Outpatient Common Denials

Introduction

Purpose

This module will familiarize participants with an overview of the most common denial messages providers receive when billing for outpatient services on the *UB-04* claim form.

Module Objectives

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

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
- Contact the Correspondence Specialist Unit (CSU)

Timeliness Policy

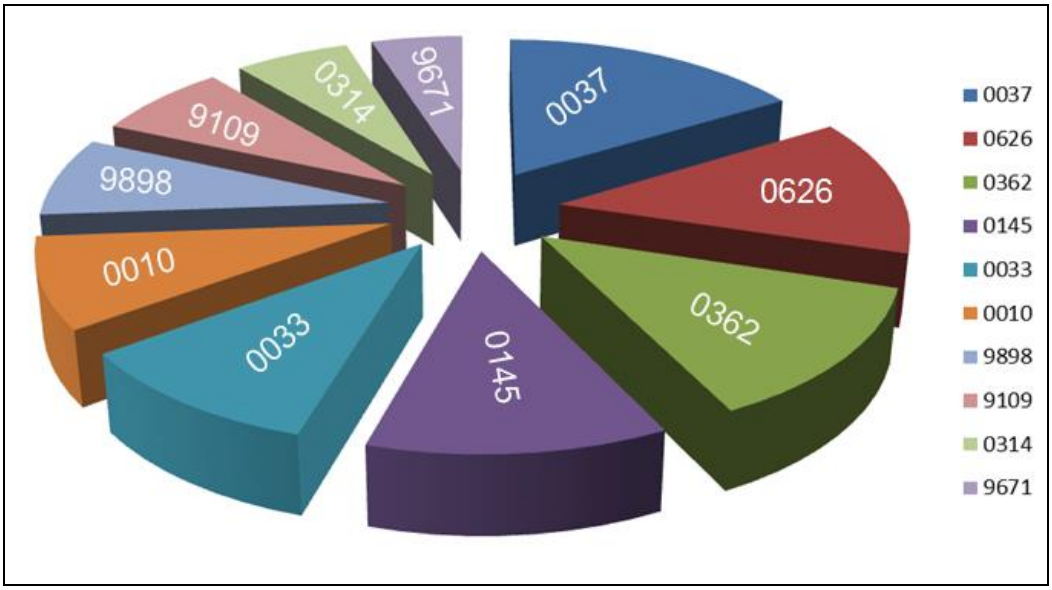
Timeliness must be adhered to for proper submission of follow-up claim forms.

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

NOTES

Outpatient Services RAD Code Chart

Top Common RAD Code Denials



NOTES

Denied Claim Root Causes

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 did not verify recipient eligibility prior to rendering services for each recipient who presents a plastic Benefits Identification Care (BIC), Managed Care Plan (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 what 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 0626

Denied Claim Message

RAD CODE: 0626	Non-emergency related services are not payable for aid code 55 recipients.

Root Cause of Denial

Provider billed non-emergency services when the recipient is only eligible for pregnancy-related, postpartum and emergency services.

Billing Tips

- Verify the recipient's eligibility prior to rendering services.

NOTE

If the services were emergency-related, refer to the "Emergency Certification" heading in the *UB-04 Completion: Outpatient Services* section (ub comp op) of the Part 2 provider manual.

NOTES

RAD Code 0362

Denied Claim Message

RAD CODE: 0362	Procedure number billed is not an authorized Medi-Cal procedure code.

Root Cause of Denial

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

Billing Tips

- Verify procedure code is a valid Medi-Cal benefit via Transaction Services or contact the Telephone Service Center (TSC) at 1-800-541-5555.

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

Provider billed for a service that is not a Medi-Cal benefit on the date of service.

Billing Tips

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

NOTES

RAD Code 0033

Denied Claim Message

RAD CODE: 0033	The recipient is not eligible for the special program billed and/or restricted services billed.

Root Cause of Denial

Recipient is not eligible for the service(s) being billed.

Billing Tips

- Verify recipient aid code(s)
- Confirm recipient may be restricted to special programs and/or service eligibility.
- Ensure provider is eligible to bill for special programs and/or services by verifying provider's Category of Service with administrator.

Refer to the *Eligibility: Service Restrictions* section (elig rstrict) of the Part 1 provider manual for restricted services codes and messages.

NOTES

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 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 9898

Denied Claim Message

RAD CODE: 9898	HCPCS Qualifier and NDC (National Drug Code)/UPN (Universal Product Number) is invalid.

Root Cause of Denial

The HCPCS qualifier and/or NDC/UPN is invalid.

Billing Tips

- Verify the product ID qualifier N4 followed by the 11-digit NDC (no spaces or hyphens) is directly following the last digit of the NDC (no space); followed by the two-character unit of measure and numeric quantity.
- Verify the NDC number on the claim is consistent with the 5-4-2 format. Hyphens (-) separate the NDC number into three segments. An 11-digit number must be entered on the claim.
- Verify the NDC is contracted with Medi-Cal.

Refer to the following Part 2 provider manual sections for more information:

- *Physician-Administered Drugs – NDC: UB-04 Billing Instructions* (physician ndc ub)
- *Drugs: Contract Drugs List Part 5 Authorized Drug Manufacturer Labeler Codes* (drugs cdl p5)

NOTES

RAD Code 9109

Denied Claim Message

RAD CODE: 9109	This service is not payable for the diagnosis billed.

Root Cause of Denial

Provider billed for a diagnosis code that is not payable for this service.

Billing Tips

- Verify procedure code is a valid Medi-Cal benefit via Transaction Services or contact the Telephone Service Center (TSC) at 1-800-541-5555.
- Ensure provider is eligible to bill for the service by verifying provider's Category of Service with administrator.

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 SOC 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 9671

Denied Claim Message

RAD CODE: 9671	Procedure code has not been authorized by CCS/GHPP (California Children's Services/Genetically Handicapped Persons Program).

Root Cause of Denial

Provider billed procedure and/or diagnosis code(s) not authorized by the California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP).

Billing Tips

- Verify procedure code and diagnosis code(s) are valid CCS/GHPP benefits via Transaction Services or contact the Telephone Service Center (TSC) to confirm at 1-800-541-5555.
- Ensure provider is eligible to bill for the service(s) by verifying the CCS/GHPP Service Code Groupings in the California Children's Services (CCS) Program Service Code Groupings section (cal child serv) of the Part 2 provider manual.

NOTES

Outpatient Common Billing Errors

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

NOTE
The following table is also available in the *UB-04 Tips for Billing* section (ub tips op) in the appropriate Part 2 Outpatient Services manual.

Box#	Field Name	Error
6	STATEMENT COVERS PERIOD (FROM-THROUGH)	Entering information in this field, which is not required by Medi-Cal for outpatient claims **Billing Tip:** For outpatient "from-through" billing instructions, see the *UB-04 Special Billing Instructions for Outpatient Services* section (ub spec op) of the appropriate Part 2 provider manual.
18 – 24	CONDITION CODES	Omitting codes or entering a Medi-Cal local billing limit exception code (A, 1 – 9) **Billing Tip:** The delay reason code is entered in the unlabeled field (Box 37A) of the claim. Enter codes in numeric-alpha order. For example, 80, 82, X1.
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. **Billing Tip:** 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.
43	DESCRIPTION	Omitting individual dates of service required after entering description of services rendered **Billing Tip:** The description must identify the particular service code indicated in the *HCPCS/Rate* field (Box 44). For more information, refer to the specific policy section in this manual or the CPT-4 codebook.

Box#	Field Name	Error
44	HCPCS/RATE/ HIPPS CODE	Entering incorrect code for provider type, omitting procedure code or omitting modifier(s) **Billing Tip:** Revenue codes are increasingly required on outpatient claims, including: • Community-Based Adult Services (CBAS) • Home and Community-Based Waiver Services (select codes) • Hospice (room and board only) • EAPC (all codes) EAPC claims must include the required revenue code in the *Revenue Code* field (Box 42) and the HCPCS code, immediately followed by the appropriate modifier, in the *HCPCS/Rate* field (Box 44). Claims submitted without all three will be denied. For Section 340B provider submitting claims for physician administered drugs: omitting the modifier UD. **Billing Tip:** Check instructions in the *UB-04 Completion: Outpatient Services* section (ub comp op) of the Part 2 provider manual for the appropriate location of modifier UD for Section 340B drugs on the *UB-04*.
46	SERVICE UNITS	Entering the wrong service units as required by the billing code **Billing Tip:** Although this is a seven-digit field, Medi-Cal only allows three digits.
54 (A – B)	PRIOR PAYMENTS (Other Coverage)	Missing prior payment or Other Health Coverage not indicated **Billing Tip:** Enter the patient's other health insurance payment. Do not enter Medicare payments in this box.
60 (A – C)	INSURED'S UNIQUE ID	Entering the recipient Medi-Cal ID number incorrectly **Billing Tip:** Verify the recipient is eligible for the services rendered by using the POS network or Automated Eligibility Verification System (AEVS). Do not enter the Medicare ID number.
63 (A – C)	TREATMENT AUTHORIZATION CODES	Entering Eligibility Verification Confirmation (EVC) number instead of the TAR number **Billing Tip:** The EVC number is only for verifying eligibility and should not be entered on the claim.
66	DX	Missing ICD indicator **Billing Tip:** An ICD Indicator of "0" is required for dates of service on or after October 1, 2015.
80	REMARKS	Reducing font size or abbreviating terminology to fit in the field **Billing Tip:** 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.

Knowledge Review 1

Fill in the blanks to complete the common RAD messages:

1. 0037: _____ enrollee, capitated service not billable to Medi-Cal.
2. 0010: This service is a _____ of a previously paid claim.
3. 0626: Non-emergency related services are _____ for aid code 55 recipients.
4. 0362: _____ billed is not an authorized Medi-Cal procedure code.
5. 0314: Recipient is not eligible for the _____of service billed.

NOTES

Answer Key: 1) Health Care Plan; 2) duplicate; 3) not payable; 4) Procedure number; 5) month

Knowledge Review 2

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

1.	_____	RAD 0145	A) HCPCS Qualifier and NDC (National Drug Code)/UPN (Universal Product Number) is invalid.
2.	_____	RAD 0033	B) Procedure code has not been authorized by CCS/GHPP (California Children's Services/Genetically Handicapped Persons Program).
3.	_____	RAD 9671	C) This procedure is not a Medi-Cal benefit on this date of service.
4.	_____	RAD 9109	D) The recipient is not eligible for the special program billed and/or restricted services billed.
5.	_____	RAD 9898	E) This service is not payable for the diagnosis billed.

NOTES

Answer Key: 1) C; 2) D; 3) B; 4) E; 5) A

Resource Information

References

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

Provider Manual References

Part 1

Appeal Process Overview (appeal)
CIF Overview (cif)
Eligibility: Service Restrictions (elig rstrict)
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: 600 – 699 (remit cd600)
Remittance Advice Details (RAD) Codes and Messages: 9000 – 9999 (remit cd9000)
Resubmission Turnaround Document (RTD) Overview (resub)

Part 2

Appeal Form Completion (appeal form)
CIF Special Billing Instructions for Outpatient Services (cif sp op)
UB-04 Completion: Outpatient Services (ub comp op)
UB-04 Special Billing Instructions for Outpatient Services (ub spec op)
UB-04 Tips for Billing: Outpatient Services (ub tips op)