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 the root causes for denied claims.
- 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 (RAD Repository) 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 one of five follow-up options to get the claim paid, depending on the reason for the denial. There are five main follow-up procedures available to providers:

- Rebill the claim
- Resubmit an electronic claim as an adjustment (frequency code “7”) or a void (“8”)
- 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.

Timeliness Policy Action and Deadlines

Follow-Up Action	Submission Deadline
Rebill a Claim	Six months from the month of service
Resubmit an Electronic Claim or Submit a CIF	Within six months of the claim payment denial date (date on RAD)
Submit an Appeal	Within 90 days of the denial date (date on RAD)

Allied Health Services RAD Code Chart

Top Common RAD Code Denials

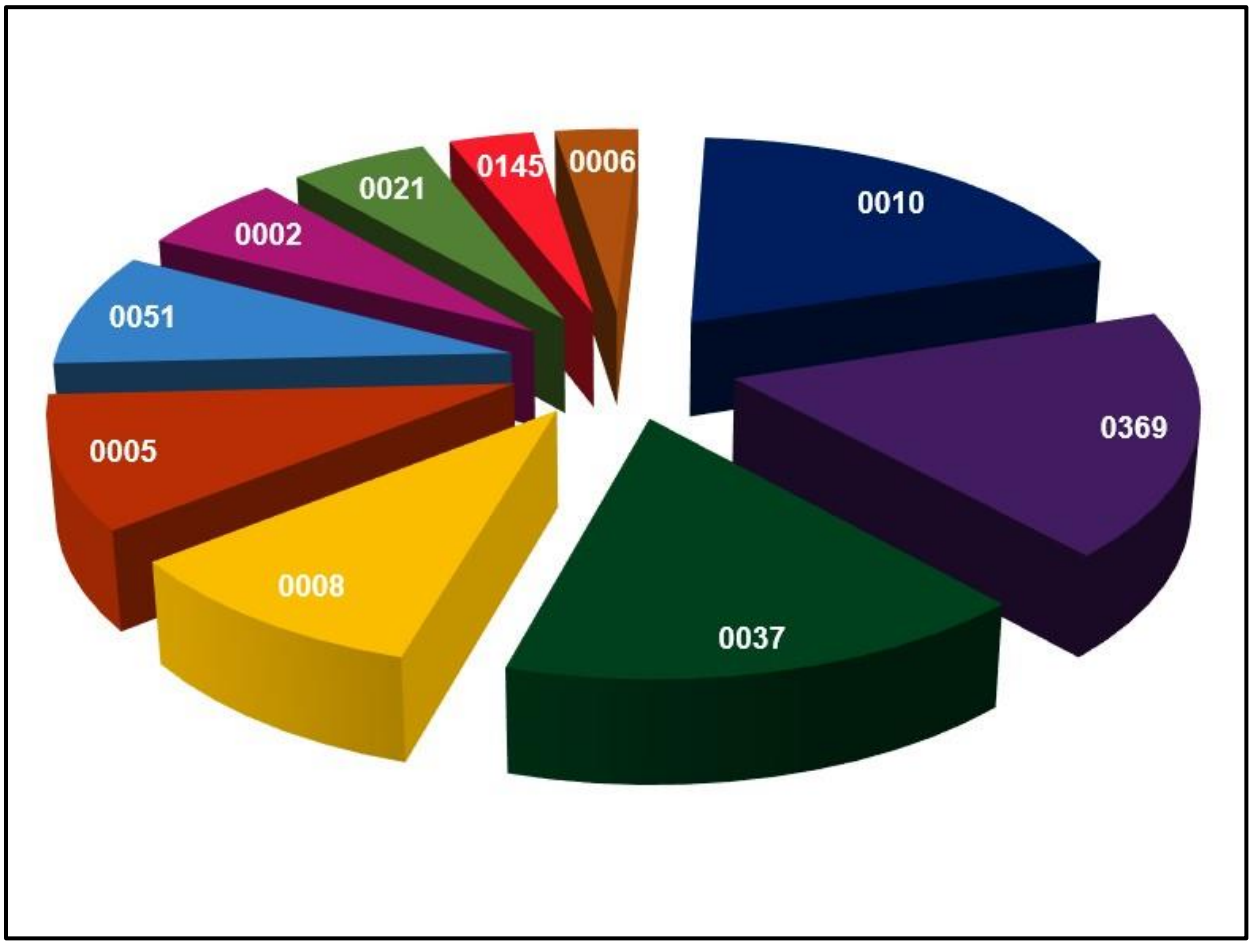

Figure 1: Top 10 Denials Allied Health & Medical.

Denied Claim Root Causes

RAD Code 0010

Denied Claim Message

RAD Code	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 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	Message
RAD Code: 0369	Medical transportation requires Emergency Statement or TAR (*Treatment Authorization Request*).

Root Cause of Denials

Emergency statement was not submitted or is lacking information.

Billing Tips

Verify Emergency Statement is in Box 19 or was submitted with claim. Verify 11-digit TCN (Tar Control Number) is listed in Box 23.

Notes:

RAD Code 0037

Denied Claim Message

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

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).

RAD Code 0008

Denied Claim Message

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

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
- For assistance contact Provider Enrollment (916) 323-1945 or TSC 1-800-541-5555

Notes:

RAD Code 0005

Denied Claim Message

RAD Code	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 Box 23 of your claim form.

RAD Code 0051

Denied Claim Message

RAD Code	Message
RAD Code: 0051	Signature is missing or not an original.

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 blue or black ballpoint pen.
- Be sure that the signature is written, not printed. Stamps, initials or facsimiles are not acceptable.

RAD Code 0002

Denied Claim Message

RAD Code	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.
- Confirm the numbers on the BIC were not transposed when verifying eligibility.

RAD Code 0021

Denied Claim Message

RAD Code	Message
RAD Code: 0021	This claim was received after the one-year maximum billing limitation.

Root Cause of Denial

Claims submitted more than 12 months from the month of service must always use delay reason code “10” and must be billed hard copy with the appropriate attachments.

Billing Tips

- Refer to the CMS-1500 Submission and Timeliness Instructions (cms sub) – section 4 of the Part 2 manual for list of documentation requirements. Claims must be submitted to the Over-One-Year Claims Unit and must include a copy of the recipient’s proof of eligibility with appropriate documentation attached. Claims must be submitted to the following special address:

California MMIS Fiscal Intermediary
Over-One-Year
Attention: Claims Preparation Unit
P.O. Box 13029
Sacramento, CA 95813-4029

RAD Code 0145

Denied Claim Message

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

Root Cause of Denial

Provider billed for a service that is not a Medi-Cal benefit on the date of service.

Billing Tips

- Verify procedure code and modifier, if required.
- Verify the “From-Thru” dates of service.
- Verify authorization information.
- Verify procedure code.

Notes:

RAD Code 0006

Denied Claim Message

RAD Code	Message
RAD Code: 0006	The date(s) of service reported on the claim is not within the TAR (*Treatment Authorization Request*) authorized period.

Root Cause of Denial

Provider billed with a date of service that was not approved on TAR.

Billing Tips

- Verify date(s) of service on the claim. If incorrect, resubmit with correct date of service.
- Verify the approved date(s) of service on the TAR. If incorrect, send a correction request in writing to the TAR Processing Center.

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.

Table of Common Billing Errors

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. Submitting the recipient's Social Security Number (SSN). **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:** *Patient's Name* 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.

Table of Common Billing Errors (continued)

Box #	Field Name	Error
21.A 21.B	Diagnosis or Nature of Illness or Injury	Entering more than two diagnosis codes **Billing Tip:** Enter all letters and/or numbers of the ICD-10-CM for tor the primary and secondary diagnosis, including the fourth through seventh characters, if present. (Do **not** enter the decimal point). Claims submitted to Medi-Cal require an ICD indicator "0" in the *ICD-Ind.* field (Box 21). Claims submitted without a diagnosis code do not require an ICD indicator.
23	Prior Authorization Number	Services requiring a TAR or SAR must indicate the 11-digit TAR Control Number (TCN). It is not necessary to attach a copy of the *Adjudication Response* 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.
24B	Place of Service	Entering the wrong Place of Service two-digit code **Billing Tip 1:** Check instructions in the *CMS-1500 Completion* (cms comp) section of the appropriate Part 2 provider manual for the correct two-digit code.

Table of Common Billing Errors (continued)

Box #	Field Name	Error
24C	EMG (or Delay Reason)	**Delay Reason Code:** If there is no emergency indicator in the *EMG* 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. 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 *CMS-1500: Submission and Timeliness Instructions* section (cms sub) in the appropriate Part 2 provider manual. **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 *EMG* field (Box 24C). 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.

Table of Common Billing Errors (continued)

Box #	Field Name	Error
24C	EMG (or Delay Reason) (continued)	For emergencies in which emergency medical transportation was provided, providers must include an emergency statement. The statement must include: • 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 A mere statement that an emergency existed is not sufficient.
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 *Additional Claim Information* field (Box 19).
31	Signature of Physician or Supplier	Submitting unsigned claims or claims with illegible signatures. Using initials or stamped signatures or signatures 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.

Table of Common Billing Errors (continued)

Box #	Field Name	Error
32	Service Facility Location Information	Entering the wrong facility NPI for the Place of Service entered in field 24B. Omitting the facility NPI when a facility-related Place of Service code is entered in field 24B. **Billing Tip:** Enter the facility NPI in Box 32A.

Knowledge Review

Match the RAD Denial Codes in the second column to the most appropriate definition in the third column. Enter the letter that precedes the definition in the blank area of the first column.

Enter Letter	RAD Code	RAD Code Definitions
_____	RAD 0010	A) The procedure is not a Medi-Cal benefit on this date of service.
_____	RAD 0369	B) Signature is missing or is not an original.
_____	RAD 0037	C) Recipient is not eligible for the month of service billed.
_____	RAD 0008	D) This service is a duplicate of a previously paid claim.
_____	RAD 0005	E) Health Care Plan enrollee, capitated service not billable to Medi-Cal.
_____	RAD 0051	F) Medical transportation requires Emergency Statement or TAR (Treatment Authorization Request).
_____	RAD 0002	G) The service billed requires an approved (TAR) Treatment Authorization Request.
_____	RAD 0021	H) This claim was received after the one-year maximum billing limitation.
_____	RAD 0145	I) The date(s) of service reported on the claim is not within the TAR (Treatment Authorization Request) authorized period.
_____	RAD 0006	J) The provider of service is not eligible for the type of service billed.

See the Appendix for the Answer Key

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 Codes and Messages (RAD Repository)

Part 2

Appeal Form Completion (appeal form)

CIF Completion (cif co)

CMS-1500 Completion (cms comp)

CMS-1500 Tips for Billing (cms tips)

Module A Answer Key

Knowledge Review 1

Question: Match the RAD Denial Codes in the second column to the most appropriate definition in the third column. Enter the letter that precedes the definition in the blank area of the first column.

- RAD Code 0010
  - Answer: D
- RAD Code 0369
  - Answer: F
- RAD Code 0037
  - Answer: E
- RAD Code 0008
  - Answer: J
- RAD Code 0005
  - Answer: G
- RAD Code 0051
  - Answer: B
- RAD Code 0002
  - Answer: C
- RAD Code 0021
  - Answer: H
- RAD Code 0145
  - Answer: A
- RAD Code 0006
  - Answer: I