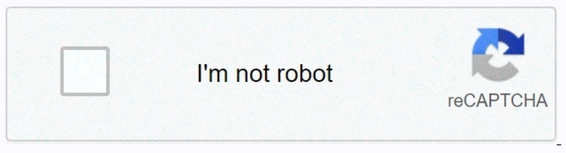

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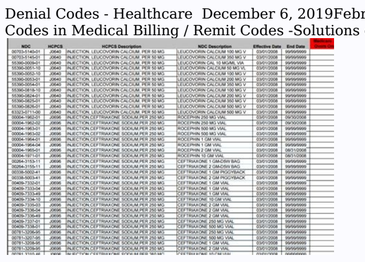
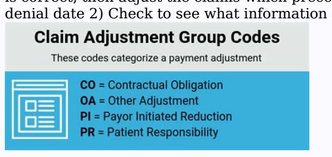
List of denial codes in medical billing pdf

**List of medical insurance denial codes. List of denial codes in medical billing.
List of cpt codes pdf. List of cpt codes in medical billing pdf.**

Denial Codes - Healthcare December 6, 2019February 29, 2020 Channagangaiah CO – Contractual Obligations OA – Other Adjsutments PI – Payer Initiated reductions PR – Patient Responsibility Let us see some of the important denial codes in medical billing with solutions: Denial CodesDenial Codes / Remit Codes Description in Medical BillingDenial Codes in Medical Billing / Remit Codes -Solutions or Questions need to ask with Insurance representative. PR 1Deductible Amount1) Get the processed date? 2) Get the allowed amount and the amount that was applied towards the patient's deductible?

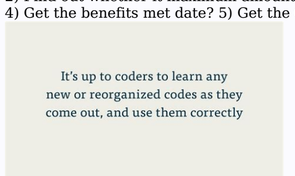


3) Get the payment details if there was any? 4) Get the patient's calendar year/lifetime deductible and how much of it has been met? (Note: If annual deductible is already met , reprocess the claim) 5) Get if the claim is processed towards in network or out of network deductible and how much deductible? 6) Get the Claim number and Calreference number? PR 2Coinsurance: Percentage or amount defined in the insurance plan for which the patient is responsible.1) Get the processed date? 2) Get the allowed amount, paid details if any and the amount that was applied towards the patient's Coinsurance? 3) Get the Claim number and Calreference number? PR 3Copayment1) Get the processed date? 2) Get the allowed amount, paid details if any and the amount that was applied towards the patient's Copayment? 3) Get the Claim number and Calreference number?
4Description for Denial code - 4 is as follows "The px code is inconsistent with the modifier used or a required modifier is missing".1) Get the Denial Date? 2) Verify whether modifier is inconsistent with procedure code or modifier missing? 3) Send for reprocess and collect the follow up date, if the denial is incorrect 4) Get the appeals information/ corrected claims address/ TFL to submit corrected claim 5) Get the Claim number and Calreference number Note: If the modifier is inconsistent with procedure code or modifier missing. Correct the modifier and resubmit the claim as corrected claim. (If the modifier submitted is correct and if the representative denies to send the claim back for reprocessing, then you have rights to appeal the claim along with medical records.) 5Denial Code - 5 is "Px code/ bill type is inconsistent with the POS" POS: It is the place where the services rendered to patient1) Get the Denial Date? 2) Verify whether procedure code is inconsistent with the place of service or bill type is inconsistent with the POS? 3) Send for reprocess and collect the follow up date, if the denial is incorrect 4) Get the appeals information/ correct claims address/ TFL to submit corrected claim 5) Get the Claim number and Calreference number Note: Correct and resubmit the claim as corrected claim, if the procedure code or bill type is inconsistent with the place of service. (If the procedure code/ bill type is correct with the place of service submitted and if the representative denies to send the claim back for reprocessing, then you have rights to appeal the claim along with medical records.) 6The procedure code/ revenue code is inconsistent with the patient's ageAsk the same questions as denial code - 5, but here need check which procedure code submitted is incompatible with patient's age?
May I know which procedure/revenue code invalid for the Patient Age ? Just to understand consider the below example: If you see the procedure codes list 99381 to 99387(New patient Initial comprehensive preventive medicine), it should bee coded based on the patient's age. 99381 coded when patient's age younger than 1 year. 99382 coded when patient's age 1 through 4 years. 99383 age 5 through 11 years. 99384 age 12 through 17 years. 99385 age 18 to 39 years. 99386 age 40 to 64 years. 99387 age 65 years and older. Similar to the above example, there are some CPT's listed which needs to be coded based on patients age.
7The procedure code/ revenue code is inconsistent with the Patient's genderAsk the same questions with representative as denial code - 5, but here check which procedure code submitted is incompatible with patient's gender. May I know which procedure/revenue code invalid with the Patient Gender ? 8The procedure code is inconsistent with the provider type/speciality (Taxonomy)Ask the same questions as denial code - 5, but here check which procedure code submitted is incompatible with provider type. 9The Diagnosis Code is inconsistent with the patient's ageSame as denial code - 11, but here check which dx code submitted is incompatible with patient's age May I know which Diagnosis code invalid for the Patient age ? 10The Diagnosis Code is inconsistent with the patient's genderAsk the same questions as denial code 11, but here check which DX code submitted is incompatible with patient's gender May I know which Diagnosis code invalid with the Patient Gender ?
11Denial code - 11 described as the "Dx Code is in-consistent with the Px code billed".1) Get the denial date? 2) Verify the procedure is inconsistent with which Diagnosis?
3) If the denial is incorrect send for reprocess? 4) Inform that we are going to submit the corrected claim with valid codes if the denial is correct and get the corrected claim address and time frame to submit corrected claim? 5) Get the Claim number and Cal reference number? 12The Diagnosis code is inconsistent with the provider typeSame as denial code - 11, but here check which DX code submitted is incompatible with provider type 13The Date of Death Precedes Date of Service1) Get the Claim denial date? 2) Get the date of death and verify with the date service provided? 3) If the date service provided is prior to the date of death, then send the claim back for reprocess? 4) If the denial is correct, then adjust the claims which precedes the date of death 4) Get the Claim# and Calref# Note: Usually we get this denials when billing DME services 14The DOB follows the DOS 15Denial code - 15. 16Denial Code 16 described as "Claim/service lacks information or has submission/billing error(s) which is required for adjudication".1) Get the denial date 2) Check to see what information required from patient or provider to process the claim? 3) If the information requested from patient, then check when the letter was sent requesting that information and also check whether the patient updated the requested info or not?



4) If patient has already updated the requested info, send the claim back for reprocessing. If still patient not updated the requested information, then request representative to resend the letter onceagain to patient. 5) Claim number and Calreference number (Get the appeal information, if claims needs to be appealed) Note: If the information requested is from provider, then update the requested info to the insurance for processing the claim. 17Denial Code 17 18Denial Code - 18 described as "Duplicate Claim/ Service".1) Get the denial date? 2) Get the DOS, billed amount, rendering physcian's name, Procedure code and Diagnosis code? 3) Send the claim back for reprocesisng , if it wasn't a Duplicate claim 4) Get the status of original claim, if the claim was denied as a duplicate claim? If the claim denied incorrectly and rep disagreed to the claim back for reprocessing (Ge the appeal information, if claim needs to be appealed) 6) Get the Claim number of Duplicate Claim as well as Original Claim and Calreference number 19"Denial Code 19". 20Denial Code - 20 21Denial code - 21 22Denial Code 22 described as "This services may be covered by another insurance as per COB".1) Get Denial Date? 2) Check any letter sent to patient? 3) If yes, check when and have they got any response from patient? 4) If response received (Coordination of Benefit's (COB) updated by patient), then send the claim back for reprocessing? 5) If no, then request representative to send a letter to patient(requesting update COB information) 6) Claim Number and Calreference Number 23Denial Code 231) Get Claim Denial date? 2) Get the allowed amount of the procedure code? 3) Check prior payer paid amount in application, if it is less than secondary insurance allowed amount send the claim back for reprocess 4) Claim number and Calreference Number 24Denial Code 24 described as "Charges are covered by a capitation agreement/ managed care plan".1) Get Claim Denial date? 2) Verify, is the beneficiary enrolled in Medicare Advantage plan and get insurance name, id#, conctact#, mailing address? 3) Claim number and Calreference number Note: Submit the claim to correct payor 26Denial code 26 defined as "Services rendered prior to health care coverage". 27Denial code 27 described as "Expenses incurred after coverage terminated".1) Get Denial Date?
2) Get Policy effective and termination date? 3) If policy is eligible at the time of service rendered, send the claim back for reprocessing 4) If the services not eligible (terminated), then check for any other active insurance available at the time of service? 5) Claim number and Calreference number? 28Coverage not in effect at the time the service was providedSame as denial code - 27 29Denial code - 29 Described as "TFL has expired". TFL- Time filing limit to submit the claim1) Get the denial date? 2) Get the date when the claim was received? 3) Get the filing Timely filing limit? 4) Send the claim back for reprocessing if the denial was incorrect(If the claim received within the set time frame) 5)Get the appeal information if claim needs to be appealed with proof of timely filing? 6) Get the claim number and Calreference number? 30Denial code 30 defined as 'Payment adjusted because the patient has not met the required spend down, eligibility, waiting, or residency requirements 31Denial code - 31 38Services not provided or authorized by designated providers 39Denial Code 39 defined as "Services denied at the time auth/precert was requested".1) Get the claim denial date? 2) Check in the application for the denied letter from insurance to verify requested authorization/precertification is denied at the time of requested or not. 3) Review other claims for the patient with same CPT/DX combination to see if the claims were paid. 4)If no, then check with representative whether we can get retro authorization for this service? If yes, then get the retro authorization from retro department and send the claim back for reprocessing If retro auth not available, You have rights to appeal the claim with medical records (Get the appeal limit and address / fax#, if claim needs to be appealed) 6) Claim# and Calreference# 50Denial code 50 defined as "These are non covered services because this is not deemed a medical necessity by the payer".1) Get Claim denial date? 2) Find out whether it as per provider contract or patient plan 3) Collect what type of services are not covered under the contract or plan? 4) Request for a copy of the EOB? 5) Get the appeals information/fax# / time frame to submit appeal 6) Claim number and Calreference number Note: If the services are covered, and if you found the denial is incorrect, then you have rights to appeal with supporting documentation. 54Denial Code 54 described as "Multiple Physicians/assistants are not covered in this case".1) Get the Claim denial date? 2) Check to see why multiple physicians/assistants are not covered for the service provided? 3) Take action as per the status provided? 4) Claim number and Calreference number Note: Insurance cover only the eligible and listed procedures to be performed by multiple physicians/assistants and should be indicated with appropriate modifiers(80/81/82/AS). If the unlisted/not eligible procedures performed by multiple physicians/assistants then the claim will not be covered. 96Non-Covered Charges1) Get Claim denial date? 2) Check which diagnosis or procedure is not deemed medically necessary by payer? 3) Get the appeals information/fax# / time frame to submit appeal 4) Claim number and Calreference number Note: If its valid diagnosis and procedure code, then you have rights to appeal with supporting documentation. 97Denial code - 97 described when "The benefit for this service is included in the payment or allowance for another service/procedure that has already been adjudicated".1) Claim denial date? 2) Verify which is primary procedure and denied procedure? Also check if the primary procedure code is paid?

3) Suggest that we will submit claim with a valid modifier along with medical records? 4) Get the Appeals info/ Corrected claim address/ TFL to submit corrected claim 5) Send for reprocess and collect follow up date if the denial is incorrect 6) Get the Claim number and Calreference number Note: 1) Submit with appropriate modifier if its required. 2) If submitted claim is correct, then you have rights to appeal along with documentation.
107Denail code - 107 defined as "The related or qualifying claim/service was not identified on this claim".Determine why main procedure was denied or returned as unprocessable and correct as needed. (For example: Supplies and/or accessories are not covered if the main equipment is denied) 109Denial Code described as "Claim/service not covered by this payer/contractor.
You must send the claim/service to the correct carrier".1) Get the Claim denial date? 2) Verify why the claim/service not covered by this payer/contractor(It may be denied because patient enrolled in Medicare advantage Plan, hence it needs to submit to medicare advantage plan(Id# and mailing address) or it may be denied because beneficiary may be in SNF stay at the time of service))? 3) Claim number and Calreference number Note: Check eligibility of HMO insurance, update the insurance and submit the claim to the correct payer 119Denial Code 119 defined as "Benefit maximum for this time period or occurrence has been reached".1) Get the denial date and the procedure code its denied? 2) Find out whether it maximum amount or visit or unit? 3) Get the maximum amount or maximum number of visits or units under the plans policy?
4) Get the benefits met date? 5) Get the Claim number or Calreference number?



122Psychiatric reduction. 140Denial Code - 140 defined as "Patient/Insured health identification number and name do not match".Check eligibility to find out the correct ID# or name. Update the correct details and resubmit the Claim.
146Denial Code - 146 described as "Diagnosis was invalid for the DOS reported".1) Get the Claim denial date? 2) Check which diagnosis code was invalid for the DOS reported? 3) Check in application whether previous DOS with same Diagnosis code received payment or not? 4) If yes, send the claim back for reprocessing? 5) If no, Get the corrected claim address and timely filing limit to resubmit the corrected claim. 6) Claim number and calreference number 181Denial Code - 181 defined as "Procedure code was invalid on the DOS".Check to see the procedure code billed on the DOS is valid or not? Resubmit the claim with valid procedure code. 182Denial Code - 182 defined as "Procedure modifier was invalid on the DOS.Check to see the indicated modifier code with procedure code on the DOS is valid or not? Resubmit with valid modifier 183Denial Code - 183 described as "The referring provider is not eligible to refer the service billed".1) Get the Denial date and check why this referring provider is not eligible to refer the service billed. 2) Review all claims in the application for this provider with same CPT and DX combinations to see if any were paid.
3) If any of the information is available, send the claim back for reprocessing. 4) Claim number and Calreference number Note: If there is no information available, place all the claims for the provider with same CPT and DX combinations on hold and escalate to the client 185Denial Code 185 defined as "The rendering provider is not eligible to perform the service billed".1) Get the Denial date and check why the rendering provider is not eligible to perform the service billed. (Check PTAN was effective for the DOS billed or not) 2) Review all claims in the application for this provider with same CPT and DX combinations to see if any were paid. 3) If any of the information is available, send the claim back for reprocessing. 4) Claim number and Calreference number Note: If there is no information available, place all the claims for the provider with same CPT and DX combinations on hold and escalate to the client 197Pre-Certification or Authorization absentThis denial is same as denial code - 15, please refer and ask the question as required 198Precertification/authorization exceeded.This denial is same as denial code - 15, please refer and ask the question as required 204Denial Code - 204 described as "This service/equipment/drug is not covered under the patient’s current benefit plan".1) Get Claim denial date? 2) Check eligibility to see the service provided is a covered benefit or not? 3) If it’s a covered benefit, send the claim back for reprocesisng 4) Claim number and calreference number B9Denial Code B9 indicated when a "Patient is enrolled in a Hospice".Check to see, if patient enrolled in a hospice or not at the time of service?