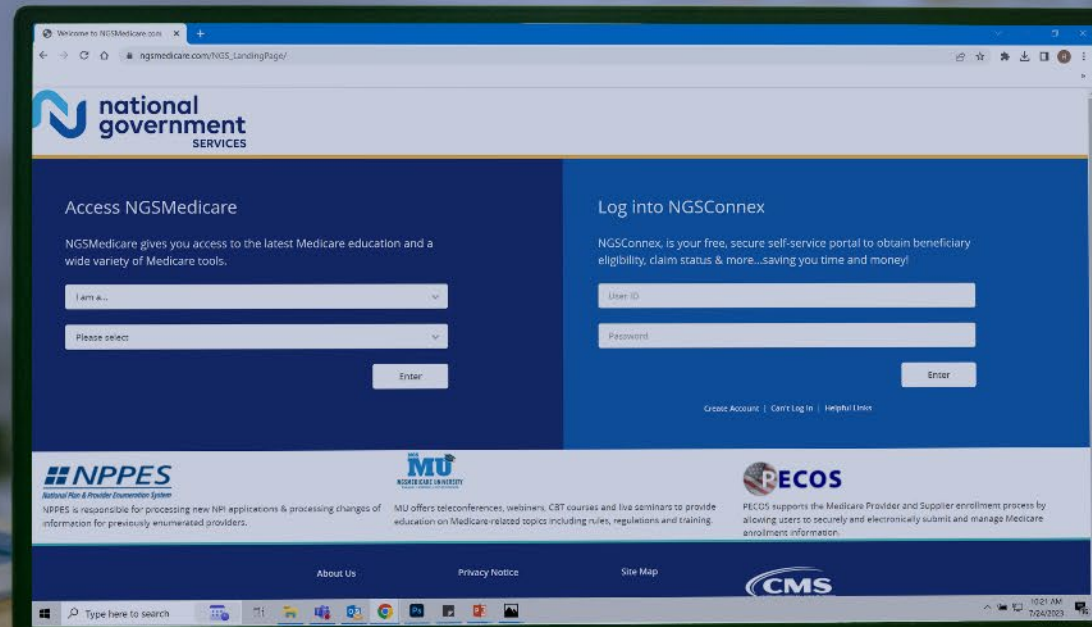
- Include appropriate documentation for service
 - Provide at the time of the initial appeal request
 - Additional information/documentation will not be requested
 - The medical documentation must be signed and dated by the physician
 - Only you can decide which documentation best supports your claim
- A guide to assist your office with the documentation required
 - [Medical Records to Support an Appeal](#)



Questions?

Thank you!

Find us online



www.NGS Medicare.com

Online resources, event calendar, LCD/NCD, and tools



IVR System

The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries



[NGSConnex](#)

Web portal for claim information



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