

First Quarter 2009 - Top Claim Submission Errors

A claim submission error (CSEs) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for January through March 2009, are provided in the following table.

Top Ten Claims Submission Errors	Number Received	Reason For Error
40022 - Procedure Code/Modifier Invalid	8,096	The procedure code and/or modifier used on this line is invalid.
40037 - Service Date Greater Than Receipt Date	1,617	The date of service is after the date the claim was received.
20322 - NPI Not Found on Crosswalk	1,394	The billing provider identifier is not found on the NPI crosswalk file.
20269 - Pointer 1 Diagnosis Invalid	1,184	Diagnosis pointer is invalid in first diagnosis field.
40068 - Invalid/Unnecessary CMN Question	1,177	The question number entered is not valid for the DME MAC CMN you are sending.
20011 - Billing Provider Invalid	851	The billing provider identifier in the 2010AA loop is invalid.
20025 - Subscriber ID Code Invalid	801	The Health Insurance Control Number (HICN) is invalid in the 2010BA loop.
20110 - Procedure Code Invalid	688	Procedure code is invalid or discontinued.
40014 - Ordering Provider Information Missing	652	The ordering provider information is missing in the 2420E loop.
40039 - From DT = TO Date and Units > 1	573	The procedure modifier is equal to RR and the number of services is greater than one (1).

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First Quarter 2009 - Top Return/Reject Denials

The below table reflects those claims that were accepted by the system and processed, however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from January through March 2009.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form(or electronic equivalent) Entry Requirement	Number Received
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	Item 24D - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	6,074
CO 16 N286 Missing/incomplete/invalid referring provider primary identifier	Item 17A - Physician UPIN (Unique Physician Identifier Number) submitted in error. Physician NPI must be submitted in Item 17B.	2,963
CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	Item 24A - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	2,414
CO 16 MA130 Claim/service lacks information which is needed for adjudication. Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	Item 11 - If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE." (Paper Claims Only).	2,409
CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid procedure code(s) and/or rates.	Item 24D - Enter the procedures, services, or supplies using the HCPCS. When applicable show HCPCS modifiers with the HCPCS code.	2,365
CO 16 MA114 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid information on where the services were furnished.	Item 32 - Enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.	1,933
CO 16 N257 Missing/incomplete/invalid billing provider/supplier primary identifier.	Item 33 - PTAN number submitted in error. Must submit NPI.	1,264
CO 16 N265, N286 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid ordering provider primary identifier.	Item 17B - Enter the NPI of the referring or ordering physician, if the service or item was ordered or referred by a physician.	1,260
CO 16 M76, M81 You are required to code to the highest level of specificity. Missing/incomplete/invalid diagnosis or condition.	Item 21 - Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number, coded to the highest level of specificity.	1,138
CO 16 M119 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).	Item 24D - Enter a valid National Drug Code (NDC).	1,070