Top 50 Billing Error Reason Codes With Common Resolutions

(09-12)

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
0453	Enrolled in HMO or an Encounter Claim for F. F. S.	Verify the enrollee eligibility and bill the claim to the appropriate carrier.
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't 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
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't locate the previous payment call the Provider Helpline ***Note**- make sure the prior remittance's provider number matches the number of the remittance with the denied claim
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.
1393	No Srvc Taxonomy Code on the Claim	Verify that the servicing provider taxonomy code was on the claim.
0309	Services Not Covered	Verify the client's eligibility on our Medicall 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
0732	Servicing Provider Invalid	Verify the 10 digit number entered for the servicing provider.
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 is required on the claim.
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.
0983	Enrollee Not on File	Verify the enrollee's Medicaid ID number.
0456	Enrollee Not Covered for this Service	Verify the enrollee is covered for the service you are billing.
0485	Authorization by Medallion PCP Not Indicated	The members primary care provider must authorize services
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 Providers Manual Chapter V pgs 2-3. For additional details regarding the timely filing regulations, please reference the appropriate Provider Manual, Chapter 5
0022	Servicing Provider is Not Eligible to Bill this Payment Request Type	The servicing provider billed on the claim is not eligible to bill this claim.
1357	NPI Servicing Provider Not on File	Verify the 10 digit NPI entered for the servicing provider.

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 in a CMS-1500 format, then the claim to **Medicaid** must be submitted on a Title XVIII claim format.
0028	Admit Date Missing or Invalid	**UB 04**–. The admit date must be numeric without any dashes or slashes.
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.
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 and UB-04: Please verify the correct PA number was entered**.**
0731	Servicing Provider Not Eligible on DOS	The servicing provider was not eligible on the date of service. Contact Provider Enrollment Unit.
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
0757	Servicing Provider Can Not be a Group Provider	The servicing provider number used on your claim can't be a group NPI number.
0756	Billing Provider is not a Group Provider	The billing provider must be enrolled as a group provider. Contact Provider Enrollment
0730	Servicing Provider Not a Member of the Group	The servicing provider is not a member of the group provider, Contact Provider Enrollment
0480	Not CLIA Certified to perform procedure	Check that the CLIA number used on the claim is certified to perform the procedure.
0129	Revenue Code Not Covered	**UB 04 –** Verify that the revenue code being billed is valid for the provider type and service

0026	Covered Days Missing or Invalid	**UB 04 –** Value code 80**, e**nter the number of covered days for inpatient hospitalization or the number of days for re-occurring out-patient claims. The format for value code is digit: do not format the number of covered or non-covered days as dollar and cents.
0004	Enrollee ID Missing or Not in Valid Format	Verify the enrollee number for eligibility. The twelve digit enrollee number should appear as it is on the Medicaid Card.
0734	Covered Days Entered is greater than the Statement Period	The covered days entered cannot exceed the difference between the from and thru dates.
1370	Invalid Present on Admission Flag	This requirement only applies to inpatient facility claims. The locator for the POA is right after the diagnosis code. A POA indicator is required for the primary, secondary and the external reason code. Review all diagnosis codes on the claim to assure the POA indicator was used. For more detail, please refer to the Hospital Manual, Chapter 5
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.
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
0191	Provider Referral Required	The procedure code entered on the CMS-1500 or the revenue code on the UB-04 requires a referral, Verify the correct provider number is entered correctly on the claim.
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 –**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.

0014	Billed Amount Missing or Invalid	**CMS-1500** – Billed charges should be on each line. Do not use a decimal point. **UB-04 –** The billed charges must be numeric without spaces.
0017	Missing Former Reference Number	The original Internal Control Number (ICN) for claims that are being submitted to adjust or void the original PAID claim must be provided.
0055	The Type of Bill Missing or Invalid	**UB 04 –**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.
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.
0158	Enrollee Disagrees with Authorization	The authorization number used on the claim is not for the same enrollee as billed.
0160	Procedure Disagrees with Authorization	The procedure billed on the claim is not the same procedure that has been authorized.
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.

0035	Missing/Invalid Type of Accommodation Code	**UB 92** –,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.
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.
0015	Primary Carrier Pay Missing or Invalid	**CMS-1500** – our records show there is a primary carrier and no TPL information is on the claim. **UB-04**: if claim was submitted with a COB code of '83' (primary carrier billed and paid) under 'code', the payment made by the primary carrier must be under 'amount."