Information on Denied Health Home Claims (revised 7/22/13)

- For additional information on all Edit Reason Codes, please see the *EDIT MAPPING FOR 835 ORDERED BY EDIT NUMBER* document
- For all claims questions, please call Computer Science Corporation (CSC) 1-800-343-9000
- For additional questions about Health Home claims, please call the Health Home provider line (518) 473-5569

Important Denied Claim Information:

EDIT MAPPING FOR 835 ORDERED BY EDIT NUMBER Document:
https://www.emedny.org/HIPAA/5010/transactions/crosswalks/Edit%20Mapping%20for%20835%20in%20the%20Order%20of%20Edit%20Number.pdf

Link to the Edit Search Tool. Select the edit in question and click search. A document explaining the edit and suggested solutions will appear: https://www.emedny.org/HIPAA/5010/edit_error/index.aspx

Edit Reason Code	Edit Reason Code Description	Suggested Next Steps
00001	RECIPIENT SEX INVALID, MUST INDICATE M OR F	Resubmit claim with a valid value of either M or F.
00036	AMOUNT CHARGED IS MISSING OR INVALID	Amount charged is a required field. The provider must decide what charge amount to submit on the claim. The charge field does not affect Health Home claim payment.
00129	RATE CODE NOT ON RATE FILE	The Health Home rate code is not on your rate file for the date of service on the claim. If you think you should have a Health Home rate code on your rate file for the date of service on the claim, contact the HH Provider Line.
00142	RECIPIENT BIRTH DATE NOT EQUAL FILE	Recipient's birth date on the claim must match the recipient's birth date on their official Medicaid File.
00144	RECIPIENT SEX NOT EQUAL FILE	Recipient's sex on the claim must match the recipient's sex on their official Medicaid File.
00162	RECIPIENT INELIGIBLE ON SERVICE DATE	Claim cannot be paid. Recipient was not Medicaid eligible on the claim's service date.
00547	RECIPIENT INELIGIBLE (COVERAGE CODE IS EQUAL TO 07)	Claim cannot be paid. Recipient had Emergency Medicaid coverage only on the claim's service date.
00689	RECIPIENT NO LONGER PREPAID CAPITATION PLAN ENROLLEE	Patient not enrolled in the billing provider's managed care plan on the date of service.
00692	DATE OF SERVICE MUST BE 1ST OF MONTH	The date of service on a Health Home claim must be the first of the month. If Health Home services were provided on 5/12/13, the date of service on the claim must be 5/1/13.
00705	DUPLICATE CLAIM IN HISTORY	This claim has already been submitted to eMedNY.
00715	PROCEDURE CONFLICTS WITH PRIOR SERVICE	If edit key is 9576 or 9641, please see table below for additional information. If the edit key is neither 9576 nor 9641, another provider has already submitted a Health Home claim for this member on this date of service. For additional information, please contact the HH provider line.
00727	NEAR DUPLICATE CLAIM IN HISTORY	Call CSC
01044	DATES OF SERVICE CANNOT SPAN ACROSS MONTHS	Each claim can only cover services provided in one calendar month.
01314	RECIPIENT INELIGIBLE - SERVICE NOT COVERED BY FAMILY PLANNING	Claim cannot be paid. Recipient had Family Planning Coverage only on the claim's service date.
02020	MISSING BILLING NPI	Resubmit claim with a valid NPI.
02068	PROVIDER RATE FOUND WITHOUT MATCHING ZIP/LOCATOR CODE	Resubmit the claim with the zip code that is associated with the location of service where the Health Home rate codes are loaded. If you cannot determine which zip code should be listed on your claim, contact the HH Provider Line.
02212	HEALTH HOME RATE CODE - CLIENT DOES NOT HAVE A VALID HEALTH HOME PAYMENT WEIGHT ON FILE	The member was not pre-identified as Health Home eligible. Make sure that the member's Health Home has submitted the member to the Tracking System. DOH will periodically review the tracking system and load the statewide average acuity score for members in the tracking system that do not have an acuity score. The claim will pend for 60 days. The system will check to see if the member's acuity score has been loaded once a week. Once the acuity score has been loaded, the claim will pay. If the member's acuity score is not loaded within the 60 window, then the claim will deny.

Additional information regarding claims denied under edit reason code 00715 and edit keys 9576 and 9641

Edit Key	Suggested Next Steps
9576	Claim was denied because the provider has exceeded three consecutive Health Home outreach (1387) claims. Providers may bill three consecutive months of outreach and then must stop billing outreach for that member for three additional months before that provider may submit another outreach claim for that member.
9641	Claim denied due to the start date and end date on the claim. Both the start date and the end date on the claim must be the same date as the date of service on the claim. You may also have to adjust the start date and end date on the member's paid claim for the previous month.