Top Denial Reasons

Reasons presented in no particular order. Top reasons ascertained from claims data, provider and MMCP report.

Denial Codes listed are from the **national code set.** For more information on remark codes **view here.**

Denial Code (Possible Remittance Advice Remark Code)	***Denial Reason***	***How to Resolve and Remit/Resubmit***	***MMCP Nuances (sourced from MMCPs)***
29	The time limit for filing has expired.	Be sure to know the filing deadlines/ timeframes. Timely filing guidelines are outlined in your contract with the MMCP. Notify your MMCP if there are extenuating circumstances where you do not believe you will be meeting timely filing deadlines for original and/or corrected claim submissions. If possible include reminders in your billing systems as the timely filing deadline nears.	**Amerigroup/BCBS of WNY:** Timely filing 120 days from the DOS. Contact Provider Relations to discuss timely filing denials. **HealthFirst:** Children's timely filing claim guidelines will apply if claim is submitted 180 days after DOS; call account manager for reconsideration of late claims submission. **United:** PI29 The time limit for filing has expired

18	Duplicate claim/service	Ensure this is not rooted in erroneously filling out Field 4 of the claim (see billing.ctacny.org) when claiming for one encounter. The last digit indicates whether this is an initial claim (first time submitting for that encounter) or a rebill. If you are rebilling for a claim because you have not heard back from the MMCP, be sure to change the last digit in Field 4 to indicate this is a rebill. This may be due to a lack of communication. Ensure people at your agency are not billing for the same time period, for example if 3 individuals who provide different services attend the same meeting for/with the client make sure they discuss who is billing. Discuss with plans and ensure that offsite claims are not being erroneously viewed as duplicative. Ensure claim includes correct rate code, procedure code/ modifier combo combination so that systems do not erroneously view as duplicates.	**Amerigroup/BCBS of WNY:** Corrected claim should be filed with the 4th digit of the bill type '7'. **HealthFirst:** HealthFirst's claim configuration was originally based on billing guidance for procedure code/modifier combinations. Previously denied telehealth claims due to the telehealth 95/GT combo have since been reprocessed. Previous denials due to this reason should not be resubmitted. Denied claims should not be resubmitted, but appealed, and only resubmitted if a correction is required.

197 62	Precertification/authorization/notification/pre-treatment Absent. (generally, this means prior authorization was required and was not obtained) Payment denied/reduced for absence of, or exceeded, pre-certification/authorization (generally means concurrent review requirements were not met).	Review manuals in order to determine which services require authorizations and at what point authorization is required (prior, concurrent, etc.). For services that require authorization, please ensure you have reminders in your billing, registration and scheduling systems. Remember in some instances a denial may be received for services where authorization is not required but notification is. In these cases. it is important to provide notification so that MMCPs know services are occurring and do not deny the claim. View the MCTAC Matrix for UM contacts for each MMCP. https://matrix.ctacny.org/ See field 63 on the Billing Tool https://billing.ctacny.org/ for further clarification.	**Amerigroup/BCBS of WNY:** For HCBS services, complete the HCBS Provider Notification Form prior to first visit with client and send to Plan. The form can be found on our website at https://providerpublic.mybcbswny.com. **HealthFirst:** Children's HCBS - Providers should check K-code eligibility (via ePaces) before providing services. **United:** CO197 Precertification/ authorization/ notification/pre-treatment absent
206 207 (N257) 208	National Provider Identifier - Missing National Provider Identifier - Invalid format National Provider Identifier - Not matched	Please make sure that your agency NPI and all appropriate NPIs are listed on the claim. See fields 56, 76, and 78 on the Billing Tool https://billing.ctacny.org/ for more information including how to handle unlicensed/un-enrollable practitioners. Pay close attention to your billing reports, which might hold claims back for missing/invalid NPI numbers. Ensure billing NPI is credentialed with the Plan to perform the service.	**Excellus:** Requires fields 81 to be populated with the first box identifying the B3 qualifier along with billing provider Taxonomy Code (this Taxonomy code is required to be the same rendering provider as field 56).

4 (N519)	The procedure code is inconsistent with the modifier used or a required modifier is missing.	See field 44 in the billing tool https://billing.ctacny.org/ for more information. Review the relevant manuals for allowable modifier combinations.	**HealthFirst:** Modifiers should be submitted in a specific sequence. Telehealth modifiers should be submitted as the last modifier. HCBS modifiers should be included in a specific order, as per HF billing manual.
16 (MA30)	Missing/incomplete/invalid type of bill.	See field 4 in https://billing.ctacny.org/ Please contact your MMCP if you need clarification on what is the appropriate digit combination for this field. View the MCTAC Matrix for billing contacts for each MMCP. https://matrix.ctacny.org/	
31	Patient cannot be identified as our insured (generally means client is not part of the MMCP).	Check via ePACES https://www.emedny.org/epaces/ to determine what plan the member is enrolled in. If the client is enrolled in the Medicaid Managed Care Plan the claim was submitted to, communicate with the plan to resolve this issue. View the MCTAC Matrix for contacts for each MMCP. https://matrix.ctacny.org/ For many plans, providers can verify member Eligibility and Benefits via the provider portal.	**United:** *PR27* Expenses Incurred after coverage terminated *N30* Patient ineligible for service

B7 (N570) B7 (N95)	The provider (organization) was not certified/eligible to be paid for this procedure/service on this date of service. - Missing/incomplete/ invalid credentialing data. This provider(organization) was not certified/eligible to be paid for this procedure/service on this date of service. - This provider type /provider specialty may not bill this service(s).	Ensure that your provider profile is up-to-date with the Plan. Communicate with the plan to determine and provide the necessary information to get this site/program credentialed/on file. View the MCTAC Matrix for each MMCP. https://matrix.ctacny.org/ Review appropriate NYS program manuals to determine the required agency license(s) and designations needed to provide and bill for each service.	**HealthFirst:** Check with account manager if provider's fee schedule was correctly set up in reimbursement. Such denied or underpaid claims should not be resubmitted, but appealed, and only resubmitted if a correction is required.
185	The rendering provider is not eligible to perform the service	Review appropriate NYS program manuals to determine the staff qualifications needed to provide and bill for each service.	**Beacon Health Options:** Confirm billing and rendering provider are correct. They should not be the same on facility claims.

	billed (generally means the individual staff person's qualifications do not meet requirements for that service).	Note: sometimes these qualifications can change, be sure you meet all up-to-date qualifications.	
199	Revenue code and Procedure code do not match.	See field 42 and 44 in the billing tool https://billing.ctacny.org/ for more information. Review the relevant NYS documentation/manuals for correct revenue and procedure codes.	**Excellus:** Requires fields 42, 43, 44, 45 ,46 and 47 for a clean claim submission **United:** CO199 Revenue code and Procedure code do not match.
24	Charges are covered under a capitation agreement/ managed care plan (often provider bills FFS when should bill MMCP).	Check via ePACES https://www.emedny.org/epaces/ to determine if the member is enrolled in Medicaid and/or a Medicaid Managed Care Plan.	
16 (M53)	Missing/incomplete/invalid days or units of service	See field 46 in the billing tool https://billing.ctacny.org/ for more information. Review the relevant NYS documentation/manuals for unit measure and limits. In some cases, unit limits are soft limits that can be exceeded given medical necessity. In these cases work with the MMCP to provide documentation to prevent (or when you adjust the claim) denial because of exceeded limits.	**Amerigroup/BCBS of WNY:** Contact Provider Relations if the unit limits will exceed the soft limits as published in the Children's HCBS billing manual. **HealthFirst:** See HF billing manual.

16 (MA36) 16 (MA39)	Missing/incomplete/invalid patient name Missing/incomplete/invalid gender.	Double check client information via agency paperwork and ePACES. https://www.emedny.org/epaces/ Communicate with the MMCP to ensure there is not an error in what the plan has regarding the client information.	
11 (N657) 16 (M76)	Diagnosis is inconsistent with the procedure/service. Missing/incomplete/invalid diagnosis or condition.	See field 67 in the billing tool https://billing.ctacny.org/ for more information. Review the medical necessity requirements for the service in NYS program manuals/documentation.	**HealthFirst:** Diagnosis must be consistent with member's age and not just procedure/service.
16 (M54)	Missing/incomplete/invalid total charges -- reimbursement amount is greater than total charge.	Remember MMCPs are required to pay APG or government rates for at least 24 months from service transition date. Review the appropriate rates for the service.	**HealthFirst:** Check with account manager if provider's fee schedule was correctly set up in reimbursement. Overpaid claims should not be resubmitted and only resubmitted if a correction is required. **United:** M49 Missing/incomplete Value code(s) or amount(s).