PCHP Provider Toolkit

Top 10 Most Common Denial Reasons

September 2023

ACRONYMS

ICN: Internal Control Number

NDC: National Drug Code

PA: Prior Authorizations

DOS: Date of Service

OHI: Other Health Insurance

CSI: Claim Status Inquiry

RESOURCES

Texas Medicaid Provider Procedures Manual

TMHP Provider Enrollment and Management System (PEMS)

Q. What is the difference between a rejected claim and a denied claim?

A. A rejected claim fails initial system edits and is returned to the provider for correction without being submitted for processing. The claim is not entered in CMS and no Internal Control Number (ICN) is assigned.

A. A denied claim passes initial system edits, is processed, and assigned an ICN, but payment is denied. Denied claims appear on the Remittance.

Q. Why is my claim being denied?

A. The following table lists the most common reasons for claim denials, as well as suggested actions.

A Claim rule is any rule that evaluates data related during claim processing—from claim header entry through payment.

PCHP system action rules generate edits at the claim header level, the claim line level, or both.

Edit Code	Denial Reason	Denial Defemination	Suggested Action(s)
Edit 197	Missing/ incomplete / invalid / deactivated / withdrawn National Drug Code (NDC).	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication	If the NDC information is missing, invalid, incomplete, or does not match the HCPCS or CPT submitted, the claim may be denied. If the claim is denied, it can be resubmitted with the appropriate NDC information for reconsideration of reimbursement
Edit 201	No enrollment exists for claim start date	Claim will deny if the member is not eligible during dates of service billed	Check member eligibility status to verify eligibility on the date of service being rendered
Edit 205	Precertification/ authorization/notification absent/ Benefit requires UM	A valid Service Authorization for this member for this service on these dates is not available.	Review a valid Prior Authorizations (PA) has been obtained. If a PA was obtained for the member prior to DOS, appeal with documentation. If no PA was obtained prior to the Date of Service (DOS), the claim will deny for UM requirements.
Edit 216	Missing COB	The Other Health Insurance (OHI) Disposition information on the claim is invalid.	Providers should verify that the correct disposition and disposition reason are selected for the type of OHI; service code(s) being billed, and service group being billed. Additionally, providers should review the following claim information for accuracy: • Other Insurance Billed Date is later than claim submission date, or • Other Insurance Billed Date is greater than 365 calendar days earlier than claim submission date, or • Other Insurance Disposition Date is later than claim submission date, or • Other Insurance Billed Date is on or after Other Insurance Disposition Date
Edit 241	Exceeds number / frequency approved / allowed within time	A frequency denial happens because the procedure code has been billed more times than can be billed for a beneficiary on a single date of service. The number of units billed is reviewed based on the Medically Unlikely Edits	If service provided exceeds the number of frequencies allowed claim will continue to deny. Please review the frequencies for service on TMHP Guidelines.
Edit 301	Invalid or Missing Admission Date	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication	An admission date is required for the following bill types: 11x, 12x, 18x, 21x, 22x, 28x, 41x, 51x, 81x, 82x
Edit 307	Duplicate Claim - Same Provider-Member-DOS	This service has already been paid. Please do not file for duplicate services.	Providers should check CSI (Claim Status Inquiry) to see if there are claims for the member for the DOS which are in a paid OR approved to pay status. If any date within a claim has been paid, the entire claim will be rejected until the dates have been corrected.
Edit 311	Limit for Filing has expired	The time limit for filing has expired, whenever the claims submitted after the time frame. The time limit is calculated from the date service provided.	Provider should validate the original or corrected claim was submitted with in the timeframe.
Edit 516	Processing Claims Missing Required Information	The claim received lacks information or contains submission and/or billing error(s) needed for adjudication.	Providers should review TMPPM to verify that the individual has Medicaid eligibility for the dates of service being billed, and that the provider is not billing across a break in eligibility. This error can also occur when an incorrect combination of service code and service group being billed is present.
Edit 6005	Provider information does not match the master provider file	Provider information does not match or inactive with TMHP	**Deny/reject** – Provider will need to contact the state to validate enrollment is up to date. Provider should validate they are billing exactly as their state enrollment. **Example 1:** If 568 PCHP Parkway suite 1 is in TMHP PEMS, and 568 PCHP Pkwy Ste 1 is billed on claim form, the claim will deny; the format be identical to your enrollment with TMHP. If claims have been rejected the provider will need to submit corrected claim with the correct information. **Example 2:** If the providers license is expired with TMHP, then the provider will not match on the provider file and claims will deny/reject. Once provider has verified that all information is updated/corrected with TMHP, provider should resubmit claims.

Questions? Contact

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