

## Document Number FOD - 7005



## Pended, Denied, Rejected and Missing Claims Quick Reference



### **Pended Claims**

A claim may be pended if it contains erroneous information, does not match the New York State Department of Health's Master Files, or requires manual review to be resolved. The New York State Department of Health's fiscal agent, Computer Sciences Corporation (CSC), will review the pended claim. Some pended claims are resolved by the Department of Health because of the nature of the pended claim, for instance manual pricing. Please refer to the Billing Section of your MMIS Provider Manual for details.

Any claim pended during the current payment cycle will appear on the remittance statement with a descriptive message about why the claim was pended. Pended claims may ultimately be approved for payment, reduced or denied. Some common reasons to pend a claim are:

- Recipient Number invalid
- New York State Medical Review required
- Procedure requires manual pricing
- No Service Authorization on file

If you received remittance statements indicating claims pended for "no UT service authorization" or "service authorization exhausted" (pend code 1154 or 1155), it means a service authorization was not on file for the appropriate date of service and the proper number of service units when the claim entered the system. You must obtain the service authorization(s) within 60 days of the date the claim first pended in order to be paid. If the service authorization is not obtained before the 60 day time period elapses, then the claim will be denied. If the claim is denied, submit a new claim.

### **Denied Claims**

A claim will be denied if the New York State Medicaid Program does not cover the service rendered, if it is a duplicate of a prior claim, if the required Prior Approval is not obtained, or if the data is invalid or logically inconsistent. Please refer to the Billing Section of your MMIS Provider Manual for details.

Providers should review the denied claim on their remittance statement and resubmit on a new claim as described within the Billing Section of your Provider Manual or the HIPAA Companion Guides available on [www.emedny.org](http://www.emedny.org).

### **Rejected Claims**

A claim will be rejected when the information is either obviously wrong or omitted from the claim. If CSC's pre-screening process detects such an error, the claim will be returned to the Provider identifying where the error(s) were made. A new claim must be submitted with the erroneous or missing information corrected.

### **Missing Claims**

If specific claims never appeared on your remittance statement, unfortunately, we have to make the assumption that these claims never reached our office. Therefore, the only way for these claims to be processed is for you to submit new original claims to CSC. Carbon copies or photocopies are not acceptable for paper submissions and will be returned if submitted.

Claim that fail edit 901 (Invoice Type unknown) may not appear on a remittance statement. The Category of Service (COS) and/or Specialty Code (SC) are used to determine the invoice type. If an incorrect or end-dated procedure code is used, then the COS or SC cannot be derived and the claim will fail edit 901. Also, if an institutional claim does not have a rate code, the claim may also fail edit 901.

### **Phone Contact**

CSC Call Center: (800) 343-9000

Hours of Operation:

**For provider inquiries pertaining to non-pharmacy billing or claims, or provider enrollment:** Monday through Friday: 7:30 a.m. - 6:00 p.m., Eastern Time (excluding holidays)

**For provider inquiries pertaining to eligibility, service authorizations, DVS, and pharmacy claims:**

Monday through Friday: 7:00 a.m. - 10:00 p.m., Eastern Time (excluding holidays) Weekends and

Holidays: 8:30 a.m. - 5:30 p.m., Eastern Time