

Allied Health Common Denials

Introduction

Purpose

This module will familiarize participants with an overview of the most common denial messages when billing on the *CMS-1500* claim form, provide billing advice and appropriate follow-up procedures for these denials. The module lists *Remittance Advice Details* (RAD) codes and messages that are used to reconcile accounts. RAD codes appear on the Medi-Cal RAD for claims that are approved, denied, suspended or adjusted, as well as for Accounts Receivable (A/R) and payable transactions.

Module Objectives

- Identify the 10 most common claim denial messages for allied health services
- Provide the appropriate follow-up procedures for listed claim denials
- Offer billing tips to prevent claim denials
- Show common billing errors that cause denials
- Highlight the correct provider manual section for each denial

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1

Aid Codes Master Chart (aid codes)

Appeal Process Overview (appeal)

CIF Overview (cif)

Eligibility: Recipient Identification (elig rec)

Eligibility: Recipient Identification Cards (elig rec crd)

Remittance Advice Details (RAD) Codes and Messages: 001 – 099 (remit cd001)

Remittance Advice Details (RAD) Codes and Messages: 300 – 399 (remit cd300)

Remittance Advice Details (RAD) Codes and Messages: 9000 – 9999 (remit cd9000)

Part 2

Appeal Form Completion (appeal form)

CIF Completion (cif co)

CMS-1500: Completion (cms comp)

CMS-1500: Tips for Billing (cms tips)

Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

NOTES

Claim Denial Description

Denied claims represent claims that are incomplete, services billed that are not payable or information given by the provider that is inappropriate. Many RAD codes and messages include billing advice to help providers correct denied claims. It is important to verify information on the original claim against the RAD.

Free-Form Denial Codes

Free-form denial codes indicate free-form denial messages that allow Medi-Cal claims examiners to return unique messages that more accurately describe claim submittal errors and denial reasons. Free-form denial codes contain four-digits beginning with the prefix 9. Refer to the *Remittance Advice Details (RAD) Codes and Messages: 9000 – 9999* section of the Part 1 provider manual for the complete list.

10 Most Common Denial Messages

Denial #	RAD Code	Message
1	0010	This service is a duplicate of a previously paid claim.
2	0037	Health Care Plan enrollee, capitated service not billable to Medi-Cal.
3	0314	Recipient is not eligible for the month of service billed.
4	0369	Medical transportation requires Emergency Statement or TAR (<i>Treatment Authorization Request</i>).
5	0031	The provider was not eligible for the services billed on the date of service.
6	0376	Billed procedure code does not match TAR procedure code. New claim and/or TAR is required.
7	9984	Emergency service indicator on claim is not valid for non-emergency services.
8	0036	RTD (<i>Resubmission Turnaround Document</i>) was either not returned or was returned uncorrected; therefore, your claim is formally denied.
9	0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
10	0006	The date(s) of service reported on the claim is not within the TAR (<i>Treatment Authorization Request</i>) authorized period.

Denied Claim Follow-Up Options

When providers receive confirmation that a claim has been denied, they can pursue follow-up options to get the claim paid, depending on the reason for the denial. There are four main follow-up procedures available to providers:

- Rebill the claim
- Submit a *Claims Inquiry Form* (CIF)
- Submit an appeal
- Correspondence Specialist Unit (CSU)

Timeliness Policy

Timeliness must be adhered to for proper submission of follow-up claim forms.

Follow-Up Action	Submission Deadline
Rebill a Claim	<u>Six months</u> from the month of service
Submit a CIF	Within <u>six months</u> of the denial date (date on RAD)
Submit an Appeal	Within <u>90 days</u> of the denial date (date on RAD)

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CIF Submission Exceptions

Do not submit a CIF for the following Remittance Advice Details (RAD) code messages. Providers should submit an *Appeal Form* instead. A review by a person in the appeals unit is commonly used to resolve denials if the claim has a unique circumstance needing human intervention. Additional information is available in the *Appeal Process Overview* and *Appeal Form Completion* sections of the appropriate provider manual.

RAD Code	Message
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
0010	This service is a duplicate of a previously paid claim.
0072	This service is included in another procedure code billed on the same date of service.
0095	This service is not payable due to a procedure, or procedure and modifier, previously reimbursed.
0314	Recipient not eligible for the month of service billed.
0326	Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service.
0525	NCCI (National Correct Coding Initiative) void of a column 2 claim previously paid when a column 1 claim has been processed for the same provider and date of service.
9940	NCCI (National Correct Coding Initiative) claim line is billed with multiple NCCI modifiers.
9941	NCCI (National Correct Coding Initiative) column 2 procedure code is not allowed when column 1 procedure has been paid.
9942	NCCI (National Correct Coding Initiative) quantity billed is greater than the allowed MUE (Medically Unlikely Edit) quantity.

Denied Claim Follow-Up Procedures

Denial Code #1

Denied Claim Message

RAD CODE: 0010	This service is a duplicate of a previously paid claim.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0010 is to submit an appeal within 90 days.

Billing Tips

Verify the:

- Provider number
- Recipient number
- "From-Thru" date of service
- Procedure code
- Modifier
- Rendering provider number

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Denial Code #2

Denied Claim Message

RAD CODE: 0037	Health Care Plan enrollee, capitated service not billable to Medi-Cal.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0037 is to bill the Managed Care Plan (MCP).

Billing Tips

- Verify the recipient's eligibility.
- Verify the recipient's 14-character ID number on the RAD.
- Check the county code.
 - Verify county code in the *MCP: Code Directory* section of the Part 1 provider manual.

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Denial Code #3

Denied Claim Message

RAD CODE: 0314	Recipient is not eligible for the month of service billed.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0314 is to submit an appeal within 90 days or rebill the claim.

Billing tips

- Verify that the recipient has a SOC (Share of Cost) and is eligible for the month of service.
- Verify date of service on the claim is correct.

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Denial Code #4

Denied Claim Message

RAD CODE: 0369	Medical transportation requires Emergency Statement or TAR (<i>Treatment Authorization Request</i>).
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0369 is to submit an appeal within 90 days or rebill the claim.

Billing Tips

- Verify TAR number is present on the claim.
- Check that the TAR number is correct.
- Include an emergency statement in the *Additional Claim Information* field (Box 19) or an attachment for all emergency transportation.
- Verify that emergency indicator “X” is in the *EMG* field (Box 24C).
- Ensure that emergency statements are signed and dated by the provider. Emergency statements must support that an emergency existed. The statement may be made by the provider of the emergency transportation. The emergency statement must include:
 - The name of the person or agency that requested the service
 - The nature of the emergency
 - The name of the hospital to which a recipient was transported
 - Clinical information on a recipient’s condition
 - The reason the services were considered to be immediately necessary (medical necessity)
 - The name of the physician accepting responsibility for the recipient

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Denial Code #5

Denied Claim Message

RAD CODE: 0031	The provider was not eligible for the services billed on the date of service.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0031 is to rebill the claim.

Billing Tips

- Verify date of service on the claim is correct.
- Verify billing provider number on the claim is correct.
- Verify rendering provider number on the claim is correct.

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Denial Code #6

Denied Claim Message

RAD CODE: 0376	Billed procedure code does not match TAR procedure code. New claim and/or TAR is required.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0376 is to submit an appeal within 90 days or rebill the claim.

Billing Tips

- Verify the procedure/modifier combination is appropriate for the services being billed.
- Verify the procedure/modifier on the claim matches the procedure/modifier on the TAR.
- When billing for supply code 9999A, determine whether the TAR is a drug TAR or an other TAR. For drug TARs, use the *Pharmacy Claim Form (30-1)*. For other TARs, use the *CMS-1500* claim form.

NOTE

Refer to the *Pharmacy Claim Form (30-1) Completion* and *CMS-1500 Completion* sections in the appropriate Part 2 provider manual for additional information.

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Denial Code #7

Denied Claim Message

RAD CODE: 9984	Emergency service indicator on claim is not valid for non-emergency services.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 9984 is to make corrections and rebill the claim.

Billing Tips

- When billing for emergency services, providers must place an "X" in the *EMG* field (Box 24C).
- When billing for non-emergency services, providers must leave the *EMG* field (Box 24C) blank.

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Denial Code #8

Denied Claim Message

RAD CODE: 0036	RTD (<i>Resubmission Turnaround Document</i>) was either not returned or was returned uncorrected; therefore, your claim is formally denied.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0036 is to rebill the claim or submit a *Claims Inquiry Form* (CIF) within six months.

Billing Tips

- RTDs automatically deny when 45 days old.

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Denial Code #9

Denied Claim Message

RAD CODE: 0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0002 is to submit an appeal within 90 days.

Billing Tips

- Verify recipient's eligibility with a valid Medi-Cal BIC prior to rendering service, except in an emergency.
- Verify eligibility on the Point of Service (POS) network.
- Check recipient's date of birth and the issue date of the BIC.
- Keep the record of the Eligibility Verification Confirmation (EVC) number.

NOTE

Refer to the *Eligibility: Recipient Identification Cards* section of the appropriate Part 1 provider manual.

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Denial Code #10

Denied Claim Message

RAD CODE: 0006	The date(s) of service reported on the claim is not within the TAR (<i>Treatment Authorization Request</i>) authorized period.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0006 is to rebill the claim or submit an appeal within 90 days of the denial date.

Billing Tips

- Verify date(s) of service on the claim. If incorrect, resubmit the claim with the correct date of service.
- Verify the approved date(s) of service on the TAR. If incorrect, request in writing a correction of the TAR from your local Medi-Cal field office.
- Refer to the *TAR Field Office Addresses* (tar field) section of the appropriate Part 2 provider manual for field office addresses.

NOTES

Common Billing Errors

The following fields must be completed accurately and completely on the *CMS-1500* claim form to avoid claim suspense or denial. The following table can be found in the *CMS-1500 Tips for Billing* section (cms tips) in the appropriate Part 2 provider manual.

Box #	Field Name	Error
1	MEDICARE/ MEDICAID	Not checking appropriate box Billing Tip: Check both the Medicaid and Medicare boxes when billing Medicare crossover claims.
1A	INSURED'S ID NUMBER	Entering the recipient Medi-Cal ID number incorrectly Billing Tip: Verify that the recipient is eligible for the services rendered by using the POS network or telephone Automated Eligibility Verification System (AEVS). Do not enter the Medicare ID number on a Medi-Cal claim.
2	PATIENT'S NAME	Not using commas between each segment of the patients name Billing Tip: <i>Patient's Name</i> field (Box 2) requires commas between each segment of the patient's name: last, first, middle initial (without a period). For example, for a patient named James T. Smith Jr., enter: SMITH, JAMES, T, JR
19	ADDITIONAL CLAIM INFORMATION	Reducing font size or abbreviating terminology to fit in the field Billing Tip: If additional information cannot be entered completely, attach additional information to the claim. Reducing font size and abbreviating terminology may result in scanning difficulties and/or medical review denials.
21.1 21.2	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Entering more than two diagnosis codes Billing Tip: No description is required. Enter additional diagnosis codes in the <i>Additional Claim Information</i> field (Box 19). Claims submitted to Medi-Cal require an ICD indicator in the <i>ICD-Ind.</i> field (Box 21). Enter the ICD indicator "0" for claims that will be received by the Fiscal Intermediary on or after October 1, 2015. Claims submitted without a diagnosis code do not require an ICD indicator.
23	PRIOR AUTHORIZATION NUMBER	Physician and podiatry services requiring a TAR or SAR must enter the 11-digit TAR Control Number (TCN). It is not necessary to attach a copy of the <i>Adjudication Response</i> to the claim. Billing Tip: Recipient information on the claim must match the _____. Only one TCN can cover the services billed on any one claim.

Answer Key: TAR

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Box #	Field Name	Error
24B	PLACE OF SERVICE	<p>Entering the wrong Place of Service two-digit code</p> <p>Billing Tip 1: Check instructions in the <i>CMS-1500 Completion</i> (cms comp) section of the appropriate Part 2 provider manual for the correct two-digit code. Enter a Medi-Cal local Place of Service code instead of a national Place of Service code.</p>
24C	EMG (OR DELAY REASON)	<p>Delay Reason Code: If there is no emergency indicator in the <i>EMG</i> field (Box 24C), and only a delay reason code is placed in this box. Enter the code in the unshaded, bottom portion of the box. If there is an emergency indicator, enter the delay reason in the shaded, top portion of this box.</p> <p>Include the required documentation. Only one delay reason code is allowed per claim. If more than one code is present, the first occurrence is applied to the entire claim. Refer to the <i>CMS-1500: Submission and Timeliness Instructions</i> section (cms sub) in the appropriate Part 2 provider manual.</p> <p>Emergency Code: Enter an "X" when billing for emergency services. Claims without an "X" in this field may be reduced or denied. Only one emergency indicator is allowed per claim. The emergency indicator must be placed in the unshaded, bottom portion of the <i>EMG</i> field (Box 24C).</p> <p>An Emergency Certification Statement is required for all OBRA/IRCA recipients and for any service rendered under emergency conditions that would otherwise have required authorization, including: emergency services by allergists, podiatrists, medical transportation providers, portable imaging providers, psychiatrists and out-of-state providers.</p> <p>For emergencies in which emergency medical transportation was provided, providers must include an emergency statement. The statement must include:</p> <ul style="list-style-type: none"> • The name of the person or agency that requested the service • The nature of the emergency • The name of the hospital to which a recipient was transported • Clinical information on a recipient's condition • The reason the services were considered to be immediately necessary (medical necessity) • The name of the physician accepting responsibility for the recipient <p>A mere statement that an emergency existed is not sufficient.</p>

Box #	Field Name	Error
24D	PROCEDURES, SERVICES OR SUPPLIES	Omitting modifiers or entering incorrect information when required Billing Tip: Do not use Medicare modifiers. Enter procedure description, if necessary, in the <i>Additional Claim Information</i> field (Box 19).
31	SIGNATURE OF PHYSICIAN OR SUPPLIER	Submitting unsigned claims or claims with illegible signatures. Using initials or stamped signatures or signature extending outside the box. Billing Tip: Signatures must be written, not printed, in blue or black ink. Do not allow signature to extend outside the box. Stamps, initials or facsimiles are not acceptable.
32	SERVICE FACILITY LOCATION INFORMATION	Entering the wrong facility ID number for the POS entered in field 24B. Omitting the facility ID number when a facility-related Place of Service code is entered in field 24B. Billing Tip: Enter the facility ID number/NPI in field A or B.
33	PHYSICIAN, SUPPLIER INFO & PH #	Entering the wrong nine-digit ZIP code according to the 10-digit NPI on file Billing Tip: The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.

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Learning Activities

Learning Activity 1: Matching Terms Puzzle

Medi-Cal Knowledge: Match the terms in the second column to the best available answer in the second column.

- | | | |
|-----------|-----------------------|---------------------------------------|
| 1. _____ | BIC | A) Client Index Number |
| 2. _____ | CIN | B) Resubmission Turnaround Document |
| 3. _____ | EOB | C) Health Care Plan |
| 4. _____ | HCP | D) Share of Cost |
| 5. _____ | NPI | E) ID card |
| 6. _____ | POE | F) Provider Number |
| 7. _____ | RAD | G) Proof of Eligibility |
| 8. _____ | RTD | H) TAR Control Number |
| 9. _____ | Spend Down | I) Remittance Advice Details |
| 10. _____ | Authorization Request | J) Explanation of Benefits |
| 11. _____ | TCN | K) TAR or SAR |
| 12. _____ | DHCS | L) Department of Health Care Services |

Answer Key: 1) E; 2) A; 3) J; 4) C; 5) F; 6) G; 7) I; 8) B; 9) D; 10) K; 11) H; 12) L

Learning Activity 2: Word Scramble

Unscramble the following words:

1. ematceRitn _____
2. OCS _____
3. alenDsi _____
4. wol-uplFo _____
5. msleTinise _____
6. CCNI _____
7. cRiiptene _____
8. ribesbrcSu _____
9. Mngaaed eraC alnP _____
10. CDI iidncrato _____

Answer Key: 1) Remittance; 2) SOC; 3) Denials; 4) Follow-up; 5) Timeliness;
6) NCCI (National Correct Coding Initiative); 7) Recipient; 8) Subscriber;
9) Managed Care Plan; 10) ICD indicator