Duplicate Claims
Part A and B

September 13 – 15, 2011

Presented By

First Coast Service Options, Inc.
Provider Outreach & Education

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Acronym List

- CMS – The Centers for Medicare & Medicaid Services
- CPT – Current Procedural Terminology
- DDE – Direct Data Entry
- DOS – Date Of Service
- FAQ – Frequently-asked Question
- FCSO – First Coast Service Options
- HCPCS – Healthcare Common Procedure Coding System
- IOM – Internet-only Manual
- IVR – Interactive Voice Response system
- PDS – Provider Data Summary
- RA – Remittance Advice
- WBT – Web-based Training module

Agenda Items

- Duplicate claims and costs
- Avoiding duplicate claims
- Common reasons for duplicates
- Tips and self-service tools
- Group exercises
- Questions and answers
- Additional resources
- Summary

Learning Objectives

- At the conclusion of this session you will be able to
  - Define a duplicate claim
  - Discuss how duplicate claims impact you financially
  - Know where to find tips and self-service tools
  - Be proactive and avoid duplicate claims

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Duplicate Claims and Costs

Duplicate Claims

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- What's a duplicate claim?
  - Exact duplicate of a previously submitted claim . . .
- Part A
  - Reject
- Part B
  - Denial

What are These Numbers?

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8

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Part B Duplicates: 2010

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9

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Part A Duplicates: 2010

Duplicate Claims Comparison

- Part A
  - January – July 2011: 16,408
  - January – July 2010: 17,353
- Part B
  - January – July 2011: 1,204,110
  - January – July 2010: 1,200,234

Associated Costs

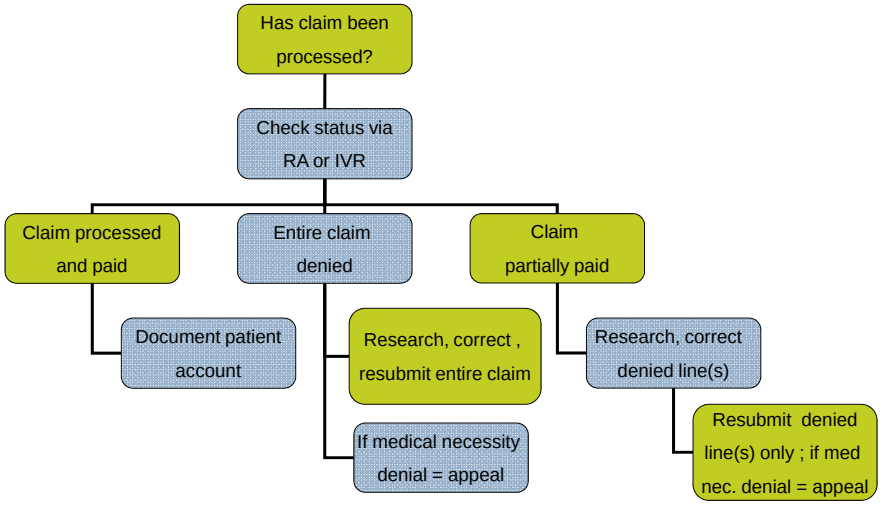
- Processing costs
- Employee costs
- Additional billing service costs
- Cost of non-productive effort
  - Paying for **nothing**

12

Avoiding Duplicate Claims

13

Avoiding Duplicate Claims-Part B



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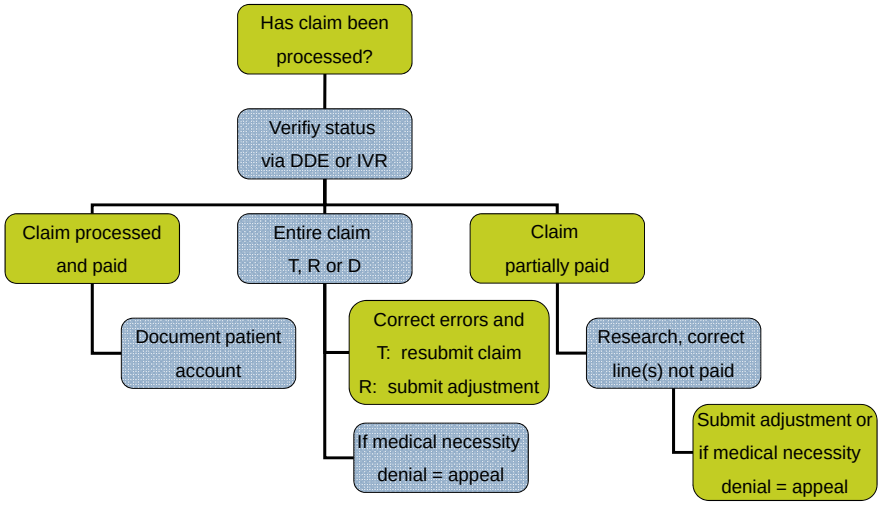
Avoiding Duplicate Claims-Part A



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Common Reasons for Duplicates

16

Common Reasons for Duplicates

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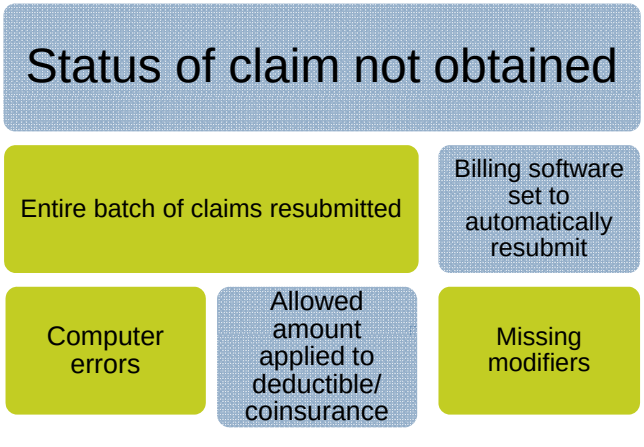

17

Modifiers

- Repeat Services—Same Day
  - Repeat services must be medically necessary and documented
    - Modifier 76 - same provider performed service
    - Modifier 77 – different provider performed service
    - If claim denies/rejects, can appeal

Modifiers (Continued)

- Unilateral/Bilateral Procedures-Same Day
  - Modifier RT – performed on right side only
  - Modifier LT – performed on left side only
  - Modifier 50 – performed bilaterally
  - If procedure code definition is “bilateral” or “unilateral or bilateral,” modifier is not applicable

Tips and Self-Service Tools

- Provider Data Summary (PDS) Report
- Tips on FCSO website
  - Part B: reason code CO18
  - Part A: reason codes 38031, 38035 and 38200
- IVR

20

Provider Data Summary (PDS) Report

21

Example of a PDS Report—Part B

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[redacted]

Reporting Period: MAR11 and APR11 By Paid Date

		APR11	% of total (A)	MAR11	% of total (B)	Change APR11-MAR11	% Change (B - A)	APR11 PEER AVG	% of total (C)	Diff(+/-)	%Diff(A - C)
Claim Totals	Total Allowed $	338,918		255,756		83,162		57,215		281,703	.
	Total Paid $	259,309		199,210		60,099		40,465		218,844	.
	Total Claims Paid	4,068		3,382		686		473		3,595	.
	Avg. Paid/Paid Claim	40		35		5		0		40	.
Claim Volumes (Services)	Paid	5,349	82.3%	4,482	76.9%	867	(5.40%)	854	82.8%	4,495	(0.50%)
	Denied	1,010	15.5%	1,027	17.6%	-17	2.10%	133	12.9%	877	2.60%
	Duplicate	62	1.00%	231	4.00%	-169	3.00%	15	1.50%	47	(0.50%)
	Subtotal (Processed)	6,421	98.8%	5,740	98.5%	681	(0.30%)	1,002	97.1%	5,419	1.70%
	Unprocessable	81	1.20%	90	1.50%	-9	0.30%	29	2.80%	52	(1.60%)
	Total	6,502	100%	5,830	100%	672	0.00%	1,032	100%	5,470	0.00%
Claim Billed Dollars (Services)	Paid	930,316	86.5%	709,661	81.4%	220,655	(5.10%)	111,113	90.2%	819,203	(3.70%)
	Denied	123,787	11.5%	109,001	12.5%	14,786	1.00%	6,688	5.40%	117,099	6.10%
	Duplicate	9,415	0.90%	25,787	3.00%	-16,372	2.10%	2,570	2.10%	6,845	(1.20%)
	Subtotal (Processed)	1,063,518	98.9%	844,449	96.9%	219,069	(2.00%)	120,371	97.7%	943,147	1.20%
	Unprocessable	11,958	1.10%	27,424	3.10%	-15,466	2.00%	2,860	2.30%	9,098	(1.20%)
	Total	1,075,476	100%	871,873	100%	203,603	0.00%	123,231	100%	952,245	0.00%
% of Services Received	Processed	98.8%		98.5%		(0.30%)		97.1%			
	Unprocessable	1.20%		1.50%		0.30%		2.80%			
% of Services Processed	Denied	15.7%		17.9%		(1.70%)		13.3%			
	Duplicate	1.00%		4.00%		(273%)		1.50%			
	Number of Patients	2,269		2,073		196					

Example of a PDS Report—Part A

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[redacted]

Reporting Period: MAR11 and APR11 By Paid Date

		APR11	% of total (A)	MAR11	% of total (B)	Change APR11-MAR11	% Change (B - A)	APR11 PEER AVG	% of total (C)	Diff (+/-)	%Diff (A - C)
Processed by Origin	Automated	10,625	73.6%	13,609	83.2%	-2,984	9.60%	7,890	73.8%	2,735	(0.20%)
	Hardcopy	3,811	26.4%	2,747	16.8%	1,064	(9.60%)	2,797	26.2%	1,014	0.20%
	Total	14,436	100%	16,356	100%	-1,920	0.00%	10,687	100%	3,749	0.00%
Processed by Place of Service	Inpatient Part A	2,395	16.6%	3,526	21.6%	-1,131	5.00%	844	7.90%	1,551	8.70%
	Hospital Based or Inpatient (Part B)	67	0.50%	152	0.90%	-85	0.40%	21	0.20%	46	0.30%
	Outpatient	11,974	82.9%	12,678	77.5%	-704	(5.40%)	8,631	80.8%	3,343	2.10%
	Other (Part B)	0	0.00%	0	0.00%	0	0.00%	1,192	11.2%	-1,192	(11.2%)
	Reserved for Natl Assignment	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
	Total	14,436	100%	16,356	100%	-1,920	0.00%	10,687	100%	3,749	0.00%
Processed by Category	Clean Claims	7,991	55.4%	10,505	64.2%	-2,514	8.80%	8,127	76.0%	-136	(20.6%)
	Rejected	500	3.50%	721	4.40%	-221	0.90%	187	1.70%	313	1.80%
	Duplicate Claim Rejects	90	0.60%	182	1.10%	-92	0.50%	26	0.20%	64	0.40%
	Sub Total	8,581	59.4%	11,408	69.7%	-2,827	10.3%	8,340	78.0%	241	(18.6%)
	Adjustments	4,399	30.5%	3,376	20.6%	1,023	(9.90%)	1,325	12.4%	3,074	18.1%
	Line Denial	1,456	10.1%	1,572	9.60%	-116	(0.50%)	1,022	9.60%	434	0.50%
	Sub Total	5,855	40.6%	4,948	30.3%	907	(10.3%)	2,347	22.0%	3,508	18.6%
	Total	14,436	100%	16,356	100%	-1,920	0.00%	10,687	100%	3,749	0.00%
Processed by DTR	0-15 days	7,692	53.3%	8,865	54.2%	-1,173	0.90%	5,416	50.7%	2,276	2.60%
	16 - 30 days	1,164	8.10%	1,698	10.4%	-534	2.30%	1,254	11.7%	-90	(3.60%)
	31 - 60 days	900	6.20%	1,305	8.00%	-405	1.80%	552	5.20%	348	1.00%
	61 - 90 days	336	2.30%	641	3.90%	-305	1.60%	246	2.30%	90	0.00%
	91 - 120 days	115	0.80%	383	2.30%	-268	1.50%	145	1.40%	-30	(0.60%)
	121 - 180 days	184	1.30%	392	2.40%	-208	1.10%	197	1.80%	-13	(0.50%)

Reason Code CO18

- **CO18: Duplicate claim/service**
  - Before resubmitting a claim, check claims status through the IVR
  - Do not resubmit an entire claim when partial payment made; when appropriate, resubmit denied lines only
  - If more than one face-to-face E/M for same related problem is provided by physician/more than one physician of same specialty in same group, physicians should select a level of service representative of the combined visits and submit the appropriate code for that level
  - Ensure necessary appropriate modifiers are appended to claim lines

Codes 38031, 38035 and 38200

- **Possible duplicate to a previously submitted claim**
  - Before resubmitting a claim, check claims status through the IVR, DDE, RA
  - Do not resubmit entire batches
  - If you need to make changes to an original claim, perform an adjustment rather than resubmitting the claim
  - Verify HCPC and modifiers coded on claim

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26

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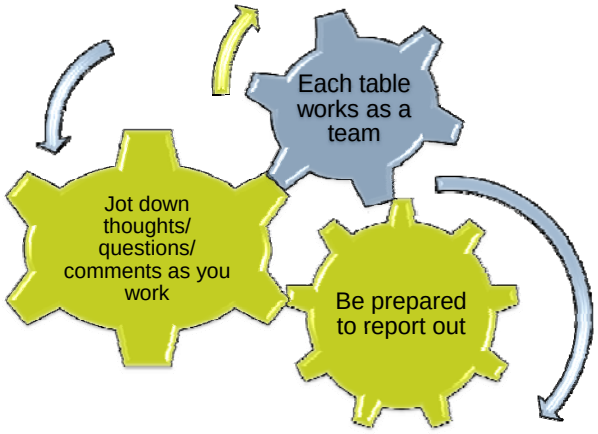
Group Exercises

27

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Group Exercises



28

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Group Exercises Report-Out

29

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Question & Answer Session

- What questions do you have?

30

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Additional Resources

31

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32

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FCSO Resources—Part A

- Resources applicable to this session
  - Top Part A inquiries
    - http://medicare.fcso.com/Inquiries_and_denials/137556.asp
  - Top Part A claims rejects
    - http://medicare.fcso.com/Inquiries_and_denials/156255.asp
  - Top Part A returned to provider (RTP) claims
    - http://medicare.fcso.com/Inquiries_and_denials/156256.asp
  - Top Part A Rural Health returned to provider (RTP)
    - http://medicare.fcso.com/Inquiries_and_denials/170982.asp
  - Top Part A Rural Health rejects
    - http://medicare.fcso.com/Inquiries_and_denials/194366.asp

33

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

FCSO Resources—Part A (Cont.)

- Resources applicable to this session
  - Appeals page
    - http://medicare.fcso.com/Appeals/index.asp
  - IVR page
    - http://medicare.fcso.com/IVR/
  - DDE page
    - http://medicare.fcso.com/Direct_data_entry/
  - Remittance Advice
    - http://medicare.fcso.com/Remittance_advice/
  - Self-audit resources page (PDS report)
    - http://medicare.fcso.com/Landing/200831.asp

34

FCSO Resources—Part B

- Resources applicable to this session
  - Top Part B inquiries
    - http://medicare.fcso.com/Inquiries_and_denials/137688.asp
  - Top Part B claim denials
    - http://medicare.fcso.com/Inquiries_and_denials/156449.asp
  - Top Part B RUCs
    - http://medicare.fcso.com/Inquiries_and_denials/156451.asp
  - Top Part B Rural Health claim denials
    - http://medicare.fcso.com/Inquiries_and_denials/149010.asp
  - Top Part B Rural Health RUCs
    - http://medicare.fcso.com/Inquiries_and_denials/194368.asp

35

FCSO Resources—Part B (Cont.)

- Resources applicable to this session
  - Modifier FAQs
    - http://medicare.fcso.com/FAQs/138438.asp
  - Appeals page
    - http://medicare.fcso.com/Appeals/index.asp
  - IVR page
    - http://medicare.fcso.com/IVR/
  - Remittance Advice page
    - http://medicare.fcso.com/Remittance_advice/
  - Self-audit resources page (PDS report)
    - http://medicare.fcso.com/Landing/200831.asp

36

Centers for Medicare & Medicaid Services

www.cms.gov

37

CMS Resources

- Resources applicable to this session
  - Internet Only Manual (IOM)
    - http://www.cms.gov/Manuals/
  - National Correct Coding Initiative Edits (NCCI)
    - http://www.cms.gov/NationalCorrectCodInitEd/

38

Summary of Today's Topics

- Today we have reviewed
  - Duplicate claims—Part A and Part B
  - How duplicate claims impact you financially
  - How you can be proactive and avoid duplicate claims
  - Some of the top reasons for duplicate claims
  - Where to find tips and self-service tools

39

Thank You for Participating

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- FCSO values your feedback
  - It is important that you complete the evaluation form and return it before leaving the class

40

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Duplicate Claims
September, 2011
PART A GROUP EXERCISE

1) **What's the FIRST step to find out if your claim has been processed—AND also to AVOID duplicate claims?**

2) **What are some resources to use pertaining to question #1 above?**

3) **What are the steps to take if your claim rejects as a duplicate?**

4) **What are the steps to take if your claim DENIES for medical necessity?**

5) **What happens if you <u>resubmit</u> a claim that denied for medical necessity?**

6) What happens if you correct one claim and resubmit the ENTIRE batch of claims?

7) What tool can you use to monitor the volume of duplicate rejects (compare month to month) in your facility?

8) Discuss (and be prepared to share) applicable steps to take if your findings indicate that your volume of duplicate rejects is increasing.

9) EXTRA CREDIT: What did Mary really want to call this class? What are we going to do?

Duplicate Claims
September, 2011
PART B GROUP EXERCISE

1) **What is a duplicate claim? What are some characteristics/elements of a duplicate claim?**

2) **If a claim is partially paid, what step(s) do you take in attempt to get the rest of the claim paid? What should you NOT do? Why not?**

3) **A patient is seen in the office and gets an EKG. The patient returns later that day and gets a second EKG---by same provider. How should these services be submitted to Medicare?**

4) **What happens if you resubmit a claim that denied for medical necessity? How should you handle a claim that denies for medical necessity?**

5) A patient is treated for a broken hand. How can the provider "tell" us (via the claim) that it was the patient's right hand?

6) When is it applicable to use modifier 76?

7) What if you did use modifier 76 and your claim still denied as a duplicate? What steps can you take?

8) What's ALWAYS the first step before resubmitting a claim—AND also to avoid duplicate claims? And what are some resources you can use to do this?

9) EXTRA CREDIT: What did Mary really want to call this class? What are we going to do?