

Outpatient 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, provide 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 outpatient services
- Show common billing errors that cause denials
- Offer billing tips to prevent 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).

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: 600 – 699 (remit cd600)

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 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)

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	0145	This procedure is not a Medi-Cal benefit on this date of service.
5	0169	This service is not payable when billed with this diagnosis.
6	0250	Quantity exceeds allowed for per-visit codes, or a claim with the same date of service and the same per-visit code was found in history. Medical justification required.
7	0093	Non-emergency services are not payable for limited service OBRA/IRCA recipients.
8	9898	HCPCS Qualifier and NDC (National Drug Code)/UPN (Universal Product Number) is invalid.
9	0036	RTD (<i>Resubmission Turnaround Document</i>) was either not returned or was returned uncorrected; therefore, your claim is formally denied.
10	0626	Non-emergency related services are not payable for aid code 55 recipients.

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 (on RAD)
Submit an Appeal	Within <u>90 days</u> of the denial date on the RAD

NOTES

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.

NOTES

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.

NOTES

Denial Code #4

Denied Claim Message

RAD CODE: 0145	This procedure is not a Medi-Cal benefit on this date of service.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0145 is to 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: 0169	This service is not payable when billed with this diagnosis.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0169 is to rebill the claim with the corrected information.

Billing Tips

- Verify primary diagnosis code.
- Verify procedure code.
- Verify modifier.

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Denial Code #6

Denied Claim Message

RAD CODE: 0250	Quantity exceeds allowed for per-visit codes, or a claim with the same date of service and the same per-visit code was found in history. Medical justification required.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0250 is to submit an appeal within 90 days or rebill the claim.

Billing Tips

- Provide reason for multiple services done on the same date of service and attach medical justification.

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Denial Code #7

Denied Claim Message

RAD CODE: 0093	Non-emergency services are not payable for limited service OBRA/IRCA recipients.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0093 is to submit an appeal within 90 days from the RAD denial date.

Billing Tips

- Check the *Emergency Verification* field.
- Attach a copy of the Emergency Verification Statement.
- Refer to the *OBRA and IRCA* section of Part 1 provider manual for billing guidelines.

NOTES

Denial Code #8

Denied Claim Message

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

The appropriate follow-up procedure for RAD code 9898 is to submit an appeal within 90 days from the RAD denial date.

Billing Tips

- Verify N4 qualifier is used.
- Verify the five-four-two format.
- Zero fill the five-four-two format if needed.
- Review NDC for transcription errors.

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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: 0626	Non-emergency related services are not payable for aid code 55 recipients.
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Follow-Up Procedure

The appropriate follow-up procedure for RAD code 0626 is to rebill the claim or CIF with the corrected information within six months from the RAD denial date.

Billing Tips

- Verify the correct aid code using the *Aid Codes Master Chart* (aid codes) section of the Part 1 provider manual. Aid code 55 is restricted to pregnancy and emergency services.

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 <i>UB-04 Special Billing Instructions for Outpatient Services</i> 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 <i>HCPCS/Rate</i> 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	<p>Entering incorrect code for provider type, omitting procedure code or omitting modifier(s)</p> <p>Billing Tip: Revenue codes are increasingly required on outpatient claims, including:</p> <ul style="list-style-type: none"> • Adult Day Health Care (ADHC) (all codes) • Home and Community-Based Waiver Services (select codes) • Hospice (room and board only) • EAPC (all codes) <p>EAPC claims must include the required revenue code in the <i>Revenue Code</i> field (Box 42) and the HCPCS code, immediately followed by the appropriate modifier, in the <i>HCPCS/Rate</i> field (Box 44). Claims submitted without all three will be denied.</p> <p>For Section 340B provider submitting claims for physician administered drugs: omitting the modifier UD.</p> <p>Billing Tip: Check instructions in the <i>UB-04 Completion: Outpatient Services</i> section of this manual for the appropriate location of modifier UD for Section 340B drugs on the <i>UB-04</i>.</p>
46	SERVICE UNITS	<p>Entering the wrong service units as required by the billing code</p> <p>Billing Tip: Although this is a seven-digit field, Medi-Cal only allows three digits.</p>
54 (A – B)	PRIOR PAYMENTS (Other Coverage)	<p>Missing prior payment or Other Health Coverage not indicated</p> <p>Billing Tip: Enter the patient's other health insurance payment. Do not enter Medicare payments in this box.</p>
60 (A – C)	INSURED'S UNIQUE ID	<p>Entering the recipient Medi-Cal ID number incorrectly</p> <p>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.</p>
63 (A – C)	TREATMENT AUTHORIZATION CODES	<p>Entering Eligibility Verification Confirmation (EVC) number instead of the TAR number</p> <p>Billing Tip: The EVC number is only for verifying eligibility and should not be entered on the claim.</p>
66	DX	<p>Missing ICD indicator</p> <p>Billing Tip: An ICD Indicator of "0" is required for dates of service on or after October 1, 2015.</p>
80	REMARKS	<p>Reducing font size or abbreviating terminology to fit in the field</p> <p>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.</p>

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 iitdcanro _____

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