Claim Submission Errors - Prevent unnecessary errors!

Are you filing your Medicare claims and making the same mistakes with each submission? You can prevent and reduce the number of claim submission errors and denials that you are receiving. The Provider Outreach and Education team offers education to help reduce claim rejections and denials that are returned to providers. The information below will assist you and your billing staff with filing claims or making corrections to denied claims.

Old Edits - Continuous denials

Returned Unprocessable Errors (RUC) are caused by incomplete or invalid information that is necessary to process the claim. The "Returned Unprocessable Claim" edits have been in effect since April 1996 and is still a top area of errors.

The edit process was developed by the Centers for Medicare and Medicaid Services (CMS) in an effort to reduce costs and administrative waste. This editing process returns paper and electronic claims to the provider as unprocessable. No appeal rights are afforded to these claims, or portion of these claims, because no "initial determination" can be made, therefore rendering the claim unprocessable. The billing staff should make corrections and must resubmit claims.

This listing is updated quarterly.

Claim Submission Errors

We have printed the top RUC denials for claims received October 1, 2011 through December 30, 2011 in an effort to help educate the provider community. These denials totaled **341,006** (**3rd qtr - 455, 066**) claims returned as unprocessable. This was a 33% decrease from the last quarter. The Reason Code, Remark and/or the Medicare Outpatient Adjudication (MOA) codes associated with the RUC denial identify each of these denials on the Provider Remittance Advice. These Reason Codes will alert you that the claim is a RUC denied claim.

The following is a list of the top RUC denials received in the fourth quarter of 2011.

Type of RUC Denial	Claim Count	Remark Code
Group Practice Information	**50,369**	**MA112:** (MOA Code) Missing/incomplete/invalid group practice information **N256:** Missing/incomplete/invalid billing provider/supplier name **N257:** Missing/incomplete/invalid billing provider/supplier primary identifier **N258:** Missing/incomplete/invalid billing provider/supplier address
Place of Service	**44,658**	**M77:** Missing/incomplete/invalid place of service
Invalid Patient Name	**41,585**	**MA36:** (MOA Code) Missing/incomplete/invalid patient name
Procedure and Modifier Inconsistent	**40,697**	**MA130:** (MOA Code) **CO 4**: The procedure code is inconsistent with the modifier used or a required modifier is missing
Billing Provider Primary Identifier	**38,922**	**N257**: Missing/incomplete/invalid billing provider/supplier primary identifier. **N290**: Missing/incomplete/invalid rendering provider primary identifier **N293**: Missing/incomplete/invalid service facility primary identifier **N297**: Missing/incomplete/invalid supervising provider primary identifier
Referring Provider Primary Identifier	**38,565**	**N285:** Missing/incomplete/invalid referring provider name **N286:** Missing/incomplete/invalid referring provider primary identifier
Clinical Laboratory Improvement Amendment Act (CLIA)	**31,130**	**MA120**: (MOA Code) Missing/incomplete/invalid CLIA certification number
Invalid Diagnosis	**22,638**	**M76:** Missing/incomplete/invalid diagnosis or condition **M81:** You are required to code to the highest level of specificity
Rendering Provider Primary Identifier	**18,673**	**MA130:** Your claim contains incomplete and/or invalid information...the claim is unprocessable **N290:** Missing/incomplete/invalid rendering provider primary identifier
Invalid days or units	**13,769**	**M53:** Missing/incomplete/invalid units or days of service

1. **Group/Rendering provider information missing:** Missing/incomplete/invalid group practice information. This error occurs when the claim is coded with the groups' NPI in block 24J (2310B/2420A EMC) **and** 33A on 1500 claim form (2010AEMC) or the rendering physicians' NPI is in 24J **and** 33A. If the rendering physician is part of a group, the rendering physician's NPI should be in 24J and the groups' NPI should be in 33A.

2. **Place of Service (POS):** This error is caused when the place of service billed on the claim is invalid or inconsistent with the procedure code billed. Providers are billing with a place of service code that is not compatible to where the service is being rendered. In order to eliminate this error, providers should verify that they are reporting the POS code that applies to the setting in which the service was provided *and* that the submitted procedure code is compatible with that POS. For example, Office or Other Outpatient (procedure codes 99201-99215) should be billed with POS codes 11 (Office), POS 22 (Outpatient Hospital), etc., while home service (99341-99350) should be billed with POS 12 (Home). For a complete listing of place of service codes and definitions, refer to the CMS Internet Online Manual, Pub.100-04, Medicare Claims Processing, Chapter 26, Section 10.

3. **Invalid patient's name:** Missing/incomplete/invalid patient name which means that the patients name does not match what Medicare has on file. The name must be submitted exactly as it appears on the beneficiary's Social Security Card. If the beneficiary has had a name change that does not reflect on the Social Security Card, the name still has to be submitted as on the card until an update has been made with Social Security.

Please include apostrophes, spaces and/or hyphens and Jr. / Sr. suffixes. It is very important that you submit the patient's complete name and HIC number to Medicare or any other health care provider you use. This will ensure that those providers have the correct patient information to file their claims as well.

4. **Procedure and modifier inconsistent:** The procedure code is inconsistent with the modifier used or a required modifier is missing: A common error among providers is billing an inappropriate modifier with a procedure code or the modifiers submitted on the line form an invalid or conflicting combination. Please see the modifier section for correct use of modifiers for Medicare billing. In addition, providers should make sure that their CLIA certificate support services billed with or without modifier QW.

5. **Billing provider information:** Providers are submitting claims with missing, incomplete or invalid billing information. This error occurs when provider is submitting claims with the incorrect NPI number in the billing provider field. Providers should verify that the correct type 1 NPI organizational number is being billed appropriately. There may be multiple facilities under the same tax identification number (TIN). For example, you may have a clinic/group organization and an Ambulatory Surgery Center (ASC) with the same TIN. There should be a separate organizational NPI for the clinic billing number and one for the ASC facility.

6. **Referring provider primary identifier:** The referring provider NPI is missing or invalid. Ensure that the NPI for the referring physician is entered on the claim if applicable. This will allow the claim to pass thru the pre-pass EDI edits instead of rejecting. If the service or item was ordered or referred by a physician, enter the name of the referring or ordering physician in 17 and the NPI of the referring/ordering physician should be listed in item 17b of the Form CMS-1500 (8/05). For services that require a referring physician see manual: https://www.cms.gov/manuals/downloads/clm104c26.pdf.

7. **Clinical Lab Improvement Amendment (CLIA):** Providers are submitting clinical labs with the following errors: omitting the CLIA certification number on the claim, transposing the CLIA number, typing the letter "O" for the number "0", the CLIA certification number does not cover the laboratory service billed to Medicare or the certification has lapsed. In order to eliminate this denial, make sure that you include your CLIA certification number in block 23 of the CMS-1500 Claim Form or Loop 2300/2400 on EMC claims. Providers should make sure that your CLIA certification is current and includes all the laboratory services you provide in your office. If you need to upgrade your certification contact your local state agency at http://www.amconlabs.com/faq/CLIA_State_Agencies.pdf. The lists of clinical laboratory tests approved as waived can be viewed at http://www.cms.gov/CLIA/downloads/waivetbl.pdf. Providers can refer to the MLN brochure on CLIA to locate information on the different types of CLIA certificates at http://www.cms.gov/MLNProducts/downloads/CLIABrochure.pdf.

8. **Invalid Diagnosis:** Claim/service lacks information which is needed for adjudication (the diagnosis is either not a valid diagnosis code or need to be carried out to the highest level). The Centers for Medicare and Medicaid Services (CMS) require all Medicare practitioners to use an ICD-9-CM code that provide the highest degree of accuracy and completeness, or the **greatest specificity.** That usually means providing an ICD-9-CM code carried to the 5th digit or as high as the diagnosis code is listed. For example, diagnosis code 482.3 should be filed as 482.30. Medicare does not accept decimal points in diagnosis codes.

9. **Rendering National Provider Identifier (NPI):** Providers are submitting claims for their group/clinic without the rendering NPI on the claim. In order to eliminate this error, always include the Group NPI (Type 1 Organizational NPI) in Item 33a of the CMS-1500 Claim Form or Loop 2010AA on EMC claims along with your individual NPI (Type 2 Individual NPI) in item 24J or Loop 2310B/2420A, REF02 (1C) on EMC claims.
This error also occurs when the individual provider does not have a reassignment on file with the billing group. Offices should make sure that they have submitted the appropriate CMS 855 application to Cahaba GBA for all active physicians and non-physician practitioners who are eligible to submit claims for Medicare Part B services.

10. **Invalid Days/Units:** Providers are submitting claims with missing or invalid units for the quantity billed and incorrect span dates for office and hospital visits. For example, a claim contains two numbers of services with a single date of service, but Medicare only recognizes that a service with one number of service. Claim review found that providers are billing CPT code 69210 (Surgical procedure cerumen removal or ear wax removal) with two units for one date of service. CPT coding manual describes this code as removal impacted cerumen, 1 or both ears; therefore, our system will deny as RUC when billed in manner described above. A final review found that when a subsequent hospital visits is billed with span dates with one unit of service.

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