

# LTC Common Denials

## Introduction

### Purpose

This module will familiarize participants with an overview of the most common denial messages when billing with the *Payment Request for Long Term Care (25-1)* claim form for Long Term Care services, providing billing advice and appropriate follow-up procedures for 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 Long Term Care (LTC) claims
- 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](http://www.medi-cal.ca.gov/mcss)).

### **References**

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

#### **Provider Manual References**

##### **Part 1**

*Eligibility: Recipient Identification Cards* (elig rec crd)

*Eligibility Medicare/Medi-Cal Crossover Claims Overview* (medicare)

*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 cd9000)

*Share of Cost (SOC)* (share)

##### **Part 2**

*Appeal Form Completion* (appeal form)

*CIF Special Billing Instructions for Long Term Care* (cif sp ltc)

*Payment Request for Long Term Care (25-1) Completion* (pay ltc comp)

*TAR Field Office Addresses* (tar field)

### **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.

## 10 Most Common Denial Messages

Denial #	RAD Code	Message
1	0010	This service is a duplicate of a previously paid claim.
2	0243	The TAR Control Number submitted on the claim is not found on the TAR master file.
3	0314	Recipient is not eligible for the month of service billed.
4	0037	Health Care Plan enrollee, capitated service not billable to Medi-Cal.
5	0006	The date(s) of service reported on the claim is not within the TAR ( <i>Treatment Authorization Request</i> ) authorized period.
6	0036	RTD ( <i>Resubmission Turnaround Document</i> ) was either not returned or was returned uncorrected; therefore, your claim is formally denied.
7	0171	Aid code 80 recipients are restricted to Medicare coinsurance and deductible payments.
8	0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
9	0044	Accommodation code is not appropriate for patient status code listed.
10	0005	The service billed requires an approved TAR ( <i>Treatment Authorization Request</i> ).

# 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 three 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 RAD)

## NOTES

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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 the appeals unit is common practice used to resolve denials if the claim has a circumstance needing 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-thru" dates.
- Check records for previous payments. If no payment is found, verify all relevant information.  
Example: Procedure code, modifier and rendering provider number/NPI
- Verify the recipient's discharge status when billing for inpatient services.

### NOTE

Submitting incorrect recipient admission and discharge dates and/or incorrect patient status codes is a frequent cause of Medi-Cal claim denials. When a provider submits a claim with erroneous from-through dates or patient status, it can result in claim denials for claims billed by another provider. When this happens, the claims are denied even if the other provider billed the claim correctly. This is most often a problem when hospitals and nursing homes transfer a patient. Providers see the result of these billing conflicts on their *Remittance Advice Details* as a claim denied with RAD code 0010.

If the providers of a denied claim choose to dispute the claim and are not able to reach consensus on the dates in question, Medi-Cal could recoup the full reimbursement of the original erroneously billed claim. In this case, Medi-Cal will not make an adjustment without a correction request form from the providers.

Incorrectly paid and denied claims can result in discrepancies in provider reimbursement data and in health service records. This can impact beneficiary Share of Cost (SOC), access to services and estate recovery.

For assistance in resolving billing conflicts, providers may write to the Correspondence Specialist Unit:

Correspondence Specialist Unit  
P. O. Box 13029  
Sacramento, CA 95813-4029

For more information about how to correctly complete a claim, refer to one of the claim completion sections in the appropriate Part 2 provider manual.



## Denial Code #3

### Denied Claim Message

RAD Code: 0314	The 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 recipient's eligibility with a valid Medi-Cal Benefits Identification Card (BIC) prior to rendering service, except in an emergency.
- Verify recipient's eligibility.
- Verify if the recipient has a Share of Cost (SOC) and is eligible for the month of service.
- Collect and spend down the SOC.

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## Denial Code #4

### 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.
- Determine the Health Care Plan (HCP).
- Bill the appropriate HCP.

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## Denial Code #5

### Denied Claim Message

RAD Code: 0006	The date(s) of service reported on the claim is not within the TAR ( <i>Treatment Authorization Request</i> ) authorized period.
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### Follow-up Procedure

The appropriate follow-up procedure for RAD code 0006 is to rebill the claim or submit a CIF within six months.

### Billing Tips

- Verify date(s) of service on the claim. If incorrect, resubmit with correct date(s) of service. Verify recipient's eligibility.
- Verify the approved date(s) of service on the TAR. If incorrect, request correction of the TAR in writing from your local Medi-Cal field office.
- Refer to the *TAR Field Office Addresses* (tar field) section in the appropriate Part 2 provider manual for field office addresses.

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# Denial Code #6

## 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.

## Billing Tips

- Verify recipient’s eligibility with a valid Medi-Cal BIC prior to rendering service, except in an emergency.
- Check recipient’s name, date of birth (DOB), date of issue (DOI) and all other relevant information.
- Resubmit claim with correct information. If the RTD form is available, find out what error resulted in a denied claim.

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## Denial Code #7

### Denied Claim Message

RAD Code: 0171	Aid code 80 recipients are restricted to Medicare coinsurance and deductible payments.
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### Follow-up Procedure

The appropriate follow-up procedure for RAD code 0171 is to rebill the claim or submit an appeal.

### Billing Tips

- If the patient is a Qualified Medicare Beneficiary (QMB) program recipient, verify that the claim is for Medicare deductible and/or coinsurance.
- Medicare non-covered services are not payable for QMB recipients, unless the recipient is eligible for Medi-Cal.
- Some Medi-Cal recipients may have additional eligibility after their Share of Cost (SOC) clears.
- Before denying services to the patient, verify billing eligibility online.

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# Denial Code #8

## Denied Claim Message

RAD Code: 0002	Recipient is not eligible for benefits under the Medi-Cal program or other special programs.
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## Follow-up Procedure

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

## Billing Tips

- Verify recipient’s SSN or the number and date of issue on the BIC. Verify the recipient’s 14-character ID number on the RAD.
- Refer to the *Eligibility: Recipient Identification Cards* section of the Part 1 provider manual for billing guidelines.

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## Denial Code #9

### Denied Claim Message

RAD Code: 0044	Accommodation code is not appropriate for patient status code listed.
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### Follow-up Procedure

The appropriate follow-up procedure for RAD code 0044 is to rebill the claim or submit a CIF within six months.

### Billing Tips

- Verify information on the approved TAR.
- Verify the patient status code.
- Verify that the accommodation code is placed in the appropriate field on the 25-1.

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# Denial Code #10

## 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 rebill the claim or submit a CIF or an appeal.

## Billing Tips

- A TAR must be submitted for services that are not part of the Medi-Cal inclusive per-diem rate for nursing facilities.
- Occupational, physical, speech and psychiatric therapy rendered to NF-A or NF-B recipients requires authorization.
- The recipient must reside in an NF-A or NF-B
- The recipient must require therapy services by a trained, licensed therapist.
- The therapy service(s) must be medically necessary and/or necessary to attain or maintain the highest practicable occupational, mental and psychosocial functioning.

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# Common Billing Errors

This section describes the *Payment Request for Long Term Care (25-1)* claim form fields that must be completed accurately and completely to avoid claim suspense or denial. Tips below are designed to supplement instructions in the *Payment Request for Long Term Care (25-1) Completion* section (pay ltc comp) of the Part 2 LTC provider manual.

Field(s)	Description	Error
Explanations	MEDICARE PART B, DUPLICATE CLAIM	<p>Billing two Part B Medicare claim lines for the same recipient with overlapping dates of service.</p> <p><b>Billing Tip:</b> Enter the reason for the overlapping dates of service in the <i>Explanations</i> field. For example, "Line 1: This is not a duplicate claim. This claim is for speech therapy. Line 2: The physical therapy claim (same recipient for overlapping dates of service was billed on an earlier date [give specific date]). A copy of the claim is attached."</p>
Explanations	SHARE OF COST	<p>Failure to identify the reason for reduction in a recipient's SOC.</p> <p><b>Billing Tip:</b> Identify the SOC for the patient, minus the non-covered services in the <i>Explanations</i> field. For example, "Share of Cost 300.00 (-) non-covered services 27.70 = Pat Liab/Medicare Deduct 272.30."</p>
11, 30, 49, 68, 87, 106	BILLING LIMIT EXCEPTIONS	<p>Omitting valid delay reason codes for claims submitted more than six months from the date of service.</p> <p><b>Billing Tip:</b> Enter the delay reason code in the designated field.</p>
14, 33, 52, 71, 90, 109	PATIENT STATUS	<p>Entering the patient status code in the wrong field.</p> <p><b>Billing Tip:</b> Enter the status code in the <i>Patient Status</i> field.</p>
15, 34, 53, 72, 91, 110	ACCOMMODATION CODE	<p>Entering the accommodation code in the wrong field.</p> <p><b>Billing Tip:</b> Enter the accommodation code in the <i>Accommodation Code</i> field.</p>
16, 35, 54, 73, 92 and/or 111	PRIM DX CODE	<p>Claims with a diagnosis code in the <i>Prim DX Code</i> field must include the ICD indicator "0". The indicator is placed as the first digit in the field, no spaces or dashes separating it from the diagnosis code.</p>

**Common Billing Errors (Continued)**

Field(s)	Description	Error
19, 38, 57, 76, 95, 114	OTHER HEALTH COVERAGE	<p>Claim submitted to Medi-Cal with a billing limit exception code or delay reason code or attachment indicating that the claim was submitted to Medicare and/or OHC more than one year from the month of service.</p> <p><b>Billing Tip:</b> Bill Medicare or the OHC within one year of the month of service to meet Medi-Cal timeliness requirements. Submit claim to the DHCS Fiscal Intermediary within 60 days of Medicare or OHC carrier's resolution. Use the OHC <i>Explanation of Benefits</i> date or Medicare <i>Remittance Advice</i> date to calculate timeliness.</p>
12 and 13, 31 and 32, 50 and 51, 69 and 70, 88 and 89, 107 and 108	DATE OF SERVICE (FROM – THRU)	<p>From – Thru dates of service do not correspond with the authorized from-thru dates of service on the TAR.</p> <p><b>Billing Tip:</b> Verify that the dates of service on the claim match the approved dates on the TAR or obtain a revised TAR.</p>
14 and 15, 33 and 34, 52 and 53, 71 and 72, 90 and 91, 109 and 110	PATIENT STATUS/ ACCOMMODATION CODE	<p>Entering an accommodation code and status code combination that is inappropriate.</p> <p><b>Billing Tip:</b> Confirm that the patient status code agrees with the accommodation code (that is, if the status code indicates leave days, the accommodation code must also indicate leave days).</p>

# Learning Activities

## Learning Activity 1: Word Scramble

Unscramble the following words:

1. ematceRitn \_\_\_\_\_
2. OCS \_\_\_\_\_
3. alenDsi \_\_\_\_\_
4. wol-uplFo \_\_\_\_\_
5. msleTinise \_\_\_\_\_
6. ImsiaC \_\_\_\_\_
7. cRiiptene \_\_\_\_\_
8. ribesbrcSu \_\_\_\_\_
9. OHM \_\_\_\_\_
10. CDI iidtrocan \_\_\_\_\_

## Learning Activity 2: Matching Terms Puzzle

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

- |                             |  |
|-----------------------------|--|
| _____ BIC                   | 1. Client Index Number                 |
| _____ CIN                   | 2. Resubmission Turnaround Document    |
| _____ EOB                   | 3. Health Care Plan                    |
| _____ HCP                   | 4. Share of Cost                       |
| _____ MCP                   | 5. ID card                             |
| _____ POE                   | 6. Provider Number                     |
| _____ RAD                   | 7. Proof of Eligibility                |
| _____ RTD                   | 8. TAR Control Number                  |
| _____ Spend Down            | 9. Remittance Advice Details           |
| _____ Authorization Request | 10. Explanation of Benefits            |
| _____ TCN                   | 11. TAR or SAR                         |
| _____ DHCS                  | 12. Department of Health Care Services |
| _____ NPI                   | 13. Managed Care Plan                  |

**Answer Key:** 1) Remittance; 2) SOC; 3) Denials; 4) Follow-up; 5) Timeliness; 6) Claims; 7) Recipient; 8) Subscriber 9) HMO 10) ICD indicator  
**Answer Key:** BIC, 5; CIN, 1; EOB, 10; HCP, 3; MCP, 13; POE, 7; RAD, 9; RTD, 2  
Spend Down, 4; Authorization Request, 11; TCN, 8; DHCS, 12; NPI, 6