

Oregon MMIS EOB's for Nursing Facilities

EOB #	EOB Description on RA	ARC	ARC Description	Remark	Remark Description	What this means	Resolution
0015	Service is a duplicate of a service previously processed/paid.	18	Duplicate claim/ service.	N/A		The claim appears to be a duplicate claim of a previously processed claim.	If provider disagrees with the denial, follow the usual appeal process. <u>If you have submitted a claim that has suspended for any reason, do not resubmit the claim until it has been fully adjudicated (paid or denied).</u>
0016	Service appears to be a duplicate of a processed claim. It may also be that part of the month was paid and this claim is an overlap, resulting in the total billed exceeding the authorized amount (too many days).	198	Precertification/ authorization exceeded.	N/A		This EOB will <u>be returned</u> if there has already been a claim paid against the plan of care line item for this time period.	Provider should check to see if they have previously been paid for any dates on the claim. If so, claim should be corrected and resubmitted.
0028	Recipients name and number disagree and DMAP cannot resolve. Correct and resubmit billing.	140	Patient/ insured health identification number and name do not match.	N/A		The client name submitted on the claim does not match the client's name in the MMIS.	Verify what the client's name is in the MMIS, correct and resubmit. (Providers can see the exact format of a client's name by checking eligibility on the Web portal or viewing the client's ID card.) Also, may need to move the client name from 8a to 8b and resubmit the claim.
0032	Recipient number missing. Refer to the Medical Care Identification for valid recipient number. Then correct and resubmit.	31	Patient cannot be identified as our insured.	N/A		The claim does not contain a client ID number.	Insert the client ID number and resubmit.
0038	Our records do not show recipient certified for billed level of care.	150	Payer deems the information submitted does not support the level of service.	N/A		Element(s) of claim do not match with the POC/Recipient/Provider for the dates billed.	Check the POC and benefit package on the Web portal to make sure the claim was billed accurately. If everything looks correct, contact the field office and let them know that your claims are suspending for this reason. You may need to change the way you are billing or the POC may need to be created/updated. Once a claim suspends for this error, DO NOT resubmit unless the claim was billed inaccurately. This error is set to automatically recycle each night. So as POC's are set up each day, any suspended claims dependent on those POC's per edit 3102 will automatically recycle.

Version 1

EOB #	EOB Description on RA	ARC	ARC Description	Remark	Remark Description	What this means	Resolution
0052	Provider ineligible to perform this procedure or type of service.	185	The rendering provider is not eligible to perform the service billed.	N95	This provider type/provider specialty may not bill this service.	This EOB indicates that a revenue code was billed that your provider type is not allowed to bill.	Check claim to make sure appropriate revenue code was billed. Re-bill as appropriate.
0054	1st diagnosis code is missing or invalid. Refer to current ICD-9-CM code book for correct code. Resubmit or adjust as appropriate.	146	Diagnosis was invalid for the date(s) of service.			The primary diagnosis on the claim is missing or invalid.	Correct the primary diagnosis code and resubmit the claim. <u>The claim must have at least one diagnosis code that is a valid code in MMIS. To verify whether the code is valid in MMIS, you can search for the code on the Provider Web Portal, or call RN Hotline.</u>
0065	Over 31 days billed. Bill no more than one calendar month on an invoice.	B5	Coverage/ program guidelines were not met or were exceeded.	N74	Resubmit with multiple claims, each claim covering services provided in only one.	A LTC claim was billed for more than a calendar month.	Correct the number of days billed and/or the from and through dates so that it does not cover more than one calendar month and resubmit the claim.
0067	Total amount billed exceeds amount authorized. Contact approving authority.	198	Pre-certification/ authorization exceeded.	N/A		This EOB is returned there was already a claim paid against the plan of care line item for this time period.	Going forward (04/28/09), denials for this reason will indicate a similar claim has already been paid or the provider is billing for dates that overlap. The new EOB that will be returned is 0016.
0076	Claim past filing time limit. See General Rule 410-120-1300 for instructions.	29	The time limit for filing has expired.	MA119	Provider level adjustment for late claim filing.	The discharge date on a UB04 claim is more than 366 days before the ICN date.	These claims will not be processed by MMIS unless DHS claims staff enter them into the system manually. <u>All claims that are past the filing limit must be submitted to the following address:</u> <u>Division of Medical Assistance Programs</u> <u>P.O. Box 14954</u> <u>Salem, OR 97309</u>
0091	Non-covered service.	204	This service/ equipment/drug is not covered under the patient's current benefit plan.	N30	Patient ineligible for this service.	The revenue code on the claim is not covered for the benefit plan/provider program on the date of service. OR The MMIS attempts to pay a claim against each benefit plan that a client may have. This EOB may be returned when the system is cycling through other benefit plans.	If the revenue code was data entered or submitted incorrectly, re-bill. If the revenue code billed should be covered but denied, contact Provider Services. OR This EOB may not impact the status of your claim. Your claim should receive a pay/deny/suspend status based on other factors. Use other EOB's listed for this claim to determine the suspend or deny reasons. If you have questions, please contact Provider Services.

Version 1

EOB #	EOB Description on RA	ARC	ARC Description	Remark	Remark Description	What this means	Resolution
0145	The recipient number listed is not in our records.	31	Patient cannot be identified as our insured.	N30	Patient ineligible for this service.	The Prime ID# on the claim does not match any Client ID# in the MMIS.	Verify the client's Medicaid ID number (prime number), correct and resubmit. *When billing on paper, be sure the number is written clearly and in block letters. <u>If your information matches, it may be a data entry error. Contact your LTC Claims Analyst to resolve.</u>
0161	The sum of days billed does not equal reported period covered.	95	Plan procedures not followed.	N/A		The sum of units (days) billed on the claim for the accommodation day revenue code(s) is not equal to the covered days. OR The covered days from the claim exceeds the number of days represented by the covered period from and through dates minus the day of discharge.	Correct the days and/or units and resubmit. Note: The total number of units billed (FL 46 on the paper UB-04) should equal the total number of days in the statement covers period (FL 6 on the paper UB-04). * Workaround: Make sure you enter patient status code 30 for all claims. If the resident discharges or expires, do not include the day of discharge in the through date on the claim. The through date should always be the day before the day of discharge or expiration date (the last paid day). If you have questions, please contact LTC Claims Analyst.
0177	Thru date of service is missing/ invalid. Correct and resubmit or adjust as appropriate.	B5	Coverage/program guidelines were not met or were exceeded.	MA31	Missing/ incomplete/ invalid beginning and ending dates of the period billed.	Dates included on the claim are missing or invalid.	Add or correct the from and through dates of service for the indicated detail item and resubmit the claim.
0182	The detail dates of service are outside the range of header dates of service. Correct and resubmit.	110	Billing date predates service date.	MA31	Missing/ incomplete/ invalid beginning and ending dates of the period billed.	The dates of services indicated on the detail item are not within the dates of service indicated at the header	Verify the header and detail dates of services. Correct the invalid dates and resubmit the claim. <u>This is a shared EOB with Professional Claims so the information may seem confusing.</u>
0193	See restrictions in the revenue code section of your provider guide.	96	Non-covered charge(s).	N30	Patient ineligible for this service.	Revenue code was billed that is either invalid or not allowed for this provider type or claim type.	Check claim to make sure appropriate revenue code was billed. Re-bill as appropriate.
0244	Number of visits or units of service missing/invalid. Correct and resubmit or adjust as appropriate.	16	Claim/ service lacks information which is needed for adjudication.	M53	Missing/ incomplete/ invalid days or units of service.	The number of units on the claim is blank.	Insert the number of units in field 46 for the appropriate line item on the UB-04 claim form. Then resubmit the claim.

Version 1

EOB #	EOB Description on RA	ARC	ARC Description	Remark	Remark Description	What this means	Resolution
1043	Claim indicates recipient expired.	13	The date of death precedes the date of service.	N/A		The patient discharge status on the claim is 20 (expired).	No action needed by provider, this is an informational message only.
1114	Taxonomy code is invalid.	208	National Provider Identifier – not matched.	N/A		This EOB indicates that the taxonomy <u>submitted</u> is not valid.	Providers should check with Provider Services to determine if their NPI information is set up correctly. Electronic submitters should verify that NPI, taxonomy and zip code being submitted on their claims match the information attached to the desired NPI. Providers who bill on paper can avoid this EOB <u>by</u> including their Oregon provider number on the claim form.
1116	No pricing segment is on file.	133	The disposition of this claim/service is pending further review.	N/A		The dates of service on the claim span multiple benefit plan segment dates.	Look at the NFC benefit package. The system will break up the NFC benefit package based on changes to the " <u>parent</u> " benefit package.
1124	Cannot prioritize recipient's program.	31	Patient cannot be identified as our insured.	N/A		The beneficiary is not eligible for any benefit plans, or the beneficiary's benefit plan or benefit plan combination is not listed on the benefit plan hierarchy table.	No action needed on the part of the provider. DHS will review the suspended claim and take appropriate action. (<u>Please do not rebill suspended claims.</u>)
3138	Missing/Invalid Type of Bill	95	Plan procedures not followed.	N/A		The type of bill on the claim is missing or invalid.	Add or correct the type of bill code in field 4 of the UB-04 claim form. Then resubmit the claim.
3313	Diagnosis code missing/not on file.	146	Diagnosis was invalid for the date(s) of service reported.	N/A		This indicates that a diagnosis code is missing or invalid.	Add or correct the diagnosis code and resubmit the claim. Call RN Hotline for questions regarding diagnosis codes.
9013	Provider and Submitter mismatched	95	Plan procedures not followed.	N/A		This EOB indicates that the claims are coming in electronically and we do not have the submitter identified in our system as an authorized submitter for you. This in no way impacts claims processing.	Providers must complete a Trading Partner Agreement. The agreement and additional information is available on our web site at: http://www.oregon.gov/DHS/edi/reg_testing.shtml See EDI Packet. <u>Or call DHS EDI Support at 888.690.9888</u>
9911	Pricing adjustment - Long Term Care Pricing applied.	45	Charge exceeds fee schedule/ maximum allowable or contracted amount.			DMAP paid the claim using the long term care pricing methodology.	No action needed on the part of the provider. This is just an informational EOB regarding how the claim was priced.

Version 1

EOB #	EOB Description on RA	ARC	ARC Description	Remark	Remark Description	What this means	Resolution
9922	Spenddown deductible applied.	142	Monthly Medicaid patient liability amount.			This is typically a header EOB that indicates patient liability deductions have been applied to the claim.	No action needed on the part of the provider, this is just an informational EOB regarding how the claim was priced.
9926	Claim has cutback amount	45	Charge exceeds fee schedule/ maximum allowable or contracted amount.			DMAP did not pay the full billed amount.	No action needed on the part of the provider, this is just an informational EOB regarding how the claim was priced.
9998	Claim was priced in accordance with current health coverage program policies.	45	Charge exceeds fee schedule/ maximum allowable or contracted amount.			DHS utilizes this EOB when we manually process a claim or adjustment.	No action needed on the part of the provider, this is just an informational EOB regarding claims processing.