Dermatology Coding Alert

Recipe for Billing Success: Do These Top-10 Denials Look Familiar? Check Your List

If you've compiled a list of your top-10 denials, compare your top denial reasons with Medicare's so you can determine where you stand compared to other practices' most frequent denial reasons.

Remember: In some instances, you may simply need to notify the payer why it was wrong in rejecting your claim. Not every insurance denial automatically means that your practice made an error. If you scrutinize your EOBs carefully, you may find that you are wrong some of the time and that the insurer is wrong sometimes.

Each Medicare carrier lists its own top-10 reasons for denying claims. The following denials represent the top-10 reasons, compiled by averaging data from nine different Medicare carriers.

1. Duplicate claim submission.
2. Bundled services.
3. Individual provider number and/or group number missing from 24k or 33 of the CMS-1500 claim form.
4. The payer does not deem the diagnosis linked to the procedure a "medical necessity" for that service.
5. Medicare is the secondary payer but is being billed as primary.
6. Non-covered services.
7. Patient is not a Medicare beneficiary.
8. UPIN and name of ordering or referring physician missing/invalid.
9. Incorrect modifier usage.
10. Procedure is a "screening" service and therefore not eligible for payment.

Note: Watch for strategies for avoiding these denials in future issues of Medical Office Billing & Collections Alert.