

# Vision Care

# Common Denials

## Introduction

### Purpose

This module will familiarize participants with an overview of the 10 most common denial messages for vision claims, provide billing advice and appropriate follow-up procedures for these denials. The module lists *Remittance Advice Details* (RAD) messages and codes that may be used to reconcile accounts. RAD codes may 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
- Show common billing errors that cause these claim denials
- Offer billing tips to prevent these claim denials
- Give 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)).



# Claim Denial Description

Denied claims result from 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.

## 10 Most Common Denial Messages

Denial #	RAD Code	Message
1	0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
2	0010	This service is a duplicate of a previously paid claim.
3	0036	RTD ( <i>Resubmission Turnaround Document</i> ) was either not returned or was returned uncorrected; therefore, your claim is formally denied.
4	0037	Health Care Plan enrollee, capitated service not billable to Medi-Cal.
5	0314	Recipient is not eligible for the month of service billed.
6	0031	The provider was not eligible for the services billed on the date of service.
7	0657	Recipient not eligible for Medi-Cal benefits until payment/denial information is given from other insurance carrier.
8	0351	Additional benefits are not warranted per Medi-Cal regulations.
9	0012	Medi-Cal benefits cannot be paid without proof of payment/description of the denial from Medicare.
10	0196	This procedure requires a modifier, modifier is not present.

## Denied Claim Follow-Up Options

When a claim has been denied, depending on reason for the denial, there are three follow-up procedures available to providers to get the claim paid:

- Rebill the claim
- Submit a *Claims Inquiry Form* (CIF)
- Submit an appeal

### Timeliness Policy

Timeliness must be adhered to for the 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	six months from the denial date (date on RAD)
Submit an Appeal	90 days from the denial date (date on RAD)

# Denied Claim Follow-Up Procedures

## Denial Code #1

### Denied Claim Message

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

### Follow-Up Procedure

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

### Billing Tips

- Verify the recipient's eligibility with a valid Medi-Cal Benefits Identification Card (BIC) prior to rendering services (except in an emergency) using the Point of Service (POS) network, Medi-Cal website ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)) or Automated Eligibility Verification System (AEVS).
- Check the recipient's Date of Birth (DOB) and Date of Issue (DOI) on the BIC.
- Verify that the recipient's 14-character Medi-Cal BIC number matches the number billed on the claim and/or on the RAD.

### NOTES

---

---

---

---

---

---

---

---

---

---

## Denial Code #2

### Denied Claim Message

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

### Follow-Up Procedure

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

### Billing Tips

- Check the NPI.
- Verify the recipient's 14-character Medi-Cal BIC number.
- Check "from-through" dates.
- Check records for previous payments. If no payment is found, verify all relevant information such as procedure code, modifier and rendering provider number/NPI.

### NOTES

---

---

---

---

---

---

---

---

---

---

## Denial Code #3

### 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.
----------------	--

### Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0036 is to rebill the claim.

### Billing Tips

- Verify the recipient's eligibility, name, DOB, DOI and all relevant information.
- Return the RTD by the date indicated at the top of the RTD.
- If the claim was resubmitted, disregard the denial.

### NOTES

---

---

---

---

---

---

---

---

---

---

---

## Denial Code #4

### Denied Claim Message

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

### Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0037 is to bill the appropriate plan if you are a contracted provider; otherwise, submit an appeal within 90 days if the services are not covered under the plan.

### Billing Tips

- Verify the recipient's eligibility prior to rendering services.
- Check the recipient's Health Care Plan. Ensure charges are covered under a capitation agreement/managed care plan and bill accordingly.
- Verify that the recipient's 14-character Medi-Cal BIC number matches the number billed on the claim and/or on the RAD to ensure the correct plan is being billed.

### NOTES

---

---

---

---

---

---

---

---

---

---

## Denial Code #5

### Denied Claim Message

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

### Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0314 is to submit an appeal within 90 days from the date on the RAD.

### Billing Tips

- Verify the date of service on the claim.
- Verify the recipient's eligibility with a valid Medi-Cal BIC prior to rendering service (except in an emergency), using the POS network, Medi-Cal website or AEVS.
- Verify if the recipient has a Share of Cost (SOC), then collect and spend down the SOC, as appropriate.
- For billing guidelines, refer to the *Share of Cost (SOC): CMS-1500* section (share cms) of the Part 2 provider manual.

### NOTES

---

---

---

---

---

---

---

---

---

---

## Denial Code #6

### Denied Claim Message

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

### Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0031 is to submit an appeal within 90 days from the date on the RAD.

### 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. Check if provider is still active. If not active, contact the Department of Health Care Services (DHCS) Provider Enrollment Division.

### NOTES

---

---

---

---

---

---

---

---

---

---

## Denial Code #7

### Denied Claim Message

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

### Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0657 is to rebill the claim, timeliness permitting. Otherwise, submit an appeal within 90 days from the date on the RAD.

### Billing Tips

- Check your records for payment and/or denial from other insurance carrier.
- Verify the primary payer information provided was reported with claim and is legible.
- Verify if the recipient has Other Health Coverage (OHC) and has attached the Remittance Advice (RA) or Explanation of Benefit (EOB).

### NOTES

---

---

---

---

---

---

---

---

---

---

## Denial Code #8

### Denied Claim Message

RAD Code: 0351	Additional benefits are not warranted per Medi-Cal regulations.
----------------	---

### Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0351 is to rebill the claim or submit an appeal within 90 days from the date on the RAD.

### Billing Tips

- Verify that the number of days or units for the services billed on the claim do not exceed the acceptable maximum.
- For interim eye examinations within the 24-month coverage period, refer to the *Professional Services: Diagnosis Codes* section in the *Part 2 – Vision Care* manual for a list of valid diagnosis codes that must be billed with CPT-4 codes 92004 and 92014 for reimbursement.

### NOTES

---

---

---

---

---

---

---

---

---

---

## Denial Code #9

### Denied Claim Message

RAD Code: 0012	Medi-Cal benefits cannot be paid without proof of payment/description of the denial from Medicare.
----------------	--

### Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0012 is to rebill the claim if still within 6 months following the month of service or submit an appeal within 90 days from the date on the RAD.

### Billing Tips

- Attach a dated copy of the Medicare EOMB/MRN/RA for the date of service
- Attach a denial from Medicare for the date of service
- If the Medicare denial description is not printed on the front of the EOMB/MRN/RA, include a copy of the description from the back of the EOMB/MRN/RA or the Medicare manual when billing for a denied claim
- Refer to the Medicare/Medi-Cal claim section in the appropriate Part 2 provider manual for unacceptable Medicare documentation

### NOTES

---

---

---

---

---

---

---

---

---

---



# Common Billing Errors

The following fields must be completed accurately and completely on the *CMS-1500* claim form to avoid suspended or denied claims.

## NOTE

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	Error
1	Medicare/Medi-Cal Other ID	Not checking the appropriate box(es) <b>Billing Tip:</b> Check both the Medicaid and Medicare boxes when billing Medicare crossover claims.
1A	Insured's ID Number	Entering the recipient's ID number incorrectly <b>Billing Tip:</b> Verify that the recipient is eligible for the services rendered by using the POS network or telephone AEVS. Do not enter the Medicare ID number on a straight Medi-Cal claim.
2	Patient's Name	The <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).
19	Additional Claim Information (Designated by NUCC)	Reducing font size or abbreviating terminology to fit in the field <b>Billing Tip:</b> If additional information cannot be entered completely, attach additional information to the claim. Reducing font size below 8 point and abbreviating terminology may result in scanning difficulties and/or medical review denials.
21 A-L	Diagnosis or Nature of Illness or Injury  Relate A-L to service line below (24E)	Entering more than two diagnosis codes <b>Billing Tip:</b> No description is required. Enter additional diagnosis codes in <i>Additional Claim Information</i> field (Box 19). <b>Note:</b> All claim forms must be submitted with an ICD indicator. A "0" indicates the claim was submitted with ICD-10-CM codes. A "9" indicates ICD-9-CM codes.
23	Prior Authorization Number	Entering Eligibility Verification Confirmation (EVC) number instead of the TAR Control Number (TCN) <b>Billing Tip:</b> The EVC number is only for verifying eligibility. Do not enter this number on the claim. Enter the 10-digit TCN followed by the Pricing Indicator (PI) on the claim (for a total of 11 digits).
24B	Place of Service	Entering the wrong two-digit Place of Service code <b>Billing Tip:</b> Enter a Medi-Cal local Place of Service code instead of a national Place of Service code.
24D	Procedures, Services or Supplies	Omitting modifiers or entering incorrect information when required <b>Billing Tip:</b> Do not use Medicare modifiers. Enter procedure description, if necessary, in the <i>Additional Claim Information</i> field (Box 19). A list of modifiers accepted by Medi-Cal may be found in the Part 2 <i>Vision Care</i> manual.

# Learning Activities

## Learning Activity 1: Matching Terms Puzzle

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

- |  |  |
|--|--|
| 1. _____ BIC   | A) Client Index Number                     |
| 2. _____ CIN   | B) <i>Resubmission Turnaround Document</i> |
| 3. _____ EOB   | C) Health Care Plan                        |
| 4. _____ HCP   | D) Share of Cost                           |
| 5. _____ NPI   | E) Benefits Identification Card            |
| 6. _____ POE   | F) National Provider Identifier            |
| 7. _____ RAD   | G) Proof of Eligibility                    |
| 8. _____ RTD   | H) TAR Control Number                      |
| 9. _____ Spend Down                                  | I) Remittance Advice Details               |
| 10. _____ Treatment/Service<br>Authorization Request | J) Explanation of Benefits                 |
| 11. _____ TCN  | K) TAR or SAR                              |
| 12. _____ DHCS                                       | L) Department of Health Care Services      |
| 13. _____ HMO  | M) Health Maintenance Organization         |

**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; 13) M

## Learning Activity 2: Word Scramble

Unscramble the following words:

1. ematceRitn \_\_\_\_\_
2. OCS \_\_\_\_\_
3. alenDsi \_\_\_\_\_
4. wol-upIFo \_\_\_\_\_
5. msleTinise \_\_\_\_\_
6. ImsiaC \_\_\_\_\_
7. cRiiptene \_\_\_\_\_
8. ribesbrcSu \_\_\_\_\_
9. MngaaederaCalnP \_\_\_\_\_

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