COMMON CLAIM DENIALS: HOW TO FIX

Denied claims may be re-billed with corrected information on a new claim form. It is important that all changes or corrections be submitted within 6 months of the date of service on the claim to avoid a reduction in payment.

Explain Codes:	Explain Reasons:	Suggested Resolution:
32	Recipient Not Eligible on Date of Service	Verify the Member's 9 digit I.D number (look for transposed numbers, make sure all digits are correct). Verify that the member is eligible with CenCal Health, and be sure to bill under the correct program for the Member (SBHI, SLOHI, PP2 (AIM) or (HKSB). If needed contact our Member Services Department at 877.814.1861.
33	Member # Invalid /Doesn't Exist/Doesn't Match Name on Claim	Verify that the member is eligible for one of CenCal Health's programs (SBHI, SLOHI, PP2 (AIM) or (HKSB). Verify the member's I.D. number (look for transposed numbers and make sure all digits are correct).
41	Not A Program Benefit	For Medi-Cal, the service billed may still have a Medi-Cal only (local) code. For a list of covered services, refer to the State Manual's "TAR and Non-Benefit List" or contact CenCal Health's Claims Department at 805-562-1083. In the instances where the benefit is considered medically necessary, Provider can obtain a TAR and indicate TAR number on claim.
50	Claim over Service Limits	Some procedures or supplies may be reimbursed over the service limits if there is supporting documentation submitted with the claim, or, an approved TAR.
70	Modifier Billed Exceeds Its Service Limits	Modifier -AG and -80 are only billable once per date of service by the same provider. Primary surgeons should use -AG on the highest valued procedure and modifier -51 (or-50 if appropriate) on each additional surgical code. Assistant surgeons should use modifier -80 on the highest valued procedure, and modifier -99 on each additional procedure with remarks (i.e. "modifier 99 = modifiers -51 and -80"). .Other modifiers may have similar limits. Refer to the State Medi-Cal manual or contact CenCal Health's Claims Department at 805-562-1083.
87	Procedure Code Invalid for Date of Service	Check for number transposition. Verify the code billed is still valid under Medi-Cal (code updates are done in late summer each year). Medi-Cal still utilizes local codes - check to see if a local code needs to be used.
3G	Recipient Not Eligible Without Pay/Deny Info - Medicare	Include a copy of Medicare's EOMB or denial letter along with your correction.
3R	Recipient Not Eligible Without Pay/deny Info-Other Carrier	Include a copy of the primary insurance (Other Health Coverage) original Explanation of Benefits or denial letter. If the service/procedure is not a covered benefit of the member's primary insurance, a copy of the original denial letter with description(s) of denial reason codes is acceptable for the same recipient and service for a period of one year from the date of the original EOB or denial letter.
4J	Claim Payment is the Responsibility of CCS/GHPP	The service billed is the responsibility of CCS unless an NOA (Notice of Action) is attached to the claim.
4X	Procedure Code or Modifier used Requires Remarks/Documentation	Refer to the State Medi-Cal Manual for specific document requirements for the procedure code or modifier billed or by contacting your Claims Customer Service Representative at 805-562-1083.

5B	Procedure/Service Requires Correct & Appropriate Diagnosis	The diagnosis billed does not meet the benefit requirements. You may appeal a denial with medical documentation and justification for the denied service or supply, or obtain an authorization for medical necessity through a TAR.
5D	Modifier is Incorrect for Procedure/Service/Description	Not all modifiers can be used on all codes. Check modifier use rules using the CPT book or in the State Medi-Cal website manuals.
5Q	The Submitted Documentation was Not Adequate	The documentation submitted was not enough information to properly review the claim. For example, an operative report is needed but the discharge summary was submitted, or an invoice is needed but the item billed is not on the submitted invoice. Carefully review all attachments to be sure they satisfy the billing requirements before resubmitting your claim.
6U	Referral Authorization Not Received for Procedure by CenCal HEALTH	Be sure to obtain authorization from the members PCP prior to rendering services. Include the approved RAF # in box #23 of the CMS 1500 or box #63 of the UB04. If the service falls under a category in which a RAF is not required (i.e. emergency or urgent services, family planning, OB-GYN visit), and no RAF was obtained, submit a statement of such in "remarks" for future consideration.
8X	Complete Description of Drug/Supply is Required for Pricing	The name, strength and dosage (or valid NDC) is required in the remarks/EDI area on the claim in order to price this claim.
9E	Rendering Provider # is Missing or Invalid	When billing under a Group Provider #, be sure to include the rendering Provider's NPI number in box 24J of the CMS 1500 or box 77 of the UB04. If your claim continues to remain denied on two more EOB's, contact CenCal Health's Provider Services Department t at 805- 562-1676 to verify the NPI for the rendering Provider.
JC	TAR Required for Procedure/Drug/Diagnosis Billed	Be sure to obtain authorization prior to rendering services that require a TAR and to include the approved TAR # in box #23 of the CMS 1500 or box #63 of the UB04. Verify that the TAR number has been entered correctly on the claim, the TAR covers the date(s) of service on the claim and that the services billed on the claim have been included and approved on the TAR.
K6	Procedure Code Requires Modifier	Surgical codes always require a modifier unless the code is one that is listed in the CPT book as "Modifier -51 Exempt", or, is an add-on code. Other services may require a modifier - consult the State Manual for the modifier requirements that apply to the services billed on your claim.
MY	NCCI Edit: Payment For This Service is Already Included in Another Service.	This denial will appear on a service billed on the same date of service by the same rendering provider which would ordinarily be considered as a component of another service on that same day. NCCI modifier exceptions may apply - check your specific billing situation.
MZ	NCCI Edit: Payment For This Visit is Included in Surgical Procedure	This denial will appear if an Evaluation and Management (E&M) service has been billed by the same rendering Provider on the same date as a surgical procedure. It may also appear if an E&M service is billed by the same Provider or Provider Group within a certain period of time before or after a surgical procedure was performed by the same Provider or Provider Group. NCCI modifier exceptions may apply - check your specific billing situation.

Please contact your Claims Customer Service Representative ay (805) 562-1083 with any questions pertaining to denials.