

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 options
- 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 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

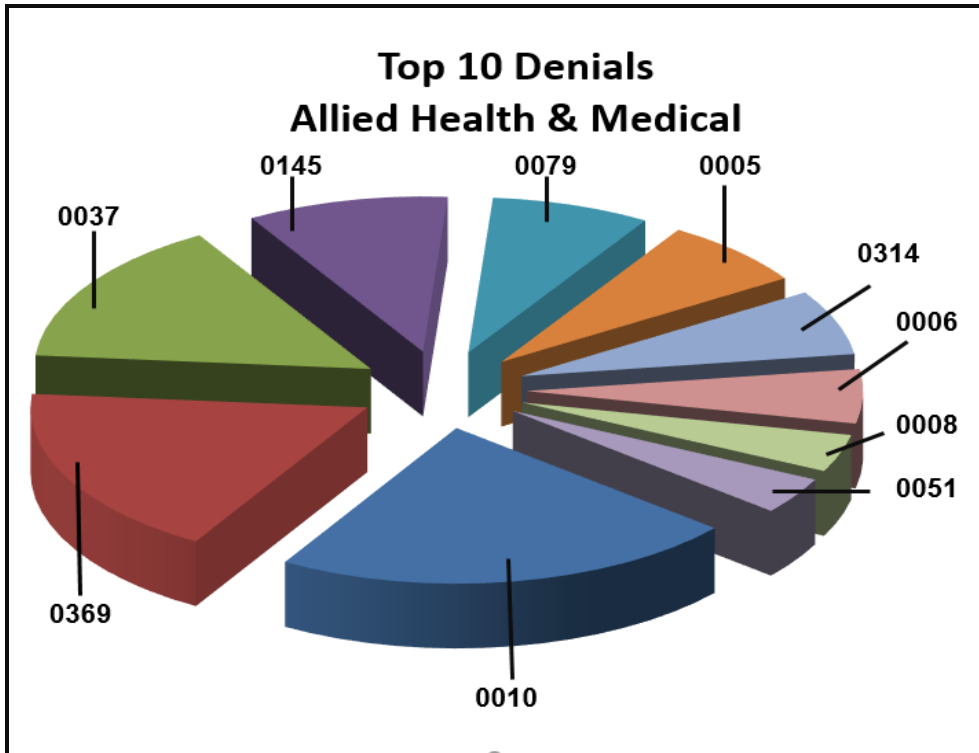
Timeliness must be adhered to for proper submission of follow-up claim forms.

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

NOTES

Allied Health Services RAD Code Chart

Top Common RAD Code Denials



Denied Claim Root Causes

RAD Code 0010

Denied Claim Message

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

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 should 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 0369

Denied Claim Message

RAD Code: 0369	Medical transportation required Emergency Statement or <i>Treatment Authorization Request</i> (TAR).
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Root Cause of Denials

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 the TAR number is correct.
- Verify that the 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 report 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 the hospital name (for example, VMC). Abbreviations are acceptable (for example, Vallet 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 0037

Denied Claim Message

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

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RAD Code 0145

Denied Claim Message

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

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RAD Code 0079

Denied Claim Message

RAD Code: 0079	Service billed exceeds the remaining occurrences on the approved TAR (<i>Treatment Authorization Request</i>).
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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.

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RAD Code 0005

Denied Claim Message

RAD Code: 0005	The service billed requires an approved TAR (<i>Treatment Authorization Request</i>).
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Root Cause of Denial

Treatment authorization number used is either missing or invalid.

Billing Tips

Some procedures/services requiring prior authorization are as follows:

- Purchase or trial period of hearing aid rentals and for repairs that cost more than \$25 per pair service
- Wheelchair carriers and covers for the carrier
- Unlisted Durable Medical Equipment (DME) code E1399
- Orthotics, Prosthetics and listed DME items exceeding the purchase, rental, repair or maintenance prior authorization thresholds as listed in the *California Code of Regulations (CCR)*, Title 22. (For threshold information, refer to the *Durable medical Equipment (DME): An Overview or the Orthotic and Prosthetic Appliances section in the appropriate Part 2 manual.*)
- Generic drug type/medical supply code not on Medi-Cal List of Contract Drugs

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RAD Code 0314

Denied Claim Message

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

The recipient has an unmet share of cost for the month of service.

Billing Tips

- Verify 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 0006

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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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 0008

Denied Claim Message

RAD Code: 0008	The provider of service is not eligible for the type of services billed.
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Root Cause of Denial

The provider is billing with an NPI that is invalid for the type of service that is billed or the provider may be billing on the wrong claim form for their provider type.

Billing Tips

- Verify correct claim form is used for services.
- Verify provider number is correct.
- Contact Provider Enrollment at (916) 636-1945.

NOTES

RAD Code 0051

Denied Claim Message

RAD Code: 0051	Signature is missing or is not original.
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Root Cause of Denial

The signature of the provider is missing or invalid in Box 31 of the *CMS-1500* claim form.

Billing Tips

- Verify that the claim is signed by the provider or an authorized representative.
- Verify that the signature is original and that it is signed in black ballpoint pen only.
- Be sure that the signature is written, not printed. Stamps, initials or facsimiles are not acceptable.

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: <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). 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 <i>Additional Claim Information</i> field (Box 19). Claims submitted to Medi-Cal require an ICD indicator in the <i>ICD-Ind.</i> 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 <i>Adjudication Response</i> 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.

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Box #	Field Name	Error
24B	PLACE OF SERVICE	<p>Entering the wrong Place of Service two-digit code</p> <p>Billing Tip 1: Check instructions in the <i>CMS-1500 Completion</i> (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.</p>
24C	EMG (OR DELAY REASON)	<p>Delay Reason Code: If there is no emergency indicator in the <i>EMG</i> 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.</p> <p>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 <i>CMS-1500: Submission and Timeliness Instructions</i> section (cms sub) in the appropriate Part 2 provider manual.</p> <p>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 <i>EMG</i> field (Box 24C).</p> <p>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.</p> <p>For emergencies in which emergency medical transportation was provided, providers must include an emergency statement. The statement must include:</p> <ul style="list-style-type: none"> • 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 <p>A mere statement that an emergency existed is not sufficient.</p>

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 <i>Additional Claim Information</i> 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.

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|-----|-------|----------|---|
| 1. | _____ | RAD 0037 | A) Medical transportation requires Emergency Statement or TAR (<i>Treatment Authorization Request</i>). |
| 2. | _____ | RAD 0010 | B) Signature is missing or is not an original. |
| 3. | _____ | RAD 0369 | C) Recipient is not eligible for the month of service billed. |
| 4. | _____ | RAD 0005 | 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 0008 | F) The date(s) of service reported on the claim is not within the TAR (<i>Treatment Authorization Request</i>) authorized period. |
| 7. | _____ | RAD 0051 | G) The service billed requires an approved (TAR) <i>Treatment Authorization Request</i> . |
| 8. | _____ | RAD 0145 | H) Service billed exceeds remaining occurrences on the approved TAR (<i>Treatment Authorization Request</i>). |
| 9. | _____ | RAD 0079 | I) This procedure is not a Medi-Cal benefit on this date of service. |
| 10. | _____ | RAD 0006 | J) The provider of service is not eligible for the type of service billed. |

Answer Key: 1) E; 2) D; 3) A; 4) G; 5) C; 6) J; 7) B; 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)