Vision Care Common Denials

Introduction

Purpose

This module will familiarize participants with an overview of the most common denial messages for vision care when billing for vision services on the *CMS-1500* claim form.

Module Objectives

- Identify common claim denial messages for vision services.
- Provide an overview of claims follow-up options.
- 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 result from 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-from denial codes contain four-digits beginning with the prefix 9. Refer to Remittance Advice Details (RAD) and Medi-Cal Financial Summary; click on the link: *Remittance Advice Details (RAD) Codes, Messages and Electronic Correlations: 9000 through 0000* section (remit cd9000) of the Part 1 provider manual for 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 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.

Table of Follow-Up Actions and Submission Deadlines

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

Vision RAD Code Chart

Top Common RAD Code Denials

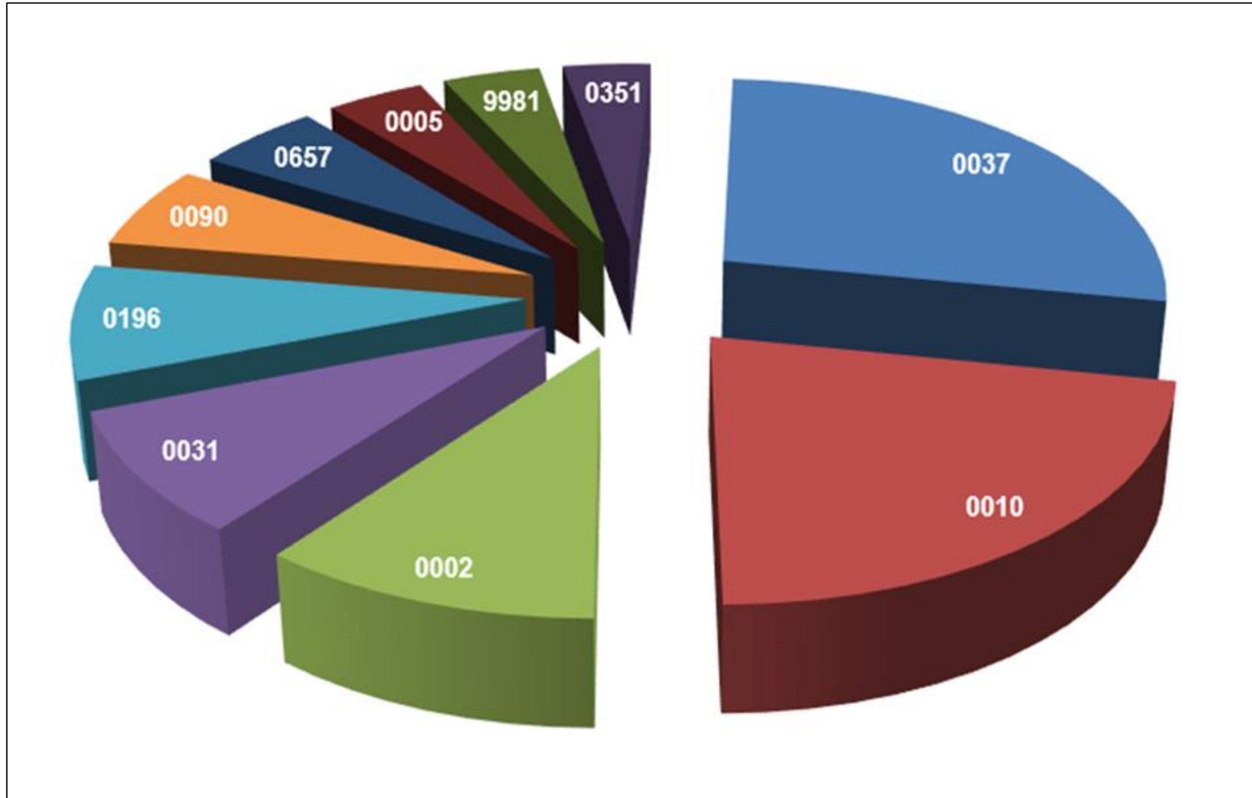

Figure 1: **Top Common RAD Code Denials**

Denied Claim Root Causes

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 not verifying recipient eligibility prior to rendering services for each patient who presents a plastic Benefits Identification Card (BIC), MCP card, paper 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* (mcp code dir) section of the Part 1 provider manual.
  - Contact the managed care plan for any specific billing instructions.
- Bill Managed Care Plan (MCP).

Notes:

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 your 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 there is no resolution between the two providers regarding the date in question, Medi-Cal should recoup the full reimbursement of the original paid claim and will not make an adjustment without 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 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 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

Provider is using ID number instead of the 14-digit Beneficiary ID Card (BIC) number.

Billing Tips

- Verify recipient SSN or the number and date of issue on the BIC.
- Refer to the Eligibility: Recipient Identification Cards (elig rec crd) section of the Part 1 manual for billing guidelines.

RAD Code 0031

Denied Claim Message

RAD Code: 0031	The provider was not eligible for the services billed on the date of service.

Root Cause of Denial

The National Provider Identifier (NPI) is either not actively enrolled with Medi-Cal or provider is not eligible to bill for the type of services performed. Provider may also be billing on a date of service that is not eligible for the patient/provider.

Billing Tips

- Verify date of service on the claim is correct.
- Verify billing provider number on the claim is correct.
- Verify rendering provider number on the claim is correct.

RAD Code 0196

Denied Claim Message

RAD Code: 0196	This procedure requires a modifier; modifier not present.

Root Cause of Denial

The modifier is missing or inappropriate for this type of service billed.

Billing Tips

- Check the claim to verify that it was billed with a modifier and that it is in the appropriate field.
- Refer to the *Modifiers Used With Vision Care Procedure Codes* (modif used vc) section in the Part 2 provider manual to find the appropriate modifier for use with billing.

RAD Code 0090

Denied Claim Message

RAD Code: 0090	Combination of procedure/modifier is not valid on date of service billed.

Root Cause of Denial

The procedure code and/or modifier billed on the date of service was not valid

Billing Tips

- Verify procedure code.
- Verify modifier.
- Verify “From-Thru” Date of service.
- Refer to Part 2- *CMS-1500 Modifier: Approved List* Section for billing guidelines.

RAD Code 0657

Denied Claim Message

RAD Code: 0657	Recipient not eligible for Medi-Cal benefits until payment/denial information is given from other insurance carrier.

Root Cause of Denial

Procedure/Service billed requires proof of payment/denial from other coverage attached to the claim.

Billing Tips

- Attach a dated copy of the EOMB/MRN/RA for the date of service.
- Attach a denial from other insurance carrier for the date of service.

RAD Code 0005

Denied Claim Message

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

Root Cause of Denial

Some procedures/services require authorization. Refer to the *TAR and Non-Benefit List* sections in the appropriate Part 2 manual for procedures requiring authorization.

Billing Tips

- Verify the TAR (Tar Control Number) is placed in the prior authorization box on the claim form.
- Verify the TCN is valid.

RAD Code 9981

Denied Claim Message

RAD Code: 9981	ICD Indicator is missing or invalid.

Root Cause of Denial

The ICD indicator field is blank or the ICD indicator used is invalid for the date of service on the claim for services billed.

Billing Tips

- For dates of service on or after 2015, claims must include ICD indicator “0”.
- Claims submitted without a diagnosis code, do not require an ICD indicator.

RAD Code 0351

Denied Claim Message

RAD Code: 0351	Additional benefits are not warranted per Medi-Cal regulations.

Root Cause of Denial

Number of acceptable units or days have been exceeded. It could also have to do with the diagnosis code or procedure/service code used.

Billing Tips

- Verify that the number days or units for the services billed on the claim do not exceed the acceptable maximum.
- For interim eye examinations within 24-month coverage period, refer to the *Professional Services: Diagnosis Codes* (pro serv cd) section in the Part 2 provider manual for a list of valid diagnosis codes that must be billed with CPT codes 92004 and 92014 for reimbursement.

Common Billing Errors

The following fields must be completed accurately and completely on the *CMS-1500* claim form to avoid suspended or denied claims.

Note: The following table can be found in the *CMS-1500 Tips for Billing* (cms tips) section in the appropriate Part 2 provider manual.

Table of CMS-1500 Claim Form Fields and Common Billing Errors

Box #	Field	Error
1	Medicare/Medi-Cal Other ID	Not checking the appropriate box(es) **Billing Tip**: Check both the Medicaid and Medicare boxes when billing Medicare crossover claims.
1A	Insured's ID Number	Entering the recipient's ID number incorrectly **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 on a straight Medi-Cal claim.
2	Patient's Name	The *Patient's Name* field (Box 2) requires commas between each segment of the patient's name: last, first, middle initial (without a period).
19	Additional Claim Information (Designated by NUCC)	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 below 8 point and abbreviating terminology may result in scanning difficulties and/or medical review denials.
21 A-L	Diagnosis or Nature of Illness or Injury Relate A-L to service line below (24E)	Entering more than two diagnosis codes **Billing Tip**: No description is required. Enter additional diagnosis codes in *Additional Claim Information* field (Box 19). **Note:** All claim forms must be submitted with an ICD indicator. A "0" indicates the claim was submitted with ICD-10-CM codes.

Table of CMS-1500 Claim Form Fields and Common Billing Errors

Box #	Field	Error
23	Prior Authorization Number	Entering Eligibility Verification Confirmation (EVC) number instead of the TAR Control Number (TCN) **Billing Tip**: The EVC number is only for verifying eligibility. Do not enter this number on the claim. Enter the 10-digit TCN followed by the Pricing Indicator (PI) on the claim (for a total of 11 digits).
24B	Place of Service	Entering the wrong two-digit Place of Service code **Billing Tip**: Enter a Medi-Cal local Place of Service code instead of a national Place of Service code.
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). A list of modifiers accepted by Medi-Cal may be found in the Part 2 Vision Care manual.

Learning Activities

Learning Activity 1: Matching Terms Puzzle

Medi-Cal Knowledge: Match the words/acronym in the first column to the best available answer in the second column.

Enter Letter	RAD Code	RAD Code Definitions
___________	RAD 0037	A) Health Care Plan enrollee or mental health plan recipient; capitated services are not billable to Medi-Cal.
___________	RAD 0010	B) Combination of procedure/modifier is not valid on date of service billed.
___________	RAD 0002	C) The provider was not eligible for the services billed on the date of service.
___________	RAD 0031	D) This procedure requires a modifier; modifier is not present.
___________	RAD 0196	E) Additional Benefits are not warranted per Medi-Cal regulations.
___________	RAD 0090	F) This service is a duplicate of a previously paid claim.
___________	RAD 0657	G) Recipient not eligible for Medi-Cal benefits until payment/denial information is given from other insurance carrier.
___________	RAD 0005	H) The service billed requires an approved *Treatment Authorization Request* (TAR)
___________	RAD 9981	I) Recipient not eligible for benefits under Medi-Cal program or other special program
___________	RAD 0351	J) ICD Indicator is missing or invalid.

See the Appendix for the Answer Key.

Resource Information

References

Provider Manual References

The following reference materials provide Medi-Cal program and eligibility information.

Part 1
Eligibility: Recipient Identification Cards (elig rec crd)
MCP: Code Directory (mcp code dir)
Remittance Advice Details (RAD) and Medi-Cal Financial Summary; click on the link: *Remittance Advice Details (RAD) Codes, Messages and Electronic Correlations.*

Part 2
CMS-1500 Tips for Billing (cms tips)
Modifiers Used With Vision Care Procedure Codes (modif used vc)
Professional Services: Diagnosis Codes (pro serv cd)

Module B Answer Key

Knowledge Review

Question 1: RAD 0037

Answer 1: A) Health Care Plan enrollee or mental health plan recipient, capitated services are not billable to Medi-Cal.

Question 2: RAD 0010

Answer 2: F) This service is a duplicate of a previously paid claim

Question 3: RAD 0002

Answer 3: I) Recipient not eligible for benefits under Medi-Cal program or other special program

Question 4: RAD 0031

Answer 4: C) The provider was not eligible for the services billed on the date of service

Question 5: RAD 0196

Answer 5: D) This procedure requires a modifier; modifier is not present.

Question 6: RAD 0090

Answer 6: B) Combination of procedure/modifier is not valid on date of service billed.

Question 7: RAD 0657

Answer 7: G) Recipient not eligible for Medi-Cal benefits until payment/denial information is given from other insurance carrier

Question 8: RAD 0005

Answer 8: H) The service billed requires an approved *Treatment Authorization Request* (TAR)

Question 9: RAD 9981

Answer 9: I) ICD Indicator is missing or invalid.

Question 10: RAD 0351

Answer 10: E) Additional Benefits are not warranted per Medi-Cal regulations.

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