

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

Reason	When Used	Tips to Decrease Denials or Closed Claims
603 - COB Verification Required From Member	This code is used when we have a new Commercial member that has dependent coverage or the member's COB record hasn't been updated in a year. Medica has sent out a letter inquiring on other medical coverage for their dependents and Medica has not received a 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 on the PRA.</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>
75 - Send Medicare EOMB	This denial is used when the member has Medicare as primary and we haven't received the Medicare payment information from the provider. This denial is frequently used on claims from non-participating providers and facility claims for our Prime Solution and Select Solution members.	<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>
47 - Send Primary Carrier's EOB	This denial is used when the Medica member has other insurance (not Medicare) and we haven't received the payment information from the other carrier.	<ul style="list-style-type: none"> <li>• Ask member routinely if they have other coverage</li> <li>• Medica will not pay claim as prime because our system shows that the member has other coverage.</li> <li>• Submit claim with primary carrier's EOB.</li> </ul>
680 – Send Primary & Secondary Carriers EOB	Medica has information that a member has other primary and secondary insurance.	<ul style="list-style-type: none"> <li>• Send in claims with other carriers EOB(s).</li> <li>• Encourage member to contact Medica to update or correct COB information.</li> </ul>
070 – Auto Insurance Liability	Diagnosis and/or procedure code on bill indicates auto accident.	<ul style="list-style-type: none"> <li>• Send in claim with the following information: Auto Insurance EOB or denial letter from auto insurance carrier.</li> </ul>
270 – URN Transplant Contractual	Member is enrolled in URN (United Resource Network) transplant program. All associated claims should be sent to URN for processing.	<ul style="list-style-type: none"> <li>• There are 5 phases to a transplant package. Phases 1, 3 &amp; 4 are included in the URN global package. Phases 2 &amp; 5 are services that are billable to the</li> </ul>

Agreement		<p>Healthplan.</p> <ul style="list-style-type: none"> <li>To determine when to bill to URN or to the Healthplan the provider should first work with their transplant coordinator or contact Medica's Provider Service Center at 952-992-2232.</li> </ul>
382 – Notification Required	This denial is used on claims when Medica has not received the required Certificate of Need form.	<ul style="list-style-type: none"> <li>Fill out the forms completely and legibly</li> <li>Forms must be sent in prior to or within 30-days of the first ride date.</li> <li>Incomplete forms will be returned to the provider.</li> </ul>
049 - Worker's Compensation Liability	Diagnosis and/or procedure code on bill indicates work- related injury.	<ul style="list-style-type: none"> <li>Bill Worker's Compensation prior to billing Medica.</li> <li>If the claim is paid or denied by Worker's Compensation send in claim with the following information: Worker's Comp EOB or denial letter from Worker's Comp.</li> </ul>
381 – Reviewed Time Limit Denial Upheld	This denial is used on claims when the supporting documentation does not support overturning the timely filing denial.	<ul style="list-style-type: none"> <li>Clarify account notes (practice management system notes) or codes by handwriting explanation in margin. Please do not 'highlight' notes.</li> </ul>
289 - Claim Filed After Time Limit	This denial is used on claims that are received beyond the 180-day filing limit. Medica requires claims from participating providers be received within 180 days from the date of service.	<ul style="list-style-type: none"> <li>Use on-line tools or contact the Provider Service Center to check status of claims in our system</li> <li>Regularly work claim send back letters and other correspondence from the HealthPlan</li> <li>Turn member over to collections prior to 180-days if member is not supplying insurance information.</li> <li>If claim is denied for timely filing supply supporting documentation (practice management notes) to show follow-up being done on claim. Submit documentation with a late claim form.</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>