Training Video

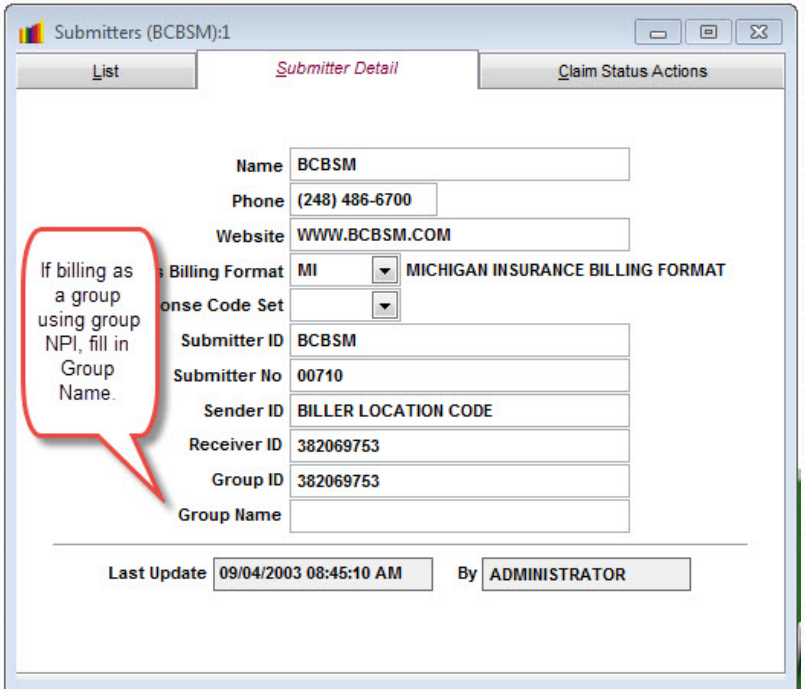
Troubleshooting 999 and 277 Rejections

What you always needed to know and didn't know who to ask!

Loops - Specific Loop Information

Loop 1000B – Qualifier 40 – clearinghouse information

Segment	Value	Troubleshooting
NM103	Name of clearinghouse	Make sure submitter name is completed in submitter screen
NM109	Submitter number	Make sure submitter number is completed in submitter screen - qualifier 46



Common Errors – ISA and GS02 segments

Incorrect submitter number

Incorrect receiver or group ID – clearinghouse

Group name filled out/not filled out

Loop 2010AA – billing provider information – qualifier XX (NPI number)

If group name is filled out in the submitter screen, Clinic Pro will look for group NPI. If group name is empty, Clinic Pro will look for individual NPI. In this loop, we send the clinic information from the system parameters screen. Make sure that the system parameters screen is filled out completely.

Segment	Value	Troubleshooting
NM102	Billing provider	If group name is filled out in submitter screen, we send 2; otherwise 1
NM103	Billing entity name	If group, returns group name. Otherwise, provider's last name.
NM109	NPI Number	Qualifier XX in NM108. If billing as a group, check each staff doctor and make sure that the Group NPI is filled in. Also make sure that the billing doctor is designated for each doctor. if billing as individual, make sure that the individual NPI is filled out for each staff doctor. Also make sure that the billing doctor is designated. Everything is completed and looks right, you can always check the NPI number at the following: http://npinumberlookup.org/
REF02	Tax ID number	The tax ID number must be the one that the doctor used when signing up with the clearinghouse or with the individual insurance carrier. If it says that the tax ID number is missing or invalid, you need to look at the tax ID number on the system parameters screen. Make sure that it has nine digits and is the one assigned to the clinic.
PER02	Billing provider contact name	Make sure that the contact name is filled out in the system parameters screen.
PER04	Billing contact phone number	Make sure that the phone number is filled out in the system parameters screen

Common errors: Group name is filled out in Submitter screen and Group NPI not filled out in Staff doctor screen.

Loop 2000B - Subscriber information

This loop sends the subscriber (insured) information.

Segment	Value	Troubleshooting
SBR01	destination insurance value	P, S or T for destination insurance. If the user has to input the primary and secondary insurances wrong or mixed them up in order, you will get an error in the segment.
SBR03	Group number	This is the group number from the Insurance/Dates screen. If the group number has been typed wrong, you will get an error. Also, if it is left empty and a group number should have been typed in, error.
SBR04	Group name	This is usually an optional segment. It returns the group name from the Insurance/Dates screen.
SBR05	Medicare secondary reason	This is an optional segment. If Medicare is being billed as a secondary carrier, the user must input the reason that Medicare is secondary on the Insurance/ Dates screen for Medicare. This error will also occur in the claim scrubber routine.
SBR09	Claim filing indicator	This tells the insurance carrier the type of claim you are sending. An error in this segment means that the insurance type is set wrong on the Insurance/Medigap screen. A Medicare advantage plan is not billed as a Medicare type – it is Blue Cross Blue Shield, if offered by Blue Cross Blue Shield or commercial if offered by a commercial carrier. This error will also be reported as "source of payment invalid." BL= BLUE CROSS / BLUE SHIELD MB= MEDICARE MC= MEDICAID FI= FEDERAL EMPLOYEES PLAN HM= HEALTH MAINTENANCE ORGANIZATION CI= COMMERCIAL WC=WORKER'S COMP CH= CHAMPUS
PAT	Relation to Insured	This segment should be created only if the patient is ***not*** the insured. If the relationship to the insured is self, this segment should not be created.

Common errors:

1. The most common error in this loop occur when the subscriber information is not input correctly and the relationship to the insured is wrong, i.e. relationship=self but insured is not self. PAT
2. When Medicare is secondary, you need a secondary reason. SBR05

Loop 2010BA - subscriber name and address, and contract number – from Insurance/Dates screen

Segment	Value	Troubleshooting
NM109	Contract number	Check the contract number from the Insurance/Dates screen. Sometimes you will get an error if the relationship to the insured is wrong or if the contract number is typed wrong.
DMG02	Subscriber date of birth	The subscriber date of birth is incorrect
DMG03	Subscriber gender	The subscriber gender is incorrect
REF02	Social Security # Qualifier= SY	This is an optional segment with the qualifier of SY. For the most part, we do not send Social Security numbers anymore.
REF02	Claim number Qualifier= Y4	This segment will only be completed. If the claim number is filled in on the insurance/dates screen. Claim numbers are assigned to auto accident and workers comp cases. It has a qualifier of Y4

Loop 2010 BB – Destination insurance name and Payer ID

Segment	Value	Troubleshooting
NM103	Insurance name	This segment is looking for the name of the insurance being billed - the destination insurance
NM109	Payer ID	This error occurs when the payer ID is incorrect. Look up the payer ID from our website, under the billing tab. There is a list of payer IDs for common clearinghouses. Input the correct payer ID into the Insurance/Medigap list
REF02	Claim office number Qualifier= FY	Look up the claim office number under the payer list and make sure that it is input correctly in the Insurance/Medigap list. Qualifier is FY

Common errors:

1. Contract number is wrong. NM109 - Check the contract number in the Insurance/Dates screen
2. Payer ID is missing or invalid. NM109 LIST.- Check the Insurance/Medigap List
3. Claim office is missing or invalid. REF02 - Check the Insurance/Medigap List

Loop 2000C - Patient Loop. This loop should only be created if the patient is ***not*** the insured - subscriber. Errors in this loop often occur when the relationship to the insured is set wrong in the insurance/dates screen.

Segment	Value	Troubleshooting
PAT01	Relationship to insured	This error occurs when the relationship to the insured on the Insurance/Dates screen is wrong.

Loop 2010 CA – this loop sends the patient's name and address and demographic information such as birthdate and gender. You will get errors in this loop If the name is not the same as the insurance company has on file or the birthdate or gender is wrong.

Segment	Value	Troubleshooting
DMG02	Patient birthdate	Patient birthdate is missing or wrong.
DMG03	Patient gender	Patient gender is missing or wrong.

Common errors: remember, this loop should only be created if the patient is not the subscriber. The subscriber might be a patient or a nonpatient.

Loop 2300 – Claim information CLM- This loop represents the claim level information and totals all of the service lines in this claim. If there is a new rendering provider, new diagnosis, new facility, new initial treatment date or other new items, a new claim level loop will be started.

Segment	Value	Troubleshooting
CLM02	Total submitted charges	This is the total submitted charges for the claim. A claim may have multiple service lines.
CLM07	Medicare assignment code	If this is being billed to Medicare and you accept assignment, it will return an A. Otherwise, it returns a C.
CLM08	Accept assignment	If assignment is accepted, it will return a Y. if assignment is not accepted on this claim, it will return and an N.
CLM09	Release of information	If the release of information box is checked on the patient detail screen, it will return a Y. If it is not checked, it will return an N.
CLM11-1	Accident indicator	If patient related is something other than None, it will return the following: EM = employment; AA=auto accident; OA = other accident
CLM12	Special program indicator	This only applies to Medicaid claims. The values are found under the SPI drop-down for Medicaid.
DTP	Qualifier 454	Date first consulted; initial treatment date for chiropractors
DTP	Qualifier 304	Last seen date – date that the patient saw the medical doctor that prescribed physical therapy
DTP	Qualifier 431	Onset date
DTP	Qualifier 453	Acute manifestation date for chiropractic care
DTP	Qualifier 439	Injury date
DTP	Qualifier 484	Date of last menstrual period if woman is pregnant
DTP	Qualifier 455	X-ray date

Common errors:

1. Accident indicator - if the "related to" drop down on the patient detail screen is set to an accident rather than None, an injury date is also expected. CLM11-1
2. Special program indicator – there should almost never be a selection under this Medicaid field. CLM12
3. DTP, qualifier 454 – this is the initial treatment date for Medicare claims for chiropractic. This is required information and found on the 2 button of the transaction screen.
4. DTP, qualifier 453 – this is found on the C button of the transaction screen.
5. DTP, qualifier 439 - injury date is found on the 2 button of the transaction screen. Required for workers comp and other accidents. AA button is used for auto accidents to indicate auto accident date.

Loop 2300 – Claim information CLM - Continued

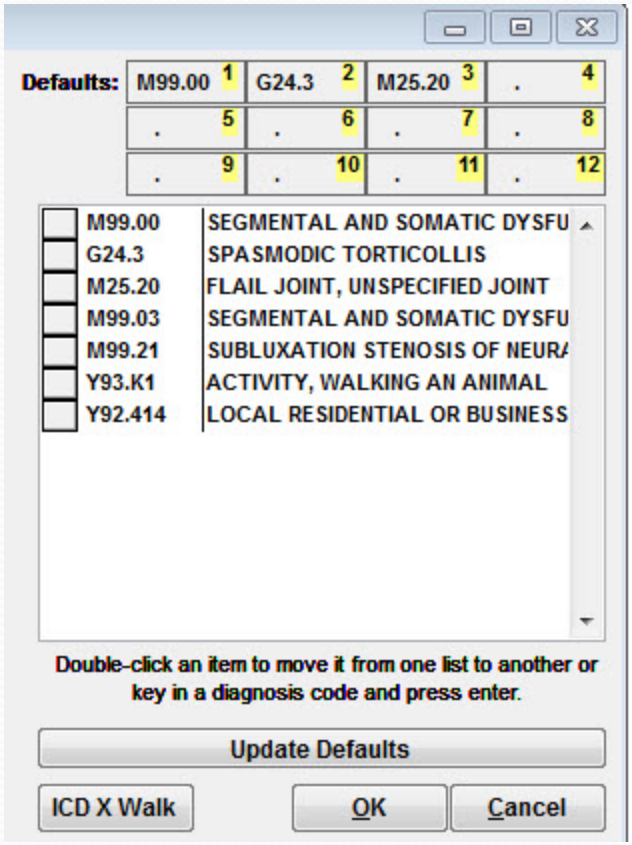
Segment	Value	Troubleshooting
DTP	Qualifier ABC	Estimated date of birth
DTP	Qualifier 360	Disability from date
DTP	Qualifier 361	Disability to date
DTP	Qualifier 297	Off work to date
DTP	Qualifier 296	Off work from date
DTP	Qualifier 435	Hospital admission date
DTP	Qualifier 096	Hospital discharge date
PWK01	Paperwork indicator	Type of documentation available from the two button on the transaction screen
PWK02	Paperwork transmission	Way that the documentation was transmitted to the insurance carrier from the two button on the transaction screen
REF02	Qualifier AN	Service exception code
REF02	Qualifier EW	Mammography's certificate number
REF02	Qualifier F9	Prior authorization or referral number
REF02	Qualifier F8	Status inquiry documentation number
REF02	Qualifier X4	CLIA lab ID used when laboratory services are provided in a medical office rather than sent to a lab
REF02	Qualifier EA	Medical record number obtained from the patient detail screen
REF02	Qualifier P4	Demonstration Project Identifier
K301		Pediatric note
NTE02	Qualifier ADD	Notes from two button

Common errors:

1. If services are provided at the hospital indicated by the place of service, there must be a hospital admission date. DTP qualifier 435
2. Type of paperwork. This is a drop-down button on the 2 button of the transaction screen. PWK01
3. Paperwork transmission. This is a top-down box on the 2 button of the transaction screen to indicate how the paperwork was transmitted to the carrier.
4. Notes. The notes button on the 2 button of the transaction screen will transmit notes to the insurance carrier. Make sure that this box is either completely empty – by highlighting in hitting the delete key – or has a complete note. NTE02. Sometimes users will attempt to erase a note by hitting the space bar. While you do not see characters on the screen, the computer reads the spaces as characters and sends an empty notes field.

Loop 2300 – Claim information CLM – Continued
HI Segment

The HI segment sends diagnosis information for the claim. In the service line loop, Loop 2400, the diagnosis indicators are designated for each diagnosis in the claim level loop.



On the diagnosis screen, we are indicating that the patient has cervical and low back problems as a result of walking his dog on a local residential street. Don't you love ICD 10?

If you had nothing better to do in your life, you could write incredibly specific diagnoses for every patient.

When the codes are transmitted to the insurance carrier, they look like the graphic below. As you can see, there are no descriptions of the codes, only the codes themselves when you transmit electronically or print them on a HCFA form.

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HI*ABK:M9900*ABF:G243*ABF:M2520*ABF:M9903*ABF:M9921*ABF:Y93K1*ABF:Y92414
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Loop 2310A Referring Doctor – Qualifier DN

Segment	Value	Troubleshooting
NM109	Referring doctor	Referring doctor NPI - http://npinumberlookup.org/ If the office needs NPI numbers

Common errors:

1. Referring doctor was not required for the procedure code billed.
2. Referring doctor does not have the NPI number.
3. Referring doctor name is empty.

Loop 2310B Rendering Doctor – Qualifier 82

This loop is created to send individual NPI of the rendering Doctor (primary Doctor on the transaction screen) when billing as a group (group name is filled out in the submitter screen.)

Segment	Value	Troubleshooting
NM109	Rendering doctor NPI	Clinic Pro is looking for the individual NPI number and the staff Doctor screen because the clinic is billing as a group.
PRV03	Taxonomy code for rendering provider	The taxonomy code is on the details page of the staff Doctor screen. If an insurance carrier requires the taxonomy code, check the taxonomy box on the insurance billing screen.
REF02	Special identification number	Special identification numbers are provider numbers assigned by the insurance carrier. Rarely used. Can be entered in the staff Doctor screen.

Common errors:

1. The individual NPI is not filled in.
2. Insurance carrier requests the taxonomy code and the taxonomy box is not checked when billing the insurance carrier. In these cases, you often have to build the insurance carrier separately.

Loop 2310C Facility information - Qualifier 77

This loop contains information about the facility where the services were performed. If the services were performed in your office, you should not send facility information. The only time that this loop should be created is of services were performed outside of your office.

Segment	Value	Troubleshooting
NM103	Type of facility	FA=Facility; 77=service location; LI=Independent; TL=Testing lab; 1C=Medicare provider; 1B=BCBS Provider
NM109	NPI Number	Group NPI required
REF02		Laboratory/Facility Secondary Identification Number FA=Facility; 77 = service location; LI = independent lab; TL = testing lab; 1C = Medicare provider; 1B = blue cross provider

Common errors: to avoid sending information about the office when services were provided in the doctors office, make sure that the address in the system parameters screen is the same as the facility address. Copy address from System Parameters to Facility. (CTRL+C, CTRL+V)
If services were provided in another facility, you must input the Group NPI number of that facility.

Loop 2310D Supervising Doctor - Qualifier DQ

Segment	Value	Troubleshooting
NM109	Supervising doctor NPI	The supervising doctor is found on the transaction card and is accessed from the referral doctor list. Make sure that the NPI number is input.

Common errors: Choosing a supervising Doctor on the transaction screen when you didn't really want one.

Loop 2320 Other insurance information

Rule #1 – if you are billing primary, this is the secondary insurance.
Rule #2 – if you are billing secondary, the primary info is sent in this segment.

Segment	Value	Troubleshooting
SBR01	P, S or T	Sending to primary, secondary or tertiary
SBR02	Relation to insured	Relationship to insured has to be 18=self, 01=spouse, 19=child, 20=employee, 21=unknown, 39=organ donor, 40=cadaver donor, 53=life partner, G8=other relationship
SBR03	Group number	This segment sends the group number if it exists; it will be empty for Medicare and Medicaid
SBR05	Medicare secondary reason	Values are: 12=working aged; 13-ESRD; 14=Auto/no fault; 15=worker's comp; 16=public health; 41=black lung; 42=VA, 43=disabled ***Usually they get an error on this segment because they didn't pick a reason why Medicare is secondary.***
SBR09	Insurance type indicator	Returns type of insurance from the insurance company list This tells the insurance carrier the type of claim you are sending. An error in this segment means that the insurance type is set wrong on the Insurance/Medigap screen. A Medicare advantage plan is not billed as a Medicare type – it is Blue Cross Blue Shield, if offered by Blue Cross Blue Shield or commercial if offered by a commercial carrier. This error will also be reported as "source of payment invalid." BL= BLUE CROSS / BLUE SHIELD MB= MEDICARE MC= MEDICAID FI= FEDERAL EMPLOYEES PLAN HM= HEALTH MAINTENANCE ORGANIZATION CI= COMMERCIAL WC=WORKER'S COMP CH= CHAMPUS

Common errors:

1. Relationship to the insured is wrong. SBR02
2. Medicare secondary reason is missing or invalid. In most cases, Medicare is primary. If Medicare happens to be secondary, there needs to be a reason indicated on the Medicare screen. SBR05
3. Insurance type indicator. SBR09.

Loop 2320 Other insurance information

Monetary amounts in CAS03 and AMT02 will only appear if you are billing a secondary insurance and reporting the payments from the primary insurance in AMT02 with qualifier D. These segments are “situational.”

The OI segments report assignment and release of information for the primary or secondary insurance depending on the circumstance.

Segment	Value	Troubleshooting
CAS03 qualifier PR	Amount that is patient responsibility	This segment only kicks in when billing Minnesota Medicaid
AMT02 qualifier D	Sum of the payer payments	This is the sum of the line item payments made by the primary payer
Amt02 qualifier EAF	Sum of the patient’s responsibility	Total patient responsibility. This segment is almost never sent in a billing file
OI03	Assignment of benefits indicator	This is the assignment of benefits indicator for the other insurance
OI04	Patient signature source	This is a patient signature source for the other insurance
OI06	Release of information	This is the release of information indicator for the other insurance

Loop 2330A - name and address of the policyholder for the other insurance

Segment	Value	Troubleshooting
NM109	Contract of the other insurance	Make sure that the contract number is filled in for the secondary insurance

Loop 2330B - payer for the other insurance

Segment	Value	Troubleshooting
NM103	Payer name	Name of the payer for the secondary insurance or the other insurance
NM109	Payer ID	Payer ID for the other insurance. If there is no payer ID because the secondary insurance is HCFA, use the payer ID of 99999.

Common errors:

1. The contract number for the secondary insurance is missing or invalid.
2. The payer name for the secondary insurance is missing or invalid.
3. Most common error – the payer ID for the secondary insurance is missing or invalid. You can check the payer list on the ClinicPro support website under the Billing tab.

Loop 2400 – Service Line Level

Segment	Value	Troubleshooting
SV101 element 1	HC	Returns HC unless being billed to workers comp in Washington, Alaska, Arizona, Oregon; ClaimOffice) = "WA03", it returns ZZ.
SVC101 element 2	CPT code	
SVC101 element 3	Modifier 1	
SVC101 element 4	Modifier 2	
SVC101 element 5	Modifier 3	
SVC101 element 6	Modifier 4	
SVC101 element 7	specialty notes	This is a note specifically attached to this procedure code. It is used for NDC drug codes and other very specific information. The notes field is found on the bottom part of the transaction card underneath the POS.
SVC102	Charge	This is the charge for this particular line item
SVC103	Units	This is the number of units for this line item
SVC104	Quantity	This is the quantity for this line item. It is also the minutes if billing for anesthesia services
SVC107 elements 1 – 12	Diagnosis indicator	There are 12 sub elements for this segment. It will return the diagnosis indicator for this line of service.
SVC109	Emergency indicator	Returns N unless emergency indicator is checked in the Insurance/Dates screen

Common errors:

1. Specialty notes are not included and they are needed. SV101-7
2. Diagnosis indicators are not pointing to correct diagnosis codes.

Loop 2400 – Service Line Level

DTP Qualifier 472	Service date for this line of transaction	
DTP Qualifier 304	Last seen date	They should only occur for physical therapy claims. This is the last seen date by the medical doctor that ordered the physical therapy. The last seen date is taken from the 2 button on the transaction screen
DTP Qualifier 455	x-ray date	This is the date of the most recent x-ray
DTP Qualifier 454	initial treatment date	This is the date of initial treatment for chiropractic claims. It is taken from the 2 button on the transaction screen
REF04 Qualifier F9	Prior authorization	This is the prior authorization number or referral number taken from the insurance/dates screen.
REF04 Qualifier EW	Mammography certification	This is the mammography certification number from the staff Dr. screen
REF04 Qualifier X4	ClIA lab ID	When laboratory services are performed in the office, we send the CLIA lab ID from the staff Doctor screen

Common errors: If any of the above information is missing or invalid, the claim will reject.

Loop 2430 - information about the primary insurance payment is sent in this loop

Segment	Value	Troubleshooting
SVD 01	Payer ID	This is the payer ID for the primary insurance.
SVD02	Amount paid	This is the amount paid by the primary insurance for this line item
SVD03	CPT code	This is the second sub element of this segment
SVD03	Modifier one	This is the third sub element of this segment
SVD 03	Modifier 2	This is the fourth sub element of this segment
SVD 03	Modifier 3	This is the fifth sub element of this segment
SVD 05	Quantity	This reports a quantity for this line of transaction
CAS qualifier PR	Payer responsibility	This reports the amount paid by the primary insurance
CAS qualifier CO	Contractual obligation	This reports the amount that has to be written off as contractual obligation
DTP qualifier 573	payment date	This reports, the date of the payment – check date – from the payment screen when the primary insurance company payment was posted

Common errors:

1. Payer ID for the primary insurance is invalid. SVD01
2. When the payment is input from the primary insurance, ClinicPro users have to be sure to put in the amount written off, the amount applied to deductible and co-pay. If those values are not found, it can cause a rejection. For the secondary carrier. CAS PR, CAS CO
3. Payment date – this is the most common error! When you are inputting a payment from a primary carrier, be sure to fill out the Check Date field. If this field is left empty, the claim will reject. DTP Qualifier 573.