Provider Bulletin

News and Information

January 6, 2022

UCare Claims Rejection Analysis, Reminders and Requests

UCare began transitioning to a new claims system in January 2019. Throughout the implementation cycle of each product into the new claims system, UCare analyzed common reasons for claims rejections, claims denials and claims appeals. As UCare begins processing claims for the largest segment of our business – Prepaid Medical Assistance Plans, MinnesotaCare, UCare Connect, Minnesota Senior Care Plus, UCare's Minnesota Senior Health Options and UCare Connect + Medicare, there is a greater likelihood provider groups will see an increase in claims rejections.

Recent claims analysis and implementation testing show some common billing errors that result in claims rejections are occurring. Most of these errors are associated with industry standard Strategic National Implementation Process (SNIP) claim validation and edits and other X12 standards for electronic billing. Many are also detailed in UCare's Provider Manual and past bulletins. UCare has summarized the errors, specific reject messages and paths to resolution in the following table.

Common Reasons for Claims Rejections	277ca Reject Message	Applicable Claim Scenarios	Provider Resolution Path
The **Admission Date** (Loop 2300, DTP) is required on all Inpatient Claims and not allowed on other claim types.	**A3:21:40** The Admission Date (Loop 2300, DTP) is required on all inpatient Claims. If not required by this Implementation guide, do not send.	Provider submitted Inpatient claim without admission date or non-inpatient claim with admission date.	If you are submitting an inpatient claim, please include the admission date and resubmit the claim. If you are not submitting an inpatient claim, please remove the admission date and resubmit the claim.
The **Admission Date** Time Qualifier (Loop 2300, DTP02) must be equal to D8, when the Facility Type Code (Loop 2300, CLM05.01) equals 32, 33, 34, 81 or 82.	**A3:21:40** The Admission Date Time Qualifier (Loop 2300, DTP02) must be equal to D8, when the Facility Type Code (Loop 2300, CLM05.01) equals 32, 33, 34, 81 or 82.	Provider submitted Inpatient claim with Facility Type Code of 32, 33, 34, 81 or 82.	If you are submitting a claim that has a Facility Type Code of 32, 33, 34, 81 or 82, please correct the Admission Date Time Qualifier to D8 and resubmit the claim.

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The **Admitting Diagnosis** (Loop 2300, HI) is only required on Inpatient claims.	**A3:21:40** The Admitting Diagnosis (Loop 2300, HI) is only required on Inpatient claims.	Provider submitted Inpatient claim without the admitting diagnosis or an outpatient claim with an admitting diagnosis.	If you are submitting any claim type other than inpatient, please remove the admitting diagnosis and resubmit the claim.
The **Rendering Provider Secondary Identification** (2420A REF) information may not be used when the Rendering Provider Identification Code (2420A NM109) is present.	**A3:21:40** The Rendering Provider Secondary Identification (2420A REF) information may not be used when the Rendering Provider Identification Code (2420A NM109) is present.	Provider submitted claim with a rendering NPI and a rendering provider secondary identifier.	If you are submitting a claim with a NPI in the Render Provider Identification Code segment, please remove the secondary rendering provider identifier and resubmit the claim.
The **Attending Provider Secondary Identification** (2310A, REF) is not allowed when the Attending Provider NPI Number (2310A, NM109) is present.	**A3:21:40** The Attending Provider Secondary Identification (2310A, REF) is not allowed when the Attending Provider NPI Number (2310A, NM109) is present.	Provider submitted claim with an attending NPI and an attending provider secondary identifier.	If you are submitting an attending provider NPI, please remove the attending provider secondary identification and resubmit the claim.
The **Billing Provider Secondary Identification** (2010BB, REF) is only required when the NM109 in Loop 2010AA is not used and an identification number other than the NPI is necessary for the receiver to identify the provider; otherwise, do not send.	**A3:21:40** The Billing Provider Secondary Identification (2010BB, REF) is only required when the NM109 in Loop 2010AA is not used and an identification number other than the NPI is necessary for the receiver to identify the provider, otherwise, do not send.	Provider submitted claims with billing NPI and a billing provider secondary identifier.	If you are submitting a claim with a billing NPI, please remove the secondary identifier and resubmit the claim.

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The **Referring Provider Identification Code** (2420F NM109) cannot be the same as the Referring Provider Identification Code (2310A NM109).	**A3:21:40** The Referring Provider Identification Code (2420F NM109) cannot be the same as the Referring Provider Identification Code (2310A NM109).	Provider submitted claims with the same referring provider identification code in 2420F NM109 and 2310A NM109.	If you are submitting a claim with a referring provider identification code in 2310A NM109, please remove the code from 2420F NM109 and resubmit the claim.
The **Service level Rendering Provider** (2420A NM1) is only required when it is different from the Billing Provider (2010AA NM1).	**A3:21:40** The Service level Rendering Provider (2420A NM1) is only required when it is different from the Billing Provider (2010AA NM1).	Provider submitted claims with rendering provider that is the same as the billing provider.	If you are submitting rendering provider data that is the same as the billing provider, please remove the rendering provider and resubmit the claim.
The **Service Facility Location** (2420C NM1) information is only required when the location of the health care service is different than that of the Service Facility Location Address (2310C N3 and N4).	**A3:21:40** The Service Facility Location (2420C NM1) information is only required when the location of the health care service is different than that of the Service Facility Location Address (2310C N3 and N4). If not required by this implementation guide, do not send.	Provider submitted service facility location information at the line level that is the same as the service facility location information at the claim level.	If you are submitting service facility data at the line level that is the same as the service facility data at the claim level, please remove the data from the line level loop and resubmit the claim.
Most common in January for Implementation Medicaid and Dual claims with a Legacy UCare Member ID and a **date of service (DOS) occurring in 2021 submitted using Payer ID 55413.** **NOTE:** Providers may also see denials if using the *new UCare member ID* and DOS in 2021 submitted to Payer ID 55413.	**A3:33:40** Missing Subscription	Provider submitted claims with dates of service in 2021 for Medicaid and Dual plans to Payer ID 55313.	For all Medicaid and Dual plans with a date of service in 2021, please resubmit claims using Payer ID 52629 with the member's 2021 Member ID.

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Providers **bill with UCare Group Practice Numbers (GPN) or Legacy ID numbers for services rendered on or after January 1, 2022,** to the new UCare Payer ID.	**A3:26:85** Missing Supplier	Provider submitted claims to payer ID with IDs only used for UCare's legacy claim system.	UCare's new claims processing system will recognize industry standard code sets. Please resubmit using your NPI or UMPI as appropriate for the service you are providing.
Paper claim submitted by a Minnesota provider whether contracted or non-contracted.	**N/A**	Provider in Minnesota submitted a paper claim rather than an electronic claim.	Submit an electronic claim through your current clearinghouse of register at MN E-Connect/Health EC for a free, AUC-compliant web-based claims data entry tool.
Provider submits a **billing or rendering NPI without the appropriate taxonomy code.**	**A6:145:85** The claim/encounter is missing the information specified in the status details and has been rejected : Entity's specialty/taxonomy code	Provider submitted claim with taxonomy code that doesn't apply to services billed.	In December 2021, UCare published a reminder bulletin on taxonomy requirements. Please be sure to submit billing and rendering taxonomy if submitting a billing and rendering NPI.
The **Ambulance Transport Information** (2300, CR1) is only required on ambulance claims.	**A3:21:40** The Ambulance Transport Information (2300, CR1) is only required on ambulance claims. Otherwise, do not send.	Provider submitted claims for non-emergency transportation and included information in 2300, CR1.	If you are submitting a claim for non-emergency transportation services, please remove the ambulance transport information and resubmit the claim.
The **Ambulance Certification** (2300, CRC) is only required on ambulance claims.	**A3:21:40** The Ambulance Certification (2300, CRC) is only required on ambulance claims. Otherwise, do not send.	Provider submitted claims for non-emergency transportation and included information in 2300, CRC.	If you are submitting a claim for non-emergency transportation services, please remove the ambulance certification and resubmit the claim.

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UCare **Missing Line Rendering Provider Taxonomy code.**	**A6:145:82** Deny Missing Rendering Provider Taxonomy Code	Provider submitted claims with rendering provider information at the line level but did not include the taxonomy code.	Please resubmit the claim with the taxonomy code for the rendering provider at the service line level, rather than claim level.
The **Taxonomy Code** is not found or the Taxonomy Code was not valid on the transaction date.	**A3:21:40** The Taxonomy Code was not valid in the version effective on transaction date YYYYMMDD. Or The Taxonomy Code is not found in Code Table Taxonomy Codes.	Provider submitted claim with invalid taxonomy code.	Please resubmit the claim with a valid taxonomy code.
The **Zip code** was not valid.	**A3:21:40** The Zip code number was not valid.	Provider submitted a claim with an invalid zip code under the subscriber, provider, or payer address.	Please resubmit the claim with a valid zip code for the subscriber, provider or payer address.