Top Claim Denial Reasons

Edit 101 will set on a claim when the processing system is not able to drive to an active contract, for the date of service, that would allow payment. This primarily sets on a claim for one of the following reasons:

- Participant is enrolled with Part B Premium coverage. This is not a Medicaid plan with coverage for any medical benefits, therefor, the provider does not hold a contract for payment with this plan and the services are denied. We encourage the provider verify the participant's eligibility for the date of service using the Verify Eligibility tile on the Form Entry page. If the participant has a Part B Premium plan and no other Medicaid coverage displays, the services are not reimbursable.
- The start date of service on the claim is before the effective date or after the termination date of the provider's contract. Verify the provider's affiliation date by navigating to the Provider Enrollment Application link within the Form Entry page. The View Enrollment link will display the enrollment record.
- The rendering provider's credentials may be expired, or the rendering provider is not affiliated to the pay-to provider for the start date of service on the claim. Verify the rendering provider's credentialing information by navigating to the Provider Enrollment Application link within the Form Entry page. The View Enrollment link will display the enrollment record.
- A service location is required to be billed, based on the provider's record set-up, and the location is missing from the claim. View the Claim Details to determine if a service location was billed on the claim.
- To determine if a service location should be billed, navigate to the Provider Enrollment Application link within the Form Entry page. The View Enrollment link will display the enrollment record.

Edit 216 will set on a claim when a participant has other insurance, and the system does not detect coordination of benefits dollar details on the claim. The system will deny the claim is an Explanation of Benefits (EOB) is not attached.

If the provider has verified with the participant that there is no other insurance and this information needs to be updated, the provider or participant may contact HMS by phone at 1(800)873-5875.

An examiner may deny the claim, as outlined in the General Billing Instructions, Idaho Medicaid Provider Handbook, section titled *Submitting Third Party Liability Claims*:

- The EOB is not a match to the claim. The date of service, code(s), provider, and participant information must match the claim billed to Medicaid.
- The Commercial EOB attached to the claim does not include the denial reason explanation or remit.
- Medicare is primary for a Medicare covered code and there is no remit provided on an EOB or Medicare coordination of benefit information.
- Medicaid is tertiary, based on the participants eligibility file, and another EOB is required.
- The EOB has payment information that the provider did not enter the information into the coordination of benefits area on the claim.
- Non-payable denial reason codes are found on the other insurance EOB

Edit 6023 will set on a claim when a participant is enrolled into a MMCP Coverage plan and the claim must be submitted to the Managed Care Organization (MCO), either Blue Cross or Molina Healthcare. Eligibility details for the participant, including who their MCO administrator is, can be viewed by performing a check through he View Member Eligibility tile.

Edit 245 will set on a claim where multiple procedures or deliveries are performed at the same session by the same individual, but the appropriate modifier is not appended to the service line. Refer to the General Billing Instructions, Idaho Medicaid Provider Handbook, section titled *Modifier 51: Multiple Surgical Procedures* for more information.

Edit 606 will set on a claim line when the prior authorization (PA) number entered on the claim or the service line is not found in the claims processing system. If a prior authorization was not necessary for the services, simply leave the field blank. Do **not** enter NONE or N/A if a PA was not necessary. If a prior authorization was obtained, it's important to validate the correct number was keyed into the field.

Edit 311 will set on a claim when the start date of service is greater than 365 days from the start date of the claim. The claim may be denied if proof of timely filing is not justified by supporting documentation. The section titled *Timely Filing Limit* in the General Billing Instructions, Idaho Medicaid Provider Handbook clearly outlines the policy, exceptions and adjustment scenarios.