

Medicare Part B Common Billing Errors

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Today's Presenters

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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
- Eligibility/MA Plan
- Timely Filing
- Excluded Services
- Bundled Services
- Rejected Claims
- 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 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

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

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](#)

Eligibility

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 Enrollee

- 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

Eligibility Verification

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

NGSConnex Eligibility Verification



HOME

What would you like to do in NGSConnex?



Eligibility Lookup



Claim Status Lookup



Part B Claim Submissions



Appeals



ADR



Inquiries

★ Resources

MBI Lookup

Remittance

Prior Authorization

Financials

Manage Account

NGSConnex Eligibility Verification

Beneficiary Eligibility

Beneficiary Information

Medicare Number	Last Name	First Name
MBI Term Date	Date of Birth	Date of Death
	12/14/1974	
Sex	Address Line 1	Address Line 2
Female		
City	State	Zip
MINNEAPOLIS	MN	

Entitlement Information

Part A Entitlement Reason	Part A Entitlement Date	Part A Termination Date
1-Beneficiary insured due to d	07/01/2012	
Prior Part A Entitlement Date	Prior Part A Termination Date	
Part B Entitlement Reason	Part B Entitlement Date	Part B Termination Date
1-Beneficiary insured due to d	03/01/2020	

Resources

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

Timely Filing Denial

Timely Filing

- Message code CO-29 ; PR 29 (unassigned claims)
- 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

- An exception to the filing limit may be requested if good cause is determined **CMS defines good cause as**
 - Administrative error by Medicare contractor
 - Retroactive 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 Services

Excluded Services

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

Bundled Services

Bundled Services

- Message Code CO-97
 - Payment is included in another service on the same day
 - 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

Rejected Claims

Missing Procedure Modifier(s)

- Message code CO-16
 - Claim lacks information, and cannot be adjudicated
- MOA Code N822
 - Missing procedure modifier(s)
- Resolution
 - Verify claim submission
 - Submit a new claim w/required modifier
 - [Modifiers Used in CMS-1500 Claim Reporting](#)

Invalid Beneficiary Medicare Number

- Message code CO-16
 - Claim lacks information, and cannot be adjudicated
- MOA Code N382
 - Missing/incomplete/invalid patient identifier
- MOA code MA27
 - Missing/incomplete/invalid entitlement number or name shown on the claim
- Resolution
 - Verify MBI & beneficiary name as it appears on their card
 - Submit a new claim

Invalid Group Practice Information

- Message Code CO-16
 - Claim lacks information, and cannot be adjudicated
- MOA code MA 112
 - Missing/incomplete/invalid group practice information
- Resolution
 - Verify billing NPI in item 33 of the CMS-1500 or electronic equivalent
 - Submit a new claim

Rail Road Beneficiary

- Message Code C0-109
 - Claim/service not covered by this payer/contractor
- MOA code N105
 - This is a misdirected claim/service for an RRB beneficiary
- Resolution
 - Submit to the RRB contractor
 - [Palmetto GBA](#)

Ordering/Referring NPI

- Message Code CO-16
 - Claim lacks information, and cannot be adjudicated
- Remark Codes N265 and N276
 - Missing/incomplete/invalid ordering/referring primary identifier (NPI)
- MOA code MA13
 - Item/service not covered when performed, referred, or ordered by this provider
- Resolution
 - Verify NPI in item 17b of the CMS-1500 or electronic equivalent
 - [Ordering and Referring Claims Information](#)
 - Submit a new claim

CLIA Number

- Message Code CO-16
 - Claim lacks information, and cannot be adjudicated
- MOA Code MA120
 - Missing/incomplete/invalid CLIA number
- Resolution
 - Verify CLIA number in Item 23 of the CMS-1500 or electronic equivalent (Loop 2300 or 2400, Segment REF02, Qualifier X2)
 - Submit a new claim
 - [Clinical Lab Improvement Amendment](#)

Wrong MAC Jurisdiction

- Message Code C0-109
 - Claim/service not covered by this payer/contractor
- MOA code N104
 - This claim/service is not payable under our claims jurisdiction
- Resolution
 - Submit claim to the correct MAC
 - [Who are the MACs | CMS](#)

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	Redetermination (Appeal – first level)
To correct a claim(s) determination resulting from minor errors	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
- 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

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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- JK

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Thank You!

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

