Outpatient Common Denials

Introduction

Purpose

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

Module Objectives

- Identify common claim denial messages for outpatient 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 are not payable or information given by the provider 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)* and *Medi-Cal Financial Summary* (remit) section of the Part 1 provider manual for a complete list.

Overview of Claims Follow-Up Options

When providers receive confirmation that a claim has been denied, they can pursue one of the five follow-up options to get the claim reimbursed, 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 Table

Follow-up Action	Submission Deadline
Rebill a Claim	Six (6) months from the month of service.
Resubmit a claim or Submit a CIF	Within six (6) months of the claim payment or denial date (on RAD)
Submit an Appeal	Within 90 days of the denial date on the RAD

Notes:

Outpatient Services RAD Code Chart

Top Common RAD Code Denials

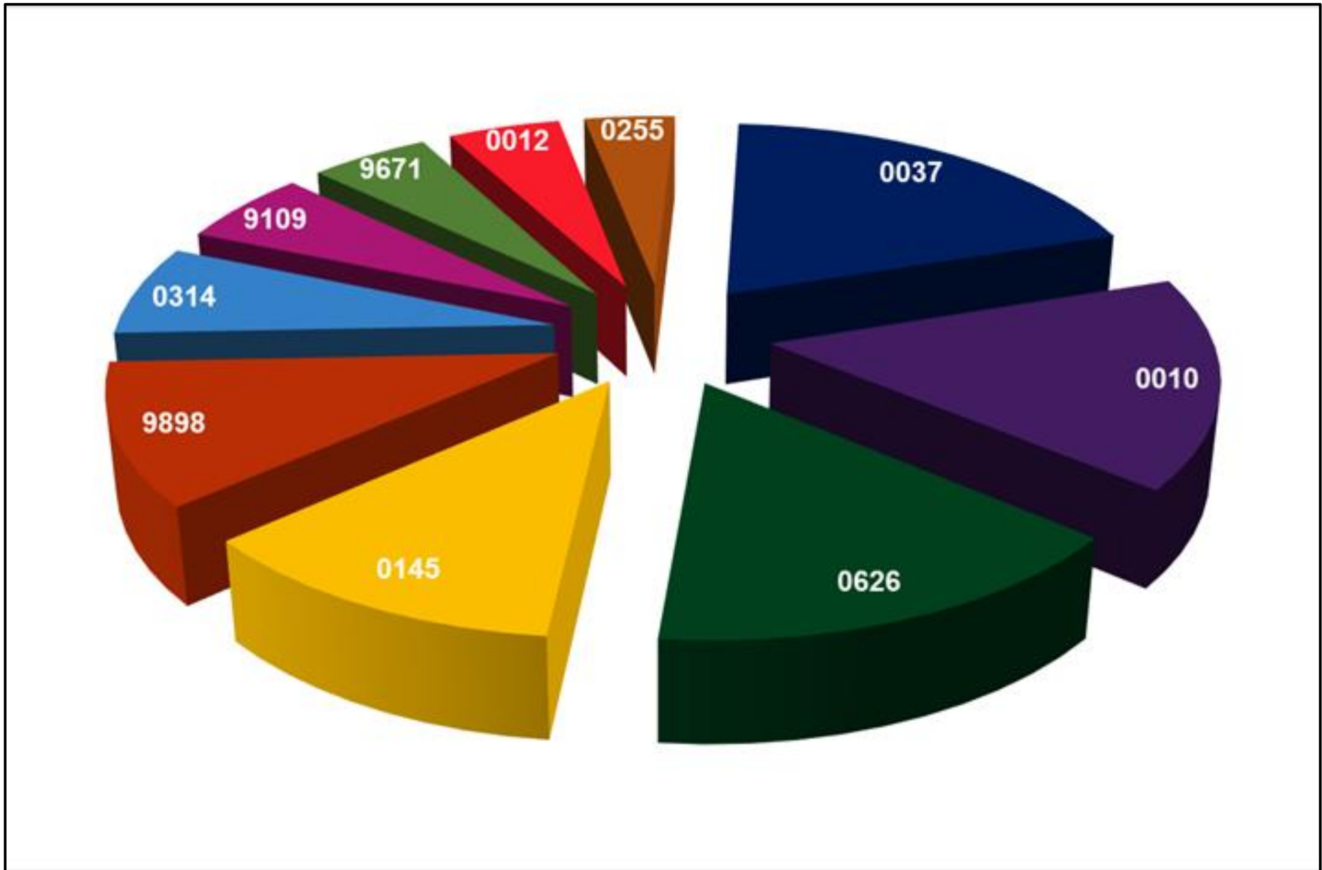

Figure 1.1: Outpatient Services RAD Code Chart.

Notes:

Denied Claim Root Causes

RAD Code 0037

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* (mcp code dir) section of the Part 1 provider manual.
  - Contact the managed care plan for any specific billing instructions.
  - Bill the Managed Care Plan (MCP).

RAD Code 0010

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 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 0626

RAD Code: 0626	Non-emergency related services are not payable for aid code 55 recipients.

Root Cause of Denial

Provider billed non-emergency services when the recipient is only eligible for pregnancy-related, postpartum and emergency services.

Billing Tips

Verify the recipient's eligibility prior to rendering services.

Note: If the services were emergency-related, refer to the "Emergency Certification" heading in the *UB-04 Completion: Outpatient Services* (ub comp op) section of the Part 2 provider manual, field/box 18-24. For additional information refer to the *Aid Codes Master Chart* (aid codes) and *OBRA and IRCA* (obra) section of the Part 1 provider manual.

Notes:

RAD Code 0145

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 revenue code

Notes:

RAD Code 9898

RAD Code: 9898	HCPCS Qualifier and NDC (National Drug Code)/UPN (Universal Product Number) is invalid.

Root Cause of Denial

The HCPCS qualifier and/or NDC/UPN is invalid.

Billing Tips

- Verify the product ID qualifier N4 followed by the 11-digit NDC (no spaces or hyphens) is directly following the last digit of the NDC (no space); followed by the two-character unit of measure and numeric quantity.
- Verify the NDC number on the claim is consistent with the 5-4-2 format. Hyphens (-) separate the NDC number into three segments. An 11-digit number must be entered on the claim.
- Verify the NDC is contracted with Medi-Cal.

Refer to the following Part 2 provider manual sections for more information:

- *Physician-Administered Drugs – NDC: UB-04 Billing Instructions* (physician ndc ub)
- *Physician-Administered Drugs – NDC (physician ndc)*

Notes:

RAD Code 0314

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

Root Cause of Denial

The recipient has an unmet SOC on the date of service.

Billing Tips

- Verify if 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 the Share of Cost (SOC) has been met.

Notes:

RAD Code 9109

RAD Code: 9109	This service is not payable for the diagnosis billed.

Root Cause of Denial

Provider billed for a diagnosis code that is not payable for this service.

Billing Tips

- Verify procedure code is a valid Medi-Cal benefit via Transaction Services or contact the Telephone Service Center (TSC) at 1-800-541-5555.
- Ensure provider is eligible to bill for the service by verifying provider's Category of Service with administrator.

Notes:

RAD Code 9671

RAD Code: 9671	Procedure code has not been authorized by CCS/GHPP (California Children's Services/Genetically Handicapped Persons Program).

Root Cause of Denial

Provider billed procedure and/or diagnosis code(s) not authorized by the California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP).

Billing Tips

- Verify procedure code and diagnosis code(s) are valid CCS/GHPP benefits via Transaction Services or contact the Telephone Service Center (TSC) to confirm at 1-800-541-5555.
- Ensure provider is eligible to bill for the service(s) by verifying the CCS/GHPP Service Code Groupings in the *California Children's Services (CCS) Program Service Code Groupings* (cal child ser) section of the Part 2 provider manual.

Notes:

RAD Code 0012

RAD Code: 0012	Medi-Cal benefits cannot be paid without proof of payment/description of the denial from Medicare.

Root Cause of Denial

Provider did not attach a copy of the payment/description of the Medicare denial.

Billing Tips

- Attach a dated copy of the Medicare RA/EOMB/MRN for the date of service.
- Attach a denial from Medicare for the date of service.
- If the Medicare denial description is not printed on the front of the RA/EOMB/MRN, include a copy of the description from the back of the RA/EOMB/MRN or the Medicare manual when billing for a denied claim.
- Refer to the Medicare/Medi-Cal claim section in the appropriate Part 2 manual for unacceptable Medicare documentation.

Notes:

RAD Code 0255

RAD Code 0255	Rendering provider is not on the Provider Master File or is not a clinical lab.

Root Cause of Denial

Rendering provider NPI is not on the Provider Master File or is not a clinical lab.

Billing Tips

- Verify that the correct 10-digit rendering provider NPI was billed.
- Verify that the 10-digit NPI has been approved by DHCS/PED.

Notes:

Outpatient Common Billing Errors

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

Note: The following table is also available in the *UB-04 Tips for Billing* (ub tips op) section in the appropriate Part 2 Outpatient Services manual.

Table of Common Billing Errors

Field	Description	Error
6	Statement Covers Period (From-Through)	Entering information in this field, which is not required by Medi-Cal for outpatient claims. **Billing Tip**: For outpatient "From-Through" billing instructions, see the *UB-04 Special Billing Instructions for Outpatient Services* section in this manual.
18 thru 24	Condition Codes	Omitting codes or entering a Medi-Cal local billing limit exception code (A, 1 thru 9). **Billing Tip**: The delay reason code is entered in the *Unlabeled* field (Box 37A) of the claim. **Billing Tip**: Enter codes in numeric-alpha order. For example, 80, 82, X1.
39 thru 41	Value Codes and Amount (Patient's Share of Cost)	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 value. Value code information is required for Medicare crossovers.

Table of Common Billing Errors (continued)

Field	Description	Error
43	Description	Omitting individual dates of service required after entering description of services rendered. **Billing Tip**: The description must identify the particular service code indicated in the *HCPCS/Rate* field (Box 44). For more information, refer to the specific policy section in this manual or the CPT code book. Omitting the product ID qualifier and NDC for physician-administered drugs. Incorrect entry of optional unit of measure and numeric quantity. **Billing Tip**: Check instructions in the *Physician-Administered Drugs – NDC: UB-04 Billing Instructions* (physician ndc ub) and *UB-04 Completion: Outpatient Services* (ub comp op) sections of the Part 2 provider manual for the appropriate product ID qualifier, NDC, unit of measure qualifier and numeric quantity, and instructions on entering this information. Unit of measure and numeric quantity are optional; however, entering the NDC quantity in the proper format is crucial to the correct payment for a billed NDC.

Table of Common Billing Errors (continued)

Field	Description	Error
44	HCPCS/Rate/HIPPS Code	Entering incorrect code for provider type, omitting procedure code or omitting modifier(s). **Billing Tip**: Revenue codes are increasingly required on outpatient claims, including: • Adult Day Health Care (ADHC) (all codes) • Home and Community-Based Waiver Services (select codes) • Hospice (room and board only) • EAPC (all codes) • EAPC claims must include the required revenue code in the *Revenue Code* field (Box 42) and the HCPCS code, immediately followed by the appropriate modifier, in the *HCPCS/Rate* field (Box 44). Claims submitted without all three will be denied. • Organ procurement For Section 340B providers submitting claims for physician administered drugs: omitting the modifier UD. **Billing Tip**: Check instructions in the *UB-04 Completion: Outpatient Services* (ub comp op) section of the Part 2 provider manual for the appropriate location of modifier UD for Section 340B drugs on the UB-04. **Billing Tip:** Check instructions in the *Evaluation & Management (E&M)* (eval), *Modifiers* (modif), *Modifiers: Approved List* (modif app) and *Modifiers Used with Procedure Codes* (modif used) sections for the appropriate use of modifiers.
46	Service Units	Entering the wrong service units as required by the billing code. **Billing Tip**: Although this is a seven-digit field, Medi-Cal only allows two digits in this field.

Table of Common Billing Errors (continued)

Field	Description	Error
50 A thru C	Payer Name	Entering a Place of Service code. **Billing Tip**: Enter the two-digit facility type and one-character frequency code as specified in the National Uniform Billing Data Element Specifications manual in the *Type of Bill* field (Box 4). Missing all payer information. **Billing Tip**: Be sure to enter the "O/P" indicator.
54 A thru B	Prior Payments (Other Coverage)	Missing prior payment or Other Health Coverage not indicated. **Billing Tip**: Be sure to enter the patient's other health insurance payment. Do not enter Medicare payments in this box.
56	NPI	Missing or incorrect NPI number. **Billing Tip:** Enter the NPI.
60 A thru C	Insured's Unique ID	Missing the recipient's Medi-Cal ID number. **Billing Tip**: Verify that the recipient is eligible for the services rendered by using the POS network or telephone AEVS. Do not enter the Medicare ID number.
63	Treatment Authorization Codes	Entering EVC number instead of the TAR number. **Billing Tip**: The EVC number is only for verifying eligibility. Do not enter this number on the claim. Enter either 11-digit TCN or the CCS SAR number with no dashes (-), spaces, # or any other characters.
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.

Knowledge Review 1

Fill in the blanks to complete the common RAD messages:

1) 0037: _______________ enrollee, capitated service not billable to Medi-Cal.
2) 0010: This service is a ____________________ of a previously paid claim.
3) 0626: Non-emergency related services are __________________ for aid code 55 recipients.
4) 0145: The procedure is not a _____________ benefit on this date of service.
5) 9898: HCPCS Qualifier and NDC/UPN Product Number is _______________.

See the Appendix for the Answer Key

Notes:

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Knowledge Review 2

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

Enter Letter	RAD Code	RAD Code Definitions
________	RAD 0012	A) Procedure code has not been authorized by CCS/GHPP (California Handicapped Persons Program).
________	RAD 0314	B) Procedure code has not been authorized by CCS/GHPP (California Children's Services/Genetically Handicapped Persons Program
________	RAD 9671	C) Rendering provider is not on the Provider Master File or is not a clinical lab.
________	RAD 9109	D) Recipient is not eligible for the month of service.
________	RAD 0255	E) This service is not payable for the diagnosis billed.

See the Appendix for the Answer Key

Notes:

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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: Service Restrictions (elig rstrict)
OBRA and IRCA (obra)
Remittance Advice Details (RAD) and Medi-Cal Financial Summary (remit): Click on Blue Hyperlink titled "*Remittance Advice Details (RAD) Codes, Messages and Electronic Correlations*

Part 2
Appeal Form Completion (appeal form)
CIF Special Billing Instructions for Outpatient Services (cif sp op)
Modifiers (modif)
Modifiers: Approved List (modif app)
*Modifiers Used with Procedure Codes (*modif used)
Physician-Administered Drugs – NDC: UB-04 Billing Instructions (physician ndc ub)
UB-04 Completion: Outpatient Services (ub comp op)
UB-04 Special Billing Instructions for Outpatient Services (ub spec op)
UB-04 Tips for Billing: Outpatient Services (ub tips op)

Appendix

Knowledge Review 1

Fill in the blanks to complete the common RAD messages:

Question 1: 0037: _______________ enrollee, capitated service not billable to Medi-Cal.

Answer: Health Care Plan

Question 2: 0010: This service is a ____________________ of a previously paid claim.

Answer: duplicate

Question 3: 0626: Non-emergency related services are __________________ for aid code 55 recipients.

Answer: not payable

Question 4: 0145: The procedure is not a ____________ benefit on this date of service.

Answer: Medi-Cal

Question 5: 9898: HCPCS Qualifier and NDC/UPN Product Number is _______________.

Answer: invalid

Knowledge Review 2

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

Enter Letter	RAD Code	RAD Code Definitions
A	RAD 0626	A) Medi-Cal benefits cannot be paid without proof of payment/description of denial from Medicare.
B	RAD 0037	B) Recipient is not eligible for the month of service.
C	RAD 9671	C) Procedure code has not been authorized by CCS/GHPP (California Children's Services/Genetically Handicapped Persons Program.
E	RAD 9109	D) Rendering provider is not on the Provider Master File or is not a clinical lab
D	RAD 0255	E) This service is not payable for the diagnosis billed.