Quick Points

May 17, 2010

Understanding and correcting rejected electronic claim submissions

Since Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) requires compliance with Minnesota Statute 62J.536, we have noticed an increase in calls regarding electronically submitted claims.

Below is a list of the most common errors in electronic submissions that cause a claim to be rejected along with the recommended corrective action. Following these instructions may eliminate the need for a phone call to Blue Cross.

Blue Cross Error Descriptions	Corrective Action
Billing provider number is not found on Blue Cross provider file or is not valid for date(s) of service on claim	This is the number assigned to the facility by CMS (NPI) or Blue Cross (Atypical). It is located in the 2010AA loop. This error will set when the submitted NPI is not on file or is not valid for the date(s) of service on the claim, OR when an Atypical provider has submitted a legacy provider number or UMPI with a G2 qualifier that is not on file or is invalid for the date(s) of service on the claim. • Identify the billing provider number in error. This should be given on the rejection report in the rejected claim details section following the label **ELEMENT CONTENTS=** • Verify with Blue Cross that the billing provider number submitted is valid for the date(s) of service and is set up correctly on the provider file. • Correct the claim(s) and resend.
Invalid alpha prefix	The alpha prefix is the three letters at the beginning of the subscriber ID card. • Identify the subscriber ID in error. This should be given on the reject report following the label **ELEMENT CONTENTS=** • Verify with Blue Cross what the correct subscriber ID is by sending an electronic eligibility request or checking online at **providerhub.com**. • Correct the claim(s) and resend.
Invalid CPT/HCPCS procedure code	CPT and HCPCS procedure codes are published quarterly by the American Medical Association (AMA) or the Centers for Medicare & Medicaid Services (CMS). They all have an effective date based on the date of service being billed. Some have a termination date. Alphabetic characters must be submitted in all capital letters. • Identify the CPT or HCPCS code that was the reason for the rejection. This should be listed on the rejection report in the rejected claim details section following the label **ELEMENT CONTENTS=** • Verify that the code was valid on the date of service for the claim (or line item if applies). • Correct the claim(s) and resend.

Distribution: Due to the importance of this information this Quick Points is being mailed to all participating providers
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Invalid procedure modifier	Procedure Modifiers are published quarterly by AMA and CMS. They all have an effective date based on the date of service being billed. Some may have a termination date. Please reference the SV1 (professional) or SV2 (institutional) to find the modifier. The Modifier is in the first sub-element of the first element for both of these segments. • Locate the procedure modifier that is in error. This should be listed on the reject report following the label **ELEMENT CONTENTS=** • Identify correct procedure modifier to use from the code source. • Correct the claim(s) and resend.
Invalid revenue code	The Revenue Code is used only on institutional (837I) claims. It is sent in the SV201. The information for where to get these codes is listed on page C.4 of the 837I Implementation Guide. • Verify the correct Revenue Code from the code source. • Revenue codes must be valid on the date the claim is created, not the date of service. • Correct the claim(s) and resend.
Rendering physician number or UPIN is not found on Blue Cross provider file or is not valid for date(s) of service on claim	This is the number assigned to the rendering practitioner. This error applies only to professional claims. This error will set when the rendering provider ID is not on file or is not valid for the date(s) of service on the claim and/or is not associated with the billing provider submitted. • Identify the rendering practitioner shown on the reject report in the rejected claim details section following the label **ELEMENT CONTENTS=** • Identify the billing provider number. • Verify with Blue Cross that the following is correct: ➢ The rendering physician number from step 2 is valid for the date of service. ➢ The rendering physician number is associated with the billing provider number. • Correct the claim(s) and resend.
If Report Type Cd (PWK01)=EB (EOB) then PWK02 (Transmission Code) must not = AA (available at provider site)	The Minnesota Uniform Companion Guide states that AA is not a valid report transmission code. Claims submitted with EB (explanation of benefits) in PWK01 and AA (available upon request) in PWK02 will be rejected and returned to the provider for correction even if the COB information is entered in the claim transaction. • Correct the claim(s) and resend.
Multiple provider ID types are not allowed on same claim	This error will set when a combination of NPIs and legacy or UMPI IDs are submitted on the same claim. ● If you are an NPI eligible provider, submit NPI only on your claim. **OR** ● If you are an NPI-eligible billing provider with non-NPI eligible rendering practitioners, submit your NPI at the billing ID and submit Tax ID as the primary identifier and submit a secondary identifier of REF01=G2 and UMPI in REF02 at the rendering levels. **OR** ● If you are not eligible for an NPI at all, submit your Tax ID as the primary identifier and submit a secondary identifier of REF01=G2 along with either your legacy ID or UMPI at all levels of the claim. Please note that UMPI is allowed at the rendering level only for PCA services.

Subscriber ID not found on membership files	This is the number assigned to the subscriber by Blue Cross. • Identify the subscriber ID in error. This should be given on the reject report. • Verify with Blue Cross what the correct subscriber ID is by sending an electronic eligibility transaction or checking online at **providerhub.com**. • This error will also set on a claim if the alpha prefix is necessary but not submitted. Submit the subscriber/patient ID exactly as found on the ID card. • Correct the claim(s) and resend.
Supervising / Rendering physician number or UPIN is not found on Blue Cross provider file or is not valid for date(s) of service on claim	This is the number assigned to the rendering or supervising practitioner. The error will set when the submitted rendering or supervising NPI is not on file or is not valid for the date(s) of service on the claim, OR when an Atypical provider has submitted a rendering or supervising legacy provider number or UMPI with a G2 qualifier that is not on file or is invalid for the date(s) of service on the claim. • Identify the rendering or supervising NPI, legacy ID or UMPI from the reject report following the label **ELEMENT CONTENTS=** • Verify that the rendering or supervising physician number submitted is valid for the date of service. • Verify that the rendering or supervising physician number is associated with the billing provider number submitted on the claim. • Correct the claim(s) and resend.
Unit value billed is inconsistent with procedure code. Please correct claim and resubmit.	**Professional Claims** This error will set when a value greater than 1 is submitted for a CPT or HCPCS code that should be submitted with only one unit of service per date of service. • Indentify the code submitted with greater than one unit of service. Date range counts should be verified carefully. • Correct the claim(s) and resend.

Questions?

After performing the corrective action indicated, if you believe that a rejection was received in error, please contact Blue Cross provider services by calling **(651) 662-5200** or toll free at **1-800-262-0820**. In order to better serve our providers when they call with questions regarding the rejection or status of electronic claims providers **must** have the following information available before making the call:

1. The claim identification number. Since provider clearinghouses often create their own version of the rejection report, this element may be labeled as a claim repository number, Availity's payer claim number, or a payer assigned number returned by the provider's clearing house that uniquely identifies the claim in question.

2. The rejection narrative description. All claims that have been rejected should have a narrative description of the reason for the rejection. If the rejection remark code is available, that would be useful for our staff to help answer the provider's questions.

3. The element contents/message element that was submitted in the claim.

4. The submission date of the claim.