LTC Common Denials

Introduction

Purpose

This module will familiarize participants with an overview of the most common denial messages providers receive when billing with the *Payment Request for Long Term Care* (25-1) claim form for Long Term Care services.

Module Objectives

- Identify common claim denial messages for Long Term Care (LTC) claims
- 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.

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

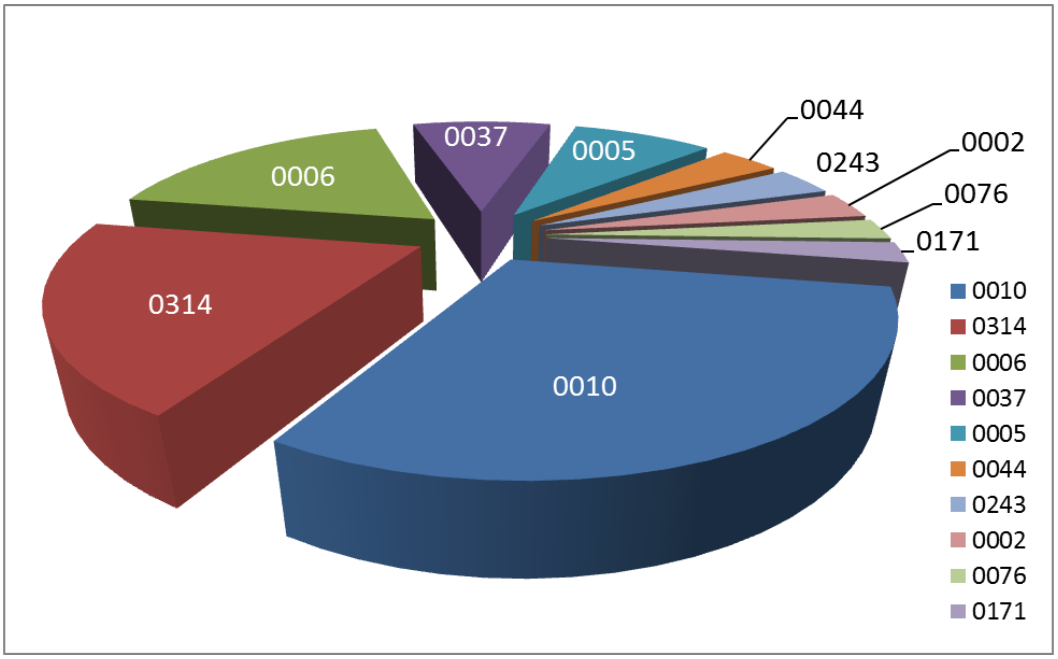
Timeliness must be adhered to for proper submission of follow-up claim forms.

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

NOTES

Long Term Care 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 this 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 corresponding RAD.
- Verify on the RAD:
  - Provider number
  - Recipient number
  - “From-Thru” date of service
  - Procedure code
  - Modifier (if appropriate)
- 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 locating the 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 the provider.

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, 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

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 on the date of service.

Billing Tips

- Verify the recipient's share of cost (SOC) has been and spent down in the Point of Service (POS) Network, ensuring the recipient is eligible for the month of service.
- Verify the 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 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 (*Treatment Authorization Request*) authorization period.

Root Cause of Denial

Provider submitted an approved TAR outside of the dates of service billed.

Billing Tips

- Verify date(s) of service on the claim is correct. 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) on the TAR. If incorrect, request correction on the TAR in writing from your local Medi-Cal field office.
- Verify the TAR Control Number (TCN) is correct. (Nine digits for LTC providers and 11 digits for all other provider types).

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 Care (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 MCP for any specific billing instructions.
- Bill the MCP

NOTES

RAD Code 0005

Denied Claim Message

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

Root Cause of Denial

Provider did not list the TAR Control Number (TCN) in Box 8 of the *Long Term Care (25-1)* claim form, or the TCN listed in Box 8 is invalid.

Billing Tips

- Verify the service requires an authorization and if it does, submit to the Medi-Cal TAR field office.
- If a TAR was approved, verify that the TCN was placed on the claim.

NOTES

RAD Code 0044

Denied Claim Message

RAD Code: 0044	Accommodation code is not appropriate for patient status code listed.

Root Cause of Denial

The *Patient Status* field (Box 14) on the *Payment Request for Long Term Care* (25-1) claim form is invalid or not appropriate for the Accommodation Code being billed.

Billing Tips

For more information, refer to the “Required Claim Form Items” heading in the *Payment Request for Long Term Care (25-1) Completion* section (pay ltc comp) of the Part 2 provider manual.

NOTES

RAD Code 0243

Denied Claim Message

RAD Code: 0243	The TAR Control Number submitted on the claim is not found on the TAR master file.

Root Cause of Denial

The TCN submitted on the claim does not match what is on the approved TAR.

Billing Tips

- Verify the TCN is correct (nine digits for LTC providers and 11 digits for all other provider types).
- Verify the TCN on claim matches the approved TCN.

NOTES

RAD Code 0002

Denied Claim Message

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

Root Cause of Denial

There is no eligibility for the patient or the type of ID number used is not valid for that patient and date of service.

Billing Tips

Verify recipient SSN or the number and date of issue on the BIC.

NOTES

RAD Code 0076

Denied Claim Message

RAD Code: 0076	The submitted documentation was not adequate.

Root Cause of Denial

The documentation required to process and pay the claim is missing or invalid according to LTC billing guidelines.

Billing Tips

- Year of birth
- Attending/referring/prescribing provider number
- Line item change
- Gross amount
- Patient status code
- Diagnosis code is on file or not missing, invalid or unclear
- “From” date of service is chronologically out of sequence with “to” date
- “From” date of service is the same month/year as “to” date of service (patient status indicated admission

NOTES

RAD Code 0171

Denied Claim Message

RAD Code: 0171	Aid code 80 recipients are restricted to Medicare coinsurance and deductible payments.

Root Cause of Denials

The recipient being billed on the claim has aid code 80 and is only eligible for Medicare coinsurance and/or deductible.

Billing Tips

- Ensure claim submitted is following the billing guidelines example in the *Medicare/Medi-Cal Crossover Claims: Long Term Care Billing Examples* section (medi cr ltc ex) of the Part 2 provider manual as a crossover claim billing Medi-Cal for the coinsurance and/or deductible only.
- If individual 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 recipient is eligible for Medi-Cal.
- Some Medi-Cal recipients may have additional eligibility once their SOC is cleared.
  - For example, a recipient with both aide codes 80 and 17 (“Aged plus a Share of Cost”) would have full coverage for Medi-Cal services after their share of cost requirement is met. Therefore, if Medi-Cal RAD code 0171 is received, verify billing eligibility online before denying services.

For more information about billing guidelines, refer to the *Medicare/Medi-Cal Crossover Claims Overview* section (medicare) in the Part 1 provider manual.

NOTES

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	Billing two Part B Medicare claim lines for the same recipient with overlapping dates of service. **Billing Tip:** Enter the reason for the overlapping dates of service in the *Explanations* 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.”
Explanations	SHARE OF COST	Failure to identify the reason for reduction in a recipient’s SOC. **Billing Tip:** Identify the SOC for the patient, minus the non-covered services in the *Explanations* field. For example, “Share of Cost 300.00 (–) non-covered services 27.70 = Pat Liab/Medicare Deduct 272.30.”
11, 30, 49, 68, 87, 106	BILLING LIMIT EXCEPTIONS	Omitting valid delay reason codes for claims submitted more than six months from the date of service. **Billing Tip:** Enter the delay reason code in the designated field.
14, 33, 52, 71, 90, 109	PATIENT STATUS	Entering the patient status code in the wrong field. **Billing Tip:** Enter the status code in the *Patient Status* field.
15, 34, 53, 72, 91, 110	ACCOMMODATION CODE	Entering the accommodation code in the wrong field. **Billing Tip:** Enter the accommodation code in the *Accommodation Code* field.
16, 35, 54, 73, 92 and/or 111	PRIM DX CODE	Claims with a diagnosis code in the *Prim DX Code* 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.

Common Billing Errors *(Continued)*

Field(s)	Description	Error
19, 38, 57, 76, 95, 114	OTHER HEALTH COVERAGE	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. **Billing Tip:** 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 *Explanation of Benefits* date or Medicare *Remittance Advice* date to calculate timeliness.
12 and 13, 31 and 32, 50 and 51, 69 and 70, 88 and 89, 107 and 108	DATE OF SERVICE (FROM – THRU)	From – Thru dates of service do not correspond with the authorized from-thru dates of service on the TAR. **Billing Tip:** Verify that the dates of service on the claim match the approved dates on the TAR or obtain a revised TAR.
14 and 15, 33 and 34, 52 and 53, 71 and 72, 90 and 91, 109 and 110	PATIENT STATUS/ ACCOMMODATION CODE	Entering an accommodation code and status code combination that is inappropriate. **Billing Tip**: 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).

Knowledge Review 1

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

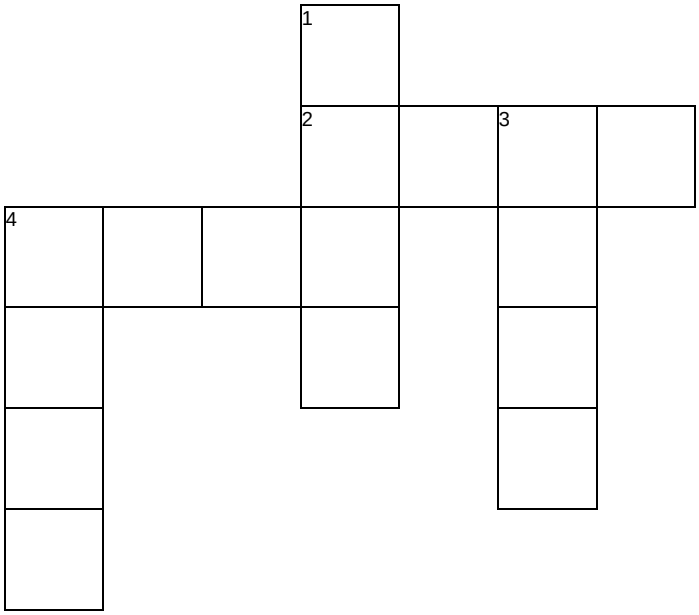
1.	_____	RAD 0010	A) AID code 80 recipients are restricted to Medicare coinsurance and deductible payments.
2.	_____	RAD 0314	B) Accommodation code is not appropriate for patient status code listed.
3.	_____	RAD 0044	C) This service is a duplicate of a previously paid claim.
4.	_____	RAD 0171	D) Health Care Plan enrollee, capitated service not billable to Medi-Cal.
5.	_____	RAD 0037	E) Recipient is not eligible for the month of service billed.

NOTES

Answer Key: 1) C; 2) E; 3) B; 4) A; 5) D

Knowledge Review 2

Complete the LTC crossword puzzle RAD code messages.



Down

1. Health Care Plan enrollee or Mental Health Plan recipient; Capitated services are not billable to Medi-Cal.

3. The provider was not eligible for the service billed on the date of service.

4. Accommodation code is not appropriate for patient status code listed.

Across

2. The date(s) of service reported on the claim is not within the TAR (*Treatment Authorization Request*) authorized period.

4. The TAR Control Number submitted on the claim is not found on the TAR master file.

Answer Key:
Down: 1) 0037; 3) 0031; 4) 0044;
Across: 2) 0006; 4) 0243

Resource Information

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)