CMS 1500 Claim Form – How to Avoid Common Denials

There are a number of reasons that a claim could be denied for payment. Most of the time, it only takes a few minutes to identify the problem. The National Uniform Claim Committee has published an instruction manual for reference:
https://ub04software.com/images/help/HCFA-Instruction-Manual.pdf

Five (5) common reasons a claim could be denied are explored below.

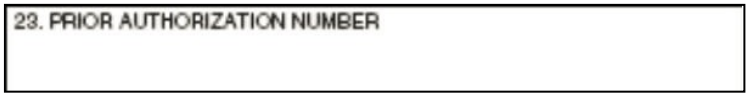
1. Lab Tests

Lab tests performed in the Clinic and billed will be denied by most payers, including Medicare and Medicaid, if the Clinic's CLIA number is not included on the claim.

Paper claims:

- Place the CLIA number in box 23 on the 1500 Claim form in order to be paid for lab services provided in the clinic.

  Further details available page 33 of NUCC 1500 Claim Guide



Electronic Claims:

- Verify that the Clinic's CLIA number has been entered in the Practice Management Software and will be electronically submitted on all claims that include a lab service that was performed in the Clinic.

2. Prior Authorizations

Remember to enter the prior-authorization number in:

Paper claims:

- **Box 23 - TITLE:** Prior Authorization Number (*this field is also used for CLIA numbers*)
- **INSTRUCTIONS:** Enter any of the following: prior authorization number, referral number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service.

Electronic Claims:

- Enter the pre-authorization number in the designated location in the practice management system**.**

3. National Drug Code (NDC)

Most payers require that the appropriate National Drug Code (NDC) appear on the claim before they will reimburse medications and vaccines. Each listed drug product is assigned a unique 10-digit, 3-segment number†. This number, known as the NDC, identifies the labeler, product, and trade package size. NCD are usually found on the drug label or outer packaging.
To search NDC codes go to: **https://www.findacode.com/ndc/ndc-national-drug-codes.html**

Paper Claims:
Enter the NDC code in box 24 on the 1500 Claim form.

Further details are available on page 45 of NUCC 1500 Claim Guide:
http://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2012_02-v4.pdf

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N459148001665 UN1													N	G2	12345678901
10	01	05	10	01	05	11		J0400		A	500 00	1	N	NPI	0123456789

Electronic Claims:

- Verify that the correct NDC numbers are loaded into the practice management system.
  NOTE: Medications and vaccine typically have multiple NDC numbers depending upon the manufacturer, dosage and packaging.

The following qualifiers are to be used when reporting NDC unit/basis of measurement:

- F2 International Unit - Products described as IU/vial or micrograms
- UN Unit – Powder for injection (needs to be reconstituted) , pellet, kit, patch, tablet, device
- GR Gram – Ointments, creams, inhalers or bulk powder in a jar
- ML Milliliter – Liquid, solution, or suspension
- ME Milligram
  Note: (ME is also a recognized billing qualifier that may be used to identify milligrams as the NDC unit of measure; however, drug costs are generally created at the UN or ML level. If a drug product is billed using milligrams, it is recommended that the milligrams be billed in an equivalent decimal format of grams (GR). BCBSTX allows up to three decimals in the NDC Units (quantity or number of units) field)

4. Incorrect number of Units

Drugs and medications will not be paid correctly if the appropriate number of units is not entered in Box 24G on the paper claim form or entered appropriately in the PMS for electronic claims.

Example:

J0561 Bicillin LA 100,000 units IM (Penicillin G benzathine):

- When billing 1.2 million units bill for 12 units based on the code description of 100,000 units
- When billing 2.4 million units bill for 24 units base on the code description of 100,000 units

5. Patient Account Numbers

Payers do not distinguish between programs when process claims and send payments. Payments, EOB's and correspondence, for all programs are combined into one document making it difficult for the LHD to identify and disseminate correspondence to their appropriate program(s).

On the paper 1500 Claim form the LHD has the option of entering a patient account number in box 26.

INSTRUCTIONS: Enter the patient's account number assigned by the provider of service's or supplier's accounting system. Do not enter hyphens with numbers. Enter numbers left justified in the field.

DESCRIPTION: The "Patient's Account No." is the identifier assigned by the provider. This could be the patient account number for internal use by the LHD.

FIELD SPECIFICATION: This field allows for the entry of 14 characters.

- If the LHD's practice management system allows the ability to add an acronym to distinguish between clinics they should do so.

***Remember* - Hyphens cannot be used and no more than 14 characters are permitted**

Examples:

- Enter a ***RH*** after the patient account number to indicate services were performed in the ***Reproductive Health*** clinic

- Enter ***IZ*** for the immunization clinic to identify services were provided in the ***IZ clinic***.

26. PATIENT'S ACCOUNT NO.
12341234 ***RH***

Adding the RH makes the account number 10 digits long in the example.