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Overview

This guide is designed to assist a user when working the various types of denials that occur in MCS after a claim has gone through the adjudication process. It provides an explanation of the denial, the corresponding HIPAA Reason Code as well as an example and the recommended action steps.

For a more in depth explanation of the claims adjudication process in MCS, please refer to the Service Breakdown document located on the MCS University.

After researching a claim, if you still do not understand why a claim was denied, don't hesitate to contact support for assistance.

If you are a provider, please contact the appropriate MCO for assistance. If you are an MCO staff member, please follow your standard procedures for contacting AlphaCM support to assist.

Override / Readju / Revert Codes

MCS Reason ID	HIPAA Reason Code	Reason Description
41	123	Readju - Audit Payback
42	123	Readju - Audit Payback
43	125	Readju - Audit Recoup
44	62	Readju - Authorization/Treatment Revisions
45	125	Readju - Billing Days Extended
46	125	Readju - Billing Terms Revised
47	125	Readju - Client Manually Matched
48	125	Readju - Contract Terminated
49	A1	Readju - Corrected Claim
50	18	Readju - Duplicate Claims
51	22	Readju - EOB Required

52	125	Readju - Other
53	22	Readju - Other Primary Insurance
54	2	Readju - Patient Liability
55	125	Readju - Provider Billing Error
56	125	Readju - Provider ID Incorrect
57	125	Readju - Rate Change
98	A1	Readju - Denial Rebilling
58	123	Overid - Audit Payback
59	123	Overid - Audit Payback
60	125	Overid - Audit Recoup
61	62	Overid - Authorization/Treatment Revisions
62	125	Overid - Billing Terms Revised
63	125	Overid - Contract Terminated
64	A1	Overid - Corrected Claim
65	18	Overid - Duplicate Claims
66	22	Overid - EOB Required
67	62	Overid - Missing/incomplete/invalid treatment authorization code
68	125	Overid - Other
69	22	Overid - Other Primary Insurance
70	142	Overid - Patient Liability
71	125	Overid - Provider Billing Error
72	125	Overid - Rate Change
73	123	Revert - Audit Payback
74	123	Revert - Audit Payback
75	125	Revert - Audit Recoup
76	62	Revert - Authorization/Treatment Revisions
77	125	Revert - Billing Terms Revised
78	125	Revert - Contract Terminated
79	A1	Revert - Corrected Claim
80	18	Revert - Duplicate Claims
81	22	Revert - EOB Required
82	125	Revert - Other
83	22	Revert - Other Primary Insurance
84	2	Revert - Patient Liability
85	125	Revert - Provider Billing Error
86	A1	Revert - Reverted because reversal/replacement claim has been submitted
110	22	Revert - Retroactive Medicaid
111	22	Revert - Medicaid coverage
117	22	Override - Medicaid Coverage
118	22	Override Retroactive Medicaid

1 Adjusted – Above Contract Rate

Description

The rate charged in the claim was higher than the rate that is in the provider's contract.

Corresponding HIPAA reason code

45-- Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Example

New Day Therapy charges \$110 for a service, but in their contract, the rate the MCO agreed to pay is \$100 so \$10 will be adjusted off.

Recommended Action Steps

MCO

The claim will be paid at the rate that's in the provider contract.

If the MCO or provider determines that the higher rate is correct, the MCO can adjust the rate in the Maintain Provider Info module. To adjust the contract rate, follow these steps:

1. Click **Menu > Provider Network > Maintain Provider Info**
2. Filter for the provider
3. Click the Contracts tab and select the appropriate contract (Stat or Medicaid)
4. Open the Contract Details tile and search for the service code on the claim
5. Open the Contract Rates tile and adjust the rate by clicking the 3 view and selecting the 'Update' button

Provider

Don't re-submit the claim.

2 Approved

Description

The claim has passed all validation checks and has been approved for payment.

Corresponding HIPAA reason code

92--Approved

Recommended Action Steps

MCO

No action needed.

Provider

Post payment for the claim.

In-Depth Look

The claim record has undergone all possible validation checks and all data is accurate and complete. The full amount of the claim is adjudicated and approved

3 Authed Units Exceeded

Description

The service on the claim was authorized; however, the provider has gone over the amount of units on the auth.

Corresponding HIPAA reason code

198-- Payment Adjusted for exceeding precertification/authorization. This change to be effective 4/1/2008: Precertification/authorization exceeded.

Example

New Day Therapy has an authorization for John Doe for 50 units of H2022. However, all 50 units have been used. When New Day enters another claim for John Doe, H2022, they will receive this denial.

Recommended Action Steps

MCO

MCO staff can confirm this error is correct by going to:
Clinical modules > Utilization Management > Authorizations

Then search for any authorizations for the consumer in question

Provider

Verify units authorized and provided. The provider will need to enter a new SAR for this service. Contact MCO if applicable. Do not refile if authed units are truly exceeded.

In-Depth look

The validation routine tests to see if the total consumed units is greater than the number of authorized units. The test is done only for procedures codes with the authorization required field set.

4 Max Basic Units Exhausted

Description

The total number of basic units allotted by the MCO has been exceeded (please refer to specific MCO for unit allotments). Basic units are renewed at the beginning of every calendar year and follow the patient across providers.

**Note-Basic units are not used when an active authorization is in place. The authed units will be used instead.*

Corresponding HIPAA reason code

96-- Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

The number of Adult Basic Units available are 8. New Day Therapy used 6 basic units and Number One Therapy used 2 units for John Doe. If New Day tries to enter another claim for 1 unit of a basic service they will get this denial.

Recommended Action Steps

MCO

MCO staff can confirm this error is correct by going to **Menu > Finance > Claims > Claim Maintenance** and filtering for all claims submitted for the patient in question that were approved. Then determine which services are basic and total the number of units approved.

Provider

A SAR will need to be entered for the service they're trying to get approved.

In-Depth Look

MCS looks at the procedure code in the claim line to look up data about the procedure code that was performed. If the procedure code is flagged as "basic", MCS looks at previously approved claims to determine how many basic units have been used. If the sum of the basic units is greater than the number of allowed basic units, the claim is denied for this reason.

5 Claim received after billable period

Description

A provider's contract specifies a certain number of allowable days to bill for a claim after the date of service. The provider did not submit the claim in time.

Corresponding HIPAA reason code

29-- The time limit for filing has expired.

Example

New Day Therapy's contract specifies that they have 30 days to submit a claim, following the date of service. The rendering provider renders service on 1/1/2012, but the claim gets submitted on 2/12/2012.

Recommended Action Steps

MCO

Verify that the claim was received within the number of days specified in the provider contract, plus a three day grace period. Verify that for reversal/replacement or COB claims, the period has been extended 90 days.

Provider

Write off charges as non-billable. Do not rebill.

In-Depth Look

MCS looks at the provider id in the claim header to look up the provider contract. The system determines the number of days allowed to submit a claim by checking the 'Claim Days' field in the provider contract.

The following checks are also performed during this operation:

1. The provider contract is verified to be active
2. The claim date of service falls between the effective date and end date of the provider contract

Next the system adds the number of allowed claim days to the claim date of service, plus 3 (each claim has a 3-day grace period) and checks that this value is greater than or equal to the insert date on the claim header.

Next, the system checks if the claim is a replacement claim. If it is a replacement claim, an additional 90 days past the insert date of the claim is allowed for processing, provided that the original claim was not denied for being received after the billing period.

Next, the system checks for the existence of a COB amount and COB reason in the claim line, and if those exist, the billable period is extended 90 days.

6 Claim submitted before service date

Description

The date of service (DOS) is later than the date the claim was submitted.

Corresponding HIPAA reason code

110-- Billing date predates service date.

Example

New Day Therapy submits a claim on 8/1, but the DOS on the claim is 8/4.

Recommended Action Steps

MCO

MCO staff can confirm this error by going to **Finance > Claims > Claim Maintenance**. The Claim

Maintenance tile will show the date the claim was submitted and the Claim Line tile will show the DOS for the particular claim line.

Provider

Check DOS for accuracy. Refile only if incorrect. Do not bill service prior to service date.

In-Depth Look

MCS looks at the date of service on the claim header. It verifies that the date and time on which the claim was inserted into the system (an internal timestamp) occurs after the date and time of service in the claim header.

7 Client has other covered insurance (COB)

Description

The client has a COB record in MCS that would cover this service however there is no COB indicated on the claim.

Corresponding HIPAA reason code

22-- Payment adjusted because this care may be covered by another payer per coordination of benefits. This change to be effective 4/1/2008: This care may be covered by another payer per coordination of benefits.

Example

New Day Therapy puts in a claim for H2022. BCBS covers this service and should pay for it, as opposed to the state insurance.

Recommended Action Steps

MCO

MCO staff can confirm this error by going to Patient > Patient Maintenance > Finance tab, and looking at the Insurance and COB tiles.

Provider

Ensure that the primary insurance for the patient has been billed and is indicated on the claim being submitted to the MCO.

In-Depth Look

MCS retrieves the patient id from the claim header and the procedure code, claim date of service, and COB amount from the claim line. The patient id is used to retrieve COB insurance data. If there is a currently active COB record for this patient in MCS, and the claim date is between the effective and end dates of the COB, the submitted claim must indicate the COB Amount and Reason.

8 Client not covered by contract

Description

A client-specific contract exists but the client is not included in the contract.

Corresponding HIPAA reason code

181-- Payment adjusted because this procedure code was invalid on the date of service. This change to be effective 4/1/2008: Procedure code was invalid on the date of service.

Example

The service on the claim wasn't in the provider's contract on the DOS.

Recommended Action Steps

MCO

To confirm a client specific contract, do the following:

1. Click **Menu > Provider > Maintain Provider Info**
2. Search for the provider using the filter under the Provider Tile
3. Click the provider name then select the Contract tab
4. Select the corresponding contract (State or Medicaid) under the Contracts tile
5. Now maximize the Contract Details tile and filter for the service

If there is a patient specific contact, it will be displayed under the Patient Specific Contract tile when the service is selected in the Contract Details tile.

Provider

Check criteria listed in provider contract for patient eligibility. Confirm patient eligibility through Enrollment and Eligibility.

In-Depth Look

You can think of the provider contract and the client-specific contract as being in a hierarchy, with the client specific contract being stored beneath the provider contract.

MCS maintains a list of client-specific contracts that are tied to the provider contract. During the adjudication process, MCS looks at the provider id in the claim header to look up the provider contract. The provider contract is then compared to the list of client-specific contracts. If a client-specific contract is found not to have a provider contract associated with it (a so-called orphan record), then the claim is denied.

9 Clinician not licensed to provide the service or license has expired

Description

The clinician who performed the service doesn't have the license required to perform the service.

Corresponding HIPAA reason code

52-- The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.

Example

Nurse Jones performs a triage when she admits a patient to inpatient therapy. The claim is billed under clinician Dr. Bob Jones, the patient's therapist. The state insurance guidelines specify that only an LPN can perform the service.

Recommended Action Steps

MCO

MCO staff can confirm the error by going to Provider Network > Clinician Maintenance, filtering for the clinician and looking at the Licenses tile for that clinician. Also ensure that the clinician's license group has a contract rate associated with the procedure code in the claim line by going to the License Group module found under Master > Master Maintenance > License Groups.

Provider

Check claim for accuracy and if no errors exist, claim cannot be billed. No action needed. If billed in error, correct and refile claim.

In-Depth Look

MCS looks at the provider id in the claim header in order to retrieve the provider contract, provider contract details and contract rates. The claim line is used to look up the procedure code and clinician id. The clinician id is used to find a corresponding clinician license, which is mapped to a license group. So, in this validation, not only does MCS look at the provider contract rates, but also the license belonging to the clinician. If the contract rate in the adjudication line is null or zero, and the claim is for a clinician-based service, then the claim is denied.

10 Coinsurance Amount

Description

This reason code is set when MCS is adjusting a claim that has a COB Amount. The adjudicated amount is subtracted from the cob amount and the difference is the adjusted amount.

Corresponding HIPAA reason code

2—Coinsurance Amount

Example

New Day Therapy submits a claim for \$100 with a COB amount of \$20. When the claim is adjudicated the \$20 will be adjusted off with this denial as the reason.

11 Another concurrent service has been approved or waiting to be processed

Description

A claim will be denied for this reason when the service being billed is not compatible with another service that was previously billed and is either processing or approved. This is to adhere to NCCI standards for compatible codes.

Corresponding HIPAA reason code

59-- Charges are adjusted based on multiple or concurrent procedure rules. (For example: multiple surgery or diagnostic imaging, concurrent anesthesia.) This change to be effective 4/1/2008: Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)

Example

Dr. Bob at New Day Therapy submits a claim for service 0911(PRTF) with DOS 2/1/2014. He then submits another claim at a later time for 0183(Therapeutic Leave) with the same DOS of 2/1/2014. These services cannot be provided on the same DOS therefore will not be allowed.

Recommended Action Steps

MCO

The MCO can check the NCCI list to ensure these services are concurrent.

Provider

The provider could confirm the service previously sent it correct and if not, send a reversal or replacement claim.

In-Depth Look

MCS looks for claim lines that been adjudicated and stamped with reason code 1 - Adjusted – Above Contract Rate or 30 – monthly case rate already paid. MCS then denies a claim if two procedures are performed by the same provider on the same date of service, as defined in non-concurrent procedure code definition.

13 Daily frequency exceeded

Description

The service has a limit on the amount of units that can be billed per day. Either the claim has exceeded that limit OR that claim in addition to other claims (for that same day and service) has exceeded the limit.

Corresponding HIPAA reason code

198-- Payment Adjusted for exceeding precertification/ authorization. This change to be effective 4/1/2008: Precertification/authorization exceeded.

Example

A clinician at New Day Therapy submits a claim for 1 unit for a service. Another clinician at New Day then submits another claim for 1 unit for that same service. They both bill but the second is denied because only 1 unit is allowed per day for that service.

Recommended Action Steps

MCO

MCO staff can confirm this error by going to the Master modules, Benefit Plans, then checking the Service/Proc Codes tile. This will tell you any limits on the service.

Provider

Only one occurrence of service is billable per day. Adjust off charges and do not refile. Only if service is billed as daily summary of units, file adjusted claim.

In-Depth Look

MCS calculates the daily limits for procedure codes that require authorization by looking up the daily limit in the procedure-code-to-benefit plan record. The units for the adjudicated claim lines for that day are summed, and if the daily amount is greater than the daily limit, the claim is denied.

14 Invalid Service or Service Discontinued

Description

The MCO is no longer reimbursing providers for performing this service.

Corresponding HIPAA reason code

204-- This service/equipment/drug is not covered under the patient's current benefit plan

Recommended Action Steps

MCO

MCO staff can confirm this by going to the Master modules, Benefit Plans. Choose the benefit plan that applies, then the appropriate service definition. The services that fall under that definition will show. The DOS of the claim should be outside the end date of the service.

Provider

Service has been lapsed/removed from benefit plan and is no longer billable. Confirm through Provider Network.

In-Depth Look

MCS looks at the procedure code in the claim line. It first validates that the procedure code in the claim

line exists in the known procedure codes located in the database. Next, MCS verifies that the claim date of service falls between the effective date and end date of the procedure code.

15 Duplicate Claim

Description

An identical claim has already been processed and approved.

Corresponding HIPAA reason code

18-- Duplicate claim/service.

Example

New Day Therapy sends in the same claim twice. Either accidentally in the same batch or in two separate batches. Also, a claim could have been sent in an 837 and someone also entered a CMS 1500.

Recommended Action Steps

MCO

MCO staff can confirm this error by going to the Claims Header Base and filtering for the claim using the search fields. Two claims with the same data should appear.

Provider

Claim has previously been submitted and adjudicated. Do not refile.

In-Depth Look

MCS considers a claim to be a duplicate if the following data matches another claim: procedure code id, provider id, patient id, and date of service. In the event that a duplicate is found, the claim that will be processed further will be the one that was adjudicated prior to the duplicate.

16 DX code is invalid for service/insurance combination

Description

The diagnosis on the claim is part of a dx group that isn't mapped to that service.

Corresponding HIPAA reason code

11-- The diagnosis is inconsistent with the procedure

17 FFS claim pended for 14 days wait

Description

NOT CURRENTLY IN USE

Corresponding HIPAA reason code

96-- Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

NOT CURRENTLY IN USE

18 Patient not enrolled on the date of service

Description

The client either wasn't enrolled in the insurance on the date of service (DOS) or they were never enrolled in it.

Corresponding HIPAA reason code

31-- Claim denied as patient cannot be identified as our insured. This change to be effective 4/1/2008: Patient cannot be identified as our insured.

Example

New Day Therapy bills a claim for Jane Doe with a DOS of 8/1/12 to state insurance. However, Jane only had Medicaid until 8/5/12, so she wasn't covered under state at the time the service was performed.

Recommended Action Steps

MCO

MCO staff can confirm this error by going to Patient > Patient Maintenance > Finance tab, and looking at the Insurances and COB's tiles. Check the existence of a patient insurance record and that the claim date of service falls between the effective and end dates of the patient insurance.

Provider

Verify that all patient information is correct on claim. If no errors exist, contact MCO.

In-Depth Look

MCS looks at the patient id in the claim header. The patient id in the header maps to the patient-to-insurance record. MCS validates the existence of the patient-to-insurance record and that the date of service on the claim falls between the effective and end dates of the patient's insurance record.

In a subsequent validation routine, MCS identifies the approved insurance by looking up the provider id in the claim header and the procedure code in the claim line. MCS uses these fields to look up the provider contract and the provider contract details, which maps a provider contract to procedure code.

Next, MCS selects the plan under which the claim is going to be adjudicated by looking at the procedure code in the claim line. The procedure code is used to look up a corresponding record in the procedure-code-to-benefit plan mapping. In this way, the system determines the types of insurances that cover the procedure code.

Finally, MCS checks the patient id in the claim line to see if the patient is enrolled in the correct benefit plan at the date of service. In this check we look up the patient's type of insurance and ensure that the claim date of service falls between the effective and end date of the patient's insurance record.

19 Incorrect Member -- Patient not enrolled on DOS

Description

The client either wasn't enrolled in the insurance on the date of service (DOS) or they were never enrolled in it.

Corresponding HIPAA reason code

140-- Patient/Insured health identification number and name do not match.

Example

A claim is received via an 837 file. The system checks the patient's name and DOB, but cannot locate a patient id.

Recommended Action Steps

MCO

MCO staff can confirm this error by going to Patient > Patient Maintenance > Finance tab, and looking at the Insurances and COB's tiles.

Provider

Verify that all patient information is correct on the claim. If no errors exist, contact the MCO.

In-Depth Look

This reason code description is the same as reason code 18, however, the validation rule is different. In this check, MCS verifies the existence of a patient id in the claim header. A patient id is an internal field that uniquely identifies each patient. If the patient id cannot be found, the system returns reason code 19.

20 Invalid Service or Service Discontinued*

Description

The service on the claim is not in the MCS database.

**Note – This denial only applies to Inpatient claims.*

Corresponding HIPAA reason code

181-- Payment adjusted because this procedure code was invalid on the date of service. This change to be effective 4/1/2008: Procedure code was invalid on the date of service.

Example

New Day Therapy bills for a service code '17765327'. This service doesn't exist in the MCO's database.

Recommended Action Steps

MCO

MCO staff can confirm this by going to the Master modules, Benefit Plans. Choose the benefit plan that applies, then the appropriate service definition. The services that fall under that definition will show. The DOS of the claim should fall within the effective and end dates of the service, OR there aren't any dates at all for the service.

Provider

Verify that all service information is correct on claim. If no errors exist, contact the MCO's Provider Network department.

In-Depth Look

MCS uses the procedure code id in the claim line to search for the existence of the procedure in the database. If no results are found, the claim is denied for this reason.

21 Invalid age group & procedure code combination

Description

The age group that the client falls into shouldn't be receiving that service.

Corresponding HIPAA reason code

6-- The procedure/revenue code is inconsistent with the patient's age.

Example

John Doe is 35 years old but the provider is billing for a child service (Ages 0-17).

Recommended Action Steps

MCO

MCO staff can confirm this by going to Master > Service Matrix. Filter for the service then select the Age Group Tab to determine which, if any, age groups the service is mapped.

Provider

Verify that consumer age corresponds with procedure code billed and that all information is submitted correctly. Refile only if incorrect.

In-Depth Look

MCS looks at the procedure code id and patient id in the claim line, and the claim date of service in the claim header. It uses the patient id to look up the patient date of birth. In the system, each procedure code is mapped to an age group. MCS validates the following:

1. The relationship of the procedure code to the age group is valid OR the procedure code is mapped to all age groups
2. The date of service on the claim line falls between the patients date of birth + the lower age limit and the patient's date of birth + the upper age limit.
3. The claim date of service falls between the effective date and end date of the procedure-code-to-age group mapping.

22 Invalid Amount

Description

The amount billed on the claim is blank, \$0, or less than \$0.

Corresponding HIPAA reason code

96-- Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

A provider submits an incoming 837 file but the data is missing or formatted incorrectly and the claim amount is not in the file. MCS stores, yet denies the claim, giving the provider a chance to re-enter the missing data.

Recommended Action Steps

MCO

MCO staff can confirm this by going to the Claim Line tile and viewing the Amount column.

Provider

Enter charge information for service. Refile Claim.

In-Depth Look

MCS checks that the claim amount being adjudicated is not null and greater than 0.

23 Invalid Diagnosis / Age Combination

Description

The diagnosis code submitted is not a valid for the age group of the consumer.

Corresponding HIPAA reason code

9-- The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Example

I claim is submitted for a child however the age group the code is mapped to is for adult only.

Recommended Action Steps

MCO

MCO staff can confirm this by confirming the consumer's age and determine which age group they fall under. Then refer to state guides to confirm the denial is true. If not, contact your MCS Support representative if requires addition.

Provider

Verify that claim data is correct and rebill as necessary with the appropriate diagnosis code for the age group. If denied in error, reach out to your MCO claims specialist.

24 Invalid PC / DX Combo

Description

The diagnosis code submitted on the claim is invalid for the service.

Corresponding HIPAA reason code

11-- The diagnosis is inconsistent with the procedure.

Example

The claim is for a DD service but the client only has an SA diagnosis.

Recommended Action Steps

MCO

MCO staff can confirm this by going to Master > Service Matrix. Filter for the service then select the Diagnosis Group Tab to determine which diagnosis groups the service is mapped.

Provider

Verify that Procedure code corresponds with DX and that all information is submitted correctly. Refile only if incorrect.

In-Depth Look

MCS looks at the procedure code, diagnostic code, benefit plan, from date, to date, and insert date on the claim line. MCS validates that the procedure code has a matching record in the procedure-to-diagnostic-group relationship. It verifies that, for that procedure, the diagnostic code has a mapping to the diagnostic-code-to-diagnostic-groups relationship. It also verifies that the procedure-to-diagnostic-group relationship has a record for the given benefit plan. It verifies the 'From' date - 'To' date of the claim line falls between the effective and end dates of the procedure-to-diagnostic-group relationship and the diagnostic-code-to-diagnostic-group relationship.

25 Missing/incomplete/invalid place of service

Description

The place of service (POS) submitted on the claim is invalid for the service.

Corresponding HIPAA reason code

5-- The procedure code/bill type is inconsistent with the place of service.

Example

The claim is for an Intensive In-Home service but the POS is "Office".

Recommended Action Steps

MCO

MCO staff can confirm this by going to Master > Service Matrix. Filter for the service then select the Place of Service Tab to determine which place(s) of service the procedure code is mapped.

Provider

Verify place of service used for billing and that it is appropriate for the service billed. If incorrect, refile under a valid place of service.

In-Depth Look

MCS looks at the procedure code id, place of service id, from date, and to date in the claim line. MCS validates the following conditions:

1. the procedure code in the claim line has a matching record in the procedure-code-to-place-of-service mapping
2. That the place of service is valid for the procedure code or that the procedure code permits ALL places of service
3. That the procedure-code-to-place-of-service mapping is active and that the 'From' and 'To' dates on the claim line fall between the mapping's effective and end dates.

26 Missing/incomplete/invalid provider identifier

Description

The provider isn't active in the MCO's network.

Corresponding HIPAA reason code

208-- NPI denial - not matched. This change to be effective 4/1/2008: National Provider Identifier - Not matched.

Example

New Day Therapy is still under credentialing with the MCO

Recommended Action Steps

MCO

MCO staff can confirm this by going to Provider Network, Maintain Provider Info and filtering for that provider. The provider should not have an status of 'Active'.

Provider

Verify that provider information is correct on claim and is valid for the service billed. Contact MCO to update, then refile.

In-Depth Look

MCS looks at the provider id in the claim header. It first invalidates any records that do not have a provider id at all. Next it checks that the provider id in the claim header has a corresponding match to the providers in the MCO's database.

27 Invalid provider NPI

Description

The NPI on the claim either isn't in the system or isn't associated with the main site on the claim for the date of service.

Corresponding HIPAA reason code

206-- NPI denial - Missing. This change to be effective 4/1/2008: National Provider Identifier - missing.

Example

MCS receives a claim via an 837 file. The NPI number on the claim does not match an NPI number in the MCO's database.

Recommended Action Steps

MCO

MCO staff can confirm this by going to **Menu > Provider Network > Maintain Provider Info** and filtering for that provider. Go to the Site tab and choose the appropriate site. Then go to the Site Mapping tab, Numbers tile, and see if that NPI shows there.

Provider

Verify that provider NPI is correct on claim and is valid NPI for the service billed. Contact MCO Provider Network to update.

In-Depth Look

MCS looks at the provider id, and provider npa number in the claim header. It checks that the provider id in the claim header is matched to a site. MCS checks that the provider npa number in the header is matched to a site. MCS checks that the provider id and provider npa number in the header has a matching provider in the database.

28 Invalid Rendering/attending provider NPI number

Description

The rendering NPI submitted on the claim either isn't in the system, isn't associated with the site or clinician on the claim for the date of service.

Corresponding HIPAA reason code

206-- NPI denial - Missing. This change to be effective 4/1/2008: National Provider Identifier - missing.

Example

The provider submits a claim for Dr. Bob Jones, who is a new practitioner at New Day Therapy. However, the provider has mistakenly entered the effective date of Dr. Jones's employment to one month later than the claim date of service.

Recommended Action Steps

MCO

MCO staff can confirm this by going to Provider Network, Maintain Provider Info and filtering for that provider. Go to the Site tab and choose the appropriate site. Then go to the Site Mapping tab, Numbers tile, and see if that NPI shows there. If the rendering NPI is for a clinician, go to Provider Network, Clinician Maintenance and filter for that clinician. The clinician's NPI will show on the 2 and 3 view.

Provider

Verify that rendering NPI is correct on claim and is valid NPI for the service billed. Contact SMC Provider Network to update, then refile.

In-Depth Look

MCS looks at the provider id, procedure code id (to determine a clinician-based procedure), rendering provider, from date, and site id in the claim line. If clinician based, MCS verifies that the provider in the header exists in the database and is matched to a site. It then validates that the rendering provider is matched to the same site. For other records, the rendering npi number in the claim line is matched to a clinician, the clinician is matched to a provider, the "from date" in the claim line falls between the effective and end dates of the clinic-to-provider relationship.

29 Invalid Units

Description

The units submitted for the claim are blank, 0 or less than 0.

Corresponding HIPAA reason code

96-- Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

A claim is received on an 837 and the claim amount was inadvertently left out.

Recommended Action Steps

MCO

MCO staff can confirm this by going to the Claim Line tile and viewing the Units column.

Provider

Verify that the units are correct for service billed, and refile claim.

In-Depth Look

MCS checks the units field in the adjudication record and verifies that it is not null and is greater than 0. In subsequent checks, the allowable number of basic units and authorized units is compared to the acceptable limit. This validation routine is the most basic of the units validation routines, in that it simply checks for the existence of a numerical value in the units field.

30 Monthly case rate already paid

Description

There is a monthly limit for TCM. Any claims beyond this set limit will deny for this reason.

Corresponding HIPAA reason code

96-- Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day Therapy can bill four TCM services a month to the MCO. They bill a fifth and get this denial.

Recommended Action Steps

MCO

Look at the Benefit Plan and see what the monthly limit is. Then look at Claim Maintenance and filter for claims for that patient for that month.

Provider

You can look at RA's or the Claims Dump to see how many services have been billed for a patient in a given period of time.

31 Monthly frequency exceeded

Description

The amount of units on the claim, along with units on other claims for the same patient and service during that same month, exceed what is allowed by the MCO.

Corresponding HIPAA reason code

198-- Payment Adjusted for exceeding precertification/ authorization. This change to be effective 4/1/2008: Precertification/authorization exceeded.

Example

New Day Therapy has submitted 8 units for John Doe during June. This is maximum that the MCO has allowed New Day to bill for this service in a month. When they try to bill a ninth unit, they will get this denial reason.

Recommended Action Steps

MCO

MCO staff can confirm this by going to the Master modules, Benefit Plans. Choose the benefit plan that applies, then the appropriate service definition. The services that fall under that definition will show. The monthly limit for the service will show on the far right hand side of the 1 view.

Provider

Units for monthly service were exceeded. Do not refile claim.

In-Depth Look

MCS calculates the monthly limits for procedure codes that require authorization by looking up the monthly limit in the procedure-code-to-benefit plan record. The units for the adjudicated claim lines for that month are summed, and if the monthly amount is greater than the monthly limit, the claim is denied.

32 No rates available

Description

A contract rate was not found for the provider and there is no rate for the service/license combination in the rate schedule.

Corresponding HIPAA reason code

147-- Provider contracted/negotiated rate expired or not on file.

Example

New Day Therapy bills a claim for a service that the MCO hasn't said how much they're going to pay for it, if at all.

Recommended Action Steps

MCO

Confirm this by going to **Finance > Rates Schedule**. Search for the appropriate Contract, then find the service and check if it has rates connected to it. If there is no rate then you can enter a rate and re-adjudicate the claim or simply override the claim.

Provider

Rate not established in rate schedule.

In-Depth Look

MCS first stamps all of the claim lines that belong to sub-capitated contracts for special processing. MCS looks at the provider id in the claim header in order to retrieve the provider contract, provider contract details and contract rates. The claim line is used to look up the benefit plan, site, procedure code and clinician id. The clinician id is used to find a corresponding clinician license, which is mapped to a license group. So, in this validation, not only does MCS look at the provider contract rates, but also the license belonging to the clinician

Please note that with this denial it is also checking if the service is clinician based (Master > Master Maintenance > Service Matrix** on the **Service** tab, click **View**). If the service is clinician based then the service will need to be in the Providers contract details for the site on the claim.

33 Non billable Service**Description**

The MCO does not reimburse providers for performing this service.

Corresponding HIPAA reason code

46-- This (these) service(s) is (are) not covered.

Example

Clinician Bob Roberts submits a claim for accompanying John Doe to a court date. The MCO has this as a service in their benefit plan but they will not pay for it.

Recommended Action Steps**MCO**

MCO staff can confirm this by going to the Master modules, Service Matrix. Filter for the service on the Base tile. On the 3 view, you're able to look at the "Is Billable?" checkbox.

Provider

Service is not covered under the benefit plan. Confirm correct service billed, and contact the provider network if disputing denial.

In-Depth Look

MCS gets the procedure code in the claim line. It looks up the procedure record in the database, and checks to see if the procedure is billable by looking for a value in the Billable column.

34 Referenced claims has already been resubmitted. Multiple resubmissions not allowed

Description

A claim that has been resubmitted and the re-submitted claim has already been adjudicated.

Corresponding HIPAA reason code

96-- Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

Clinician Bob Roberts submits a claim for a service but inadvertently enters the incorrect number of units. After receiving the RA, he realizes his mistake and submits a replacement claim after correcting the number of units.

Recommended Action Steps

MCO

Check the Resub/Ref # in the resubmission to verify that it references an original claim. The duplicate resubmission will contain the same reference.

Provider

Duplicate claim. Do not refile claim. Contact SMC Claims Specialist.

In-Depth Look

When a claim is re-submitted, a new claim is created and the new claim gets stamped with the claim header id of the old claim. MCS uses this data to verify that a re-submitted claim gets processed only once.

35 Service is not authorized

Description

The service performed by the provider was not authorized.

Corresponding HIPAA reason code

62-- Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Example

Clinician Bob Roberts enters a claim for therapy that he's doing with John Doe but the SAR he submitted hasn't been approved yet or no SAR has been submitted.

Recommended Action Steps

MCO

To verify if a service is authorized for a procedure code for a particular provider, do the following

1. Click Menu > Clinical > Utilization Management > SAR
2. Search by Patient or Procedure Code

Provider

Verify Service Authorization for consumer. Contact SMC Service Management.

In-Depth Look

MCS looks at the claim header for the provider id and uses that to look up, in the provider contract details, if authorization is required for the procedure in the claim line. A list of authorization codes is generated for each procedure performed, based on the data taken from the provider contract details. If authorization is required for the procedure code for that site and the authorization code is not found in the database, the claim is denied. The validation rules for the reason code do not apply to procedures flagged as basic or institutional. If the procedure code for the claim has been added to the site-enforced list for your MCO, the site on the Auth must match the site on the claim, and the site must be in contract, or the claim will deny.

36 Service not in contract

Description

The patient is enrolled with a particular type of insurance plan, such as State or Medicaid, but the provider contract does not specify that the provider can render the service.

Corresponding HIPAA reason code

109-Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.

Example

New Day Therapy bills for H2022. However, they're only contracted to do therapy with the MCO.

Recommended Action Steps

MCO

Confirm this by going to Provider Network > Maintain Provider Info, search for that provider and go to the Contracts tab. Find the appropriate contract in the Contracts tile, then go to the Contract Details tile to confirm that the service is not in the provider's contract. If this is showing in the Providers contract then refer to the Suspensions Tab to see if the provider's contract has been suspended.

Provider

Review your contract with the Provider Network prior to refiling claim.

In-Depth Look

MCS looks at the provider id in the claim header to look up the provider contract. The provider contract identifies the approved types of insurance for that provider. Next MCS determines whether the claim is going to be adjudicated as a claim going to the State, Medicaid B, Medicaid C, or Medicaid FFS. If the approved types of insurance for that provider do not cover the type of service being rendered, then the service is not in the provider's contract and the claim is denied.

37 Service not in provider profile

Description

A provider's contract details what procedure codes the provider can render. The procedure code in the claim line is not a procedure that can be rendered by the provider.

Corresponding HIPAA reason code

181-- Payment adjusted because this procedure code was invalid on the date of service. This change to be effective 4/1/2008: Procedure code was invalid on the date of service.

Example

New Day Therapy bills for H2022. However, they're only contracted to do therapy with the MCO.

Recommended Action Steps

MCO

Verify that service is included in provider profile.

Provider

Confirm through your Provider Network prior to refiling claim.

In-Depth Look

MCS looks at the provider id, procedure code id, and claim date of service, in order to look up the provider contracts in the database. In Alpha CMS, each provider is mapped to a contract, and each provider's contract is matched to a set of procedure codes. MCS checks the provider contract to validate the following: 1) that a contract exists with the provider 2) that the procedure code exists in the provider contract details 3) that the claim date of service is between the effective and end dates of the provider contract and contract details.

38 Sub-capitated Provider/Service

Description

Provider has already been paid through a capitation agreement, so this will not be paid even if it's approved.

Corresponding HIPAA reason code

24-- Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. This change to be effective 4/1/2008: Charges are covered under a capitation agreement/managed care plan.

Example

New Day is a provider who has sub-capitated services—they are regularly paid by the MCO regardless of the claims that come in—so when a claim is approved, it's still not going to pay since it's already been paid once.

Recommended Action Steps

MCO

Check the contract of the provider. Go to **Contract Details**, find the service that was on the claim, and click the 3 view to see if the **Sub capitated** checkbox is checked.

Provider

Refer to your contract with the MCO and call them with any questions.

39 The procedure code is inconsistent with the provider type/specialty (taxonomy).

Description

The MCO doesn't have on file that the provider uses the taxonomy entered for the claim, OR the MCO doesn't have that taxonomy associated with the site specified on the claim.

Corresponding HIPAA reason code

8-- The procedure code is inconsistent with the provider type/specialty (taxonomy).

Example

New Day Therapy bills using taxonomy 101TXNMY but the MCO doesn't have this taxonomy on file as one that New Day uses.

Recommended Action Steps

MCO

Confirm this by going to Provider Network, Maintain Provider Info, search for the provider, then go to the Site tab to select the site that was billed. Then go to Site Mapping tab, Taxonomy tile. Look for the taxonomy there.

Provider

Verify the Taxonomy code filed for the claim. If incorrectly submitted, correct and refile. Contact SMC Provider Network to add taxonomy code.

40 Weekly frequency exceeded

Description

The service has a limit on the amount of units that can be billed per week. Either the claim has exceeded that limit OR that claim in addition to other claims (for that same week and service) has exceeded the limit.

Corresponding HIPAA reason code

198-- Payment Adjusted for exceeding precertification/ authorization. This change to be effective 4/1/2008: Precertification/authorization exceeded.

Example

A clinician at New Day Therapy submits a claim for 1 unit for a service on Monday. Another clinician at New Day then submits another claim for 1 unit for that same service on Tuesday. They both bill but the second is denied because only 1 unit is allowed per week for that service.

Recommended Action Steps

MCO

MCO staff can confirm this error by going to the Master modules, Benefit Plans, then checking the Service/Proc Codes tile. This will tell you any limits on the service. If a SAR was submitted for this patient and service, staff can go to Clinical, Utilization Management, SAR, search for the patient and find the SAR for this service, then go to the Service tile to view if any exceptional limits were put on the service just for this patient.

Provider

Limit to occurrence of service billable per week. If necessary, submit a SAR for service authorization. Adjust off charges and do not refile. Only if service is billed in error, file adjusted claim.

In-Depth Look

MCS calculates the weekly limits for procedure codes that require authorization by looking up the weekly limits in the procedure-code-to-benefit plan record. The units for the adjudicated claim lines for that week are summed, and if the daily amount is greater than the weekly limit, the claim is denied.

87 Adjusted Against Co-Insurance

Description

The adjudicated amount has been adjusted by subtracting the amount paid by the patient's co-insurance.

Corresponding HIPAA reason code

142-- Claim adjusted by the monthly Medicaid patient liability amount. This change to be effective 4/1/2008: Monthly Medicaid patient liability amount.

Example

John Doe has BCBS, who pays \$100 for a service, then the claim goes to Medicaid, which is administered by the state in this case. Medicaid is going to adjust off what BCBS paid.

Recommended Action Steps

MCO

Look at patient's Insurances or COB's in the Patient module to ensure they have other payers that were active during the DOS.

Provider

Look at patient's Insurances or COB's in the Patient module to ensure they have other payers that were active during the DOS.

88 Invalid inpatient/ED DX code

Description

CURRENTLY NOT BEING USED

89 No contract exists or rate is not set up yet*

Description

If code 0100 or 0101 is not in the contract, or a rate is not set up for 0100 or 0101, claims will be denied for this reason.

**Note – This is for inpatient claims only*

Corresponding HIPAA reason code

147-- Provider contracted/negotiated rate expired or not on file.

Example

New Day Therapy bills a DRG service but this isn't in their contract.

Recommended Action Steps

MCO

Check the provider's contract by going to Provider Network > Maintain Provider Info then filter for the provider in question. Select the provider in the Provider tile then go to the Contract tab. Select the corresponding contract (State or Medicaid) then filter for 100/0100 or 101/0101 in the Contract Details tile.

Provider

Refer to your contract and call the MCO with any questions.

90 Non-Covered Ancillary Services

Description

A claim is identified as a drug claim by revenue code '100' or '0100', but it wasn't administered at an ICF site.

Corresponding HIPAA reason code

48-- This (these) procedure(s) is (are) not covered.

Example

New Day Therapy bills 0100 for a patient being seen at a site that isn't marked as ICF.

Recommended Action Steps

MCO

Go to **Provider Network > Maintain Provider Info** then filter for the provider. Select the provider in the Provider tile and select the Sites tab. Look at the 3 view for the site on the claim to see if "Is ICF Site" is marked. If it's not, and it should be, click 'Update' and check the 'Is ICF Site' check box.

Provider

Go to **Provider > Provider Details > Site**, and look at the 3 view for the site on the claim to see if "Is ICF Site" is marked

91 Invalid Revenue Code**

Description

An invalid revenue code was provided for a drug claim. For these types of claims, the revenue code and procedure code must match.

***Note - This only applies to ED claims*

Corresponding HIPAA reason code

199—Revenue code and Procedure code do not match.

92 Excess amount over allowed Medicare copayment

Description

The adjudicated amount has been adjusted by subtracting the Medicare copayment.

Corresponding HIPAA reason code

99-- Medicare Secondary Payer Adjustment Amount.

Example

John Doe has Medicare, who pays \$100 for a service, then the claim goes to Medicaid, which is administered by the state in this case. Medicaid is going to adjust off what Medicare paid.

Recommended Action Steps

MCO

Look at patient's Insurances or COB's in the Patient module to ensure they have other payers that were active during the DOS.

Provider

Look at patient's Insurances or COB's in the Patient module to ensure they have other payers that were active during the DOS.

93 Invalid DCN (Document Ctrl #) or resubmission ref

Description

This is for replacement and reversal claims. The claim number entered for the original claim that the replacement/reversal claim is referencing is invalid.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day Therapy submits a replacement claim but the reference number (the original claim number that the new claim is replacing) doesn't exist in the MCO's system because New Day entered it incorrectly.

Recommended Action Steps

MCO

Go to Finance > Claims > Claim Maintenance and look up the reference number to see if it exists. You can also look at all past claims for a patient to see if you can find that number.

Provider

Look at your RA with the original claim number and make sure you entered it correctly.

94 Resubmitted claim DOS is after original claim submission date

Description

This is for replacement claims. The original claim was submitted earlier than the DOS on the referenced claim.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day Therapy submits a claim for the 1st of the month (DOS) on the 5th (submission date). They then send a replacement claim on the 15th (second submission date) but the DOS on that claim is the 6th.

Recommended Action Steps

MCO

Go to **Menu > Finance > Claims > Claim Maintenance** and filter to view the original claim's submission date.

Provider

Check your RA to view the original claim's submission date.

95 Resubmitted claim does not match with the reference claim

Description

A replacement claim must match the original claim for three out of six of the following criteria:

1. Provider
2. Patient
3. Service rendered
4. Place of service
5. Date of service
6. Principle diagnosis.

If less than three of the criteria do not match then MCS returns reason code 95.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day Therapy sends in a claim to replace a previous claim because the POS was wrong in the original. However, the replacement claim has a different POS, date of service and principal diagnosis. This differs too greatly from the original claim.

Recommended Action Steps

MCO

Go to Claims Maintenance and search for the original claim. The Claim Line tile will have the information you'll need to compare and contrast to the replacement claim.

Provider

In your claims dump and in your RA, you can see the information from the original claim that you need to compare and contrast to the replacement claim.

96 Referenced claim has already been resubmitted. Multiple resubmissions not allowed

Description

This is for replacement and reversal claims. The original claim being referenced has already been resubmitted. A claim can only be resubmitted once.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Recommended Action Steps

MCO

Go to Finance > Claims > Claim Maintenance and filter by provider, DOS and patient to find all claims that are identical and when they were submitted. You can also look up the patient in the Patient module to find all claims entered for the patient in question.

Provider

You can look in the Patient module to find all claims are entered for that patient and see which are identical and when they were submitted.

97 Charges are covered under a capitation agreement/managed care plan

Description

There has been a cap placed on the provider/service/definition/age group/dx group/ benefit plan that has been reached. This claim would exceed that amount.

Corresponding HIPAA reason code

42-- Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)

Example

New Day Therapy has been given a \$500,000 cap on H2022 by the MCO. They reach that cap, then submit a claim that asks the MCO to reimburse them over that amount and they receive this denial.

Recommended Action Steps

MCO

Go to Finance > Funding Capitation and look up funding caps related to that claim (same service, provider, age group, service definition, etc.

Provider

Contact the MCO so they can review any funding caps that may apply to this claim.

100 Invalid date range/Invalid date for discharge claim

Description

For discharge claims (bill type ending in 1 or 4), if the day of discharge on the claim line matches the claim's date of service, the claim is denied. This is because the last date of discharge, the bed will be vacant. So the total billed units should be days minus 1. If total days in the date range are the same as the total units, the last date will be denied for this reason.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day enters a discharge claim for three days. As with all discharge claims, the last day won't pay.

101 Patient does not have a valid Target Pop. on DOS

Description

A claim is covered by state insurance for a particular procedure. However, the patient record has not been assigned to a target population correlating to the service, as required by the state.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

The provider enters a claim for the 90801AH - CLINICAL INTAKE- CLINICAL PSYCH procedure for patient Jane Doe. However, Jane Doe has active insurance coverage with the state but has not been assigned to a Target Population.

Recommended Action Steps

MCO

Verify the patient's Target Population by doing the following:

1. Go to **Menu > Patient > Patient Maintenance**
2. Search for the patient by Last Name, First Name and other criteria
3. Select the patient in the search results.
4. Click the Doc, Assignment tab
5. In the IPRS Target Pops tile, you can verify the patient's assigned Target Pop(s)

Provider

Verify that consumer has a valid and current IPRS target population for the date of service billed. Contact MCO for assistance. If no errors exist, do not refile.

In-Depth Look

MCS looks at the patient id and date of service in the claim header. The system validates the following:

1. The claim is covered by state insurance
2. The patient has been assigned to a target population
3. The claim date of service falls between patient-to-target-pop effective date and end date.

102 Patient does not have a valid Target Pop. for DX submitted in claim

Description

A claim is covered by State insurance; however the patient is in a target population and given a diagnosis that are not valid for that specified target population.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This

change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

A female patient is diagnosed with Alzheimer's Dementia/Late Onset Uncomplicated and is not assigned to a valid target population, such as Adult Veteran or Adult MH Crisis.

Recommended Action Steps

MCO

Verify the patient's Target Population by doing the following:

1. Go to **Menu >Patient >Patient Maintenance**
2. Search for the patient by Last Name, First Name and other criteria
3. Select the patient in the search results.
4. Click the Doc, Assignment tab
5. In the IPRS Target Pops tile, you can verify the patient's assigned Target Pops

Verify the Target Population to Diagnostic Code Relationship by doing the following:

1. Go to **Menu > Master > Target Pops > TP to Diagnosis**
2. Search for a target population
3. Verify that the diagnostic code has been assigned to that Target Pop.

Provider

Verify the consumer has a valid IPRS target population that corresponds with the diagnosis information on claim. Contact MCO for assistance. If no errors exist, do not refile.

In-Depth Look

MCS looks at the patient id, diagnosis code, and date of service in the claim header. The system validates the following

1. The claim is covered by state insurance
2. The patient has been assigned to a target population
3. The target-population-to-diagnosis code relationship exists
4. The claim date of service falls between the effective and end dates of the target-population-to-diagnosis code relationship

103 Patient does not have a valid Target Pop for service submitted in claim

Description

A claim is covered by state insurance for a particular procedure however, the procedure performed is not valid for the patient's target population.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

The provider enters a claim for the 90801AH - CLINICAL INTAKE- CLINICAL PSYCH procedure for patient Jane Doe. Jane Doe has active insurance coverage with the State but has not been assigned to a corresponding Target Population

Recommended Action Steps

MCO

You can verify that patient's Target Population by doing the following:

1. Go to **Menu > Patient > Patient Maintenance**
2. Search for the patient by Last Name, First Name and other criteria
3. Select the patient in the search results.
4. Click the Doc, Assignment tab
5. In the IPRS Target Pops tile, you can verify the patient's assigned Target Pops

You can verify that Target Population to Procedure Relationship by doing the following:

1. Go to **Menu > Master > Target Pops > TP To Proc Code**
2. Search for a target population
3. Verify the procedure code has been assigned to that Target Pop

Provider

Verify that consumer has a valid IPRS target population that corresponds with the procedure on the claim. Contact MCO for assistance. If no errors exist, do not refile.

In-Depth Look

MCS looks at the patient id, diagnosis code, and date of service in the claim header. The system validates the following

1. The claim is covered by state insurance
2. The patient has been assigned to a target population
3. The target-population-to-diagnosis code relationship exists
4. The claim date of service falls between the effective and end dates of the target population

104 Loaded from legacy system – No reason available

Description

The claim information was loaded into MCS during the initial data upload without a reason attached to it.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day Therapy has been working with the MCO for years before the MCO started using MCS. When the MCO made the transition to Alpha, they uploaded many New Day claims. Unfortunately, some did not have reason codes attached.

Recommended Action Steps

MCO

If the MCO still has access to the legacy system, they can look there and investigate as to what the reason could be.

Provider

Get in touch with the MCO

105 Pended for manual review (**)

Description

A claim will pend for manual review in the following situations:

1. If a service is marked as "Manual Review Required" in the Provider's Contract.
2. If a claim line amount exceeds the claim line limit set by the MCO. Typically \$5,000
3. ED Claims for revenue codes 0450 – 0459
4. POS Emergency Room on professional claims and bill type 0131 on Institutional claims

*Note: Inpatient claims **do not** pend for manual review.*

The below are also excluded from manual review:

- Any bill type with a care type of 'IP', 'ICF', or 'RES' (select * from tb_ub04_bill_types where care_type in ('IP', 'ICF', 'RES'))
- Bill types 065x, 066x, 089x-
- Any procedure mapped to a procedure summary where the descriptions contains the string 'ICF', 'PRTF', or 'Residential'
- Procedure YP821

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day sends in claim for \$6000 but the MCO has said they want to manually review all claims over \$5000. MCO staff will have to look at the claim and manually adjudicate it.

Recommended Action Steps

MCO

Review the claim to ensure accuracy in billing by following standard internal processes and submit a decision to either approve or deny.

Provider

Get in touch with the MCO and ask for a timeframe around when the claim should be adjudicated.

106 Pended for COB since patient has no COB record

Description

The claim had a COB amount on it but the patient has no COB on record. For this reason, the claim has gone to "Manual Review Required" status and MCO staff must manually adjudicate it.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day bills a claim with a COB amount of \$20. However, the MCO has no record of that patient having a COB.

Recommended Action Steps

MCO

Go to **Patient > Patient Maintenance**, search for the patient, then go to the Finance tab and view any COB records and their effective dates.

Provider

Go to **Patient > Patient Search**, search for the patient, then go to the Finance tab and view any COB records and their effective dates.

107 The procedure code/bill type is inconsistent with the place of service (**)

Description

The procedure code or bill type is inconsistent with the place of service, as defined in the procedure code-to-place-of-service mapping.

**When a claim is identified as ED with a bill type in the 13_ range or 'Emergency Room' as the POS, and includes an R & B code, it will be denied for the above reason because it is not consistent with the bill type.

Corresponding HIPAA reason code

5-- The procedure code/bill type is inconsistent with the place of service.

Example

Examples of a place of service are: Office, Home, Inpatient Hospital, Emergency Room, etc. An invalid place of service for a particular procedure could be, for example, listing a clinical intake as taking place in someone's home.

Recommended Action Steps

MCO

Go to **Master > Service Matrix** and search for the service, then select the POS tab to see what places of services are mapped to the service on the claim

Provider

Contact your MCO.

108 No coverage available for Patient/Service/Provider combo

Description

A benefit plan could not be mapped to the claim since there's an inconsistency in the dates the patient had the benefit plan and the provider was contracted to perform that service.

Example

New Day Therapy submits a claim for John Doe, DOS 1/30/2014. The service is a state only service and is in the provider's state contract however John Doe does not have effective State insurance that covers the DOS on the claim.

Recommended Action Steps

MCO

Go to **Patient > Patient Maintenance** and search for the patient. Then navigate to the **Finance tab > Insurance tile** to view when the patient was covered under what insurances. Then go to **Provider Network > Maintain Provider Info** and search for the Provider. Next, click the Contract tab then select the appropriate contract (State or Medicaid) and check the effective dates of the contract.

Finally, if all of the above is correct, go to **Master > Service Matrix**, search for the service, then make sure it is mapped to the appropriate benefit plan by selecting the Benefit Plan tab.

Provider

Go to Patient > Patient Search and search for the patient in question. Check the Insurance tile to ensure the patient has effective insurance covering the DOS submitted on the claim. If this appears to be correct then contact the MCO for further assistance.

109 Service is not authorized for the supplied site

Description

The service is in the provider's contract but for a different site than what was entered on the claim.

Example

New Day Therapy sends in a claim for 90832 done at Site A. However, this service is only in their contract for Site B.

Recommended Action Steps

MCO

Go to **Menu > Provider Network > Maintain Provider Info** then search for the corresponding Provider. Next, navigate to the **Contracts tab > Contracts tile**. Select the appropriate contract then go to Contract Details. Here you can search for services and see which site they're attached to in the Site column.

Provider

Go to **Provider > Provider Details > Contract tab**. Select the appropriate contract then go to Contract Details. Here you can search for the service and see which site(s) is (are) contracted to perform the service.

112 Add-on code cannot be billed by itself

Description

The service code submitted on the claim cannot be billed unless a corresponding primary code is billed on the same date, by the same attending provider.

Corresponding HIPAA reason code

A1--Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Example

New Day Therapy bills service code 90833 for DOS 5/1/2013 however service codes 99201-99255, 99304-99337 or 99341-99350 were not billed on the same DOS by New Day Therapy.

Recommended Action Steps

MCO

This denial directly correlates with the NCCI Edits implemented by the CMS. For further information on how MCS handles these edits please refer to the **CCI Edits** document on the MCS University located under the 'General' sub-heading.

For more specific details surrounding the NCCI edits please go to:

<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>

Provider

Contact your MCO for further assistance.

113 The taxonomy code for the billing provider is missing

Description

The taxonomy submitted on the claim does not match the taxonomy associated with the NPI submitted on the claim.

Example

New Day Therapy sends in a claim with a taxonomy that is not associated with the Clinician's NPI in the Clinician Maintenance module.

Recommended Action Steps

MCO

Go to Master > Provider Network > Clinician Maintenance, search for the clinician then look at the Clinician Taxonomy tile. Verify that the taxonomy code submitted on the claim is listed.

Provider

Check and confirm that the taxonomy submitted on the claim is associated with the NPI submitted. If so, contact your MCO for assistance.

115 Missing/incomplete/invalid diagnosis or condition

Description

The diagnosis code submitted on the claim is no longer billable or accepted by NCTracks and will deny at the State level.

Corresponding HIPAA reason code

167 – This (these) diagnosis(es) is (are) not covered

Example

New Day Therapy sends in a claim with a diagnosis code of 291.8 when they need to submit with 291.80.

Recommended Action Steps

MCO

Identify the diagnosis code on the claim. If the DX submitted is a 3 digit general code or with one trailing DX identifier and not two, then this is a non-billable Diagnosis. The MCO will need to instruct the provider to rebill w/a valid diagnosis code*.

Provider

Rebill the claim with a valid corresponding Diagnosis code*

*For a complete list of valid diagnosis codes please visit <http://www.icd9data.com/>

121 The rendering provider is not eligible to perform the service billed.

Description

This denial will check that the rendering NPI on the claim is appropriate for the code submitted on the claim. This means that non-clinician-based services such as H0004 must not have a clinician NPI, and clinician-based services may not have a site NPI.

Corresponding HIPAA reason code

185 – The rendering provider is not eligible to perform the service billed

Example

Provider submits a clinician based therapy code and submits the Site SFL NPI as the rendering NPI, the claim will now deny because the rendering NPI is not a clinician's NPI.

Recommended Action Steps

MCO

Check the rendering NPI on the claim to determine if it is a Clinician or a Site NPI. Then go to Master > Service Matrix, filter for the service on the claim, click the 3 view button and select 'View'. There is a check box labelled 'Is Clinician Based'. If this is checked then the rendering NPI on the claim must be a clinician's NPI. If it is not marked as clinician based then it must be the provider's NPI.

Provider

If service is marked as clinician based, rebill with the correct clinician NPI as the rendering. If not marked as clinician based, update the rendering NPI to the site's NPI where the service was performed.

122 A specific site could not be determined

Corresponding HIPAA reason code

A1 Claim/Service denied remark code MA130

123 Non-Covered days/Room Charge adjustment

Description

Denies the claim if the day is a discharge day for a professional claim and the procedure shouldn't be paid on the discharge day.

Example

Provider bills YP821 for dates of service 6/16 – 6/22 but has a discharge date of 6/16 on the claim header, the entire claim will deny b/c the discharge date is prior to the dates of service. If the provider has 6/22 as the discharge date then the claim will pay up to 6/22 and dos 6/22 will deny for 123.

Unless the "Pay Discharge Day" is set to True in the Benefit plan for the service.

125 Annual frequency exceed

Description

The amount of units on the claim, along with units on other claims for the same patient and service during that same year, exceed what is allowed by the MCO.

Corresponding HIPAA reason code

119 Benefit maximum for this time period or occurrence has been reached.

Example

A claim is received for Johnny Alpha for 90834 on 12/14/2014 and denies for this reason.

MCO

When the MCO sees this denial they can use the Service Matrix to research this topic. In the Service Matrix the user will search for the service code and select the appropriate benefit plan and scroll over to see the Yearly Limits. Verify the limits and research to see how many claims have been submitted for the consumer with this service.

126 Lifetime frequency exceeded

Description

The amount of units on the claim, along with units on other claims for the same patient and service during the consumer's lifetime has exceeded what is allowed by the MCO.

Corresponding HIPAA reason code

119 Benefit maximum for this time period or occurrence has been reached.

Example

A claim is received for Johnny Alpha for 90834 on 12/14/2014 and the consumer has had over the allotted lifetime maximum of "2500" and the provider bills the "2501" unit.

127 The impact of prior payer(s) adjudication including payments and/or adjustments.

Description

The impact of prior payer(s) adjudication, including payments and/or adjustments. This denial is used to report impact of prior payers' adjudication on Medicare payments in the case of a secondary claims. This is used along with the Lesser of Methodology.

Corresponding HIPAA reason code

23 The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)

Primary Adjudication	Example #1	Example #2	Test Grid	
Total Billed Charges	159	159	130	Enter Claim Header amount < (optional)
Medicare Contractual Adjustment	-58.66	-78.74	0.00	
Medicare Allowed Amount	100.34	80.26		
Medicare Coinsurance Amount	20.39	16.05	17.85	<< Enter Patient Paid Amount
Medicare Paid Amount	79.95	64.21	68.65	<< Entry COB Paid Amount
Secondary (MCS) Adjudication				
Medicaid Allowable	84.29	85.2	62.05	<< Enter Contract rate (x DOS)
Medicare Paid Amount	79.95	-64.21	0.00	
Net Medicaid Allowable	4.34	20.99	0.00	
Lesser of Medicare Coinsurance and Net Medicaid Allowable Amount	4.34	16.05		

\$0.00

*If negative amount, pay \$0

<https://www.nctracks.nc.gov/content/public/providers/provider-communications/provider-announcements/Medicare-Crossover-Update.html>

128 Amount in excess of prior payer(s) coinsurance

Description

The MCO will pay the lesser of:

- 1) The COB coinsurance amount and
- 2) The difference between what Medicaid will pay and what the COB already has.

In the case of this denial, the first option was less.

Example

	Example #1	Example #2
Total Billed Charges	159.00	159.00
Medicare Allowed Amount	100.34	80.26
Medicare Paid Amount	79.95	64.21
Medicare Contractual Adjustment	(58.66)	(78.74)
Medicare Coinsurance Amount	20.39	16.05
Medicaid Allowable	84.29	85.20
Medicare Paid Amount	(79.95)	(64.21)
Net Medicaid Allowable	4.34	20.99
Lesser of Medicare Coinsurance and Net Medicaid Allowable Amount	4.34	16.05

131 Quarterly frequency exceed

Description

The amount of units on the claim, along with units on other claims for the same patient and service during that same quarter, exceed what is allowed by the MCO.

Corresponding HIPAA reason code

119 Benefit maximum for this time period or occurrence has been reached.

Example

A claim is received for Johnny Alpha for 90834 on 12/14/2014 and denies for this reason.

Recommended Action Steps

MCO

When the MCO sees this denial they can use the Service Matrix to research this topic. In the Service Matrix the user will search for the service code and select the appropriate benefit plan and scroll over to see the Quarterly Limits. Verify the limits and research to see how many claims have been submitted for the consumer with this service.

132 Invalid Attending Provider for PRTF

Description

For any PRTF claim with a Date of Service > 6/30/15 and a revenue code of 0911, the attending provider NPI submitted with the claim must be for a clinician holding an MD license.

Corresponding HIPAA reason code

A1-- Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

and HIPAA Remark Code : N253 (Missing/incomplete/invalid attending provider primary identifier. Start: 12/02/2004

Example:

New Day Therapy submitted a claim for PRTF service code 0911, and the attending provider NPI is not in the Alpha system, or the attending clinician associated with that NPI is not a licensed MD.

Recommended Action Steps

MCO

MCO staff can confirm this error is correct by going to:

Claims Maintenance> Claims Lines, and review the Clinician Name located in the tile. Confirm the clinician's MD license in Provider Network> Clinician Maintenance, and filter for the clinician in question, then view the Clinician Licenses tile.

If no Clinician Name is listed in the Claims Maintenance tile, the attending provider NPI may not be in the Alpha system. The attending provider NPI can be viewed in the 837I or the UB-04 the claim was submitted through.

Provider

Confirm attending clinicians for PRFT services have valid MD licenses.