

Top 10 Claim Mistakes...

and how to correct them

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Overview

Top 10 claim mistakes

1. Duplicate Claims
2. Eligibility
3. Payer ID Missing or Invalid
4. Billing Provider NPI Missing or Invalid
5. Rendering Provider NPI Missing or Invalid
6. Diagnosis code Invalid or not effective on Service Date
7. Procedure code Invalid
8. Claim Frequency Code
9. Zip Code
10. Smart Edits

Claim rejections

- One or many errors found before processing.
- May be a clerical error, but a result of mismatched ICD and procedure codes.
- Prevents insurance companies paying as is.
- Requires corrections and resubmission.



Claim denials

- Processed and deemed unpayable by the payer (explanation provided).
- May violate terms of the payer-patient contract.
- May contain errors caught after processing.
- Can be appealed yet process is time-consuming and costly.



Mistake 1: Duplicate Claims

Duplicate claims mistakes

A duplicate claim is a claim from the same provider for the:

- Same patient
- Same item/service
- Same date of service



May lead to or result in: delay in payment or identification as an abusive biller

Most common rejection descriptions

- Duplicate Claim: Invalid; Claim submitted previously
- Duplicate of a previously process claim/line
- Duplicate Claim

Unnecessary filing duplicate claims cost healthcare offices valuable time and resources to process these rejections.

Tips for avoiding: Duplicate claims

1. Check remittance advice for previously processed claim.
2. Verify reason initial claim was denied/rejected.
3. Modifier requirement.
4. Submit an appeal for denied claims providing documentation with a redetermination request (if payer requires such form).
5. Do not resubmit claims while identical claim is pending.

Avoid automatic re-billing:
Re-billing unpaid claims to payers can produce duplicate claim rejections.

Always check status of a claim(s) before resending – clearinghouse and/or the payer.

Mistake 2: Eligibility

Cost of eligibility

Costs \$2.55 on average for an employee to perform an insurance verification.

10 minutes can save you thousands.

Based on a published article dated October 13, 2012

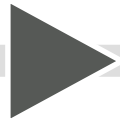
Verifying eligibility

Front desk staff should gather accurate patient information before or during patient registration.

1

Scheduling

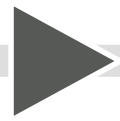
Collect patient demographic and insurance information on the phone. Verify eligibility and benefits.



2

Pre-visit

Re-verify eligibility and benefits a few days before the patient's visit.



3

Check-in

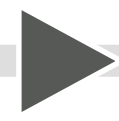
Verify patient demographic and insurance information at time of check-in.



4

Forms

Ensure completed forms match patient identification and demographic information collected.



5

Return visit

Ask patient to review print out of forms to verify information is correct.

Most common eligibility descriptions

- Ack/reject inval info - entity's contract/member number. usage: this code requires use of an entity code. - insured or subscriber
- Ack/returned - subscriber and subscriber id not found
- Ack/reject inval info - subscriber and subscriber id not found
- Ack/reject inval info - entity not eligible for benefits for submitted dates of service. usage: this code requires use of an entity code. - patient

Tips for avoiding: Eligibility


- Obtain copies of the patients insurance card.
- Check data for data entry errors.
- Verify dates of eligibility.
- Verify benefit coverage.
- Obtain authorization when needed.



Mistake 3: Payer ID Missing or Invalid

Most common payer ID descriptions

- Common Payer ID Missing or Invalid Mistakes Description
- Payer Id Missing or Invalid


SIGN UP FOR DEMO

Browse Claims Payers

SEARCH BY PAYER NAME

LINE OF BUSINESS

SEARCH BY PAYER ID

STATE

CLEAR FILTERS
DOWNLOAD PAYERS LIST

| PAYER NAME (GW PAYER ID) | PROFESSIONAL | | | INSTITUTIONAL | | | DENTAL | | | ELIGIBILITY (V/N) |
|---|--------------|-----------------|--------|---------------|-----------------|--------|--------|-----------------|--------|-------------------|
| | CLAIM | SECONDARY CLAIM | REMITS | CLAIM | SECONDARY CLAIM | REMITS | CLAIM | SECONDARY CLAIM | REMITS | |
| Park District Risk Management (G5019) | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | |
| 1199 National Benefit Fund (G1242) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | ✓ |
| 1st Auto And Casualty (G3475) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | |
| 21St Century Insurance (G1755) <small>View Alternate Names</small> | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | |
| 21St Century Insurance And Financial Svc (G1844) | ✓ | | ✓ | ✓ | | | | | | |
| 22125 Roscoe Corp (G3834) | ✓ | | | ✓ | | | | | | |
| 3P Admin (G1318) | ✓ | ✓ | | ✓ | ✓ | | | ✓ | | |
| 888 Ohiocomp (G3221) | ✓ | ✓ | | | | | | | | |
| A & I Benefit Plan Administrators (G2360) | ✓ | ✓ | | ✓ | ✓ | | | ✓ | | |
| A.D.N. Administrators Inc (G5140) | | | | | | | ✓ | ✓ | | |
| AAA Minnesota Iowa (G2150) | ✓ | | | ✓ | | | | | | |
| AAA Northern California Nevada and Utah Insurance (G3835) | ✓ | | | ✓ | | | | | | |
| AAG Benefit Plan Administrators (G2178) | ✓ | ✓ | | ✓ | ✓ | | | | | |

Tips for avoiding: Payer ID Missing or Invalid

- Verify correct payer ID matches line of business.
 - Institutional vs. Professional vs. Dental
- List secondary payer if secondary insurance is attached.
 - Verify the correct/current payer ID being used



Mistake 4 & 5: Billing Provider/ Rendering Provider

Billing provider vs rendering provider

Billing Provider

The entity or provider that the payer issues payment.

- Box 33 on a paper claim format.
- Loop 2010AA within the electronic claim format.

Rendering Provider

The provider who actually performed the services.

- Box 24J on a paper claim format displays the Rendering Provider NPI.
- Box 31 on a paper claim format displays the name of the Rendering Provider.
- Loop 2310B Segment NM109 within the electronic claim format = Rendering Provider NPI.
- Loop 2310B Segment NM103 within the electronic claim format = Rendering Provider Name.

Common billing provider descriptions

- Ack/reject relational - submitter not approved for electronic claim submissions on behalf of this entity. Usage: this code requires use of an entity code. - Billing provider
- Ack/reject relational - entity's national provider identifier (npi). Usage: this code requires use of an entity code. - Billing provider
- Ack/reject inval info - entity's national provider identifier (npi). Usage: this code requires use of an entity code. - Billing provider
- Enrollment: required: provider is not enrolled/approved for edi claims with this payer
- Billing provider npi missing or invalid
- Billing provider taxonomy code missing or invalid
- Billing provider address: invalid > cannot be a PO BOX

Tips for avoiding: Billing provider

- Confirm credentialing:
 - Billing provider with the payer(s).
 - Billing provider with the clearinghouse to submit electronic claims.
 - NPI (group or individual).
 - Tax ID.
- Confirm the correct billing taxonomy is being used.



Common rendering provider descriptions

- Rendering Provider; Not enrolled with Payer
- Rendering Provider Information: Required; Must be entered for Payer
- Rendering Provider Taxonomy Code
- Rendering Provider NPI; Must Match the NPI registered with Payer



Tips for avoiding: Rendering provider

- Confirm credentialing:
 - Rendering provider with the payer(s).
 - Rendering provider with the clearinghouse to submit electronic claims (if submitting as an individual).
 - NPI; and rendering provider NPI with tax ID.
- Confirm the correct rendering provider taxonomy is being used for the service provided.



Mistake 6: Diagnosis Code

Diagnosis code changes yearly

Each year new, changed and deleted diagnosis codes are released and become effective or deactivated on October 1.



Bookmark: [Link](#) to access new codes, deletions and/or code revisions from CMS.

Common diagnosis code descriptions

- Diagnosis code invalid or not effective on service date
- Ack/reject inval info - diagnosis code.
- Ack/reject inval info - principal diagnosis code.
- Diagnosis code: invalid; must be a valid icd-10-cm diagnosis code
- Ack/reject inval info - icd10. Usage: at least one other status code is required to identify the related procedure code or diagnosis code.
- Diagnosis code: invalid; diagnosis code must be most specific
- Diagnosis code: invalid; must not be a duplicate of another diagnosis code on the claim for payer

Tips for avoiding: Diagnosis Code

- Validate the Diagnosis is active for date of service.
- Validate the diagnosis is consistent with procedure being performed.
- Make sure you are sending ICD-10 diagnosis codes for dates 10/1/2015 to current.
- Make sure the should not be listed as the primary diagnosis code.
- Make sure you are coding the diagnosis code to the highest level.
- Make sure indicate the admitting diagnosis on Inpatient claims.



Mistake 7: Procedure Code

Common procedure code descriptions

- Procedure Code: Invalid; Must be a valid AMA (CPT4 or HCPCS) Code
- Service Line Procedure Modifier: Invalid; Must be a valid modifier
- National Drug Code: Required; Must be entered on same service line as submitted procedure code
- Procedure code inconsistent with patients age/sex

Tips for avoiding: Procedure code

- Confirm you are coding out a valid procedure code for services provided.
- Confirm you are using a valid modifier and appropriate modifier for services provided.
- Make sure you are using a valid NCD code/Description.
 - This can be found on the box/container or vial for the services being provided.
- Make sure the procedure code you are using is appropriate for the patient's age.



Mistake 8: Claim Frequency Code

Claim Frequency Code Mistakes

Indicates the claim is:

- (1) an original claim,
- (7) a replacement or corrected claim, or
- (8) a voided claim.



Tip: When a claim frequency code 7 or 8 is used the original reference number must be submitted. This is also referred to as ICN.

Common claim frequency code descriptions

- Claim Frequency code: Invalid; Must be a valid Frequency Code
- Claim Original Reference Number: Required; Must be entered when Claim Frequency code is equal to 7 or 8
- INV: Claim Frequency Code

Tips for Avoiding: Claim frequency code

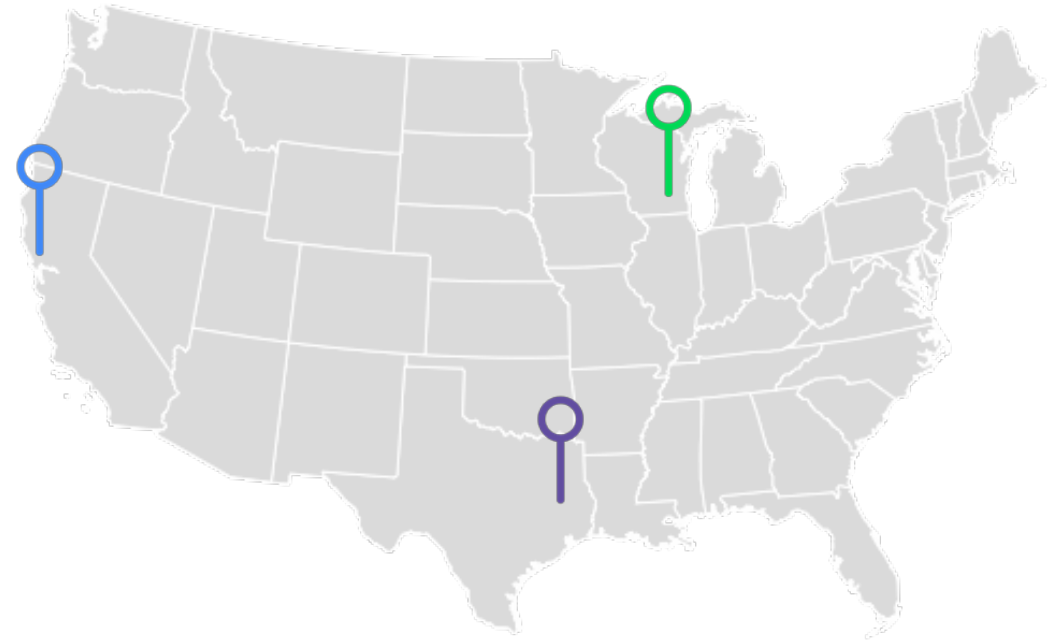
- Use a valid claim frequency code (1, 7 or 8).
- Verify you are submitting the original claim reference number (also known as ICN).



Mistake 9: Zip Code

Common zip code descriptions

- Zip Code Missing or Invalid
- Subscriber Zip Code Missing or Invalid
- Patient Zip Code Missing or Invalid
- Subscriber Zip Code Does not Match State
- Patient Zip Code Does not Match state



Tips for avoiding: Zip code

- Do not use all 9s or 0s, and do not leave blank.
- Match the zip code used to the state.



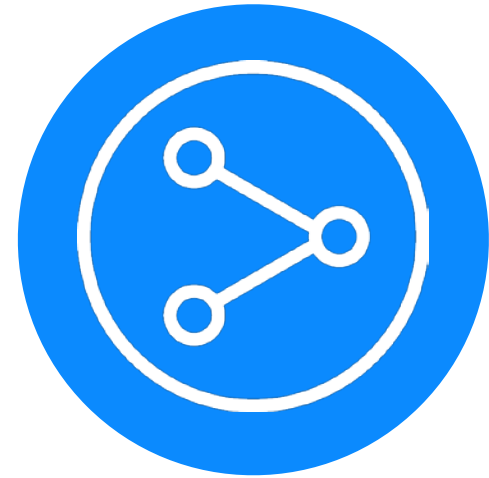
Bookmark: [United States Postal Service Zip Code Look Up](#)

Mistake 10: Smart Edits

Smart Edits

Return pre-adjudicated claims information through claim acknowledgement transaction reports based on the Medicare 277CA.

- All direct submitters will receive the Medicare 277CA report with the new Smart edits.
- Claims rejecting the pre-adjudication editing process are not forwarded to the claims adjudication system.
- If you choose not to correct the claim, just resubmit the claim for processing.



Tip: Review the [list of Smart Edits](#).

Smart Edit Examples

- SMARTEDIT MSP PER MEDICARE GUIDELINES PROCEDURE CODE 15260 IS WITHIN THE GLOBAL PERIOD OF HISTORY PROCEDURE CODE 15260 PERFORMED ON 05/03/2018 BY THE SAME PROVIDER. REVIEW DOCUMENTATION TO DETERMINE IF A MODIFIER IS APPROPRIATE.
- SMARTEDIT MUO PER CCI GUIDELINES PROCEDURE CODE 93000 HAS AN UNBUNDLE RELATIONSHIP WITH PROCEDURE CODE 93288 BILLED FOR THE SAME DATE OF SERVICE. REVIEW DOCUMENTATION TO DETERMINE IF A MODIFIER OVERRIDE IS APPROPRIATE.
- SMARTEDIT POS PROCEDURE CODE 99232 IS NOT TYPICALLY PERFORMED BY A PHYSICIAN AT PLACE OF SERVICE 11 OFFICE.

Greenway Clearinghouse Services

170K
PROCESSED
CLAIMS PER DAY

>\$13B
CLAIMS VALIDATED

98%
PAYER ACCEPTANCE
RATE

Like more information?

Request follow-up from a Greenway Health representative to further improve your billing.

Thank you!
