NGS MU
NGSMEDICARE UNIVERSITY
MEANINGFUL • INFORMATIVE • SIMPLIFIED EDUCATION

National Government Services

Medicare Part B Common Billing Errors

1/13/2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Jennifer Lee
  - Provider Outreach and Education Consultant
- Jennifer DeStefano
  - Provider Outreach and Education Consultant

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS website.

No Recording

- 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

Agenda

- Duplicate Billing
- Provider Enrollment Related Errors
- Eligibility
- More Than One E/M Service By PA/NP On Same Day
- 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

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 Verification

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

Resources

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

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

More Than One E/M Service by 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

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

- Message code CO-16
  - Claim lacks information, and cannot be adjudicated
- Check for additional remark code on RA
  - Example REM N822 – “Missing procedure modifier(s)”
  - Example REM N382 – “Missing/incomplete/invalid patient identifier”

Invalid Beneficiary Medicare Number

- Message code CO-16
  - Claim lacks information, and cannot be adjudicated
- Check for additional remark code on RA
  - 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

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

  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

Thank You!

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

FOLLOW US

National Government Services

NGS MU