

Hints and Tips

Provider Type- Social Service Medical
Category- Billing

This document defines several common remittance advice (RA) reason and remark codes. ProviderOne assigns the codes when the amount billed is less than the amount paid. You will need to understand the codes to understand payment, payment adjustments and/or rebilling. The codes also help ProviderOne staff to research and answer claims questions.

Adjustment Reasons

RA adjustment reason/remark code/Description	Possible causes	Provider action
142- Monthly Medicaid patient liability amount.	Client responsibility (participation) applied to the claim	You will collect this amount from the client
198- Precertification/authorization exceeded	Social Service Authorization Approved Units have been previously claimed	Contact your case worker if you question the number of units authorized

Denial Reasons

RA adjustment reason/remark code/Description	Possible causes	Provider action
16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication	<ol style="list-style-type: none"> 1. Claims dates of service are not within the social service authorization period 2. The social service authorization line is in error 	<ol style="list-style-type: none"> 1. Contact your case worker if you have questions about the authorization dates 2. Contact your case worker if you have questions about authorization errors
18- Exact duplicate claim/service	<ol style="list-style-type: none"> 1. Claimed units on two different lines for the same day, or 2. Claim is an exact duplicate 	<ol style="list-style-type: none"> 1. Adjust the claim and report the number of units on a single claim line 2. No action is needed if duplication was unintended.
146- Invalid Use of DX per IC9-CM	Diagnosis code is not used for billing in ProviderOne	Visit CMS website: http://www.cms.gov/medicare-coverage-database/staticpages/icd-9-code-lookup.aspx to
204-This service/equipment/drug is not covered under the patient's current benefit plan	<ol style="list-style-type: none"> 1. Social Service Authorization number and/or modifier is missing or 2. Authorization is not missing but Medicaid may cover this service and is the first payer 	<ol style="list-style-type: none"> 1. Add the social service authorization number and/or modifier or 2. Correct the claim to include requirements for straight medical Medicaid claims and resubmit
B7-This provider was not certified/eligible to be paid for this procedure/service on this date of service	Your contract may be expired.	Contact your contract manager or case worker if you have questions
N54- Claim information is inconsistent with pre-certified/authorized services	Social services authorization is in cancelled status	View the authorization list page and contact your case worker if you have questions
N63-Rebill services on separate claim lines	A separate claim line is required for each date of service for the service/procedure code entered	If you are billing quarter hour units or for each unit types, do not use a date span (example: 1/1/2015 to 1/31/2015) to bill. Adjust the claim to reflect separate claim lines for the date of service for each service provided and resubmit claim
N329- Missing/incomplete/invalid patient birth date	<ol style="list-style-type: none"> 1. Client date of birth (DOB) Mismatch 2. Missing/incomplete/invalid patient birth date 	<ol style="list-style-type: none"> 1. Correct DOB and resubmit the claim 2. Add/correct DOB and resubmit claim.
N362 : The number of Days or Units of Service exceeds our acceptable maximum	Example: Provider billed two units on monthly units or provider billed two units on daily units with one day date span	Change the number of units to the correct amount and resubmit your claim