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Unprocessable Script

Thank you for joining me today to learn about unprocessable claims.

The goals of this training are:

- Identifying unprocessable claims;
- Defining unprocessable claims;
- Listing the top 15 unprocessable claims reasons;
- Determining what causes an unprocessable claim;
- Fixing the unprocessable claims;
- And the do's and don'ts of unprocessables claims.

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.”

Here are a few examples of missing information:

- Missing Provider Identification Number (PIN);
- Missing your Unique Provider Identification Number (UPIN);
- Missing procedure codes;
- Missing a date of birth.

Some information that is incorrectly submitted on a claim will also cause unprocessable denials.

Incorrect information is defined as information that is submitted on a claim but it is not correct.

Here are some examples:

- Incorrect provider number;
- Incorrect Health Care Identification Number (HICN);
- Expired provider number.

You may be missing or have incorrect conditional information, which will also cause unprocessable claims.

Here are some examples:

- Referring provider number, when required;
- The hospitalization date, when required;
- Other health insurance information or Medicare Secondary Payer information, when required.



Take a moment to think of reasons why a claim may be unprocessable. Can you think of any?

If you can, that is great. If you can not, we are going to look at WPS Medicare's top 15 unprocessable claims reasons.

1. Invalid/missing rendering physician;
2. Invalid/missing modifier;
3. Missing referring attending physician;
4. Missing CLIA number;
5. Missing address of facility;
6. MSP Information;
7. Dates of charges missing (a quantity issue);
8. Health Insurance Claim Number not entitled;
9. Primary EOB missing or incomplete;
10. Invalid/procedure modifier;
11. Truncated diagnosis code;
12. Invalid/incorrect diagnosis code;
13. Invalid procedure/modifier;
14. Missing initial date of treatment;
15. PA, NP, or CNS not associated with the billing provider.

The next step is to review each denial on an individual basis.

The most frequent seen unprocessable reason is "Missing incomplete or invalid rendering physician." On the CMS-1500 paper claim form 08/05 version, check item 24J; or check the electronic equivalent if you are billing electronically. The reject is indicating that the rendering physician is a member of a group, and the individual physician information was not entered correctly or left blank. The group number belongs in item 33 on the CMS-1500 claim form.

Reason code CO-16: "Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate."

Remarks code MA-112: "Missing/incomplete/invalid group practice information."

The next reason is "Missing or invalid modifier." The item on the CMS-1500 claim form is 24D and contains the procedure code/modifier combination. The list below provides possible reasons that may cause this unprocessable denial:

- The modifier/procedure code combination may not be valid for Medicare;
- The Modifier has never been valid;
- The modifier is no longer valid;
- The modifier is not valid yet.

For help with "Missing or invalid modifier" check Medicare Physician Fee Schedule Database (MPFSDB). The MPFSDB indicates whether certain modifiers are billable with



the indicated procedure code. Not all modifier/procedure code combinations are on MPFSDB. If you need more information on the Medicare Physician Fee Schedule Database, please review the [Computer-Based Training] CBT on the WPS Medicare Website, the Mediasite recording, or research it directly on the CMS Website.

To fix the error try the following:

- Verify the modifier is required or not required when billing;
- Verify the modifier is current and active: it has not been changed or deleted.

Reason code CO-4: "The procedure code is consistent with the modifier used, or a required modifier is missing." Medicare does not use a remarks code for this denial.

The third denial is "Missing referring/attending physician." Check item[s] 17, 17A, and 17B on the CMS-1500 claim form or its electronic equivalent. This is a conditional field, because not all services require a referring/attending physician. Examples of services that may require a referring or attending are:

- Consultations;
- Immunosuppressive drug claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Durable medical equipment.

Reason code CO-16: "Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate."

Remarks code N-286 "Missing/incomplete referring primary identifier."

The fourth reason is a Clinical Laboratory Improvement Acts (CLIA) number is missing or invalid. What is the CLIA number? The number laboratories must indicate on claims even if it's a CLIA waived test. If the CLIA number is missing in item 23D of the CMS-1500 claim form, we are unable to process the laboratory services on the claim.

Reason code CO-16: "Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate."

Remarks code MA-120: "Missing/incomplete/invalid CLIA number."

The next reason is "Missing address of the facility." The unprocessable code is used when the service is not provided in Place of Service (PSO) 11 (office) or 12 (home). The exception for POS 11 is if the provider's office is a different location than indicated in item 33. Item 32 must contain the name and address of the facility or location where the services were provided. You do not need to fill out or complete anything in 32A or B, but if these items are completed the information does need to be correct.



Reason code CO-16: "Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate."

Remarks codes MA-114: "Missing/incomplete/invalid information on where the services were furnished" and M-58 "Missing/incomplete/invalid information resubmit after corrections are made."

MSP information is reason number 6. MSP information is different for electronic billers than for paper billers. Small providers offices, approved to bill on paper, need to complete item 11 with "None" if Medicare is the primary payer. However, more frequently WPS Medicare sees this denial because on the electronic 837 transition there is something in one of the fields, but not all of the information is complete. You need to remember to do one of two things: all fields for other health insurance information must be complete, if a beneficiary has other health insurance information, or if they do not leave all fields blank.

Reason code CO-16: "Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate."

Remarks code M-83 "Did not indicate whether we are primary or secondary payer."

Reason number 7 is "Missing or invalid from dates." This denial is not actually indicating you are missing a from date of service, it is indicating a quantity bill issue. Typically, a service was quantity billed and could not be or should have been and was not. An example of this is a claim received has a "2" in the days/units field with a single date of service, but the Medicare system will only recognize that service with days/units of "1. You must call Customer Service to verify if a procedure code can be quantity billed.

Reason code CO-16: "Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate."

Remarks code M-83 "Missing incomplete invalid from dates of service."

Reason number 8 is "Health Insurance Claim Number (HICN) not entitled." The HICN is located on the right/top of the CMS-1500 claim form in item 1A. If the number billed is not entitled, a patient's responsibility reason code is used. You need to ask the patient to see their Medicare card. Verify the following on the Medicare card:

1. The Medicare number;
2. Patient Name;
3. Date of Birth;
4. Effective Date.

Also, verify eligibility via our Interactive Voice Response [IVR] system, or our phone system, or the CMS Secured Network Access Pilot (C-SNAP)



Reason Code PR-16: "Claim service lacks information which is needed for adjudication."

Remarks code M-61: "Missing incomplete invalid Social Security Number of Health Insurance Claims Number."

Reason number 9 is the "Primary EOB is missing or incomplete." If Medicare is the secondary payer, it is important that you attach a primary EOB, meaning the explanation of benefits to the paper claim form. Electronically, make sure that you complete the fields required with the primary insurance information. Medicare is able to accept secondary payer electronically. Review the article in our January 2003 *Communiqué* on our Website pages 68-70 for help.

Reason Code PR-16: "Claim service lacks information which is needed for adjudication."

Remarks code MA-04: "Secondary payment cannot be considered without the identifier or payment information from the primary insurance. The information was either not reported or illegible." In some cases, we simply could not read it.

Reason number 10 is "Invalid procedure code/ modifier"[and] indicates a procedure code is not payable with the modifier submitted. Check Medicare policy, the MPFSDB, and current CPT guidelines, and verify the combination is valid for the date of service.

Reason code COB-18: "Payment adjusted because this procedure code and modifier were invalid on the date of service."

Remarks code M-51: "Missing/incomplete/invalid procedure code."

Reason number 11 is "Truncated diagnosis code." The reason indicates that a diagnosis code located in item number 21 of the CMS-1500 claim form or its electronic equivalent must be taken out to the greatest level of specificity. That means that if you have a 5-digit diagnosis code, do not put a four-digit or three-digit on the claim, or if you have a four-digit, do not put a three-digit on the claim. Medicare must have as many digits as possible to further explain the diagnosis code.

Reason code CO-16: "Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate."

Remarks code M-81: "You are required to code to the highest level of specificity."

Reason 12 is "Invalid/incorrect diagnosis code" indicates the diagnosis code used in 24E is not recognized by Medicare. The diagnosis code may have changed, was never valid, or is not valid for that date of service. Check and make sure you have the most current ICD-9 listing or that you are using the listing current for the date of service on the claim.



Reason code CO-16: "Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate."

Remarks code M-76: "Missing incomplete valid diagnosis code or condition."

Reason 13 is "Invalid procedure/Modifier" [and] is similar to reason both numbers 7 and 10. The reason indicates a procedure code/modifier combination is not valid for that date of service. The procedure code is valid and the modifier is valid, but the combination you put on the claim is not valid. The two cannot be billed together to Medicare for that date of service.

Reason code CO-16: "Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate."

Remarks code M-76: "Missing/incomplete/invalid information."
"Missing date of initial treatment" is the next reason. The reason is specifically for chiropractic claims and is indicating the initial date of treatment in item 14 is missing. If you are not a chiropractor, this does not typically apply to you.

Reason code CO-16: "Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate."

Remarks code M-122: "Missing/incomplete/invalid/ initial treatment date."

The last denial is "PA, NP, or CNS not associated with the billing provider." The denial must be correct in the provider enrollment files before resubmitting. The information on the claim may be correct, but the rendering provider is not affiliated to the billing provider in the Provider Enrollment System. The other issue that can cause this denial is two numbers on the claim are not correct. In this case, correct the numbers and resubmit the claims.

Reason code CO-16: "Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate."

Remarks code M-81: "Missing/incomplete/invalid billing provider supplier contact information."



To review the do's of unprocessable claims

- Do include the rendering physician ID on claim in box 24K;
- Do include the referring/attending physician information in box 17, 17A and B;
- Do include your CLIA number in the appropriate box 23.

The Don'ts of unprocessable claims:

- Do not quantity bill codes that are not able to be quantity billed. Contact Customer Service to find out if you can quantity bill;
- Do not abbreviate diagnosis codes. ICD-9 codes must be carried out to their greatest specificity;
- Do not use modifiers that are not appropriate for the procedure code. The combination will cause unprocessable claims.

Thank you.