Allied Health Common Denials

Introduction

Purpose

This module will familiarize participants with an overview of the most common denial messages for Allied Health services when billing on the *CMS-1500* claim form.

Module Objectives

- Identify common claim denial messages for allied health services
- Provide an overview of claims follow-up for denied claims
- Offer billing tips to prevent claim denials
- Show common billing errors that cause denials

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete 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 Remittance Advice Details (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 (remit cd9000) of the Part 1 provider manual for the complete list.

NOTES

Overview of Claims 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

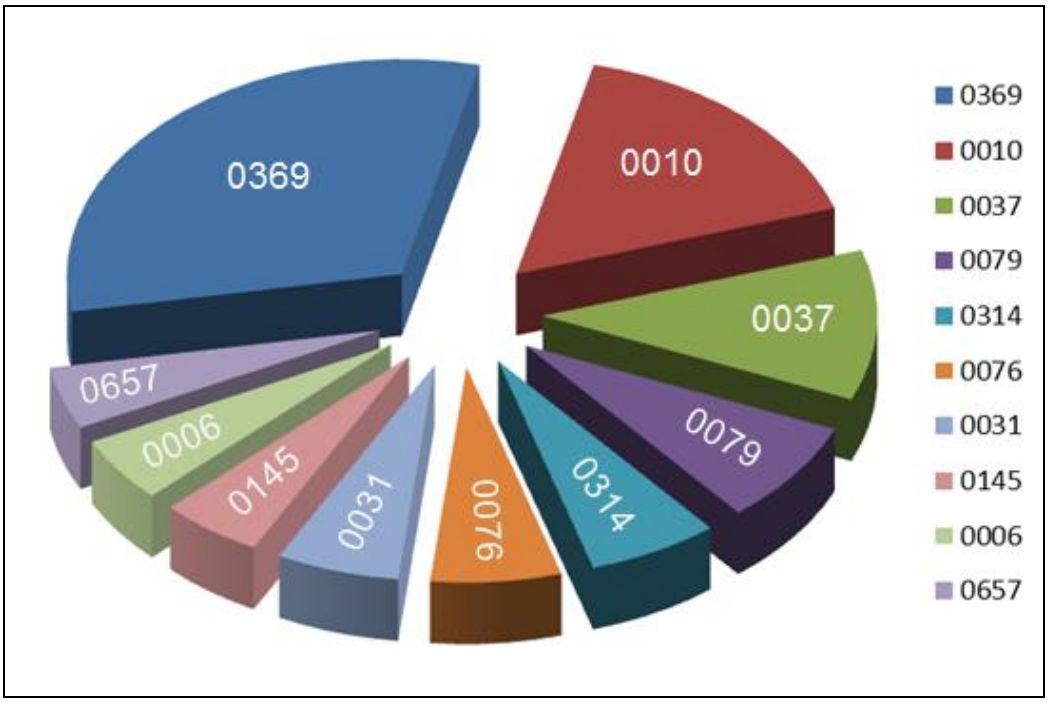
Timeliness must be adhered to for proper submission of follow-up claim forms.

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

NOTES

Allied Health Services RAD Code Chart

Top Common RAD Code Denials



NOTES

Denied Claim Root Causes

RAD Code 0369

Denied Claim Message

RAD Code: 0369	Medical transportation requires Emergency Statement or TAR (*Treatment Authorization Request*)

Root Cause of Denial

The root cause of this denial may vary. The most common reasons for this denial are missing or invalid emergency statement on the claim and documentation requirements are not followed.

Billing Tips

- Verify TAR number is present on the claim.
- Check that the TAR number is correct.
- Verify that emergency indicator "X" is in the *EMG* field (Box 24C).
- Include an emergency statement in the *Additional Claim Information* field (Box 19) or an attachment for all emergency transportation.
  - 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 nature of the emergency
    - The name of the hospital to which a recipient was transported
    - No acronym in place of a hospital name (for example, VMC). Abbreviations are acceptable (for example, Valley Med. Ctr.)
    - Clinical information on a recipient's condition
    - The name of the physician (Doctor of Medicine [M.D.] or Doctor of Osteopathic Medicine [D.O.]) accepting responsibility for the recipient. The name of the staff M.D., D.O. or emergency department medical director is acceptable.

NOTE

A physician's signature is not required.

Refer to the *Medical Transportation – Ground* section (mc tran gnd) of the Part 2 provider manual for billing guidelines.

RAD Code 0010

Denied Claim Message

RAD Code: 0010	This service is a duplicate of a previously paid claim.

Root Cause of Denials

Claim history identifies a payment for a National Provider Identifier (NPI) with the same recipient ID, date of service and procedure code.

Billing Tips

- Ensure that you have reconciled all payments with the RAD.
- Verify the following on the RAD:
  - Provider number
  - Recipient number
  - "From-Thru" date of service
  - Procedure code
  - Modifier
- If you are unable to locate claim payment on the RAD and are within six months from the month of service, you can submit a CIF tracer to assist in locating your Warrant Number and payment date.
  - CIF tracer does not keep your claim timely.
- Submit an *Appeal* within 90 days from the date on the RAD.
- Should the denied provider choose to dispute the claim and there is no resolution between the two providers regarding the dates in question, Medi-Cal could recoup the full reimbursement of the original erroneously paid claim, and will not make an adjustment without a correction request from that provider.

  Incorrectly paid and denied claims can also create incorrect provider reimbursement data and inaccuracies in the health service records that may impact beneficiary share of cost (SOC), access to services and estate recovery.

  For assistance in resolving these issues, providers are advised to write to the Correspondence Specialist Unit (CSU) at:

  Correspondence Specialist Unit

  P.O. Box 13029

  Sacramento, CA 95813-4029

RAD Code 0037

Denied Claim Message

RAD Code: 0037	Health Care Plan enrollee, capitated service not billable to Medi-Cal.

Root Cause of Denial

Providers not verifying recipient eligibility prior to rendering services for each recipient who presents a plastic Benefits Identification Card (BIC), MCP card, paper Immediate Need or Minor Consent card.

Billing Tips

- Verify the recipient's eligibility.
- Verify the recipient's 14-character ID number on the RAD is the same as was reported on the eligibility response and claim.
- Check the county code.
  - Verify county code in the *MCP: Code Directory* section (mcp code dir) of the Part 1 provider manual.
  - Contact the managed care plan for any specific billing instructions.
- Bill the Managed Care Plan (MCP).

NOTES

RAD Code 0079

Denied Claim Message

RAD Code: 0079	Service billed exceeds the remaining occurrences on the approved TAR (*Treatment Authorization Request*).

Root Cause of Denial

Services billed exceeded the occurrences remaining on the approved TAR(s).

Billing Tips

- Verify the occurrences on the claim are within the units approved on the TAR.
- Verify the number of units on the claim is correct.
- Confirm in Transaction Services the remaining units from the approved TAR.

NOTES

RAD Code 0314

Denied Claim Message

RAD Code: 0314	Recipient is not eligible for the month of service billed.

Root Cause of Denial

The recipient has an unmet share of cost on the date of service.

Billing Tips

- Verify if the recipient's SOC has been met and spent down in the Point of Service (POS) Network, ensuring the recipient is eligible for the month of service.
- Verify date of service on the claim is correct.
- Submit an Appeal within 90 days from the date on the RAD.

Attach a copy of the eligibility printout as proof that SOC has been met.

NOTES

RAD Code 0076

Denied Claim Message

RAD Code: 0076	The submitted documentation was not adequate.

Root Cause of Denial

The provider's claims were denied for not submitting proper "By Report" documentation for medical supplies, drugs, DME orthotics and prosthetics, air transportation or hearing aids.

Billing Tips

- Manufacturer and product number for item(s) billed is not specified.
- The "By Report" documentation (for example, manufacturer, product number, description) is not specific to the item billed and does not match the item description on the claim.
- Verify "By Report" documentation includes the following, if appropriate:
  - Catalog page, invoice or manufacturer's price list and/or product number
- Quantity billed is not specified.

NOTE

"By Report claim submissions do not always require a claim attachment. For some procedures, entering information in *Additional Claim Information* field (Box 19) of the claim may be sufficient.

Refer to the appropriate Part 2 provider manual sections for additional "By Report" requirements (for example, Durable Medical Equipment [DME], Medical Supplies and Orthotic and Prosthetics).

NOTES

RAD Code 0031

Denied Claim Message

RAD Code: 0031	The provider was not eligible for the services billed on the date of service.

Root Cause of Denial

The provider is not eligible for the services billed on the date of service.

Billing Tips

- Verify date of service on the claim is correct.
- Verify billing provider number on the claim is correct. If correct, work with Provider Enrollment Division (PED) to ensure effective dates related to your category of service or provider type is within the dates of service on the claim.
- Verify rendering provider number on the claim is correct.
- If your billing provider number was entered incorrectly on the claim, your follow-up method would be to correct the claim and rebill.
- If you are working with PED, keep claims timely by submitting a CIF or an Appeal.

NOTES

RAD Code 0145

Denied Claim Message

RAD Code: 0145	This procedure is not a Medi-Cal benefit on this date of service.

Root Cause of Denial

Providers billed for a service that was not a Medi-Cal benefit on the date of service.

Billing Tips

- Verify the procedure code and modifier, if required
- Verify the “From-Thru” dates of service
- Verify authorization information

NOTES

RAD Code 0006

Denied Claim Message

RAD Code: 0006	The date(s) of service reported on the claim is not within the TAR (*Treatment Authorization Request*) authorized period.

Root Cause of Denial

The provider submitted an approved TAR outside of the dates of service billed.

Billing Tips

- Verify date(s) of service on the claim. If incorrect, resubmit the claim with the correct date(s) of service if within six months from the month 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* section (tar field) of the Part 2 provider manual for field office addresses.

NOTES

RAD Code 0657

Denied Claim Message

RAD Code: 0657	Recipient not eligible for Medi-Cal benefits until payment/denial information is given from other insurance carrier.

Root Cause of Denial

The Explanation of Benefits (EOB) from the other health insurance carrier was not submitted with the claim.

Billing Tips

- Verify eligibility prior to rendering services
- Bill other insurance prior to submitting the claim to Medi-Cal
- Submit EOB with claim indicating payment/denial information

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:** *Patient's Name* 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 *Additional Claim Information* field (Box 19). Claims submitted to Medi-Cal require an ICD indicator in the *ICD-Ind.* 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 *Adjudication Response* to the claim. **Billing Tip:** Recipient information on the claim must match the TAR. Only one TCN can cover the services billed on any one claim.

Box #	Field Name	Error
24B	PLACE OF SERVICE	Entering the wrong Place of Service two-digit code **Billing Tip 1:** Check instructions in the *CMS-1500 Completion* (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.
24C	EMG (OR DELAY REASON)	**Delay Reason Code:** If there is no emergency indicator in the *EMG* 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. 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 *CMS-1500: Submission and Timeliness Instructions* section (cms sub) in the appropriate Part 2 provider manual. **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 *EMG* field (Box 24C). 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. For emergencies in which emergency medical transportation was provided, providers must include an emergency statement. The 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 A mere statement that an emergency existed is not sufficient.

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 *Additional Claim Information* 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.

NOTES

Knowledge Review

Match the RAD Denial Codes in the second column to the most appropriate definition.

1.	_____	RAD 0037	A) Medical transportation requires Emergency Statement or TAR (*Treatment Authorization Request*).
2.	_____	RAD 0010	B) The provider was not eligible for the services billed on the date of service.
3.	_____	RAD 0369	C) Recipient is not eligible for the month of service billed.
4.	_____	RAD 0031	D) This service is a duplicate of a previously paid claim.
5.	_____	RAD 0314	E) Health Care Plan enrollee, capitated service not billable to Medi-Cal.
6.	_____	RAD 0657	F) The date(s) of service reported on the claim is not within the TAR (*Treatment Authorization Request*) authorized period.
7.	_____	RAD 0076	G) Recipient not eligible for Medi-Cal benefits until payment/denial information is given from other insurance carrier.
8.	_____	RAD 0145	H) Service billed exceeds remaining occurrences on the approved TAR (*Treatment Authorization Request*).
9.	_____	RAD 0079	I) This procedure is not a Medi-Cal benefit on this date of service.
10.	_____	RAD 0006	J) The submitted documentation was not adequate.

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

Resource Information

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)