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Duplicate Script

Thank you for taking the time today to join me to learn about duplicate claims.

Today's agenda:

- Identifying the top reasons for duplicate claims denials
- Tips to avoid those denials, and
- The resources available to help you

[Wisconsin Physicians Service] WPS Medicare has four states within our jurisdiction: Wisconsin, Illinois, Michigan, and Minnesota. We process approximately 5.8 million claims annually, and approximately 5.5% of those claims are duplicates. CMS' target goal for duplicate claims denials is 1% of claims processed. That means that we still have work to do.

How does it cost a provider to file a duplicate claim? First of all you need to consider how much it cost to actually send your claim to Medicare. Yes, there are costs for claims submission, but there are also costs for preparing a claim, and doing the other work that needs to be completed in order to get those claims filed. Let's say that on average a claim costs you \$2.00. Then that means that in our provider community at 5.8 million claims times \$2 that 11.6 million dollars is spent annually for processing claims, of which \$638,000 is spent annually on duplicate claims.

Remember, time is money and is one of the factors you need to consider. How much does it cost you [in] time? How does it cost you money in that way? Well, someone needs to keep records in your office; someone needs to be calling Medicare to find out how it is a duplicate or to research records. Someone also spends time deciding if an appeal is appropriate. Therefore, there is possibly one person, or more, whose time is dedicated solely to looking and researching claims that come back as duplicate denials. Again, time is money.

How does it cost Medicare when Medicare processes a duplicate claim? Well, on average it costs Medicare \$0.96 to process a claim. That is WPS Medicare's cost; we are the lowest price cost contractor in the United States. So if you take that \$0.96 times 319,000 claims, you've got \$30,624 a year just spent on processing duplicate claims. And if we divide that \$30624 by 4, because we have 4 states in our jurisdiction, we get \$7,656. On a national level, if we take \$7,656 times 50 we have got a potential of approximately \$400,000 coming out of the Medicare trust fund just for processing duplicate claims annually. That is a big amount of money that we can hopefully avoid or reduce.

So, how does it cost us money to process a duplicate claim? Well, WPS Medicare has to have a processing system in place with a certain amount of money built in for each claim that is processed. We have to be able to answer all phone calls, whether they come in on the inquiry or appeals lines. We also have time spent by our Medical Review staff looking at records and other things that you are submitting, possibly an appeal of in other areas. Medicare also has something called a Comprehensive Error Rate Testing (CERT) contractor. They review the claims processed by WPS Medicare and all other



carriers and processors within the United States. This program also costs money; each process in the different areas has to be accounted for when you figure the amount of money it costs WPS Medicare to process a duplicate claim.

The number one thing that we want you to know is that you should be looking at your remittance advices to find out if you have a duplicate claim. We do send those back electronically or in paper depending on what format you choose to receive. If you are looking at a remittance advice, you would want to look for a remarks code of CO-18 on your remittance advice. That stands for duplicate claims. There are reason codes that will sometimes come with that, but many times the remarks code will just be duplicate claims. A couple of other areas of the remarks code that you might see are services denied because payment was already made on the same claim or similar procedure within that timeframe that is a duplicate claim. We just want you to be aware of that one also.

Duplicate claims fall into three categories. So let's take a look at those. Duplicate charges previously paid on another claim is the largest category at 53% of all the duplicate claim denials. Duplicates of charges now in processing is 44%, and 3% fall under the duplicate of another service on this claim. Which is the exact same claim you submitted; there is a duplicate on it. If you think about it, charges now being processed means that someone did not check claims status on the IVR or on C-SNAP. By simply checking status and finding out your claim is processing, you could avoid 44% of your duplicate claims denials.

What I would like to do now is just take a minute to look at a couple of myths versus realities.

- It is a myth that resubmitting a claim will speed up payment. The reality is it does not change the processing time; it is really going to stay the same. It is 14 days to process an electronic claim and 29 days to process paper claims. Please remember that resubmitting does not help you in any way.
- Resubmitting a claim extends the period for which you have to request an appeal. That is not true. All appeals are based on the original claim submission, so if you submitted a claim because you were outside your 120 days appeal time and you are thinking that is going to help you get more or another 120 days, that is actually incorrect. We cannot do an appeal on a duplicate claim.
- Resubmitting saves time. Well, you may think that is true, but at some point, once you find out this is a duplicate claims submission, you have to go back and do that research anyway. It is not saving anyone time or money if you are doing research on the backend.
- And it is not OK to routinely resubmit a claim without checking the status. CMS considers this to be abuse. They want you to do your job, which is to check the status and make sure everything is done up front. It just makes it a little bit easier that way.

Where can you verify claim receipt?

- You can call the IVR.
- You can check C-SNAP if you are using that tool.
- You can look at your electronic pre-pass edits if you're using those.



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- Or check to make sure you did not get anything back from the mailroom, our WPS Medicare mailroom, if you are submitting on paper.

Where can you verify claims processing?

- You can check your remittance advice electronically or on paper.
- You can check C-SNAP.
- You can check the IVR.

This slide simply talks about whether or not you should resubmit. Do not resubmit if the claim is currently in process. Do not resubmit if the original claim was approved and paid or approved and not paid this means the claims was approved and went to patient deductible. This is not something we can change or adjust.

The original claim is denied correctly based on the information submitted, whether it was denied for medical necessity or a variety of other denials, resubmitting these claims will only cause duplicate denials.

If a claim is denied as unprocessable, then that claim is considered to have never been entered into our system. You should correct whatever was wrong with it and resubmit it. This is also true if the original claim was denied in error due to some information that was entered in error. You should correct the information and resubmit the claim. And always resubmit if the claim is not actually in our system and you cannot verify that we've received it. We would like to provide you with some guidelines about when to resubmit, how long to wait, and what to look for.

- First of all, as I mentioned earlier, it takes 14 days for an electronic claim to process, that is an important number to know.
- It takes 29 days for a paper claim to process.

So, if anything, and you want to resubmit, you need to at least wait these amounts of time; however, WPS Medicare recommends that you wait 60 days. Why 60 you may ask? Well, if there is development that needs to be done, or anything else that needs to occur, that 60 days will allow for that time frame to occur. Therefore, we recommend that you wait 14 days to allow the electronic claims to process and give us 45 days if there is any development that needs to be done. Combining those together you've got 60 days, that's where we get our number. So again, we would really appreciate it if you would wait 60 days before you resubmit.

Always check your remittance advice for other denied charges and whether or not they are the patient's responsibility. Make sure that you enter the information on the remittance advice into your records timely so that the people submitting claims within your office can identify services that have already been paid. So please, check your remittance advice and make sure everything is entered timely.

If you have a billing service, verify their submission dates. Verify they are not submitting routinely every so often and never less than the payment floor of 14 days for the electronic claims submission. If they submit every 10 days, you're automatically going to have duplicate claim denials. Also, it can cost you a lot of money to have this happen, so



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talk to your billing services, and talk to your vendors to make sure this is not happening. Find out how much you are being charged each time they submit a claim.

One of the other areas that we looked at, which is the smallest percent of duplicate denials, is a duplicate service on a claim denial. Duplicate lines happen when you bill two services on the same day. Our system looks at these as duplicates. It could be they should have a modifier, or perhaps something else to indicate they are not actually the same service. Please make sure you are including modifiers and all information needed in this situation. Also duplicate lines occur when you have a line that needs to be resubmitted, just one that needs to be resubmitted, and you submit the other 4 lines on a claim that were already paid. That is going to cause four duplicate lines plus on the second submission that will not get paid the second time. Please make sure that if you have a claim that has certain lines already submitted and rejected or paid, that you do not resubmit those lines. Just resubmit the denied lines you with corrections for Medicare to reconsider.

Thank you and have a good day.