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# 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
- 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) 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. The five main follow-up procedures available to providers are:

- 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 months from the month of service |
| Resubmit a Claim or Submit a CIF | Within six months of the claim payment or denial date on the RAD |
| Submit an Appeal | Within 90 days of the denial date on the RAD |

# Inpatient Services RAD Code Chart

## Top Common RAD Code Denials

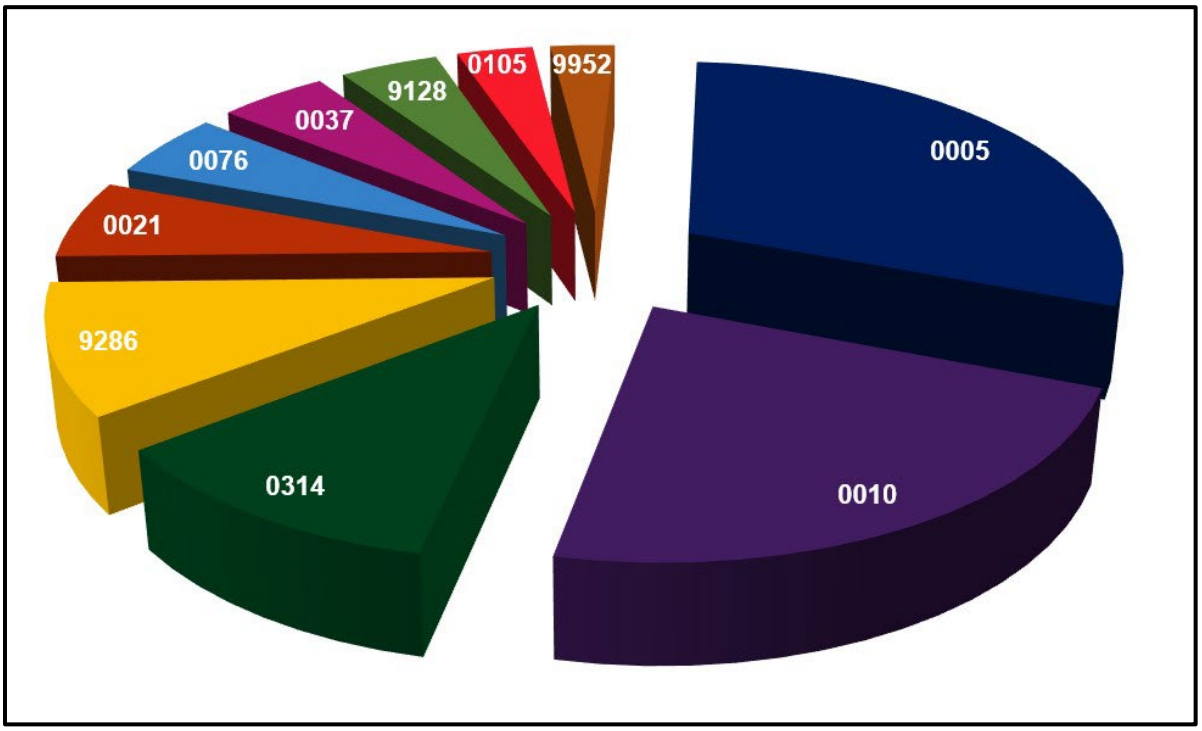


**Figure 1.1:** Inpatient Services RAD Code Chart

# Denied Claim Root Causes

## RAD Code 0005

### Denied Claim Message

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

### Root Cause of Denial

TCN (TAR Control Number) missing or TCN listed on claim was not approved.

### Billing Tips

- Verify the approved 11-digit TCN.
- 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 TCN in field 63 of your claim form.

**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 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* (ancil cod) section 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 0021

## Denied Claim Message

| | |
|---|---|
| RAD Code: 0021 | The 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 *UB-04 Submission and Timeliness Instructions* (ub sub) section of the Part 2 provider manual for a 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

**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:
  - Not missing or invalid
  - Not before admission 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

**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).

# RAD Code 9128

## Denied Claim Message

| | |
|---|---|
| RAD Code: 9128 | Type of Admit missing/invalid |

## Root Cause of Denial

The type of Admit was missing or invalid in Field 14.

## Billing Tips

- Verify the type of Admit was entered on the claim
- Refer to the *UB-04 Completion: Inpatient Services* section (ub comp ip) of the Part 2 provider manual for list of Admission types.
- Rebill the claim with corrections if within six months from the month of service or submit an electronic claim adjustment if within six months from the date of the RAD.

# RAD Code 0105

## Denied Claim Message

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

## Root Cause of Denial

Requires a valid sterilization *Consent*.

## Billing Tips

- Refer to the *Sterilization* (ster) section of the appropriate Part 2 provider manual.
- Rebill the claim with required attachment if claim is 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.

# RAD Code 9952

## Denied Claim Message

| | |
|---|---|
| RAD Code: 9952 | Type of Bill Code for APR-DRG Claim Invalid or Missing |

## Root Cause of Denial

The Type of Bill Code entered on the claim was not correct or Type of Bill Code was missing and was required for the type of services being billed.

## Billing Tips

- Verify the appropriate three-character Type of Bill Code entered on the claim is correct.
- Refer to the *UB-04 Completion: Inpatient Services* (ub comp ip) section of the Part 2 provider manual for a complete list of Type of Bill codes.

# 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 the *UB-04 Tips for Billing: Inpatient Services* (ub tips ip) section in the Part 2 Inpatient Services provider manual.

| Box # | Field Name | Error |
|---|---|---|
| 18 thru 24 | Condition Codes | Omitting codes or entering a Medi-Cal local billing limit exception code (X0, X1 thru X9)<br>**Billing Tip**: The delay reason code is entered in (Box 37A) of the claim. Enter codes in numeric-alpha order. For example, 80, 82, A1 |
| 39 thru 41 (A thru 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<br>**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 thru C) | Payer Name | Missing all payer information<br>**Billing Tip:** Enter the "I/P" indicator.<br>Example: I/P MEDI-CAL |
| 54 (A thru B) | Prior Payments (Other Coverage) | Missing prior payment or Other Health Coverage not indicated<br>**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. |

| Box # | Field Name | Error |
|---|---|---|
| 56 | NPI | Missing or incorrect NPI number<br>Billing Tip: Enter the NPI |
| 60<br>(A thru C) | Insured's Unique ID | Entering the recipient's Medi-Cal ID number incorrectly<br>**Billing Tip**: Verify the recipient is eligible for the services rendered by using the POS network. Do not enter the Medicare ID number |
| 63<br>(A thru C) | Treatment Authorization Codes | Entering EVC number instead of the TAR number<br>**Billing Tip**: The EVC number is only for verifying eligibility and should not be entered on the claim. |
| 74<br>(A thru B) | Principal Procedure Code and Date | Missing or incorrect ICD-10-PCS code or a CPT/HCPCS procedure code entered.<br>**Billing Tip:** Hospitals paid according to the diagnosis-related groups (DRG) reimbursement methodology are encouraged to enter all applicable procedure codes (up to six on a paper claim) in the *Principal/Other Procedure* fields so the claim will reimburse at the appropriate level. |
| 76 | Attending Physician ID | Missing or incorrect attending physician's NPI<br>**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 and 79 | Other (Admitting Physician Provider Number) NPI | For inpatient provider use only: Missing or incorrect admitting physician's NPI is entered here. |
| 80 | Remarks | Reducing font size or abbreviating terminology to fit in the field<br>**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

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 0005 | A) Cost Center missing/invalid. |
| _____ | RAD 0010 | B) The service billed requires an approved TAR (*Treatment Authorization Request*). |
| _____ | RAD 0314 | C) Requires a valid sterilization consent form. |
| _____ | RAD 9286 | D) The claim was received after the one-year maximum billing limitation. |
| _____ | RAD 0021 | E) This service is a duplicate of a previously paid claim. |
| _____ | RAD 0076 | F) The submitted documentation was not adequate. |
| _____ | RAD 9952 | G) Type of Bill Code for APR-DRG claim invalid or missing. |
| _____ | RAD 0037 | H) Type of Admit missing or invalid. |
| _____ | RAD 9128 | I) Health Care Plan enrollee, capitated service not billable to Medi-Cal. |
| _____ | RAD 0105 | J) Recipient is not eligible for the month 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

*Appeal Process Overview (appeal)*
*CIF Overview (cif)*
*Electronic Methods for Eligibility Transactions and Claim Submissions (elect)*
*Remittance Advice Details (RAD) and Medi-Cal Financial Summary (remit) "Click" on* Link titled: *Remittance Advice Details (RAD) Codes, Messages and Electronic Correlations.*

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)*
*UB-04 Completion: Inpatient Services (ub comp ip)*
*UB-04 Tips for Billing: Inpatient Services (ub tips ip)*

# Appendix

## Acronyms

| Acronym | Description |
|---|---|
| **APR DRG** | All Patient Refined Diagnosed Related Groups |
| **BIC** | Benefits Identification Card |
| **CA-MMIS** | California Medicaid Management Information System |
| **CCN** | Claim Control Number |
| **CCS/GHPP** | California Children's Services and Genetically Handicapped Persons Program |
| **CSU** | Correspondence Specialist Unit |
| **EPSDT** | Early and Periodic Screening, Diagnostic and Treatment |
| **MCP** | Managed Care Plan |
| **NPI** | National Provider Identifier |
| **SOC** | Share of Cost |

# Module A Answer Key

## Knowledge Review

| Enter Letter | RAD Code | RAD Code Definitions |
|---|---|---|
| B | RAD 0005 | A) Cost center code missing/invalid. |
| E | RAD 0010 | B) The service billed requires an approved TAR (*Treatment Authorization Request*). |
| J | RAD 0314 | C) Requires a valid sterilization consent form. |
| A | RAD 9286 | D) The claim was received after the one-year maximum billing limitation. |
| D | RAD 0021 | E) This service is a duplicate of a previously paid claim. |
| F | RAD 0076 | F) The submitted documentation was not adequate. |
| G | RAD 9952 | G) Type of Bill Code for APR-DRG Claim Invalid or Missing. |
| I | RAD 0037 | H) Type of Admit missing or invalid. |
| H | RAD 9128 | I) Health Care Plan enrollee, capitated service not billable to Medi-Cal. |
| C | RAD 9291 | J) Recipient is not eligible for the month of service. |