The Top Ten Billing Errors—And How to Avoid Them

Common Claims Reporting Errors

Claims processing experts identified the top ten common errors that cause claims to process incorrectly. Please review the Trading Partner Portal for documentation on Highmark's transition to the National Provider Identifier to identify providers.

Some Practices Make These Errors	Correction
Incorrect provider number listed	If practices are unsure which number to use (assignment account/group or individual practitioner/group member), they should seek advice from their Provider Relations representative. Generally, the billing provider number is the assignment account, while the performing provider number is the individual practitioner.
Performing provider name and number	The performing practitioner name and practitioner identification number should be reported on the claim when it is different than the billing provider identification number.
Invalid place of service codes submitted and/or the facility name and number is not listed	Ensure the correct place of service code is being used. Ensure a facility name and identification number are reported when the place of service is different than the billing provider's service location (ex. Hospital or SNF).
NOC (not otherwise classified) codes listed without descriptions	Descriptions of the service provided must be reported on the claim for NOC codes.
Applicable coordination of benefits/other insurance information and/or documentation is not accompanying the claim	Please make an effort to report electronically or attach coordination of benefits/other insurance information
Member identification numbers are incomplete	List the complete member identification number including any alpha prefix.
Zero charges or adjustments are being reported	Unless the claim is an encounter, zero dollars or blank charges are not acceptable.
Claims are range dated, but the number of services do not clearly correspond with the date range (e.g., indication that services were performed 01-01-04 through 01-10-04, but list only 5 services)	When services span over a period of days, the number of services should correspond on a one-on-one basis if you are range dating (indicating that services span from one date through another date). If they do not correspond on a one-on-one basis, you should itemize the services.
Submit HCPCS codes that are not valid for the time the service was rendered (e.g., billing for a service performed in 2006 with a code that wasn't in place until 2007 or vice versa)	Report correct and valid procedure codes that reflect the correct date of service.
Invalid diagnosis code	Report diagnosis codes that are the highest degree of specificity and valid for the date of service.