

# Inpatient Common Denials

## Introduction

### Purpose

This module will familiarize participants with an overview of the most common denial messages providers receive when billing on the *UB-04* claim form, providing billing advice and appropriate follow-up procedures for these denials. The module lists Remittance Advice Details (RAD) messages and codes 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 inpatient services
- Show common billing errors that cause denials
- Offer billing tips to prevent claim denials
- Provide the appropriate follow-up procedures for listed claim 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](http://www.medi-cal.ca.gov/mcss)).

### **References**

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

#### **Provider Manual References**

##### **Part 1**

*Appeal Process Overview* (Appeal)

*CIF Overview* (cif)

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

*Remittance Advice Details (RAD) Codes and Messages: 100 – 199* (remit cd100)

*Remittance Advice Details (RAD) Codes and Messages: 200 – 299* (remit cd200)

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

*Remittance Advice Details (RAD) Codes and Messages: 9000 – 9999* (remit cd900)

*Resubmission Turnaround Document (RTD) Overview* (resub)

##### **Part 2**

*Appeal Form Completion* (appeal form)

*CIF Special Billing Instructions for Inpatient Services* (cif sp ip)

*Diagnosis-Related Groups (DRG): Inpatient Services* (diagnosis ip)

*Sterilization* (ster)

*UB-04 Completion: Inpatient Services* (ub comp ip)

*UB-04 Tips for Billing: Inpatient Services* (ub tips ip)

### **Acronyms**

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

# 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	0314	Recipient is not eligible for the month of service billed.
3	0037	Health Care Plan enrollee, capitated service not billable to Medi-Cal.
4	0005	The service billed requires an approved TAR ( <i>Treatment Authorization Request</i> ).
5	0021	This claim was received after the one-year maximum billing limitation.
6	0076	The submitted documentation was not adequate.
7	0105	This service requires a valid sterilization <i>Consent Form</i> .
8	0243	The TAR Control Number submitted on the claim is not found on the TAR master file.
9	0036	RTD ( <i>Resubmission Turnaround Document</i> ) was either not returned or was returned uncorrected; therefore, your claim is formally denied.
10	9968	No Approved TAR on File for APR-DRG Inpatient Admission.

# 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 reimbursed, 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
- Write or call the 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 on the RAD
Submit an Appeal	Within <u>90 days</u> of the denial date on the 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

- Check the provider number/National Provider Identifier (NPI).
- Verify the recipient's 14-character ID number.
- Check "from-through" dates of service.
- Check records for previous payments. If no payment is found, verify all relevant information.

Example: Procedure code, modifier and rendering provider number/NPI

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## Denial Code #2

### 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.

### Billing Tips

- Verify the recipient's ID number with a valid Medi-Cal Benefits Identification Card (BIC) prior to rendering service, except in an emergency.
- Verify if the recipient has a Share of Cost (SOC) and is eligible for the month of service.
- Confirm the recipient's eligibility.
- Collect and spend down the SOC.

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## Denial Code #3

### 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 #4

### Denied Claim Message

RAD CODE: 0005	The service billed requires an approved TAR ( <i>Treatment Authorization Request</i> ).
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### Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0005 is to obtain an approved TAR and rebill the claim.

### Billing Tips

- Verify procedure code.
- Verify “from-through” dates of service.
- Verify authorization information.

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## Denial Code #5

### Denied Claim Message

RAD CODE: 0021	This claim was received after the one-year maximum billing limitation.
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### Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0021 is to appeal the claim.

### Billing Tips

Refer to claim form submission and timeliness instructions in the appropriate Part 2 manual for billing limitations.

- Verify “from-through” dates of service.
- Determine if this service was previously denied for another reason, with a denial date that indicates the claim is current.
- Use the most appropriate delay reason code. Place the code in box 37 of the *UB-04* claim.
- Submit initial claims that are over one year old to:  
Xerox State Healthcare, LLC  
Over-One-Year Attention: Claims Preparation Unit  
P.O. Box 13029  
Sacramento, CA 95813-4029

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## Denial Code #6

### Denied Claim Message

RAD CODE: 0076	The submitted documentation was not adequate.
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### Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0076 is to rebill the claim.

### Billing Tips

Inpatient providers should verify:

- Date of birth
- Admission date
- Discharge date
- The “from” date of service is in chronological sequence with the “thru” date
- Primary procedure code is on file and not missing, invalid or unclear
- Secondary procedure code is on file
- Attending physician provider number

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## Denial Code #7

### Denied Claim Message

RAD CODE: 0105	This service requires a valid sterilization <i>Consent Form</i> .
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### Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0105 is to correct and rebill the claim.

### Billing Tips

- The only sterilization consent form accepted by Medi-Cal is the Department of Health Services *Consent Form* (PM 330).
- Claims submitted with a computer-generated form or any other preprinted version of the PM 330 will not be reimbursed.
- Instructions must be followed exactly or the PM 330 will be returned and reimbursement delayed or denied.
- See the *Sterilization (ster)* Part 2 provider manual for instructions on completing the PM 330.

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## Denial Code #8

### Denied Claim Message

RAD CODE: 0243	The TAR Control Number submitted on the claim is not found on the TAR master file.
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### Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0243 is to correct the TAR number and rebill or submit an appeal within 90 days from the RAD denial date.

### Billing Tips

- Verify the TAR Control Number on the claim matches the number on the approved TAR.

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## Denial Code #9

### 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 CIF with the corrected information within six months or submit an appeal within 90 days from the RAD denial date.

### Billing Tips

- Submit missing documentation.
- Submit corrected claim.
- If the RTD form is available, find out what error resulted in a denied claim.

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## Denial Code #10

### Denied Claim Message

RAD CODE: 9968	No Approved TAR on File for APR-DRG Inpatient Admission.
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### Follow-Up Procedure

The appropriate follow-up procedure for RAD code 9968 is to rebill the claim.

### Billing Tips

- An admit TAR is a TAR that is submitted to request authorization for the entire hospital stay.
- For DRG-reimbursed hospitals, most inpatient stays require only an admit TAR and not a daily TAR.
- Review the *Diagnosis-Related Groups (DRG): Inpatient Services* (diagnosis ip) section of the Part 2 provider manual for exceptions.

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# Inpatient Common Billing Errors

The following fields must be completed accurately and completely on the *UB-04* claim form to avoid claims suspense or denial.

## NOTE

The following table can be found in *UB-04 Tips for Billing: Inpatient Services* section (ub tips ip) in the Part 2 Inpatient Services manual.

Box#	Field Name	Error
18 – 24	CONDITION CODES	Omitting codes or entering a Medi-Cal local billing limit exception code (X0, X1 – X9)  <b>Billing Tip:</b> The delay reason code is entered (Box 37A) of the claim. Enter codes in numeric-alpha order. For example, 80, 82, A1.
39 – 41 (A – D)	VALUE CODES AND AMOUNT (Patient's SOC)	Missing value code information. Entering only the value code and not the amount. Entering only the amount and not the value code.  <b>Billing Tip:</b> Value codes and amounts should be entered from left to right, top to bottom in numeric-alpha sequence starting with the lowest level. Value code information is required for Medicare/Medi-Cal crossovers.
50 (A – C)	PAYER NAME	Missing all payer information  <b>Billing Tip:</b> Enter the "I/P" indicator.
54 (A – B)	PRIOR PAYMENTS (Other Coverage)	Missing prior payment or Other Health Coverage not indicated  <b>Billing Tip:</b> Enter the patient's other health insurance payment. Do not enter Medicare payments in this box.
56	NPI	Missing or incorrect NPI number  <b>Billing Tip:</b> Enter the NPI.
60 (A – C)	INSURED'S UNIQUE ID	Entering the recipient's Medi-Cal ID number incorrectly  <b>Billing Tip:</b> Verify the recipient is eligible for the services rendered by using the POS network. Do not enter the Medicare ID number.

Box #	Field Name	Error
63 (A – C)	TREATMENT AUTHORIZATION CODES	Entering EVC number instead of the TAR number <b>Billing Tip:</b> The EVC number is only for verifying eligibility and should not be entered on the claim.
66	DX	Missing ICD indicator <b>Billing Tip:</b> An ICD Indicator of “0” is required for dates of service/discharge on or after October 1, 2015.
74 (A – B)	PRINCIPAL PROCEDURE CODE AND DATE	Missing or incorrect ICD-10-PCS code or a CPT-4/HCPCS procedure code entered
76	ATTENDING PHYSICIAN ID	Missing or incorrect attending physician’s NPI <b>Billing Tip:</b> Do not enter the operating or admitting NPI in this field.
77	OPERATING PHYSICIAN ID	Missing or incorrect operating physician’s Medi-Cal provider number/ID Qualifier/NPI
78 – 79	OTHER (Admitting Physician Provider Number) NPI	Missing or incorrect admitting physician’s NPI
80	REMARKS	Reducing font size or abbreviating terminology to fit in the field <b>Billing Tip:</b> If additional information cannot be completely entered in this field, attach the additional information to the claim. Reducing font size and abbreviating terminology may result in scanning difficulties and/or medical review denials.

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# Learning Activities

## Learning Activity 1: Matching Terms Puzzle

Medi-Cal knowledge: Match the words in the first column to the best available answer in the second column.

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|-----|-------|-----------------------|--|
| 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.  | _____ | DRG                   | E) ID card                                   |
| 6.  | _____ | POE                   | F) Diagnosis Related Group                   |
| 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 (DHCS) |

**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. lmsiaC \_\_\_\_\_
7. cRiiptene \_\_\_\_\_
8. ribesbrcSu \_\_\_\_\_
9. DCI iitdacnro \_\_\_\_\_

**Answer Key:** 1) Remittance; 2) SOC; 3) Denials; 4) Follow-up; 5) Timeliness; 6) Claims; 7) Recipient; 8) Subscriber; 9) ICD indicator