Inpatient Common Denials

Introduction

Purpose

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

Module Objectives

- Identify common claim denial messages for inpatient services
- Provide an overview of claims follow-up options
- 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 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 reimbursed, 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

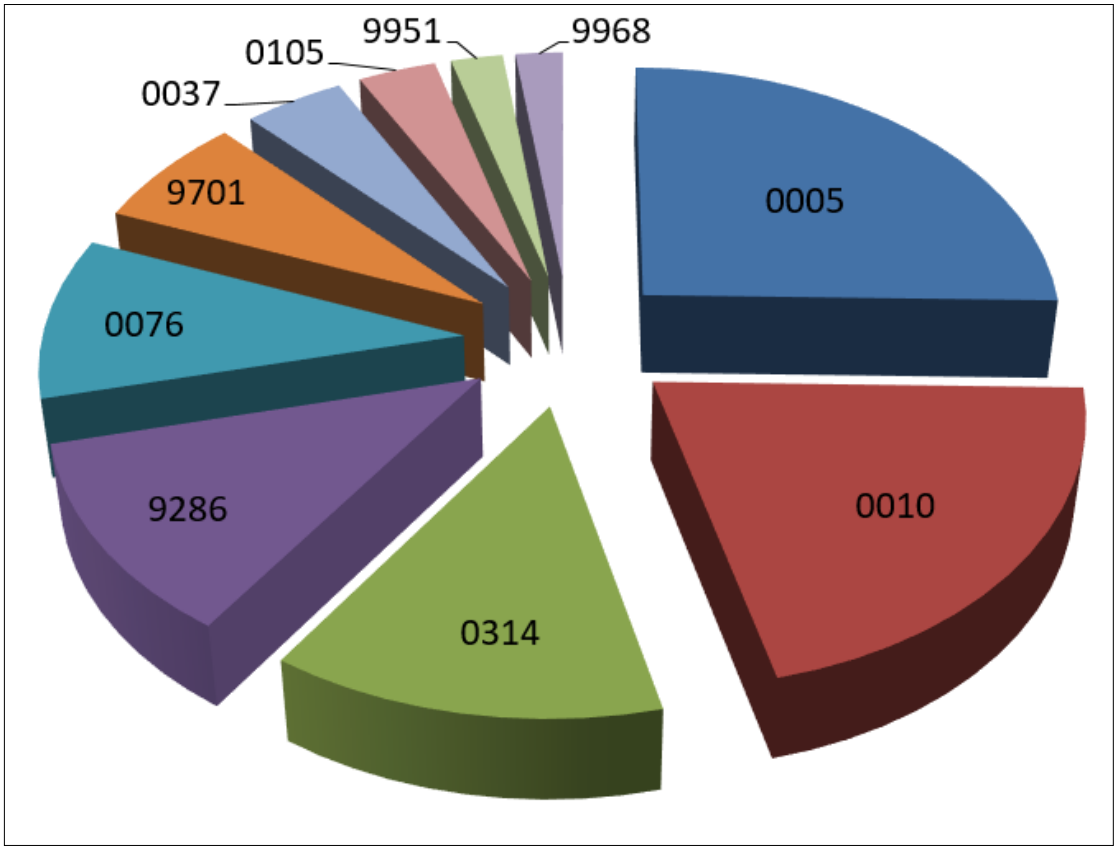
Timeliness must be adhered to for proper submission of follow-up claim forms.

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 the RAD
Submit an Appeal	Within 90 days of the denial date on the RAD

NOTES

Inpatient Services RAD Code Chart

Top Common RAD Code Denials



NOTES

Denied Claim Root Causes

RAD Code 0010

Denied Claim Message

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

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 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 appropriate)
- 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 0314

Denied Claim Message

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

Root Cause of Denial

Recipient has an unmet share of cost (SOC) on the date of service.

Billing Tips

- Verify if the recipient's share of cost 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 of service on the RAD.

Attach a copy of the eligibility printout as proof the share of cost (SOC) has been met.

NOTES

RAD Code 9286

Denied Claim Message

RAD Code: 9286	Cost center code missing/invalid.

Root Cause of Denial

The cost center code is either missing or invalid.

Billing Tips

- Refer to the *Ancillary Codes* section (ancil cod) of the Part 2 provider manual for ancillary codes in Medi-Cal.
- Review your *UB-04* claim form and make sure you have only billed with the appropriate ancillary codes shown in the provider manual.
- Rebill the claim with the correct information if within six months from the month of service.
- If outside the six-month billing limit, submit a CIF within six months from the date of the RAD.
- Submit an appeal within 90 days from the date of the RAD.

NOTES

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 Card (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 0076

Denied Claim Message

RAD Code: 0076	The submitted documentation was not adequate.

Root Cause of Denial

The submitted documentation was not adequate.

Billing Tips

Inpatient providers should verify:

- Date of birth
- Admit
  - Date
  - Hour
  - Date is chronological sequence with discharge date
- Discharge
  - Date
  - Hour
  - Date is prior to “thru” date
- “From” date of service is in chronological sequence with “thru” date
- Surgery/delivery date is note:
  - Missing or invalid
  - Before admission on or after discharge date
- Primary diagnosis procedure code is on file or not missing, invalid or unclear
- Secondary diagnosis procedure code is on file
- Primary surgical procedure code is on file or not missing, invalid or unclear
- Secondary surgical procedure code is on file
- Attending physician provider number
- Family Planning EPSDT indicator
- Cost Center
  - Charge number
  - Code
  - Accommodation
  - Units of Service
- Blood deductible amount
- Medicare
  - Date of RA (Remittance Advice)/EOMB (Explanation of Medicare Benefits)
  - Deductible amount
  - Coinsurance amount
- Total charges billed is entered and valid
- Recipient Share of Cost amount
- Net amount is entered and valid

Claims Follow-Up

- Rebill the claim with the correct information if within six months from the month of service.
- If outside the six-month billing limit, submit a CIF within six months from the date of the RAD.

NOTES

RAD Code 9701

Denied Claim Message

RAD Code: 9701	The ancillary code is invalid for date of service.

Root Cause of Denial

The ancillary code is invalid for date of service.

Billing Tips

- Verify the ancillary code being billed with the date of service is correct for that date.
- Refer to the *Ancillary Codes* section (ancil cod) of the Part 2 provider manual to see if the specific ancillary code can be billed with administrative days.
- Correct your claim and rebill it if still within six months following the month of service.
- Submit a CIF within six months from your last RAD date.

NOTES

RAD Code 0105

Denied Claim Message

RAD Code: 0105	This service requires a valid sterilization *Consent Form*.

Root Cause of Denial

Claim was submitted without a sterilization *Consent Form* (PM 330).

Billing Tips

- Instructions must be followed exactly or the PM 330 will be returned and reimbursement delayed or denied.
- For more information regarding claim form completion requirements, refer to the *Sterilization* section (ster) in the Part 2 provider manual.
- Rebill your claim and attach the *PM-330 Sterilization Consent* form.

NOTES

RAD Code 9968

Denied Claim Message

RAD Code: 9968	No Approved TAR on File for APR-DRG Inpatient Admission.

Root Cause of Denial

An approved *Treatment Authorization Request* (TAR) was not on file for the date of admission.

Billing Tips

- An admit TAR is a TAR that is submitted to request authorization for the entire hospital stay.
- For DRG-reimbursed hospitals, most inpatient stays require only an admit TAR and not a daily TAR.
- Confirm the TAR is for the same date as the admission date on the claim.
- Verify TAR was approved and not cancelled.
- Review the *Diagnosis-Related Groups (DRG): Inpatient Services* section (diagnosis ip) of the Part 2 provider manual for exceptions.
- If you obtained a valid TAR, make sure you entered the 11-digit number in field 63 of your *UB-04* claim form.

NOTES

RAD Code 0005

Denied Claim Message

RAD Code: 0005	The service billed requires an approved TAR (*Treatment Authorization Request).*

Root Cause of Denial

TAR field number on the claim was blank or the TAR listed on the claim was not approved.

Billing Tips

- Verify the TAR number on the claim.
- Verify the date(s) of service on the claim matches the date(s) on the TAR.
- Verify the TAR was approved.
- Rebill claim and enter approved 11-digit TAR number in field 63 of your claim form.

NOTES

RAD Code 9951

Denied Claim Message

RAD Code: 9951	APR-DRG – Mother and Newborn Services Cannot Be Billed On Same Claim.

Root Cause of Denial

APR-DRG – Mother and newborn services cannot be billed on the same claim.

Billing Tips

- Refer to *Obstetrics: Revenue Codes and Billing Policy for DRG-Reimbursed Hospitals* section (ob rev drg) of the Part 2 provider manual for instructions on how to bill for mother and newborn services.
- The mother's delivery and hospital stay are billed on one claim.
- The newborn's services and hospital stay are billed on a second claim separate from the mother's claim.
- Claims for the newborn must be billed using the same ID number for the entire length of the hospital stay.
- Hospitals are encouraged to complete the *Newborn Referral Form* and submit it to the County Welfare Office to expedite assignment of the newborn's ID number.
- If separate claims (interim claims) are submitted for services rendered to the newborn, each claim must contain the same recipient ID number from the date of admission through the final discharge claim.

NOTES

Inpatient Common Billing Errors

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

NOTE
The following table can be found in *UB-04 Tips for Billing: Inpatient Services* section (ub tips ip) in the Part 2 Inpatient Services manual.

Box#	Field Name	Error
18 – 24	CONDITION CODES	Omitting codes or entering a Medi-Cal local billing limit exception code (X0, X1 – X9) **Billing Tip:** The delay reason code is entered (Box 37A) of the claim. Enter codes in numeric-alpha order. For example, 80, 82, A1.
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.
50 (A – C)	PAYER NAME	Missing all payer information **Billing Tip:** Enter the "I/P" indicator. Example: **I/P MEDI-CAL**
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 a decimal, dollar ($), plus (+) or minus (-) sign. Do not enter Medicare payments in this box.
56	NPI	Missing or incorrect NPI number **Billing Tip:** Enter the NPI.
60 (A – C)	INSURED'S UNIQUE ID	Entering the recipient's Medi-Cal ID number incorrectly **Billing Tip:** Verify the recipient is eligible for the services rendered by using the POS network. Do not enter the Medicare ID number.

Box #	Field Name	Error
63 (A – C)	TREATMENT AUTHORIZATION CODES	Entering 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/discharge on or after October 1, 2015.
74 (A – B)	PRINCIPAL PROCEDURE CODE AND DATE	Missing or incorrect ICD-10-PCS code or a CPT/HCPCS procedure code entered
76	ATTENDING PHYSICIAN ID	Missing or incorrect attending physician's NPI **Billing Tip:** Do not enter the operating or admitting NPI in this field. Enter attending physician's NPI.
77	OPERATING PHYSICIAN ID	Missing or incorrect operating physician's Medi-Cal provider number/ID Qualifier/NPI. Enter operating physician's NPI number here.
78 – 79	OTHER (Admitting Physician Provider Number) NPI	Missing or incorrect admitting physician's NPI Enter the admitting physician's NPI here.
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.

NOTES

Knowledge Review

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

1.	_____	RAD 0010	A) APR-DRG – Mother and Newborn Services Cannot Be Billed On Same Claim
2.	_____	RAD 0314	B) The service billed requires an approved TAR (*Treatment Authorization Request*).
3.	_____	RAD 9286	C) No Approved TAR on File for APR-DRG Inpatient Admission.
4.	_____	RAD 0037	D) This service requires a valid sterilization *Consent Form*.
5.	_____	RAD 0076	E) The ancillary code is invalid for the date of service.
6.	_____	RAD 9701	F) The submitted documentation was not adequate.
7.	_____	RAD 0105	G) This service is a duplicate of a previously paid claim.
8.	_____	RAD 0005	H) Cost center code missing/invalid
9.	_____	RAD 9968	I) Health Care Plan enrollee, capitated service not billable to Medi-Cal.
10.	_____	RAD 9951	J) Recipient is not eligible for the month of service billed.

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Answer Key: 1) G; 2) J; 3) H; 4) I; 5) F; 6) E; 7) D; 8) B; 9) C; 10) 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)
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 cd900)

Part 2

Ancillary Codes (ancil cod)
Appeal Form Completion (appeal form)
CIF Special Billing Instructions for Inpatient Services (cif sp ip)
Diagnosis-Related Groups (DRG): Inpatient Services (diagnosis ip)
Obstetrics: Revenue Codes and Billing Policy for DRG-Reimbursed Hospitals (ob rev drg)
Sterilization (ster)
UB-04 Completion: Inpatient Services (ub comp ip)
UB-04 Tips for Billing: Inpatient Services (ub tips ip)