

**Physician Claims Top Denial or Closed Code Reasons**

Denial/Closed Code/Reason	When Denial or Closed Code is Used	Tips to Decrease or Follow-up Denials or Closed Claims
603 – COB verification required from the 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"> <li>• Provider may bill member for services based on the information provided in the closed claim letter</li> <li>• Proactively call the member when receiving the denial, reminding members to contact their Health plan</li> <li>• 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</li> <li>• Provider is unable to update the member COB record</li> </ul>
047 – Send primary carrier’s EOB	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"> <li>• Ask member routinely if they have other coverage</li> <li>• Submit claim with primary carriers EOB</li> <li>• Medica will not pay claim as prime because our system shows that the member has other coverage</li> </ul>
075 – Send Medicare EOMB	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"> <li>• Ask member routinely if they have other coverage</li> <li>• Submit claim with Medicare EOMB</li> <li>• Medica will not pay claim as prime because our system shows that the member has other coverage</li> </ul>
680 – Send Primary And Secondary Carrier’s 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"> <li>• Ask member routinely if they have other coverage</li> <li>• Submit claim with primary and secondary carrier’s EOB</li> <li>• Medica will not pay claim as primary because our system shows that the member has coverage with 2 other carriers</li> </ul>
049 – Workers 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"> <li>• Ask member routinely if accident situation was work related</li> <li>• Submit claim with Workers Compensation EOB, if known</li> <li>• Medica will not pay as primary because our system shows that the services should be a Worker’s compensation liability</li> </ul>

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"> <li>• Ask member routinely if accident situation was auto related.</li> <li>• Submit claim with Auto Insurance EOB, if known</li> <li>• Medica will not pay as primary because our system shows that the services should be billed through the auto carrier</li> </ul>
270 – URN Transplant Contractual Agreement	This denial is used when Medica receives a claim and the claim is part of the URN transplant contractual agreement.	<ul style="list-style-type: none"> <li>• Majority of URN denials are due to Medica requiring URN to submit claims to Medica for tracking the services</li> </ul>
024 – Referral Required	This denial is used when services are rendered that require a referral but no referral has been entered or received for the member and their services.	<ul style="list-style-type: none"> <li>• Check referral guidelines on <a href="http://www.Medica.com">www.Medica.com</a></li> <li>• If referral is necessary, obtain referral before services are rendered</li> </ul>
276 – Required Info Not Received From Member	This denial is used when required information requested has not been received from the member. Generally used to flag pre-existing conditions.	<ul style="list-style-type: none"> <li>• Check eligibility to determine if pre-ex condition exists</li> <li>• Member liability till the information that is requested from the member is received and claim can be reprocessed</li> </ul>
016 – Group Termed – Bill Member	This denial is used when a group has termed and the member no longer has active coverage with Medica.	<ul style="list-style-type: none"> <li>• Routinely ask member if their insurance has changed to make sure that you have their current coverage information listed</li> <li>• Self-Insured groups have a 6 months run out period after term date</li> </ul>
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"> <li>• Provider may bill member for services based on the information provided in the closed claim letter</li> <li>• 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</li> </ul>
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"> <li>• Resubmit the claim with the active procedure code for the date of service being billed</li> </ul>
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"> <li>• Resubmit the claim with the active procedure code for the date of service being billed</li> </ul>
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"> <li>• Resubmit the claim with the active diagnosis code for the date of service being billed</li> </ul>