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NGS MU NGSMEDICARE UNIVERSITY
MEANINGFUL • INFORMATIVE • SIMPLIFIED EDUCATION

Medicare Part B Common Billing Errors

9/22/2022

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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

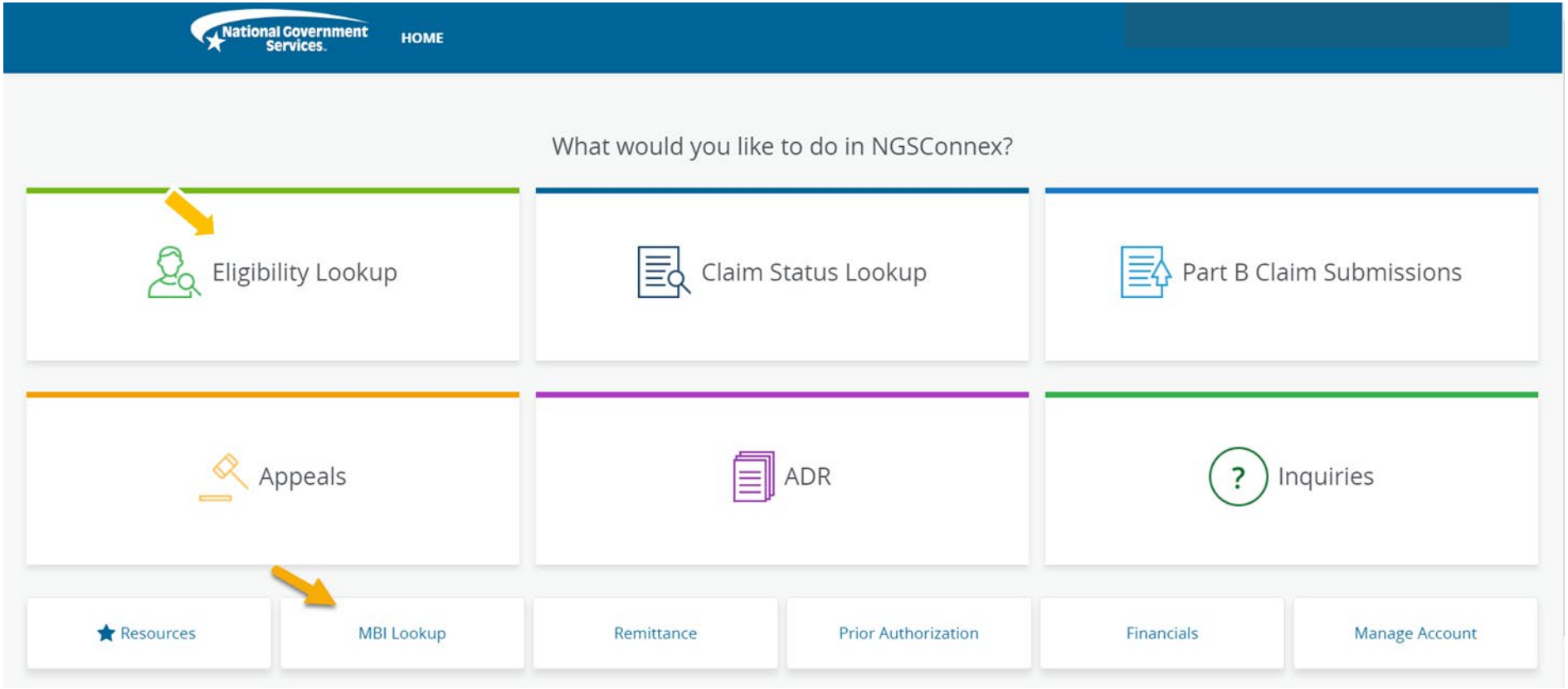
Medicare Advantage Plan Enrollee

- 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

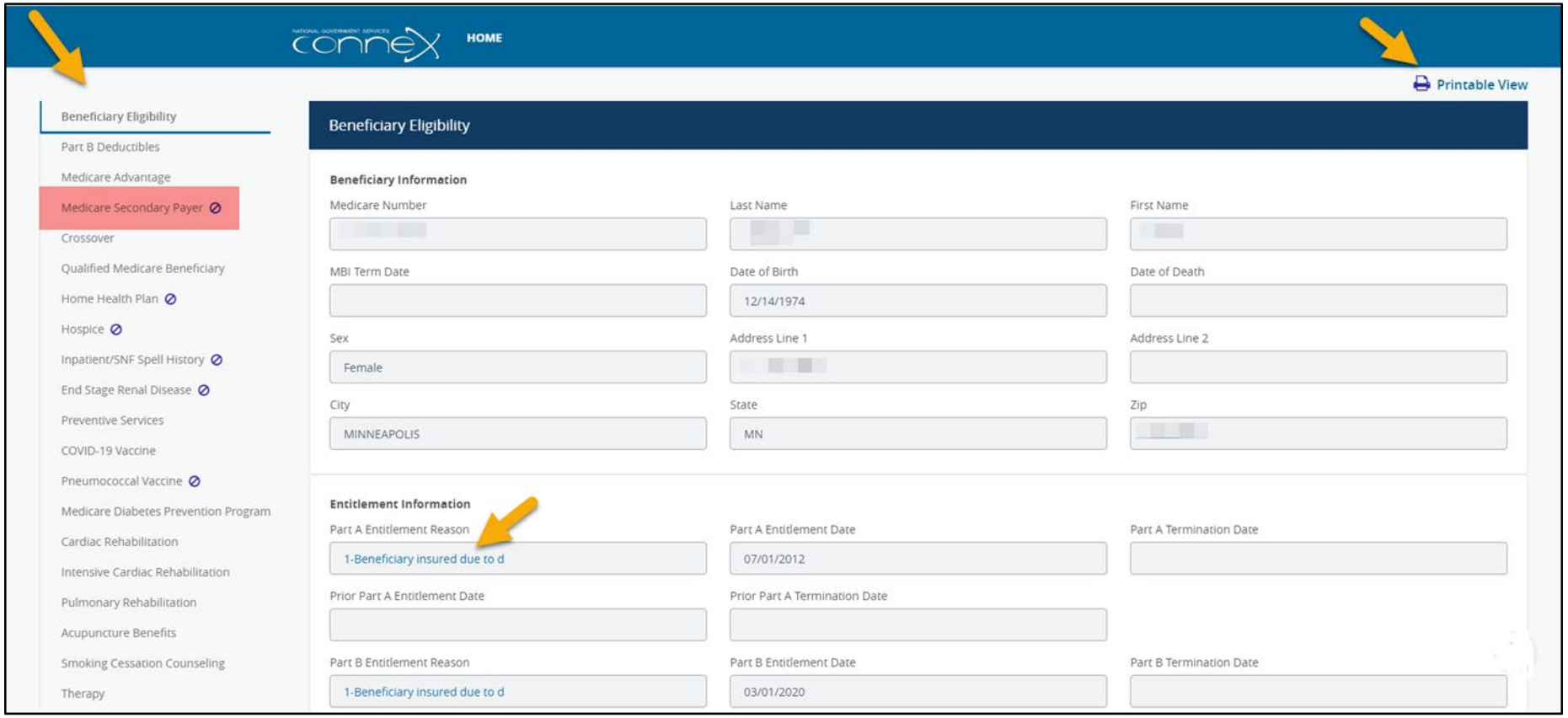
Eligibility Verification

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

NGSConnex Eligibility Verification



NGSConnex Eligibility Verification



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 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
- 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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Thank You!

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

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