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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 Mediware support to assist.
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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 Authorized 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 authorized 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 fiscal year and follow the patient across providers.

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

**Corresponding HIPAA reason code**
119-- Benefit maximum for this time period or occurrence has been reached.

**Example**
For example, the MCO has their number of Adult Basic Units available set to 24 units. New Day Therapy used 23 basic units and Number One Therapy used 1 units for John Doe. If New Day tries to enter another claim for 1 unit of a basic service they will get this denial.

*Note: Basic units for Adults and Children are set per MCO.*

**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/services 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, and if the Provider’s contract for the service is marked as “Authorization Required”. If the sum of the basic units is greater than the number of allowed basic units, and the service is Auth Required in the Provider’s contract the claim is denied for this reason.

**5 Claim Received After Billing 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. 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 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 or if COB amount and/or COB reason exists, 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. This is capped at 180 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 that 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.

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
185 -- The rendering provider is not eligible to 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 Is 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.

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

**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 Go to **Master > Service Matrix** and search for the service. Review the **Benefit Mappings** in the Service Details for the daily allowed limits.

**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
181-- Procedure code was invalid on date of service.

Recommended Action Steps

MCO
MCO staff can confirm this by going to the Master Module > Service Matrix > Search for Service, then checking the Benefit Plans associated with service. The DOS of the claim should outside the end date of the service.

Provider
Service has been lapsed/removed from benefit plan and is no longer billable or does not exist in the system. 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. If 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 diagnosis group that isn’t mapped to that service.

Corresponding HIPAA reason code
11-- The diagnosis is inconsistent with the procedure

Example
New Day Therapy submits a Medicaid claim with diagnosis code F39.0 and procedure code of 90837. This diagnosis code is only mapped to the substance abuse (SA) diagnosis group for State. The procedure code is mapped to diagnosis group mental health (MH).

Recommended Action Steps
MCO
Filter for service in Master Module > Service Matrix > ensure that service is mapped to the correct diagnosis group and benefit plan. Confirm in Service Maintenance > Diagnosis Group to Diag that the group is associated with the Diagnosis code submitted on the claim.

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

18 Patient Not Enrolled on Date of Service
Description
The client either wasn't enrolled in the insurance on the date of service (DOS) or they were never enrolled.

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 was unable to identified by the information received on the claim.

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
In this check, MCS verifies the existence of a patient id in the claim header. This is similar to reason code 18 however in this validation a patient id is unable to be determined.

21 Invalid Age Group & Procedure Code Combination

Description
The age group that the client falls into is not mapped to the service that was submitted on the claim.

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 patient’s 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
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
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
New Day Therapy submits a claim is for a child however the age group the diagnosis 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.
**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 review the Place of Service details 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.

27 A specific provider could not be identified by the NPI submitted

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 NPI 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 NPI number in the header is matched to a site. MCS checks that the provider id and provider NPI 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, or 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 submitted

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

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
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.

31 Monthly limit exceeded

Description
The number 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
119-- Benefit maximum for this time period or occurrence has been reached.

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, or the provider’s contract was suspended on the claim’s date(s) of service.

**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 and the provider wasn’t under suspensions for the claim’s date(s) of service, 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. MCS will also look for any provider suspends. So, in this validation, not only does MCS look at the provider contract rates, but also the license belonging to the clinician.
Note: This denial 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. If the claim was submitted on an 837I/UB-04 with a revenue code in the 09xx series, the HRCCR contract details/rate will need to be added to the provider’s contract.

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 > Master Maintenance > Service Matrix. In the Service Details screen 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 Claim 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
46-- This (these) service(s) is (are) not covered.
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
197-- Precertification/authorization/notification absent.

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. If the procedure code for the claim has been added to the site-enforced list for your MCO, the site on the Authorization 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.

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

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 Go to Master > Service Matrix and search for the service. Review the Benefit Mappings in the Service Details for the weekly allowed limits.

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.

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.

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**93 Invalid DCN (Document Control Number) or Resubmission Reference Number**

**Description**
The claim number entered for the original claim that the replacement/reversal claim is referencing is invalid.

**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 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 the RA with the original claim number and make sure you entered it correctly.

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**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
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 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

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

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 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
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.)

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 is a funding capitation 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
119-- Benefit maximum for this time period or occurrence has been reached.

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 capitation 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
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 enters a discharge claim for three days. As with all discharge claims, the last day won’t pay.

Recommended Action Steps

MCO

Provider

101 Patient Does Not Have a Valid NC Tracks Benefit Plan (TP) on DOS

Description
A claim is covered by State insurance for a procedure, however the patient record has not been assigned to an NC Benefit Plan (target population) correlating to the service, as required by the State.

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
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 an NC Benefit Plan.
Recommended Action Steps

**MCO**
Verify the patient’s Target Population by doing the following:

1. Go to **Menu > Patient > Patient Maintenance**
2. Filter for the desired patient, then click on the Detail button
3. Click on the NC Tracks Benefit Plans option in the Doc, Assignment tab
4. Verify the patient’s assigned NC Tracks Benefit Plans(s) and effective and end dates

**Provider**
Verify that consumer has a valid and current NC Tracks Benefit Plan 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 an NC Tracks Benefit Plan
3. The claim date of service falls between patient-to-NC BP effective date and end date.

**102 Patient Does Not Have a Valid NC Tracks Benefit Plan (TP) For Dx Submitted In Claim**

**Description**
A claim is covered by State insurance, the claim was submitted with a diagnosis that is not mapped to that patient’s NC Tracks Benefit Plan.

**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**
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. From the Doc, Assignment tab select NC Tracks Benefit Plans from the menu
5. From here you can verify the patient’s assigned NC Tracks Benefit Plan(s)

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

1. Go to Menu > Patient > NC Tracks Benefit Plans
2. Search for a benefit plan, then click Details
3. From the NC Tracks Benefit Plan to Diagnosis tab search for the diagnosis in question to see if it’s mapped.

Provider
Verify the consumer has a valid NC Tracks Benefit Plan 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 benefit plan
3. The benefit plan-to-diagnosis code relationship exists
4. The claim date of service falls between the effective and end dates of the benefit plan-to-diagnosis code relationship

103 Patient Does Not Have a Valid NC Benefit Plan (TP) 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 NC Benefit Plan (target population).

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
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. From the Doc, Assignment tab select NC Tracks Benefit Plans from the menu
5. From here you can verify the patient’s assigned NC Tracks Benefit Plan(s)

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

1. Go to Menu > Patient > NC Tracks Benefit Plans
2. Search for a benefit plan, then click Details
3. From the NC Tracks Benefit Plan to Proc Codes tab search for the procedure in question to see if it’s mapped.

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, procedure 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 benefit plan
3. The benefit plan-to-procedure code relationship exists
4. The claim date of service falls between the effective and end dates of the benefit plan

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.

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 click Details 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.

Corresponding HIPAA reason code
31-- Patient cannot be identified as our insured.

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. Click on Details then navigate to Finance from the Insurance tab 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.

Provider
Go to Patient > Patient Search and search for the patient in question. Check the Insurance 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.

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
234-- This procedure is not paid separately. 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.

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

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**  
**Description**  
A site could not be determined based on the information submitted on the claim.

**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 submits a claim, however the NPI and/or zip code submitted on the claim is associated with multiple sites, or isn’t associated with a site.

**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 and zip code is correct on claim and is valid NPI for the service billed. Contact MCO Provider Network to update.

---

**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.

**Corresponding HIPAA reason code**

**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.

**Recommended Action Steps**

---

**125 Annual limit exceeded**

**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.

**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 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.

**Recommended Action Steps**

### 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)

<table>
<thead>
<tr>
<th>Primary Adjudication</th>
<th>Example #1</th>
<th>Example #2</th>
<th>Test Grid</th>
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<tbody>
<tr>
<td>Total Billed Charges</td>
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<td>130</td>
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<tr>
<td>Medicare Contractual Adjustment</td>
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<td>Medicare Allowed Amount</td>
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<tr>
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<td>17.85</td>
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<table>
<thead>
<tr>
<th>Secondary (MCS) Adjudication</th>
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<th></th>
<th></th>
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<tr>
<td>Medicaid Allowable</td>
<td>84.29</td>
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<td>62.05</td>
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Mediware Information Systems, Inc.
11711 West 79th Street, Lenexa, Kansas 66214
Mediware.com | 1.888.Mediware
### Medicare Paid Amount

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount 1</th>
<th>Amount 2</th>
<th>Amount 3</th>
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<tbody>
<tr>
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<td>-64.21</td>
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### Net Medicaid Allowable

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<tbody>
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<td>Net Medicaid Allowable</td>
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</table>

### Lesser of Medicare Coinsurance and Net Medicaid Allowable Amount

<table>
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<tr>
<th>Description</th>
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<th>Amount 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesser of Medicare Coinsurance and Net Medicaid Allowable Amount</td>
<td>4.34</td>
<td>16.05</td>
</tr>
</tbody>
</table>

---

**$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.

**Corresponding HIPAA reason code**

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

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<td>16.05</td>
</tr>
</tbody>
</table>

Recommended Action Steps

**131 Quarterly limit 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 service

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.

134 Missing or invalid CPT/HCPCS code

Description
If an ED claim comes in with revenue code 045X and no (or invalid) HCPCS code it will deny for this reason.

Corresponding HIPAA reason code
46- This (these) service(s) is (are) not covered.
Example
An ED claim was submitted with a revenue code missing of 0451, but the procedure code on the claim doesn’t exist in the system.

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

Claims Maintenance> Claims Lines, and review the revenue code submitted on the claim. Then find the procedure code, and confirm its validity in the Service Matrix.

Provider
Confirm ED claims are submitted with valid CPT/HCPCS

135 Discontinued Service
Description
The procedure code submitted on the claim has been end dated or is no longer active.

Corresponding HIPAA reason code
181-- Procedure code was invalid on the date of service.

Example
A claim was submitted with a procedure code that was effective from 7/1/2016 to 12/31/2017, but the claim date of service was 1/1/2018

Recommended Action Steps
MCO
Identify the procedure code on the claim. Filter for the code in the Service Matrix, then confirm that the claim date of service is within the effective and end date of the procedure, and that the procedure is active.

Provider
Rebill the claim with a valid procedure code.

136 Invalid Units: claimed below minimum amount
Description
If H2035 is billed at less than 4 units, the claim will deny for this reason.
Corresponding HIPAA reason code
16-- Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Example
Provider New Day Services bill H2035 for 3 units instead of 4

Recommended Action Steps

**MCO**
Verify procedure code on the claim is H2035, and that at least 4 units are billed for each date of service.

**Provider**
Rebill the claim with valid units.

137 Invalid Units: Units Claimed Does Not Equal # of Days for Discharge Claim

Description
Inpatient claim units do not equal to the number of days billed.

Corresponding HIPAA reason code
16-- Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Example
New Day Therapy submits an Inpatient discharge claim with a date range of 6/29 to 7/3, but only bills 3 units

Recommended Action Steps

**MCO**
Verify the discharge bill type on the claim, the date range of the claim, and the number of units submitted.
Provider

Review the units billed and date range, and rebill with corrections.

**138 Invalid Units: Units Claimed Does Not Equal # of Days for Interim Claim**

Description

Claim submitted with units not equal to the number of days for interim/continuing claim.

Corresponding HIPAA reason code

16-- Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Example

Recommended Action Steps

MCO

Provider

**140 Clinician Not Associated with Provider**

Description

The Clinician is not associated with Provider. For claims with Clinician based services, this is based off of the rendering NPI, or by Attending NPI if it's a PRTF claim. PRTF claims require the attending NPI to be an MD Clinician’s NPI.

Corresponding HIPAA reason code

185-- The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Example

New Day Therapy submits claim for Group Therapy (90853), but the rendering NPI submitted on the claim is not associated with any clinician.
Recommended Action Steps

MCO

For Clinician based services, review the Clinician information submitted on the claim. Go to Provider Network> Maintain Provider Info, and filter for the Provider. Then click on the Clinicians tile to verify the Clinician is associated with the provider. If it’s a PRTF service, go to the Provider Maintenance tile and filter for the Clinician, then verify the Clinician is an MD via the Clinician Licenses tile.

Provider

Verify the Clinician’s information on the claim and rebill.

141 R&B Service Already Exists - Cannot Bill Another One

Description

Only one R&B service can be billed per day, and one has already approved for this date of service.

Corresponding HIPAA reason code

59-- Processed based on multiple or concurrent procedure rules. (For example, multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Example

New Day Therapy has billed an R&B service for 7/1/2017, but another R&B service has already been approved for that patient/date of service.

Recommended Action Steps

MCO

For inpatient claims, check to make sure another R&B service has already paid on that day.

Provider

Only one occurrence of service is billable per day. Adjust off charges and do not refile.

142 Invalid or Missing Discharge Code for Discharge Claim

Description

A discharge claims was submitted without a valid discharge code, or was missing a discharge code.
**Corresponding HIPAA reason code**
16-- Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

**Example**
New Day Therapy submits an Inpatient claim with a discharge code of 98, but this is not a valid discharge code.

**Recommended Action Steps**

**MCO**
Review the discharge information on the claim, and verify that it’s valid.

**Provider**
Rebill claim with valid discharge information.

---

**143 Ungroupable/Missing DRG**

**Description**
Deny inpatient claims where no DRG service was submitted along with the inpatient service.

**Corresponding HIPAA reason code**
A8-- Ungroupable DRG.

**Example**

**Recommended Action Steps**

**MCO**

**Provider**

---

**144 Service has lapsed/expired for the contracted site**

**Description**
The service is in the provider’s contract, but has been end dated and is not contracted during the claim’s date(s) of 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
A claim is submitted with a service that has been end dated in the provider’s contract.

Recommended Action Steps
MCO
Verify the service billed on the claim and the claim date of service, then go to Provider Network> Provider Maintenance, and filter for the Provider in question. Review the contract details for the procedure, and verify that the claim date of service is within the effective and end date of the contract.

Provider
Service has been end dated from contract and is no longer billable. Confirm through Provider Network.

145 NCCI - Collective limit for the day exceeded
Description
Corresponding HIPAA reason code
59-- Processed based on multiple or concurrent procedure rules. (For example, multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Example
Recommended Action Steps
MCO

Provider

147 Member ineligible based on age/service/provider type
Description
If a claim is submitted with an IMD (Institute for Mental Disease) site, and the consumer is under 21 or over 64 and it’s will deny for this reason. Only consumers between 21 and 64 are eligible.
Corresponding HIPAA reason code
16-- Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Example
New Day Therapy submits a claim with a service for an IMD site, but the patient is 20 years old.

Recommended Action Steps
MCO
Verify that the patient’s age. Then verify the site information by going to Provider Network> Maintain Provider Info, and clicking on the sites tab. Filter for the site on the claim, and ensure the “Is IMD” box is checked.

Provider
Verify the consumer’s age. Do not re bill if the consumer is under 21 or over 64.

148 Admit date and/or admit source missing for Inpatient claim
[FL14-15]

Description
If an Inpatient claim is submitted with no admit date, or if the admit date is greater than the last date of service on the claim it will deny for this reason.

Corresponding HIPAA reason code
16-- Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Recommended Action Steps
MCO
Verify the admit date on the claim

Provider
Rebill claim with correct admission information.

149 Discharge status code missing for Inpatient claim [FL17]

Description
A discharge claims was submitted without a valid discharge code.

Corresponding HIPAA reason code
16-- Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Example
New Day Therapy submitted an Inpatient claim with a discharge date, but no discharge code.

Recommended Action Steps
MCO
Verify the claim is was submitted with a discharge status.

Provider
Rebill claim with valid discharge information

150 ED consumer admitted to Inpatient facility

Description
If a provider submits an ED claim, and there's already an Inpatient claim out there for the same Pat/DOS, the ED claim will deny.

Corresponding HIPAA reason code
16-- Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be
Example
New Day Therapy submitted an ED claim for 7/1/2017, but there is already an approved Inpatient claim in Alpha for 7/2/2017.

Recommended Action Steps
MCO

Review the ED claim’s date of service, and filter in Claims Maintenance for a claim submitted with a DOS the following day. If there is an approved Inpatient claim on the day following the ED claim DOS, the denial is valid.

Provider

151 Assessment or differed diagnosis period has passed

Description
If a State funded claim is submitted for a consumer between the ages of 6-17, or a Medicaid claim is submitted for a consumer <21, and the consumer has had 6 claims submitted and approved with an assessment diagnosis/service combo, the 7th claim will deny for this reason.

Corresponding HIPAA reason code
16-- Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Example
New Day Therapy has submitted a Medicaid claim with a diagnosis/service combination that is mapped to the AO diagnosis for an 18-yr old consumer. However the consumer already has 6 of these claims approved.

Recommended Action Steps
MCO
Review the procedure and diagnosis code submitted on the claim, then go to the Service Maintenance module and review the Diagnosis Group to Service mappings for diagnosis group AO. Click the Details button, select the funding source, and verify that the procedure code is mapped to AO. Now go to the Diagnosis Group to Diag module and select the funding source, filter for the diagnosis from the claim, and confirm that the Diagnosis is mapped to AO as well.

Filter in Claims Maintenance for approved claims submitted for that consumer that also have diagnosis/procedure codes mapped to AO.

Provider
The service/diagnosis combination is no longer billable for the consumer.

152 Billing taxonomy submitted is not associated with the billing NPI
Description
If the Billing NPI and Taxonomy combo submitted on the claim is not in the Provider’s Site Number tile and Taxonomy tile, then the claim will deny for this reason.

Corresponding HIPAA reason code
16—Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Example
Recommended Action Steps
MCO
In Provider Network> Maintain Provider click on the Sites tab and filter for the correct site. Now click on the Site Mapping tab, and the Numbers tile. Verify that the NPI is listed here. Now look at the Taxonomy tile and verify that the taxonomy form the claim is listed.

Provider
Rebill claim with correct taxonomy/NPI information
**153 Rendering taxonomy submitted is not associated with the rendering NPI**

**Description**
If the Rendering NPI and Taxonomy combo submitted on the claim is not in the Provider’s Site Number tile and Taxonomy tile, then the claim will deny for this reason. This is for non-clinician based services. – this edit is checking to make sure the taxonomy at the line level is associated with the NPI submitted at the line level in the site numbers tile.

**Corresponding HIPAA reason code**
16-- Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

**Example**

**Recommended Action Steps**

**MCO**

In Provider Network> Maintain Provider click on the Sites tab and filter for the correct site. Now click on the Site Mapping tab, and the Numbers tile. Verify that the NPI is listed here. Now look at the Taxonomy tile and verify that the taxonomy form the claim is listed.

**Provider**

Rebill claim with correct taxonomy/NPI information

**154 Clinician Taxonomy Submitted is Not Associated With the Clinician**

**Description**
If the Clinician NPI and Taxonomy combo submitted on the claim is not in the Clinician tile and Clinician Taxonomy tile, then the claim will deny for this reason. This is for clinician based services.

**Corresponding HIPAA reason code**
16-- Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

**Example**

**Recommended Action Steps**

**MCO**

In Provider Network > Clinician Maintenance filter for the clinician and verify the clinician’s NPI. Then look in the Clinician Taxonomy tile and verify that the taxonomy is listed there.

**Provider**

Rebill claim with correct Clinician taxonomy/NPI information

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**155 Admit date is not valid for the bill type**

**Description**

If an interim or a discharge Inpatient claim is submitted with an admission date that is greater than the first date of service on the claim, it will deny for this reason.

**Corresponding HIPAA reason code**

16-- Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

**Example**

New Day Therapy submits an interim claim with a date range of 7/1 – 7/5, but an admit date of 7/3.

**Recommended Action Steps**

**MCO**

Verify the first claim date of service, then review the admission date

**Provider**

Rebill the claim with the correct information
**156 Benefit Plan Invalid for Pc/License Combo**

**Description** --TBD

**Corresponding HIPAA reason code**
1 -- Deductible amount

**Example**

**Recommended Action Steps**

**MCO**

**Provider**