Resolving Common Claims Rejections

MHS Claims Operations provides guidance on common claims rejection reasons to assist providers in quickly resolving rejected claims. A rejected claim is a claim that has missing or insufficient information that will prevent the claim from entering the claim system. A complete list of rejection reason codes can be found online at mhsindiana.com. Choose For Providers > Provider Resources > Guides and Manuals and look in the Claims/Billing section for the most current listing.

REJECTED CLAIMS GUIDELINES:

- If a claim is rejected and you are correcting a field and re-submitting the changed claim, please submit the claim as **a first time claim**.
- Rejections are not proof of timely submissions. Rejected claims must be resolved and resubmitted within the timely filing guidelines.
- MHS does not accept black and white forms or handwritten claims.

RESOLVING COMMON REJECTIONS:

- **B2 REJECTION:** *Not enrolled with MHS with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim.*

  Issue: The Rendering NPI and TIN that were billed are not in the MHS system for the program the member is assigned to.

  Resolution (Non-contracted provider):
  - Step 1: Ensure the NPI is registered with Indiana Health Care Programs.
  - Step 2: If not previously completed, have the provider submit a non-contracted enrollment request via MHS website.
  - Step 3: Once provider load is completed, submit as first time claim.
  - Step 4: If non-contracted enrollment was submitted more than 45 days and provider is not set up, create an OMNI Intent (See OMNI PS QRG).
  - Step 5: If the provider is active/updated on PR0300 screen in Amisys, create an OMNI Intent (See OMNI PS QRG)

  Resolution (Contracted provider):
  - Step 1: Ensure a contracted enrollment form was submitted to MHS.
  - Step 2: Once contracted enrollment is complete, a welcome email/letter will be sent.
  - Step 3: If more than 60 days have passed since the enrollment was submitted, please contact your Provider Network Representative.
  - Step 4: Once provider load is completed, submit as a first time claim.

- **09 REJECTION:** *Member Invalid on Date of Service*

Issue: Member is not showing effective in MHS for the DOS being billed. Member may have coverage through another carrier, or an update was not transmitted to MHS from the State.

Resolution:

- Step 1: Review member RID on the state Provider Healthcare Portal for the date range (month of the claim)
- Step 2: If the state file shows that the member is enrolled with MHS, contact MHS Provider Services for assistance with updated member record. Provider Services will request to have eligibility updated and provide you with a case number.
- Step 3: Submit first time claim once member's eligibility has been updated, within 90 days.
- Step 4: If the state file does not show member as MHS, provider should bill to the correct carrier.

01 REJECTION: *Invalid Provider ID – Billing Physician (EDS Table)*

Issue: 3 possible issues

Resolution

Issue #1: *Group NPI billed has not been reported to IHCP*

- Step 1: Physician's office or credentialing department must complete the enrollment process with IHCP.
- Step 2: Once loaded with IHCP, submit a non-contracted enrollment request via mhsindiana.com
- Step 3: Submit as first time claim, once provider is updated with MHS.

Issue #2: *Unable to make a one to one selection based on the information billed*

- Step 1: Review the information billed compared to the information on the IHCP website.
- Step 2: Review billing providers' service location.
  - Ensure billing with correct zip plus 4 of service location and not payment location.
  - Ensure billing with correct taxonomy code for the address billed allowing for a one to one match. This is the billing providers' service location reported to IHCP, not the payment location.
- Step 3: If information billed is correct, and is a one to one match, contact our EDI team at 1-800-225-2573 ext. 6075525.

Issue# 3: *Review the detail billed on the group level*

- Step 1: Review the NPI billed in Box 33A.
- Step 2: Determine if the submitted information is the rendering provider's NPI in billing level or Box 33A on a CMS 1500 and not the provider's Group NPI.
- Step 3: Correct billing level or Box 33A on CMS 1500 to the Group NPI that is reported on the Provider Healthcare Portal.

77 REJECTION: *Invalid Claim Type*

Issue: CMS removed the need for claims with DOS after 1/1/2016 for Laboratory only billing to not require Bill Type 131 with the L1 modifier, or Bill Type 141 with no modifier.

Resolution

- Step 1: Review DOS being billed and type of service being billed.
- Step 2: If claim is for ALL LABS and DOS is prior to 1/1/2016, those requirements are still in place. Provider should submit a first time claim (not correction of rejected claim) by using Bill Type 141 without modifiers.
- Step 3: If claim rejection is not for an all Laboratory claim, resubmit.

B1 REJECTION: *Rendering and Billing NPI are not tied on state file*

Issue: The address being billed is missing the rendering provider's NPI being completely tied at the Provider Healthcare Portal. Most often, this is related to the Rendering Tab of the Group address record.

Resolution

- Step 1: Review Provider Healthcare Portal (IHCP) provider set up.
- Step 2: Locate the address on the group record that provider is billing.
- Step 3: Review the Rendering Tab associated with the address and taxonomy code billed. Determine if the rendering provider is fully tied to the address as an LPI and NPI will both be listed. If not, the providers' office or their credentialing department will need to correct either online or contact their IHCP representative.
- Step 4: Submit as first time claim once the Provider Healthcare Portal reflects the correction.

08 REJECTION: *Invalid Member Date of Birth*

Issue: Member's date of birth does not match

Resolution

- Step 1: Verify the DOB being billed to ensure it matches the DOB loaded on the Provider Healthcare Portal.
- Step 2: If incorrect on the portal, member will need to notify DFR to have the date corrected.
- Step 3: If DOB was entered incorrectly by provider, the provider should correct DOB on claim and submit the claim as a first time claim.
- Step 4: Verify the DOB loaded with MHS matches the Provider Healthcare Portal.
- Step 5: If the two systems do not match, contact MHS Member Services and they can assist with having the member information updated with MHS.
- Step 5: Once updated, submit the claim as a first time claim.

07 REJECTION: *Invalid Subscriber/Member ID*

Issue 1: This error occurs commonly if this is a new member to Medicaid through the Hospital Presumptive Eligibility (HPE).

Resolution

- Step 1: It can take 2-3 weeks for this information to be received from the State.
- Step 2: Providers are asked to hold claims for 2-3 weeks from date of eligibility and submit as a first time claim.

Issue 2: If the State eligibility shows the member is with Managed Health Services (MHS)

Resolution

- Step 1: Provider should contact Member Services for assistance in having member updated.
- Step 2: Member Services will send to have updated, and will give you a case number.
- Step 3: Submit as a first time claim once eligibility is updated, within 90 days.

Issue 3: Incorrect Member ID submitted

Resolution

- Step 1: The only number appropriate is the Member's Medicaid ID (RID).
- Step 2: Correct Member ID and submit claims as first time claim.

90 REJECTION: *Invalid or Missing Modifier*

Issue: There are some codes that require a modifier.
Example: G0477 modifier QW and 99354 modifier TH (notification of pregnancy)

Resolution

- Step 1: Review claim with codes billed to ensure they meet IHCP requirements.
- Step 2: Update missing or invalid information and submit as a first time claim.

A3 REJECTION: *Errors number exceeds ETL limit of 1000*

Issue: Claim has too many claim lines.

Resolution

- Step 1: Service Line limited to 97 per claim submission on a UB-04.
- Step 2: Correct claim and submit as first time claim.

76 REJECTION: *Payer Claim Control Number is required, Original claim number required*

Issue: Rejected claims being billed as corrected claims as opposed to first time claims.
Bill type on claim submitted reflects a "7" which indicates it was billed as a correction to a previously submitted claim.

Resolution

- Step 1: When submitting a corrected claim ALWAYS submit the “original” claim number that was on previous EOP.
- Step 2: If this is a correction for a rejected claim, it needs to be submitted as a first time claim.
  - Do not submit an original claim number.
  - Do not use the indicator “7” which indicates this is a correction.

ACRONYM LEGEND:

DFR = Department of Family Services
DOB = Date of Birth
DOS = Date of Service
EOP = Explanation of Payment
HCFA= Health Claim Form 1500
MCE = Managed Care Entity (Carrier)
MHS = Managed Health Services
NPI = National Provider Identifier
RID = Member Medicaid ID Number
TIN = Tax Identification Number