# Part B Insider (Multispecialty) Coding Alert

## Part B Coding Coach: Cut Duplicate Claims With This Expert Insight

**Tip: Review the basics on repeat modifiers to decrease denials.**

If Medicare denials are piling up at your practice, you need to figure out why. Duplicate claims are a common culprit, but you can sidestep this problem by following a few steps and appending the correct modifier.

That was the word from **Michelle Coleman, CPC**, and **Arlene Dunphy, CPC**, provider outreach and education consultants, with the Part B Medicare Administrative Contractor (MAC) National Government Services (NGS) in the recent webinar "How to Avoid Duplicate Claim Denials."

Heed their expert advice to make sure you don't fall into the trap of submitting duplicate claims at your practice.

**Watch Out for These Common Issues**

"When a claim comes into the system, we compare elements to identify an exact duplicate," Coleman said. "When the claim comes into the front end, we're looking at certain elements."

These elements include:

- Medicare Beneficiary Identifier (MBI) or provider number
- From date of service
- Through date of service
- Type of service
- Procedure code
- Place of service
- Billed amount

When the claim comes in, if the system already has a claim that's processed or is in process with the same elements, it's either going to be held up, suspended, or will be denied as a duplicate, Coleman explained.

**Avoid these hassles:** Submitting duplicate claims can cause several problems such as delaying payment, increasing administrative costs to the Medicare program, being identified as an abusive biller, or resulting in an investigation for fraud if a pattern of duplicate billing is identified, Coleman said.

"We get a report once a month of the top 100 providers who have submitted the most duplicate claims," according to Coleman. "We review the report, and if you are on that report, you could be getting a call from the provider outreach and education department. We try to work with the provider, and the majority of the time, it's a system glitch the provider had no idea was happening. So, they can either go to their vendor or their clearinghouse and have the problem rectified."

However, Coleman added that if they see you are still submitting duplicate claims after the provider outreach department has spoken to you, you could be identified as an abusive biller and be investigated for fraud.

**Circumvent Denials With 6 Handy Steps**

Coleman shared some helpful steps you can follow to avoid denials in your practice.

**Step 1:** Check your remittance advice for the previously posted claim.

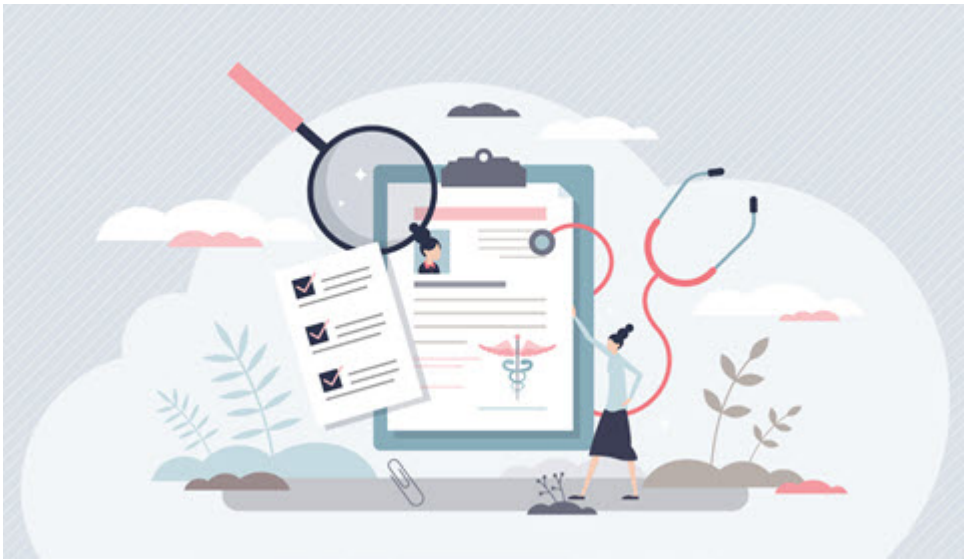
**Step 2:** Verify the reason the initial claim was denied.

**Step 3:** Don't just resubmit to correct a denial.

**Step 4:** Use the interactive voice response (IVR) or NGSConnex to check on current claim status.

**Step 5:** Allow 30 days from the receipt date.

**Step 6:** Make sure your billing service/clearinghouse is waiting the appropriate time frame.



**Append Repeat Modifiers Properly**

When you are submitting claims for multiple instances of services or procedures, your claims should include an appropriate modifier to indicate that the service or procedure is not a duplicate, Dunphy said.

You will accomplish this by using a modifier depending upon your case and what you're billing for because that's what is

going to allow your claim to go through the system, get processed, and be paid, Dunphy added.

Take a look at some common repeat modifiers you might see:

**Modifier 76** (Repeat procedure or service by same physician or other qualified health care professional)

Appropriate uses for modifier 76:

- Same procedure or service performed on the same day.
- On a procedure code in which quantity or number of units cannot be billed.
- List procedure code on the first line, and then again with modifier 76 (second line item).
- Second line item will have the appropriate quantity billed amount.

Inappropriate uses for modifier 76:

- Do not add to each line of service.
- Do not use it for repeat services due to equipment or other technical failure.
- Do not use for services repeated for quality control purposes.
- Modifier 76 cannot be used with an evaluation and management (E/M) code.

**Modifier 77** (Repeat procedure by another physician or other qualified health care professional)

Appropriate uses for modifier 77:

- Add to the professional component of an X-ray or EKG procedure when a different physician repeats the reading because another physician's expertise is needed or when the patient has two or more tests, and more than one physician provides the interpretation and report.
- Add when billing for multiple services on a single day and the service cannot be quantity billed.

Inappropriate uses for modifier 77:

- Do not add when billing for multiple services bundled based on National Correct Coding Initiative (NCCI) edits.
- Modifier 77 cannot be used with an E/M code.

### **Modifier 91** (Repeat clinical diagnostic laboratory test)

**Appropriate use for modifier 91:** It is appropriate to use modifier 91 for a subsequent medically necessary laboratory test on the same day of the same laboratory test.

Inappropriate uses for modifier 91:

- Due to testing problems for the specimen or testing problems of the equipment
- Rerun of a laboratory test to confirm results
- When the procedure code describes a series of tests.