

Top 50 Billing Error Reason Codes With Common Resolutions (03-10)

On the following table you will find the top 50 Error Reason Codes with Common Resolutions for denied claims at Virginia Medicaid. This list has been provided to assist you with resolving these denied claims prior to calling the Helpline. Please print and post this list within your office for easy reference and use. Whenever you are advised to contact the Helpline or MediCall please access the following telephone numbers.

Provider Helpline - 800-552-8627 or 800-786-6273

MediCall - 800-884-9730; 800-772-9996; 804-965-9732; 804-965-9733

Error Code	Description	Common Resolutions
0004	Enrollee ID Missing or Not in Valid Format	<p>CMS-1500 - verify the enrollee number for eligibility. Place the correct 12 digit enrollee number as it appears on the Medicaid Card in Locator #1a</p> <p>UB-04 - verify the enrollee number for eligibility. Place the correct 12 digit enrollee number as it appears on the Medicaid Card in Locator #60</p>
0014	Billed Amount Missing or Invalid	<p>CMS-1500 – Billed charges should be on each line 24F. Do not use a decimal point.</p> <p>UB-04 – The billed charges must be numeric without spaces.</p>
0015	Primary Carrier Pay Missing or Invalid	<p>CMS-1500 – our records show there is a primary carrier and no TPL information is on the claim.</p> <p>UB-04: if claim was submitted with a COB code of ‘83’ (primary carrier billed and paid) in Locator 39-41 under ‘code’, the payment made by the primary carrier must be under ‘amount.’”</p>
0017	Missing Former Reference Number	<p>CMS-1500 – For an adjustment or a void, the former reference number must be in block 22 in the space labeled Original Ref. No.</p> <p>UB-04: Locator 64 is to be used to place the original Internal Control Number (ICN) for claims that are being submitted to adjust or void the original PAID claim.</p>
0026	Covered Days Missing or Invalid	<p>UB 04 – In locator 39, value code 80, enter the number of covered days for inpatient hospitalization or the number of days for re-occurring outpatient claims. The format for value code is digit: do not format the number of covered or non-covered days as dollar and cents.</p>
0028	Admit Date Missing or Invalid	<p>UB 04– Locator 12 is to be used to place the admit date. It must be numeric or not in a valid date format for Title 18 payment requests with Medicare coverage code A</p>
0035	Missing/Invalid Type of Accommodation Code	<p>UB 92 – Locator 47, enter the total number of covered accommodation days or ancillary units of service where appropriate. This number is equal to the number of covered days.</p>

0039	Qualified Medicare Beneficiary Only Enrollee. Medicaid coverage limited to deductible and coinsurance.	Qualified Medicare Beneficiary (QMB) Only clients are eligible only for payment of Medicare premiums, deductibles, and coinsurance. If a QMB Only claim is denied by Medicare then there will be no reimbursement by Medicaid.
0044	NDC Missing or Not in Valid Format	CMS-1500 – If a “J” code is submitted, a valid NDC code must be present in the pink shaded area on each claim line. Valid format would be NDC1234567890 (10 digit NDC) UB 92 – For Outpatient Claims, when billing for Revenue codes 0250-0259 or 0630-0639, in locator 43, you must enter the NDC qualifier of N4, followed by the 11-digit NDC number, and the unit of measurement followed by the metric decimal quantity or unit. Do not enter a space between the qualifier and NDC. Do not enter hypens or spaces within the NDC. The NDC number being submitted must be the actual number on the package or container from which the medication was administered. (ex: N412345678901UN1234.567)
0055	The Type of Bill Missing or Invalid	UB 04 – Locator 4 Type of Bill - Enter the code as appropriate
0077	Adjustment Denied - Original Payment Request Already Adjusted/Voided	An adjustment or void request cannot be submitted for a payment that has been previously adjusted or voided.
0110	Diagnosis Code Does Not Agree with Age	The diagnosis given is not compatible with the enrollee's age.
0116	Invalid/Missing Prescribing Physician Number	The Prescribing physician’s 9 digit Medicaid number is required for claims submission. You can access prescribing provider ID numbers by contacting the MediCall line 1-800-884-9730 and selecting option “6”.
0119	Service Period Not Equal Accommodation Days	UB 04 - If a revenue code(s) is billed for accommodation or room and board, the service units billed for the revenue code(s) must be equal to the number of days covered by the from-thru dates of service for the payment request.
0129	Revenue Code Not Covered	UB 04 – Verify that the revenue code being billed is valid for the provider type and service

0144	Billing Provider Not Eligible on DOS	The billing provider on the claim is not enrolled for the date of service on the claim.
0146	Procedure Code/Type Not on File	The procedure code billed is not on file. Please check that the CPT code is valid.
0155	Procedure Requires Authorization	The procedure/revenue code billed requires a preauthorization and there is no PA number on the claim. You must get preauthorization from the appropriate area depending on the service being provided. The preauthorization number received from is required in Locator 23 of the CMS-1500 and Locator 63 of the UB-04. If a preauthorization letter is received, it must be attached to the CMS-1500 with the word "Attachment" in Locator 10D and a modifier "22". On the UB-04 it must be attached with the word "Attachment" in Locator 80.
0157	Approved Authorization Not on File	The procedure billed requires authorization and the authorization is not on file. Verify that the authorization number on the claim is the correct authorization for the service billed.
0158	Enrollee Disagrees with Authorization	The authorization number used on the claim is not for the same enrollee as billed.

0159	Provider Disagrees with Authorization	The provider billing the claim is not the same provider that has been authorized.
0160	Procedure Disagrees with Authorization	The procedure billed on the claim is not the same procedure that has been authorized.
0161	Authorization Not Valid for Dates of Service	The payment request's from and thru dates of service must fall within the PA's begin and end dates. CMS – 1500: Please verify the correct PA number was entered in block 23. UB-04 - Please verify the correct PA number was entered in block 63
0162	Number of procedures exceeds number authorized	The number of units or visits billed is greater than the number of units or visits authorized on the PA

0171	Claim Type Does Not Match Original Invoice	If an adjustment or void request is submitted, the claim type on the adjustment/void must match the original claim type.
0178	Invalid Diagnosis Code	The primary diagnosis is not valid. Please verify that the diagnosis code is valid and is in the correct format.
0179	Invalid Discharge Status for Type Bill	UB-04 – Locator 17, Enter the code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill (If the third position of type of bill is 2 or 3 the discharge status should be 30. If the third position of type of bill is 1 or 4 the discharge status should not be 30.
0301	Duplicate Payment Request-Same Provider, Same Dates of Service	Provider has already received payment for this date of service. Review your prior remittances to identify the payment, which has already been made. If you can not locate the previous payment call the Provider Helpline *Note- make sure the prior remittance's provider number matches the number of the remit with the denied claim

0302	Duplicate of History File Record, Same Provider, Same Dates of Service	Provider has already received payment for this date of service. Review your prior remittance to identify the payment, which has already been made. If you can not locate the previous payment call the Provider Helpline *Note- make sure the prior remittance's provider number matches the number of the remit with the denied claim
0308	Your payment request was filed past the filing time limit without acceptable documentation	Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Medicaid is not authorized to make payment on claims submitted after the 12 month timely filing limit, except under the conditions listed in the Physicians Manual Chapter V pgs 2-3.
0309	Services Not Covered	Verify the client's eligibility on our Medicaid system. If the client is eligible, contact the Provider Helpline to verify that the client is enrolled in the program for which services were billed.
0313	Enrollee is covered by private insurance, refer to third party information of this R/A	Our system indicates that there is a primary carrier, which needs to be billed prior to Medicaid. This carrier is now listed on your remittance advice under the claims information for that particular client. Please refer to this other coverage information which should be billed as primary. *NOTE: If the client states there is no other coverage then they will need to contact their case worker at the Department of Social Services to have this information corrected
0318	Enrollee not eligible on DOS	Claim will deny if the client is not eligible during dates of service billed. Check enrollee eligibility status through MediCall to verify eligibility on the date of service being rendered. If the enrollee is not eligible no payment will be received from Virginia Medicaid. If upon verification you find that the client is now eligible on that date of service resubmit the claim.
0330	Duplicate of History File Record, Same Provider, Overlapping Dates of Service	The payment request being processed is a duplicate of a payment request from a previous cycle. Dates of service can not overlap.

0339	Hysterectomy Certificate Not Acceptable	The payment request is billed with a hysterectomy procedure code and the certificate attached is not valid.
0352	Only Paid Payment Requests Can be Adjusted/Voided	Only paid payment requests can be adjusted or voided. If the claim previously denied, you must submit the claim as a new claim.
0364	Primary carrier payment equals or exceeds DMAS' allowed amount	The claim was submitted with COB code indicating there was a primary carrier which paid on this claim and that the primary carrier's payment to you equaled or exceeded Medicaid's allowed amount. DMAS will not reimburse you if the primary carrier payment exceeds the Medicaid allowed amount.
0367	This enrollee is covered by Medicare part B, Rebill on Title 18	Medicaid requires claims be submitted on a Title 18 for Medicare Part B deductible and coinsurance. See Medicaid Memo dated 3/18/04.
0370	Wrong Procedure Code Billed	Check your claim to verify that the correct/valid procedure code was billed, if you feel the code is correct call the Provider Helpline to verify the code billed
0385	Re-bill on Title XVIII Invoice	If the claim is being submitted to Medicaid for deductible and coinsurance secondary to Medicare's payment, and the claim to Medicare was submitted on a CMS-1500 form, then the claim to Medicaid must be submitted on a Title XVIII claim form.

