TexMedConnect—Claim Processing, Denials, and Rejections FAQ

Information posted November 2, 2020

Q. What is the difference between a rejected claim and a denied claim?

A. A **rejected** claim fails initial system edits and is returned to the provider for correction without being submitted for processing. The claim is not entered in CMS and no Internal Control Number (ICN) is assigned. A **denied claim** passes initial system edits, is processed and assigned an ICN, but payment is denied. Denied claims appear on the Remittance & Status (R&S) Report in the Non-Pending section.

Q. Why has my claim been denied?

A. The following table lists the most common reasons for claim denials, as well as suggested actions.

Denial EOB Code	Denial Reason	Suggested Action(s)
F0138	A valid Service Authorization for this client for this service on these dates is not available.	• Providers should review the Medicaid Eligibility and Service Authorization Verification (MESAV) to verify that there is a valid service authorization for ALL dates of service being billed. If there is a break in the authorization dates (for example: 6/1 through 6/10 and 6/11 through 6/16), the provider should separate the claim and bill 6/1 through 6/10 on one line and 6/11 through 6/16 on a different line. • If the provider is a nursing facility or hospice, and the appropriate forms have been submitted on the LTC online portal but do not appear on the MESAV, contact HHSC Provider Claims Services (PCS) Hotline at (512) 438-2200, Option 1. • In instances where the MESAV and claim are correct, contact the Texas Medicaid & Healthcare Partnership (TMHP) LTC Help Desk at 1-800-626-4117, Option 1 for assistance.
F0165	This service has already been paid. Please do not file for duplicate services.	Claims deny with EOB F0165 because a claim has already been paid for the same dates of service. Providers should check CSI (Claim Status Inquiry) to see if there are claims for **any** of the dates of service which are in a paid OR approved to pay status. If any date within a claim has been paid, the entire claim will be rejected until the dates have been corrected.
F0307	Client has OI coverage that is missing from claim and must be billed prior to Medicaid. See the client's MESAV for OI and resubmit.	Providers should verify that all OI (Other Insurance) information on the claim matches the MESAV exactly, including OI company name, address, subscriber/policy number, etc.

Q. Why has my claim rejected?

A. The following table lists the most common reasons for claim rejections, as well as suggested actions.

Rejection EOB Code	Rejection Reason	Suggested Action(s)
F0077	Billing Code was not submitted or cannot be determined.	• The majority of rejections for this Explanation of Benefits (EOB) involve either the service authorization or Level of Service (LOS). The most common errors involve either: A) Billing for a date where there is no level or service authorization; B) Billing across a break in service authorization or levels. • Check MESAV to ensure that there is an established Resource Utilization Group (RUG) level, if needed, and a valid service authorization for the entire timeframe billed. • Check MESAV to ensure that the correct LTC service group, service code, and procedure code are used. Refer to the most recent Long Term Care (LTC) Bill Code Crosswalk located at https://hhs.texas.gov/laws-regulations/legal-information/long-term-care-bill-code-crosswalks. • If the MESAV and claim are correct, contact TMHP at 1-800-626-4117, Option 1 for assistance.
F0147	Client's Level of Service (LOS) Type and Level do not match Service Group and Billing Code Requirements.	• Providers should review the MESAV to verify that there is a valid level for the dates of service being billed. • If all information on the claim is correct, the consumer has a valid, active LOS for the dates of the claim and the error persists, contact TMHP at 1-800-626-4117, Option 1 for assistance.
F0155	Unable to determine appropriate Fund Code for Service billed, verify Medicaid Eligibility.	• Providers should review the MESAV to verify that the individual has Medicaid eligibility for the dates of service being billed, and that the provider is not billing across a break in eligibility. This error can also occur when an incorrect combination of service code and service group being billed is present. • If the individual has no eligibility for the service billed, contact the Medicaid Eligibility Worker. • If the individual has eligibility for the service billed, all information on the claim is correct and the error persists, contact TMHP at 1-800-626-4117, Option 1 for assistance.
F0297	The OI Disposition information on the claim is invalid.	Providers should verify that the correct disposition and disposition reason are selected for the type of OI; service code(s) being billed, and service group being billed. Additionally, providers should review the following claim information for accuracy: • Other Insurance Billed Date is later than claim submission date, or • Other Insurance Billed Date is greater than 365 calendar days earlier than claim submission date, or • Other Insurance Disposition Date is later than claim submission date, or • Other Insurance Billed Date is on or after Other Insurance Disposition Date

Q. What actions must a provider take to resolve a negative balance?

A. If an adjustment claim is processed either by the provider or systematically by the Claims Management System which results in a negative balance, these claims will appear on the pending claims section of the R&S report with a status of “A” - Approved to Pay. The provider will remain in a negative balance if no subsequent positive claim(s) are submitted for processing. Below are the steps required to resolve a negative balance.

1. Claim submission for positive amounts is the primary method to resolve a negative balance. Providers must submit all unprocessed billing and adjustments.
2. If the pending “A” status claim(s) remain in a negative rollup for over thirty calendar days, HHSC Provider Recoupments and Holds (PRH) may contact the provider with a reimbursement request to clear the negative balance.

Call HHSC PRH at 512-438-2200, Option 3, if you have questions about a negative balance on your pending R&S.

Call the TMHP LTC Help Desk at 1-800-626-4117 with additional questions or assistance. Providers are encouraged to review and share this information with appropriate billing staff to reduce errors and maximize efficiency.