Indiana Medicaid Resolutions Manual

NAME: **2504 MBR CVRD BY PRIVATE INSURANCE (DTL)**

ERROR TYPE: Batch Edit, Hard Coded

HEADER/DETAIL: Detail

OVERRIDABLE: Y

ALLOW DENIAL: Y

DESCRIPTION:

Fail this edit if a member has private insurance on the TPL Resource File, there is no TPL amount on the claim, the services billed are applicable to the policy's type of coverage, the claim dates of service are within the policy effective dates, the coverage type has been Setup for TPL edit checking and no exceptions are met to bypass TPL edit checking, and there is no attachment.

CRITERIA:

If a claim is submitted and the member has private insurance on the TPL resource file, there is no ($0.00) TPL amount on the claim, the Resource Cost Avoidance Indicator = "Y" (yes), and the detail DOS falls within the policy dates (From DOS is less than or equal to policy termination date and Thru DOS is greater than or equal to the policy effective date), fail this edit with EOB 2504. See additional criteria below.

Physician (CMS 1500 Medical) Claims
Bypass edit 2504 for Private Insurance if one of the following is true:

Coverage type not valid for the member's private insurance on (T_Coverage_Xref) Coverage type other than B, C, F, I, K, Q (not on T_Cov_Claim_Xref) If primary diagnosis code is:

- Preventive Pediatric (diagnosis group 100011) for age 0-21. The diagnosis group types can be found in interChange MMIS/Main Menu/BPA/Related Data/Open Tab/Other/Diagnosis Group Type)
- EPSDT6 (diagnosis group 100007)

Global maternity procedure codes 59400, 59410, 59510, 59515, 59610, 59614, 59618 and 59622 bypass criteria:

- Members that have an active applicable TPL span coverage type A, B, Q or MS

- Claim contains an attachment a valid EOMB from Private Insurance indicating payment in part or full for the date of service

If procedure code is:

- On procedure list
- If the procedure code or group is excluded in the other insurance rules in CoreMMIS and the date of service falls within the effective and end dates.

If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the Policy Restriction Window for the Policy.

If the coverage type is "F" (Cancer), if the diagnosis code is not part of diagnosis group 100045
If the coverage code is "I" (Optical), billing provider is neither 18(Optometrist) nor 19 (Optician), and the specialty is not 330 (Ophthalmologist)
If the coverage type is "I" (Optical), billing provider is neither 18 (Optometrist) nor 19 (Optician), specialty is 330 (Ophthalmologist), but the procedure code does not fall within any of the following ranges:
92009-92499 V2020-V2799
If the coverage type is "K" (Mental Health), if the diagnosis code is not part of diagnosis group 100046 and billing provider type is not 11 (Mental Health) and the specialty is not 339 (Psychiatrist).
If the coverage type is "B" (Medical) and billing provider type is 07 (Capitation), 14 (Podiatrist), 18 (Optometrist), 19 (Optician) or 26 (Transportation).
If the coverage type is "C" (Major Medical) and billing provider type is 07 (Capitation), 18 (Optometrist), or 19 (Optician), or billing provider specialty is 262 (Bus), 263 (Taxi), 264 (Common Carrier-Ambulatory), 265 (Common Carrier-Non Ambulatory), or 266 (Family Member).
If the coverage type is "Q" (Combination: Hospital, Medical, Major Medical) and the billing type is 07 (Capitation), 14 (Podiatrist), 18 (Optometrist), 19 (Optician), or 26 (Transportation).

Dental Claims
Bypass edit 2504 for Private Insurance if one of the following is true:
If coverage type is other than D (Dental)
If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the Policy Restriction Window for the policy.

Long Term Claims
Bypass edit 2504 for Private Insurance if one of the following is true:
If coverage type is other than G (LCARE)
If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the Policy Restriction Window for the policy.

Home Health Claims
Bypass edit 2504 for Private Insurance if one of the following conditions is true:
If coverage type is other than H (Home Health)

If primary diagnosis code is:

- Preventive Pediatric (diagnosis group 100011) for age 0-21 The diagnosis group types can be found in interChange MMIS/Main Menu/BPA/Related Data/Open Tab/Other/Diagnosis Group Type)
- EPSDT (diagnosis group 100007)

If procedure code is:

- On procedure list in the procedure rules and the date of service falls within the effective and end dates of the procedure group

If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the Policy Restriction Window for the policy.

Outpatient claims
Bypass edit 2504 for Private Insurance if one of the following conditions is true:
If primary diagnosis code is: Preventive Pediatric (diagnosis group 100011) for age 0-21 (Reference/Table Maintenance/System Code Tables/Diagnosis Type) If procedure code is:

- On procedure list in the procedure rules and the date of service falls within the effective and end dates of the procedure group If provider number is:
    - State psychiatric hospital:
        - 100273120 Evansville Psych. Children's Center
        - 100272090 Evansville State Hospital - LTC
        - 100273500 Evansville State Hospital
        - 100273300 Richmond State Hospital & Psych
        - 100273130 Neurodiagnostics Center
        - 100273320 Madison State Hospital
        - 100272180 Madison State Hospital - ICF/MR
        - 100273150 Logansport State Hospital - ICF/MR
        - 200042130 Logansport State Hospital

If any data on the claim (diagnosis code, billing provider type or specialty) on the date of service, coincide with TPL restrictions on the Policy Restriction Window for the policy.

If the coverage type is F (Cancer), but the diagnosis code is in diagnosis group 100045

If the coverage type is K (Mental Health), but the diagnosis code is in diagnosis group 100046. If the coverage type is C (Major Medical) and the billing provider type is 07 (Capitation), 18 (Optometrist), 19 (Optician), or provider specialty is 262 (Bus), 263 (Taxi), 264 (Common Carrier - Ambulatory), 265 (Common Carrier - Non-ambulatory), or 266 (Family member).

DISPOSITION:

Note: EOB 9999 with a Do Not Post status is for internal system use only. This EOB is used to avoid potential system processing abends. This EOB is not posted on the RA and the disposition may be ignored.

Claim Type: 0 - All Claim Types **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
02	00	2505	DENY
02	11	2505	SUSPEND
02	21	2505	SUSPEND
02	23	2505	SUSPEND
02	30	2505	PAY
02	32	2505	PAY
02	33	2505	PAY
02	34	2505	PAY
02	50	2505	PAY
02	51	2505	PAY
02	52	2505	PAY
02	55	2505	PAY
02	61	2505	SUSPEND
02	64	2505	PAY
02	70	2505	PAY
02	72	2505	PAY
02	73	2505	PAY
02	74	2505	PAY
02	80	2505	SUSPEND
02	91	2505	SUSPEND

Claim Type: A - Inpatient Xover Claims **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
02	00	2505	DENY
02	11	2505	SUSPEND
02	21	2505	SUSPEND
02	23	2505	SUSPEND
02	30	2505	PAY
02	32	2505	PAY
02	33	2505	PAY
02	34	2505	PAY
02	50	2505	PAY

02	51	2505	PAY
02	52	2505	PAY
02	55	2505	PAY
02	61	2505	SUSPEND
02	64	2505	PAY
02	70	2505	PAY
02	72	2505	PAY
02	73	2505	PAY
02	74	2505	PAY
02	91	2505	SUSPEND

Claim Type: B - Professional Xover Claims **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
02	00	2505	DENY
02	11	2505	SUSPEND
02	21	2505	SUSPEND
02	23	2505	SUSPEND
02	30	2505	PAY
02	32	2505	PAY
02	33	2505	PAY
02	34	2505	PAY
02	50	2505	PAY
02	51	2505	PAY
02	52	2505	PAY
02	55	2505	PAY
02	61	2505	SUSPEND
02	64	2505	PAY
02	70	2505	PAY
02	72	2505	PAY
02	73	2505	PAY
02	74	2505	PAY
02	91	2505	SUSPEND

Claim Type: C - Outpatient Xover Claims **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
02	00	2505	DENY
02	11	2505	SUSPEND
02	21	2505	SUSPEND
02	23	2505	SUSPEND
02	30	2505	PAY
02	32	2505	PAY
02	33	2505	PAY
02	50	2505	PAY

02	51	2505	PAY
02	52	2505	PAY
02	55	2505	PAY
02	61	2505	SUSPEND
02	64	2505	PAY
02	70	2505	PAY
02	72	2505	PAY
02	73	2505	PAY
02	74	2505	PAY
02	91	2505	SUSPEND

Claim Type: L - Long Term Care Claims **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
02	00	2505	DENY
02	11	2505	SUSPEND
02	21	2505	SUSPEND
02	23	2505	SUSPEND
02	30	2505	PAY
02	32	2505	PAY
02	33	2505	PAY
02	34	2505	PAY
02	50	2505	PAY
02	51	2505	PAY
02	52	2505	PAY
02	55	2505	PAY
02	61	2505	SUSPEND
02	64	2505	PAY
02	70	2505	PAY
02	72	2505	PAY
02	73	2505	PAY
02	74	2505	PAY
02	91	2505	SUSPEND

Claim Type: M - Professional Claims **Member Plan:** MRT **Status:** Do Not Post

Location	Region	EOB	Disposition
02	00	2505	PAY

Claim Type: M - Professional Claims **Member Plan:** PASMR **Status:** Do Not Post

Location	Region	EOB	Disposition
02	00	2505	PAY

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Claim Type: M - Professional Claims **Member Plan:** PASMI **Status:** Do Not Post

Location	Region	EOB	Disposition
02	00	2505	PAY

EOB: 2505 - THIS MEMBER IS COVERED BY PRIVATE INSURANCE WHICH MUST BE BILLED PRIOR TO MEDICAID.

ARC Code	ARC Description	Effective Date	End Date
22	This care may be covered by another payer per coordination of benefits.	19950101	22991231

Remark Code	Remark Description	Effective Date	End Date
N245	Incomplete/invalid plan information for other insurance .	20040801	22991231

METHOD OF CORRECTION:

Incontinence Vendors. The list of supplies applicable to this edit are found in the billing rules for the Incontinence (INCON) and Incontinence Provider (INCPR) Contracts in the Business Rules Editor of CoreMMIS. All T codes in the contract rules and A4363 are also in the OI (Other Insurance) rules. Therefore, the following methods of correction will apply.

- **Non-contracted Provider:** Edit 2504 - Member Covered by Private Insurance -. When a claim suspends for edit 2504 - Member Covered by Private Insurance and the provider is a non-contracted provider, force claim to pay for edit 2504 when the "method of correction" indicates payment. Claim will pay details per HCPC procedure code pricing methodology. The claim will bypass edit 4168 and the claim will not deny.
- **Contracted Provider:** Edit 2504 - Member Covered by Private Insurance - When a claim suspends for edit 2504 - Member Covered by Private Insurance and the provider is a contracted provider, force claim to pay for edit 2504 when the "method of correction" indicates payment. Claim will pay details per the contracted rates and TPL amount will be deducted from the allowed amount. The claim will bypass edit 4168 and the claim will not deny.

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The following workflows are for paper and electronic claims:

Paper Medical Claim Workflow
Paper claim suspends for edit 2504

- If the primary payer **did not** make a payment (actually pay dollars to the provider), override edit 2504 if one of the following conditions exists:
    - Provider submitted an EOB showing a valid denial (see ARC Attachment A). Note: All DOS and codes MUST match "Exception: if a K code is billed to Medicare and is billed to Medicaid as an E code"
    - "90 days no response" on the top of claim form or in the note panel
    - "Blanket denial" written on the top of the claim form and on the primary insurer's EOB
    - Court order is attached
- If the primary **payer made a payment** (actually pay dollars to the provider), override edit 2504 if all of the following conditions exists (if not, deny edit 2504 with EOB 2505):
    - Provider completed box 22 correctly
    - Provider completed TPL form correctly
    - Global maternity procedure codes 59400, 59410, 59510, 59515, 59610, 59614, 59618 and 59622 with members that have an active applicable TPL segment for coverage types A, B, Q or MS for the claim date of service and the claim contains an attachment a valid EOMB from Private Insurance indicating payment in part or full for the date of service

Paper Dental Claim Workflow
Paper claim suspends for edit 2504

- If the primary payer **did not** make a payment (actually pay dollars to the provider), override edit 2504 if one of the following conditions exists:
    - Provider submitted an EOB showing a valid denial (see ARC Attachment A). Note: All DOS and codes MUST match
    - "90 days no response" on the top of claim form or in the note panel
    - "Blanket denial" written on the top of the claim form and on the primary insurer's EOB
    - Court order is attached
- If the primary **payer made a payment** (actually pay dollars to the provider), override edit 2504 if all of the following conditions exists (if not, deny edit 2504 with EOB 2505):
    - Provider completed box 35 correctly
    - Provider submitted the TPL attachment form
    - Provider completed TPL form correctly

Paper UB04 Claim Workflow
Paper claim suspends for edit 2504

- If the primary payer **did not** make a payment (actually pay dollars to the provider), override edit 2504 if one of the following conditions exists:
    - Provider submitted an EOB showing a valid denial (see ARC Attachment A). Note: All DOS and codes MUST match
    - "90 days no response" on the top of claim form or in the note panel
    - "Blanket denial" written on the top of the claim form and on the primary insurer's EOB
    - Court order is attached
- If the primary **payer made a payment** (actually pay dollars to the provider), override edit 2504 if all of the following conditions exists (if not, deny edit 2504 with EOB 2505):
    - Provider completed field 50A-50C
    - Provider completed TPL form correctly

Electronic/Portal Medical Claim Workflow
Electronic claim suspends for edit 2504

- If the primary payer **denied or paid zero dollars** override edit 2504 if one of the following conditions exists:
    - Provider submitted an EOB showing a valid denial (see ARC Attachment A). Note: All DOS and codes MUST match "Exception: if a K code is billed to Medicare and is billed to Medicaid as an E code"
    - "90 days no response" on the top of claim form or in the note panel
    - "Blanket denial" written on the top of the claim form and on the primary insurer's EOB
    - Court order is attached
- If the primary **payer made a payment** (actually pay dollars to the provider), override edit 2504 if all of the following conditions exists (if not, deny edit 2504 with EOB 2505):
    - Primary provider made a payment greater than zero
    - Provider submitted the payment in the appropriate COB panels
    - Global maternity procedure codes 59400, 59410, 59510, 59515, 59610, 59614, 59618 and 59622 with members that have an active applicable TPL segment for coverage types A, B, Q or MS for the claim date of service and the claim contains an attachment a valid EOMB from Private Insurance indicating payment in part or full for the date of service

Electronic/Portal UB04 Claim Workflow
Electronic claim suspends for edit 2504

- If the primary payer **denied or paid zero dollars** override edit 2504 if one of the following conditions exists:
    - Provider submitted an EOB showing a valid denial (see ARC Attachment A). Note: All DOS and codes MUST match
    - "90 days no response" on the top of claim form or in the note panel
    - "Blanket denial" written on the top of the claim form and on the primary insurer?s EOB
    - Court order is attached

- If the primary payer **made a payment** (actually pay dollars to the provider), override edit 2504 if all of the following conditions exists (if not, deny edit 2504 with EOB 2505):
    - Primary provider made a payment greater than zero
    - Provider submitted the payment in the appropriate COB panels

Electronic/Portal Dental Claim Workflow
Electronic claim suspends for edit 2504

- If the primary payer **denied or paid zero dollars** override edit 2504 if one of the following conditions exists:
    - Provider submitted an EOB showing a valid denial (see ARC Attachment A). Note: All DOS and codes MUST match
    - "90 days no response" on the top of claim form or in the note panel
    - "Blanket denial" written on the top of the claim form and on the primary insurer's EOB
    - Court order is attached
- If the primary payer **made a payment** (actually pay dollars to the provider), override edit 2504 if all of the following conditions exists (if not, deny edit 2504 with EOB 2505):
    - Primary provider made a payment greater than zero
    - Provider submitted the payment in the appropriate COB panels

Region 80 (reprocessed) claims: The resolutions clerk should look at the attachment of the original denied claim to ensure that the proper insurance information is supplied. If supplied the edit should be overridden, if not then the claim should be denied with EOB 2505.

Attachment A

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ARC	Description
1	Deductible Amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.

11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
19	This is a work-related injury/illness and thus the liability of the worker's compensation carrier.
20	This injury/illness is covered by the liability carrier.
21	This injury/illness is the liability of the no-fault carrier.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
31	Patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Insured has no dependent coverage.
34	Insured has no coverage for newborns.
35	Lifetime benefit maximum has been reached.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement .
49	This service is non-covered, because it is a routine/preventive exam or a diagnostic/screening procedure performed in conjunction with a routine.
50	These services are non-covered because this is not deemed a "medical necessity" by the payer.
51	These services are non-covered because this is a pre-existing condition.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case.
55	Procedure/treatment/drug is deemed experimental/investigational by the payer.
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.
96	Noncovered charge(s). At least one Remark Code must be provided (may be either the National Council for Prescription Drug Programs [NCPDP] Reject Reason Code or Remittance Advice Remark Code that is not an ALERT).
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
119	Benefit maximum for this time period or occurrence has been reached.
146	Diagnosis was invalid for the date(s) of service reported.
149	Lifetime benefit maximum has been reached for this service/benefit category.
160	Injury/illness was the result of an activity that is a benefit exclusion.
166	These services were submitted after this payer's responsibility for processing claims under this plan ended.
167	These diagnoses are not covered.

168	Services have been considered under the patient's medical plan. Benefits are not available under this dental plan.
171	Payment is denied when performed/billed by this type of provider in this type of facility
177	Patient has not met the required eligibility requirements.
181	Procedure code was invalid on the date of service.
182	Procedure modifier was invalid on the date of service.
185	The rendering provider is not eligible to perform the service billed.
188	This product/procedure is only covered when used according to FDA recommendations.
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
198	Precertification/notification/authorization/pre-treatment exceeded.
200	Expenses incurred during lapse in coverage.
201	Patient is responsible for amount of this claim/service through "set aside arrangement" or other agreement. (Use only with Group Code PR.) At least one.
202	Non-covered personal comfort or convenience services.
203	Discontinued or reduced service.
204	This service/equipment/drug is not covered under the patient's current benefit plan.
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to.
211	National Drug Codes (NDCs) not eligible for rebate, are not covered.
212	Administrative surcharges are not covered.
215	Based on subrogation of a third-party settlement.
216	Based on the findings of a review organization.
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.
231	Mutually exclusive procedures cannot be done in the same day/setting.
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
234	This procedure is not paid separately.
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day.
245	Provider performance program withhold.
246	This non-payable code is for required reporting only.
247	Deductible for professional service rendered in an institutional setting and billed on an institutional claim.
256	Service not payable per managed care contract.
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state, or local authority may cover the claim/service.

269	Anesthesia not covered for this service/procedure.
273	Coverage/program guidelines were exceeded.
274	Fee/service not payable per patient Care Coordination arrangement.
275	Prior payer's (or payers') patient responsibility (deductible, coinsurance, copayment) not covered. (Use only with Group Code PR.).
276	Services denied by the prior payer(s) are not covered by this payer.
296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.
B1	Non-covered visits.
B5/272	Coverage/program guidelines were not met.
B5/273	Coverage/program guidelines were exceeded.
B14	Only one visit or consultation per physician per day is covered.
W3/P14	The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
W8/P19	Procedure has a relative value of zero in the jurisdiction fee schedule; therefore, no payment is due. To be used for Property and Casualty only.
W9/P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.