Dynamic Chiropractic

BILLING / FEES / INSURANCE

Common Errors/Omissions That Will Cause Medicare to Reject Your Claim

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Q: I am having difficulty getting paid for Medicare claims; for the past six to nine months, all of my Medicare EOBs have $0 payment and the reason is always CO-16. What am I doing wrong?

A: I understand your frustration, but want you to know that Medicare can be one of your better payers, if done per Medicare specifications. Simply, Medicare has unique rules for how the claim is to be completed and submitted; if these rules are not followed exactly, the claim is automatically rejected. In your case, I know this to be the case, as CO-16 indicates there is missing or incomplete information on the claim form.

The following are the most common errors and omissions. It would be helpful and allow for a better understanding and visualization if you have a 1500 claim form to review while you read this information; in fact, I recommend you use one that was rejected by Medicare.

Probably the most common mistake or omission on the 1500 claim form is block 11. This section is to contain the word "none" when there is no insurance that is primary to Medicare (most common). If it's left blank, Medicare will send the EOB with CO-16 because it cannot determine if there is insurance primary to the Medicare coverage. When Medicare is the primary coverage, simply write the word "none" in block 11 and leave sections 11a-d blank. Note, this provision is not new; Medicare has actively enforced this claim form rule for the past year and a half.

Block 14 also must be completed, but it must contain the date of "initiation of care." This means the date will correspond to the initial date of service for this condition or flare-up and not the date of injury or accident. If left blank or if the date does not match the initial date of service, the claim will be rejected.

When the claim to Medicare contains services that are excluded (exams, X-rays, physical therapy), block 17 should contain the treating doctor's name; 17a should contain his or her UPIN (Unique Personal Identification Number). Note also on the updated 1500 claim form, revised in August 2005 and available for use in 2007, that block 17b also should contain the provider's NPI (National Provider Identifier). Reminder: Excluded services billed in block 24 should be appended with modifier GY, to indicate the services are excluded. The use of the GY modifier is in addition to any other modifiers that might be necessary for the service/code.

Block 21 for diagnosis should contain only the diagnosis codes and not any description. Note that there is no space designated for a written diagnostic description, and any added letters or characters might cause the Medicare scanner to read the information incorrectly. There also should be no punctuation used in the diagnosis code, meaning the diagnosis should be represented by the first three digits of the code followed by a space and then the additional necessary digits.

For chiropractic claims, subluxation must be the primary diagnosis in block 21 (except in Florida). For the coding of subluxation, most states require the use of the 739 series, though some will allow use of both the 739 and 839 series. Verify specific requirements with your individual state carrier.

Any code other than subluxation as the primary will result in an automatic denial except in Florida. For Florida claims, you need not have subluxation on the billing form and may code the musculoskeletal diagnosis first, but the subluxation must be included in the chart notes and be available for review.

In block 24, specifically section 24b, the place of service must be completed. If it was your office, the place of service is "11," whereas if place of service was the patient's home, mark "12." Type of service 24c is to be left blank. Note that on the revised 1500 form, 24c is no longer the place of service and also is to remain blank for chiropractic claims.

Section 24d should contain your service codes and modifiers. When billing for chiropractic manipulative therapy (CMT) codes 98940 through 98942, the code must be appended with modifier AT, to indicate services are considered acute or medically necessary. If this modifier is omitted, Medicare assumes you are indicating services are maintenance or preventative in nature and will automatically deny those services.

Section 24e should contain a single number only and is to reference the diagnosis responsible for the encounter. Therefore, for Medicare claims it should be #1 only, as the reason for care or manipulation is spinal subluxation, which must be in the #1 position of block 21. I understand that many computer programs will automatically place all 1-4 or 1,2,3,4 in block 24e but they actually should allow the provider to designate which diagnosis is for which service. This use of a single digit in block 24e is not unique to chiropractic claims; medical claims also might contain only one numeral in 24e. (Note that in Illinois, WPS Medicare wants the #2 only in block 24e).

Block 32 must contain your office name and address, even if it's the same as block 33. This is a Medicare requirement and is contrary to the statement on the CMS1500 form, as it states, "if other than home or office." If left blank, the claim automatically will be rejected. Note that on the revised 1500 claim form, the wording was updated and now states "service facility location." Of course, with this new designation, it makes sense to have the information in block 32, as block 33 is billing provider information, which may or may not be the same as the service facility location. Medicare simply was implementing the change earlier to prepare its system for the update to the new form.

In my experience, these are the most common errors that cause a chiropractic claim to be returned with CO-16. Reference the claim you sent with the above information and you likely will be able to correct the error.

For those who wish to have a block-by-block instruction on Medicare claim form filing, e-mail me at sam@hjrossnetwork.com and I will send a basic Medicare claim form instruction sheet. Please indicate which state you practice in, as there are variations, as noted earlier in my response. Your local Medicare carrier also publishes a chiropractic billing manual available online for download; it gives chiropractic specific Medicare billing and coding information, as well as instructions for completing the claim form.

JANUARY 2007