

Ancillary Claims Top Closed or Denial Reasons

Reason	When Used	Tips to Decrease Denials or Closed Claims
603 - COB Verification Required From Member	This denial is used when we have a new member that has dependent coverage and Medica has sent out a letter inquiring on the medical coverage for their dependents and Medica has received no response. This letter is sent out when a member newly enrolls and once a year thereafter.	<ul style="list-style-type: none"> • Provider may bill member for services based on the information provided in the closed claim letter. • If member calls in to provider regarding being billed for services provider should encourage member to contact Medica Customer Service regarding the survey letter they received about coverage information.
075 - Send Medicare Summary Notice	This denial is used when the Medicare member has Medicare as primary and we haven't received the Medicare payment information from the provider. This denial is frequently used with our Prime Solution product (non-par & facility claims) and our Select Solution product for all claims.	<ul style="list-style-type: none"> • Ask member routinely if they have other coverage. • Submit claim with Medicare EOMB. • Medica will not pay claim as prime because our system shows that the member has other coverage
047- Send Primary Carrier's EOMB	This denial would be used when the Medica member has other insurance (not Medicare) and we haven't received the payment information from that other carrier.	<ul style="list-style-type: none"> • Ask member routinely if they have other coverage • Submit claim with primary carrier's EOB. • Medica will not pay claim as prime because our system shows that the member has other coverage
499 – Submit claim to Chiro Care	This denial is used when claim(s) should be submitted directly to ChiroCare.	<ul style="list-style-type: none"> • Claims submitted for Chiropractic services should be sent directly to ChiroCare.
850 – Forward to pharmacy network	This denial is used when claim should be submitted directly to pharmacy administrator	<ul style="list-style-type: none"> • Please submit claim(s) directly to MedImpact (pharmacy administrator).
070 - Auto Insurance Liability	This denial is used when our records indicate that services rendered may have been a result of an auto insurance incident. These expenses should be billed to the auto insurance carrier.	<ul style="list-style-type: none"> • Ask member routinely if accident situation was auto related. • Submit claim with Auto Insurance EOB, if known • Medica will not pay as primary because our system shows that the services should be billed through the auto carrier.

049 Worker's Compensation Liability	Worker's Compensation Liability - A work related injury or illness is not covered under the member's medical plan. These expenses should be sent to the member's workers' compensation.	<ul style="list-style-type: none"> • Ask member routinely if accident situation was work related • Submit claim with Workers Compensation EOB, if known • Medica will not pay as primary because our system shows that the services should be a Worker's compensation liability
284 – Claim previously paid to provider	This denial code would be used when the charge is a duplicate charge and the first charge received has already gone out to the provider in payment.	<ul style="list-style-type: none"> • Check cash posting status within billing office • Check incoming mail • Do not resubmit claims without checking status first with Provider Call Center or through on-line service.
380 – Duplicate original claim pending	This denial will edit on claims where there is another entry of the same claim data and that claim is perhaps pending on reviews, so it is not ready to be released for payment yet, but it is being worked. The duplicate claim will deny so that we don't end up paying on two identical charges.	<ul style="list-style-type: none"> • Do not resubmit claims without checking status first with Provider Call Center or through on-line service
680 – Send Primary & Secondary EOB	This denial is used when a member has 2 other carriers listed as their primary and secondary insurance. Medica would then be their third and in order to process claims we would need the EOB from both carriers.	<ul style="list-style-type: none"> • Ask member routinely if they have other coverage • Submit claim with primary and secondary carrier's EOB • Medica will not pay claim as primary because our system shows that the member has coverage with 2 other carriers
407 – Claim Pending Receipt of Pre-Ex Info	This closed code is used when we have a new member that has a pre-existing condition hold and Medica has not received a response from the member regarding providers previously seen.	<ul style="list-style-type: none"> • Provider may bill member for services based on the information provided in the closed claim letter • If member calls in to provider regarding being billed for services, provider should encourage member to contact Medica Customer Service regarding the closed claims and the pre-existing condition hold
300 – Submit active procedure code for date of service	This closed code is used when the procedure code billed is no longer effective.	<ul style="list-style-type: none"> • Resubmit the claim with the active procedure code for the date of service being billed

220 – Invalid procedure code for date of service	This closed code is used when the procedure code billed is not valid.	<ul style="list-style-type: none"> • Resubmit the claim with the active procedure code for the date of service being billed
219 – Invalid diagnosis code for date of service	This closed code is used when the diagnosis code billed is not valid	<ul style="list-style-type: none"> • Resubmit the claim with the active diagnosis code for the date of service being billed

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