OPTUM® | Maryland

Claim Denials and Rejections Quick Reference Guide

This Quick Reference Guide details the most common reasons for claims denials that providers may encounter and offers guidance and useful tips on how to successfully submit claims and avoid denials.

1. Denial code 94: The claim is a duplicate of a previously submitted paid claim
    - Providers should first verify the status of the original paid claim through the Incedo Provider Portal (IPP). If a correction to the original paid claim is needed, complete and submit a corrected claim.
    - When submitting a correction to a previously paid CMS-1500 claim, the provider must clearly mark the claim as “corrected” and use the appropriate resubmission code.
    - When submitting a correction to a previously paid UB-04 claim, the provider must use bill type ending in “7”.
2. Denial Code 79: Payment is denied when billed with this provider type
    - This denial will be encountered if the provider is not eligible to render the service, based on their provider type. For example, a SUD Program submitting a claim for mental health services.
    - The provider should make sure the primary diagnosis given on the authorization request matches the primary diagnosis given on the claim.
    - The provider should confirm that their licensure is current and up-to-date through the Medicaid ePREP Portal.
    - The provider should confirm they are eligible for reimbursement for services based on their provider type. Click here to view fee schedules.

3. Denial Code 93: Invalid Level of Care, Modifier or Place of Service combination

    - Place of service (POS) 02 is not a valid POS for Maryland providers to use. Submit with the appropriate POS as if the service were performed in person.

    - The GO, GQ and 95 modifiers are ineligible telehealth modifiers. Maryland Medicaid uses Modifier GT to indicate that the service provided was rendered through telehealth by a provider who is permitted to deliver services via telehealth (COMAR 10.09.49).

    - The UB modifier, which has expanded permission for use during the State of Emergency, indicates the service was rendered through telephone only. This is an "and/or condition" and both modifiers may **not** be billed with the same procedure Code.

    - The provider should verify place of service is appropriate for services rendered. For example, a provider cannot bill an office visit procedure code for inpatient hospital setting (21).

4. Denial Code 16: The service performed is not a covered benefit

    - The provider should verify that the service is covered for the eligibility span attached to the participant (e.g., PRP services are not payable for participants who are receiving Long Term Care (LTC) and have an open LTC eligibility span).

    - Occurs when the provider bills services that are not payable by the Public Behavioral Health System (PBHS).

5. Denial Code 170: Claim detail lines cannot span dates.

    - CMS-1500 claims "from" and "through" dates must be the same day. Each date should be billed on a separate line.

    - Outpatient UB-04 Statement Covers "from" and "through" field should reflect the same date. Line level date must also match statement cover date. Only one date of service is allowed per claim.

The following methods can be used by providers to resubmit a claim:

- Via 837 form
- Via the IPP
- By paper claim

A full list of claims denials reasons, with descriptions and reason codes can be found here.

Incorrect Billing Trends

- Providers must bill the correct provider type. For example, a provider cannot bill 90834 under the PRP NPI.
- RESRB may only be billed with PT54 and ***not*** with PT50. This is the Room and Board portion of an adult *residential* Substance use disorder stay which occurs by a PT54.

Other Reminders

- Rendering providers that have a Primary Specialty type that is non-Behavioral Health, such as Pediatrics, need to confirm they are credentialed correctly in ePREP in order to render Behavioral Health services.
- Providers who bill for child and adolescent services must bill using the UA modifier to be paid the correct child and adolescent rate. For details, click here for an explanatory Provider Alert.
- Group Practices: In order to be able to bill the PBHS, group practices must be either a physicians' group (Provider Type 20), which can only consist of physicians (MDs) or a Mental Health Group Practice (Provider Type 27). A Mental Health Group Practice can encompass individual provider types physicians, psychologists, nurse practitioners, (with or without a PMH Certification), physician assistants, social workers and professional counselors; individually licensed professionals who are eligible to directly bill for services as individual providers (excluding interns, and LG/LM level license). Please confirm you are credentialed with an active license and enrolled as an active provider through the Medicaid ePREP Portal. If you need assistance to change your practice from a PT 15, 23, 94, CC etc. group practice to a PT 27 group practice, you may contact: mdh.bhenrollment@maryland.gov