



Unprocessable Claim Rejections and Corrections

The Internet Only Manual (IOM) describes an unprocessable claim as “Any claim with incomplete or missing, required information or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required conditionally. Incomplete information is information that is required to be on the claim but it is not submitted.”

Medicare defines incomplete information as required or conditional information that is missing from the claim. A few examples of incomplete information include, missing an NPI, missing a procedure code or a date of birth.

Unprocessable claims also include those claims that contain incorrect information. This includes an incorrect NPI, an incorrect Health Care Identification Number (HICN), or the incorrect spelling of the patient’s name.

Some other types of incorrect or invalid information that cause unprocessable claims include invalid procedure codes, ICD-9s, or place of service.

When a Medicare claim contains incomplete or invalid information, it may be returned as unprocessable. Because Medicare was unable to complete processing and make an initial determination on the claim, there are not any appeal rights available. These claims must be corrected and resubmitted.

Claims that Medicare return as unprocessable will appear on the remittance advice with a CO-16 reason code and a remark code identifying what to correct before resubmitting the claim.

To assist you in making the appropriate corrections, we provide you with the:

- beneficiary’s name
- HICN
- dates of service, and
- claim control number

Some of the top reasons claims are returned as unprocessable include:

1. Invalid/missing rendering physician;

This rejection indicates that the rendering physician is a member of a group and the individual physician information was not entered correctly or is missing.

2. Invalid/missing modifier;

Possible reasons for rejection:

- The modifier/procedure code combination may not be valid for Medicare
- The modifier is not valid for Medicare
- The modifier is not yet valid for Medicare

For help with a missing or invalid modifier rejection, check the Medicare Physician Fee Schedule Database (MPFSDB). The MPFSDB may indicate whether certain modifiers are



billable with the procedure code. Not all modifier/procedure code combinations are on the MPFSDB. The MPFSDB is located at <http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp>

Verify the modifier is required or not when billing, that it is current and active.

3. Missing referring/attending physician;

If you receive this rejection, check items(s) 17, 17A and 17B of the CMS-1500 claim form or loops 2310A NM103 (DN), 2310A REF(01), and 2310A NM109 (XX) of your electronic claim. This is a conditional field because not all services require a referring/attending physician. Services that may require this information include:

- Consultations
- Immunosuppressive drug claims,
- Diagnostic laboratory services,
- Diagnostic radiology services,
- Portable x-ray services, and
- Durable Medical Equipment

4. Missing CLIA number;

If the CLIA number is missing in item 23D of the CMS-1500 claim form or in Loop 2300 REF02(X4) of your electronic claim, we are unable to process the claim.

5. Missing address of facility;

Place of service (POS) is other than 11 (office) or 12 (home) and the address of the facility is missing or incomplete in item 32. Information is not required for items 32A or 32B of the CMS-1500 claim form or electronic loop 2310D NM109 (FA, TL, &&, LI); however, if the information is entered, it must be correct.

6. Medicare Secondary Payer (MSP) information;

Required MSP information is different for paper and electronic claim submitters. Paper claim submitters must indicate "None" in item 11 if Medicare is the primary payer. Electronic claim submitters need to do one of two things: all loops (2320 SBR03, 2320 SBR09, 2320 DMG02, 2320 DMG03, 2330A NM109, 2000B SBR05 and 2320 SBR 04) for other health insurance information must be complete if a beneficiary has other health insurance information, or if they do not have other health insurance, leave all fields blank.

7. Dates of charges missing (a quantity issue);

This rejection does not always indicate the from date of service is missing. Sometimes it is an indication there is a quantity bill issue. Typically, a service was quantity billed and could not be or should have been and was not.

For instance, a claim contains 2 numbers of services with a single date of service, but Medicare only recognizes that service with 1 number of service.

8. Health Insurance Claim Number (HICN) not entitled;

The beneficiary's HICN is not entitled. Verify the information on the beneficiary's Medicare card. The information submitted to Medicare must appear exactly as it is on the beneficiary's Medicare card or the claim will reject as unprocessable.

**9. Primary EOB missing or incomplete;**

Medicare's file indicates that Medicare secondary and the primary insurer's information is missing or incomplete.

Please visit http://www.wpsmedicare.com/mac/business/b_msp_claims.pdf for instructions on how to file electronically when Medicare is the Secondary Payer.

10. Invalid/procedure modifier;

This can mean the procedure code/modifier combination is invalid or the procedure code or modifier is invalid. Check Medicare policy, the MPFSDB and current CPT guidelines to verify the procedure, modifier and/or the combination are valid for the date of service.

11. Truncated diagnosis code;

Medicare requires that claims indicate the greatest level of specificity diagnosis codes. This means if there is a 5-digit diagnosis code, do not submit a 3 or 4-digit diagnosis code on the claim.

12. Invalid/incorrect diagnosis code;

Verify the diagnosis code is valid for the date of service on the claim.

13. Missing initial date of treatment;

This rejection is specific to chiropractic claims and indicates the initial date of treatment is missing.

14. PA, NP, or CNS is not associated with the billing provider.

Verify the information submitted on the claims. If it is correct, contact provider enrollment to update the provider files before resubmitting the claim.

Visit <http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf> for information on completing the CMS-1500 claim form and http://www.wpsmedicare.com/mac/business/b_npi_1500_claimformcrosswalk.pdf for HIPAA electronic claim submission requirements.

Additional information about unprocessable claims is available in the CMS Internet Only Claims Processing Manual, Publication 100-4, Chapter 1, Section 80.3.1, available at: <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>