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NGS Medicare Virtual Conference

Fall 2021

Medicare Part B Common Billing Errors

11/10/2021

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- We will discuss claim denials that include repetitive and incorrect billing patterns
- The material being presented will be helpful in preventing unnecessary claim rejections, denials, and duplicate submission of claims

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Agenda

- Duplicate Billing
- Provider Enrollment Related Errors
- Eligibility
- Unprocessable Claim Rejections
- Reopenings

Duplicate Billing

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

Elements Compared to Identify an Exact Duplicate

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

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Tip to Avoiding Duplicate Claims

- Use NGSConnex or the IVR to verify the status of the original claim
  - Denied/rejected
  - Pending
  - Approved to pay
- Electronic claims 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

EDI - Duplicate Claim Rejects

- Electronic claims that are duplicates to already received electronic claims will not be accepted into the Part B claims processing system
  - And 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

NGS Is on YouTube!

- NGS Medicare YouTube
  - Educational videos
  - Proper claim completion and submission
  - Common billing errors
  - Service specific coverage
  - Instructions for using NGSConnex
  - Snapshots from our webinars
    - Tips to Avoiding Duplicate Billing Denials

Provider Enrollment Related Errors

Reassignment of Benefits

- Can be identified on RA with
  - Message code N290
    - Missing incomplete/invalid rendering provider primary identifier
  - Physician/NPP has not been assigned a PTAN with the group
- Group submits a CMS-855R
  - 855R approved
  - PTAN created
  - Group can bill for services rendered by that physician/NPP
  - Effective date may be dated back 30 days from receipt of application
- Resolution
  - Enroll provider and resubmit once provider enrollment approval letter is received

Provider Enrollment Resources

- PECOS
- NGS Provider Enrollment Web Page
- CMS Provider Enrollment Revalidation

Eligibility

Eligibility

- Message code CO-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

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

Eligibility

- 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

Eligibility

- Message code PR-B9 (Remark code N90)
  - Patient is enrolled in a hospice
  - Covered only when performed by the attending physician
- Resolution
  - Services provided by attending physician?
  - GV modifier
  - Services provided are not related to terminal condition?
  - GW modifier
  - Reopen? To add the appropriate modifier
  - If related to hospice, work directly with hospice program for reimbursement
- The Medicare Hospice Benefit: Effects on Other Provider Types

Eligibility

- Message code CO-16
  - Claim lacks information, and cannot be adjudicated
    - Remark code N382
      - Missing/incomplete/invalid patient identifier
    - MOA code MA27
      - Missing/incomplete/invalid entitlement number or name shown on the claim
- Resolution
  - Verify MBI and proper name with patient
  - Submit a new claim

Eligibility

- Message code CO-109
  - Claim not covered by this payer/contractor.
    - Remark code N105
      - Claim/service for a RRB beneficiary
- Resolution
  - Submit the claim to Palmetto GBA, the RRB MAC

Eligibility Verification

- **Prior** to claim submission, verify your patient's eligibility using one of our self-service tools
  - NGSConnex
  - Interactive Voice Response System

More than one E/M service by a PA/NP on Same Day

- CMS permits one E/M service per beneficiary, per day, per provider specialty type
  - Multiple E/M services on the same DOS may be permissible, when each episode of care is addressing a different clinical condition
- Include information on each E/M claim, defining the specialty of the physician group performing services
  - Item 19 on the CMS-1500 claim form or the electronic equivalent
    - Example: “Spec 06” (for a cardiology group) or “Spec 26” (for a psychiatry group)
- Can be identified on RA with
  - Remark Code B16 – ‘New Patient’ qualifications were not met
  - Remark Code M13 – Only one initial visit is covered per specialty per medical group
- Resolution
  - Resubmit the claim with the information in item 19; as referenced above

Resources

- Checking Eligibility and Knowing your Point of Contact
- CMS IOM Publication 100-09, *Beneficiary and Provider Communications Manual*, Chapter 6, Section 50.1

Unprocessable Claim Rejections

Identifying and Correcting

- Identifying Unprocessable Services
  - An unprocessable service is rejected using one of the following methods
    - Message code MA130 appears on your remittance advice indicating the claim is unprocessable
    - Paper claims are screened and if information needed to process the claim is missing, the claim is mailed back to you with a form letter indicating why the claim is being returned
    - Electronic claims that fail initial edits will be returned via the acceptance report
- Correcting Unprocessable Claims
  - Unprocessable claims must be corrected and submitted as a new claim

Missing/Incomplete Information

- Can be identified on RA with
  - Message code C0-16
    - Claim/service lacks information or has submission/billing error(s)
- Check for additional remark code on RA
  - Example REM N822 – “Missing procedure modifier(s)”
  - Example REM N382 – “Missing/incomplete/invalid patient identifier”

Invalid Beneficiary Name

- Invalid characters included on the claim in the beneficiary name fields
  - Item 2 on CMS-1500 Claim Form or Electronic Equivalent
    - Example: Smith01, John
  - List exactly as it appears on the beneficiary's Medicare card
- The claim suspends for manual intervention causing
  - Delay in claim processing/payment
  - Improper payments
  - Decreases efficiencies
- Can be identified on RA with
  - Message code MA130 – Your claim contains incomplete and/or invalid information

Resources

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 10 and Section 80.3.1
- Washington Publishing Company

Reopenings

Reopening vs. Redetermination

Reopening **To correct a claim(s) determination resulting from minor errors**	**Redetermination (Appeal – first level)** **For partially paid or denied claim(s) resulting from more complex issues that require analysis of documentation**
• Mathematical or computational mistake • Inaccurate data entry • Computer errors • Incorrect data items • Transposed procedure or diagnostic codes	• Coverage of furnished items and service • Overpayment determinations • Medical necessity claim denials • Determination on limitation of liability provision

Methods to Initiate a Reopening

- NGSConnex
  - Preferred method
    - NGSConnex Part B User Guide
- Telephone Reopening Unit
- Written Reopening
  - Reopenings for Minor Errors and Omissions

Reopenings Handled by Telephone Reopening Unit

- Assignment of claims (carrier errors only)
- CLIA certification denials
- Adding or changing order/referring/supervising physician (refer to the Medicare Part B 101 Manual, Ordering and Referring Claims Information for instructions on how to enter the information on the claim)
- Duplicate denials
- MA plan denials (clinical trial or hospice related only)
- Modifier GV and GW
- Fee schedule incorrect
- HIC/MBI corrections (carrier error only)
- MSP – Medicare now primary
- Patient paid amount (carrier error only)

Modifier Reopenings

- Duplicate denials
  - Must be adding a modifier to indicate the service is not a duplicate
    - Examples of modifiers 59, 78, RT or LT (As long as these modifiers do not exceed the MUE, if modifier is required to exceed MUE must send in a redetermination)
- Adding/changing a modifier
  - Excluding modifiers AQ, AR, QU, QB, 22, 23, 52, 53, 62, 66, GA, GY and GZ

Contact Information

- NGSConnex provider portal
  - NGSConnex is available 24/7
- Telephone Reopening Unit
  - JK: 888-812-8905
  - J6: 877-867-3418

Written Reopening Address

- J6

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Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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