

Top Fee-for-Service (FFS) Billing Errors and Resolutions

The Department of Human Services (DHS) processes claims for health-care-related services through a computerized system known as the Medicaid Management Information System (MMIS). The purpose of MMIS is to ensure accurate payment of claims within authorized amounts for covered services.

MMIS searches daily for the presence and validity of data. Claims that fail edits are either automatically denied or suspended to a DHS staff person who checks various items of information on the claim. When staff determines that the claim cannot be paid due to missing or invalid data, they deny the claim.

DHS produces for the provider either a paper or electronic Remittance Advice (RA) listing all claims paid, denied, and/or adjusted (with payment if appropriate). Paper RAs also list suspended claims. An explanation of benefits (EOB) appears on the RA with text that explains the resolution to a claim for your review and appropriate action.

Some EOBs are informational only and do not affect payment; others require provider action for resolution. By reading the explanation and following the instructions listed in the EOB, you will be able to correct the error in a timely manner. The following list indicates a few common fee-for-service billing EOBs with their resolutions, if action needs to be taken.

Reminders

- Read your provider-specific rulebooks and supplemental information. Make sure you have the most current information that is in effect for the date of service being billed.
- Verify patient eligibility on the date the service is provided.
- For electronic claims, include your National Provider Identifier (NPI) and taxonomy.
- For paper claims, use commercially available “red forms” (not black and white copies). Include the DHS provider ID.
- Read the explanation of benefit codes on your Remittance Advice. They will tell you what the error is. Descriptions of all EOBs are listed on the last page of your RA (“EOB Descriptions”).
- Contact DMAP Provider Services at 800-336-6016 or dmap.providerservices@state.or.us for assistance regarding any billing and remittance advice questions you may have.

Top FFS Billing Errors – Non-Pharmacy Claims

EOB	EOB Description	HIPAA ARC	HIPAA Remarks	NCPDP Response Code	NCPDP Response Text	Error Code	Error Description	What this Means	What Providers Can Do
0090	SERVICE IS COVERED BY A MANAGED CARE PLAN. CLAIM MUST BE BILLED TO THE APPROPRIATE MANAGED CARE PLAN.	24	N/A		Product/ Service Not Covered	2017	RECIPIENT SERVICES COVERED BY HMO PLAN	The service is covered by the recipient's managed care plan.	<p>The edit sets when a FFS provider submits a FFS claim for a recipient whose managed care assignment plan covers the services.</p> <p>The FFS provider should verify the recipient's eligibility on the web portal which will return the managed care information, or contact Provider Services.</p>
0028	RECIPIENTS NAME AND NUMBER DISAGREE AND DMAP CANNOT RESOLVE. CORRECT AND RESUBMIT BILLING.	140	N/A	CB	M/I Patient Last Name	513	RECIPIENT NAME AND NUMBER DISAGREE	The recipient's first and/or last name on their current or historical eligibility record does not match the recipient's first and/or last name submitted on the claim.	<p>Verify that the recipient's name is correctly keyed on the claim, if not, correct it and resubmit the claim.</p> <p>If the correct name is already on the claim, contact Provider Services.</p>
0091	NON-COVERED SERVICE.	204	N30	N/A	N/A	4070	Modifier Restriction for Procedure code	This procedure-modifier combination is not covered.	<p>Verify that the procedure-modifier combination billed on the claim is valid. If not, correct it and resubmit the claim.</p> <p>If the correct procedure and modifier is already on the claim, contact Provider Services.</p>

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0091	NON-COVERED SERVICE.	204	N30	N/A	N/A	4021	COVERAGE/ RULE NOT FOUND FOR THE PROCEDURE/ BP	The procedure is not covered for the recipient's benefit plan for that date of service.	Verify that the data is correct on the claim and if not, correct and resubmit the claim. Provider can contact Provider Services if they feel the claim denied in error.
0015	SERVICE IS A DUPLICATE OF A SERVICE PREVIOUSLY PROCESSED/PAID.	18	N/A	83	Duplicate Paid/ Captured Claim	5001	EXACT DUPLICATE	The submitted claim exactly matches a previous claim in history.	Verify that the data is correct on the claim and if not, correct and resubmit the claim.
2599	SUSPEND FOR PAYMENT REVIEW	133	N/A	N/A	N/A	3319	SUSPEND PAYMENT FOR REVIEW	All paper claims are subject for payment review.	There is no action the provider needs to take. The claim will be released after review by a DHS Claims Analyst.
0252	RECIPIENT NAME IS MISSING. COMPLETE AND RESUBMIT.	31	N/A	CB	M/I Patient Last Name	238	RECIPIENT NAME IS MISSING	This posts if the recipient's first or last name or missing or contains spaces.	Verify that the correct recipient name is on the claim; if not, correct it and resubmit the claim.
1042	CLAIM HAS THIRD-PARTY PAYMENT	22	N/A	4C	M/I Coordination Of Benefits/ Other Payments Count	576	CLAIM HAS THIRD-PARTY PAYMENT	The recipient has third-party eligibility for this DOS but no payment or valid third party reason code was submitted on the claim.	Either a third party payment must be submitted with the claim, or a valid HIPAA ARC (for non-paper) or valid TPR code (for paper claims) must be submitted.

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1022	PROCEDURE REQUIRES PRIOR AUTHORIZATION	15	N/A	N/A	N/A	3003	PROCEDURE CODE REQUIRES PA	A prior authorization is required for the billed procedure code.	Verify that a PA has been submitted and approved for this procedure before resubmitting the claim.
0003	OUR RECORDS SHOW RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE.	31	N30	68	Filled After Coverage Expired	2002	RECIPIENT NOT ELIGIBLE FOR HEADER DATE OF SERVICE	The recipient does not have benefit plan eligibility for the date of service billed on the claim header.	Verify that the data is correct on the claim and if not, correct and resubmit the claim.
9013	PROVIDER AND SUBMITTER MISMATCHED	95	N/A	N/A	N/A	1804	PROVIDER and SUBMITTER MISMATCHED	The Provider and Submitter billing relationship is not in the EDI record.	This edit is informational only and does not affect claim payment. EDI Support Services will contact you if action is required.
1805	PROVIDER IS NOT ELIGIBLE FOR ELECTRONIC SUBMISSION	95	N/A	N/A	N/A	1805	PROVIDER IS NOT ELIGIBLE FOR ELECTRONIC SUBMISSION	For Medicare crossover claims, there is no EDI record indicating a relationship between Medicare and the provider.	This edit is informational only and does not affect claim payment. EDI Support Services will contact you if action is required.

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0044	CLAIM FORM INCONSISTENT WITH PROVIDER TYPE. RESUBMIT ON CORRECT CLAIM FORM.	170	N34	N/A	N/A	1038	PERFORMING PROV TYPE/ CLAIM TYPE MISMATCH	The performing provider type is not allowed to be submitted with the claim type.	<p>If a billing provider (type 9) is being used to submit the claim, make sure that the actual provider who is performing the service is entered on the claim detail.</p> <p>If you have determined all details on your claim are accurate, contact Provider Enrollment at 800-422-5047 or provider.enrollment@state.or.us.</p>

Top FFS Billing Errors – Pharmacy Claims

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0090	SERVICE IS COVERED BY A MANAGED CARE PLAN. CLAIM MUST BE BILLED TO THE APPROPRIATE MANAGED CARE PLAN.	24	N/A		Product/ Service Not Covered	2017	RECIPIENT SERVICES COVERED BY HMO PLAN	The service is covered by the recipient's managed care plan.	The edit sets when a FFS provider submits a FFS claim for a recipient whose managed care assignment plan covers the services. The FFS provider should verify the recipient's eligibility on the web portal which will return the managed care information, or contact Provider Services.
	CLAIM GENERATED AN INFORMATIONAL PRODUR ALERT	133	N/A	N/A	N/A	7001	INFORMATIONAL PRODUR ALERT	A ProDur alert has been posted that is informational in nature.	The provider should review the ProDUR alert set on the claim for additional information. There is no other action required.
0091	NON-COVERED SERVICE.	204	N30	70	Product/ Service Not Covered	4002	Non-Covered Drug	The pharmacist should verify that the NDC submitted is covered under the recipient's benefit plan for the date of service submitted.	If any part of the claim was submitted incorrectly, correct and resubmit. The pharmacist should contact the Pharmacy Call Center at 888-202-2126 if they feel the claim was denied in error.

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7002	DENIED FOR PRODUR REASONS. ENTER VALID INTERVENTION AND OVERRIDE CODES	133	N/A	N/A	N/A	7002	CLAIM DENIED FOR PRODUR REASONS	The response submitted (Conflict Code, Intervention and Outcome) caused the claim to deny, or the pharmacist could not override the conflict code.	This claim cannot be resubmitted.
1048	PRESCRIBING PROVIDER NOT ON FILE	208	N/A	25	M/I Prescriber ID	1026	PRESCRIBING PHYSICIAN ID NOT ON FILE	The prescribing physician's NPI was not entered in this field.	Look up the correct NPI at https://nppes.cms.hhs.gov or contact the prescriber for the NPI.
7000	CLAIM FAILED A PRODUR ALERT. ENTER VALID INTERVENTION AND OVERRIDE CODES	133	N/A	88	DUR Reject Error	7000	CLAIM FAILED A PRODUR ALERT	The claim has failed for a ProDUR alert.	Review the ProDUR alert codes set on the claim. Resubmit the claim with the appropriate Conflict Code, Intervention and Outcome.
0030	DAYS SUPPLY GREATER THAN MAX ALLOWED.	154	M53	76	Plan Limitations Exceeded	4165	DAYS SUPPLY MORE THAN ALLOWED FOR COVERED NDC	The quantity per day submitted on the claim is greater than the maximum quantity per day allowed.	Verify the correct quantity has been submitted on the claim. If the correct quantity has been submitted, please contact the Pharmacy Call Center .

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0154	THIS NATIONAL DRUG CODE NOT COVERED ON DATE DISPENSED.	211	M119	70	Product/ Service Not Covered	4891	Not covered drug class	Posts when the drug therapeutic class of the NDC is not covered for the recipient's benefit plan.	Verify that the NDC is correct on the claim and if not, correct and resubmit the claim. If the correct NDC has been submitted, please contact the Pharmacy Call Center.
1056	PRIOR AUTHORIZATION REQUIRED. CALL (888) 202-2126	15	M62	75	Prior Authorization Required	3002	NDC REQUIRES PA	A prior authorization is required for the billed NDC.	Verify that a PA has been submitted and approved for this NDC before resubmitting the claim.
0154	THIS NATIONAL DRUG CODE NOT COVERED ON DATE DISPENSED.	211	M119	70	Product/ Service Not Covered	4890	Non covered drug class	Posts when the drug class of the NDC (prescription versus over the counter) is not covered for the recipient's benefit plan.	Verify that the NDC is correct on the claim and if not, correct and resubmit the claim. If the correct NDC has been submitted, please contact the Pharmacy Call Center.
1100	NON-PARTICIPATING MANUFACTURER	211	N/A	70	Product/ Service Not Covered	1016	NON-PARTICIPATING MANUFACTURER	The claim was submitted for a manufacturer that is not participating in drug rebate for that date of service.	Verify that the NDC submitted is correct.