Optometry Coding & Billing Alert

Reader Questions: Don't Let Common Mistakes Mess Up Your

Question: We receive a ton of denials on paper claims, and I think it's mostly due to the fact that the claims are not clean. What are some easy ways to clean up our paper claims and avoid unnecessary denials?

Connecticut Subscriber

Answer: You can find a solution to your long-standing paper claim denial problem - if you know where to look.

According to CIGNA Healthcare Medicare Administration, practices that still submit paper claims should check out Cigna's list of the most common CMS-1500 claim form errors.

Here's what you need to plug in on the trickiest boxes of the CMS-1500:

Item 17 and 17A: Remember to list the referring/ ordering physician name (that's one name only) and a valid unique provider identification number (UPIN). Not all tests require that information; a regular office visit doesn't, but tests like threshold field exams do.

Item 21: List up to four ICD-9 codes. Make sure you file a new claim form for billed items not linked to one of the four valid diagnosis codes.

Item 24e: Each procedure that you bill on a claim line should include only one diagnosis reference number (1, 2, 3 or 4) and should refer to the primary diagnosis from item 21 if you are listing multiple diagnoses. Don't list ICD-9 codes here - save those for item 21.

Item 28: Put "continued" here when you require multiple claim forms for the same beneficiary, with the total charge on the last page.

Item 29: Enter only the total amount that the beneficiary paid on his covered charges. Do not include payment for noncovered charges, deductibles, previous claims or primary insurers.

Item 31: Get the signature - computerized, stamped or authentic - and the date signed from the practitioner, supplier or his representative. Initialing or writing just a company name is a no-no.

CPT® 2023 American Medical Association. All rights reserved.