KERN HEALTH SYSTEMS

PROVIDER bulletin

Adjustment/Suspension Codes

CODE	Description
AD1	Add-on code, bill with the primary procedure
A25	Modifier 25
A57	Modifier 57
C1	Maximum benefits paid by prime insurance
C2	Prime carrier – applied to deductible or service is not covered.
C10	Payment reduced by primary payment
C11	Approved special fee
C12	Medical supplies
C13	Documentation submitted does not support level of service requested. Procedure code changed to pay appropriate level of service.
C14	Paid under fee-for-service
C15	Benefit paid per surgery guidelines
C16	Claim reviewed and approved
C17	Non-emergent er service –authorization not requested. Medical screening reimbursement only.
C18	Payment of contract rates
C19	Tech only w/prof services same day
C20	Level reduced – w/o supporting notes
C21	Proc code changed to surgeon's code
C22	Rental paid equals purchase price
C23	By report procedure
C24	Unauthorized non-emergent ER-MSE pd
C25	ER/UC services authorized by PCP
C26	Claim for medical screening exam only
C27	Unauthorized non-emergent urgent care – MSE paid
C28	Procedure codes rebundled
C29	Authorized pre-operative visit
C30	Verbal authorization confirmed
C31	Initial visit, this diagnosis
C32	Initial ob ultrasound
C33	Authorized per retro review
C34	Authorized by after hours service
C34	Hard copy authorization attached
C36	Taxi
C37	Authorization on file
C39	Add'l yearly payment for well child
C43	Procedure code/modifier correction
C45	TPL refund/recovery
C46	Correction to procedure. Modifier not covered for Medicare lab service.
C47	Payment of required component
C69	Procedure code corrected to reflect actual services rendered.

CODE	Description
C70	Room and board code changed to pay authorized level of service.
C71	Payment as authorized
C72	Modifier not required for procedure code billed
C73	Code x1500 has a maximum reimbursement of $14.99 per day.
C91	Changed to correct code for age group
CBH	Covered by hospice
CCM	Continue conservative management
CCS	California children's services
CDD	Second level appeal approved
CMC	Paid at CMAC rate.
CMD	Continue conservative management after delay
COS	Cosmetic procedure
CPD	Duplicate service by a different provider on the same date of service
CPP	Covered under pre/post op period
CRR	Authorization not obtained. Payment reduced per contract.
CRV	Second exam or visit on the same date of service
CSA	No co-surgeon allowed
D001	Manufacturer's invoice must be submitted with claim and itemized bill of service required.
D1	Member not eligible on service date
D2	Service is not a covered benefit
D3	Duplicate of prior processed claim. If this is not a duplicate service, please submit supporting records.
D4	EOB required from primary carrier
D5	Consent form not received
D6	Unauthorized non-par provider
D8	Medical necessity not established
D9	Additional information not received
D10	Not a valid Medi-Cal billing code
D12	Service not related to diagnosis
D14	Claim exceeds referral limit
D16	Claim exceeds days authorized
D17	Services covered by ccs
D18	Service not separately reimbursable
D19	Pharmacy claim covered by Argus
D20	Ob tracking form required
D21	Should be included in surgical fee
D22	Denied – prior auth not obtained
D22r	Denied prior auth not obtained reversed
D23	Provide HCPCS and/or NDC and total dosage administered (unlisted meds only)
D24	Inappropriate setting for service
D26	Non-covered self-referral
D27	Member covered under hospice care
D28	Provider not member's assigned PCP
D29	Service ordered by non-par provider
D30	Late charges, no additional monies due

CODE	Description
D31	Unauthorized non-emergency service
D32	Covered by VSP
D33	Authorization required – request medical records
D34	Limited – 1 visit in 6 month period
D35	Itemized bill of services required
D36	Procedure code requires a modifier
D37	Manufacturer's invoice must be submitted with claim (unlisted supplies)
D38	Primary carrier provider not used
D39	Global billing not reimbursable
D40	Institutional inmates ineligible
D41	Code not effective yet for Medi-Cal or healthy families members
D42	Referring physician not indicated
D43	Invalid modifier code
D44	CPT code not billable w/icd-9 code
D45	Limited to 90 day supply
D46	Copy of trip sheets required
D47	Complete hospital ER records needed
D48	Complete hospital records needed
D49	Referral/order sheet required
D51	Supporting medical records required
D52	Pending receipt of CLIA information
D53	DME – rental paid to purchase price
D54	Order slip and test results needed
D55	Sterilization consent requirements not met
D56	Provider is not credentialed for services rendered
D57	Claim denied for corrected billing
D58	Included in urgent care case rate
D59	Included in lab panel reimbursement
D60	Same services paid to another provider
D61	Denial/payment upheld-explanation letter sent separately
D62	Service not billable by provider
D63	Included in rate paid for same date
D64	Medicare primary – submit copy of EOB
D65	Western growers primary – submit EOB
D66	Claim submission time limit expired
D67	Medicare denied – waive benefit liability
D68	Copy of dictated notes required
D69	Procedure code incorrect for service
D71	Claim forward to Argus for processing
D72	Copy of operative or procedure report required
D73	Pre-op/pre-admit tests not payable
D74	Send appeal to prime carrier regarding EOB denial
D75	Services covered by kern regional
D76	Copy of Medi-Cal card and other form of identification required. Member information on claim does not match

CODE	Description
	membership information in our records.
D77	Anesthesia start and stop time required
D78	Lab services not covered for provider
D79	Pre-op visit included in surg payment
D80	Incurred within global follow-up period
D81	Name of consulting physician needed
D82	Prime carrier denial reason needed
D83	Time limit to request claim reconsideration has expired
D84	Custodial care not a benefit
D85	Missing/invalid diagnosis code
D87	Dx billed incompatible for provider
D88	Dx billed incompatible for gender
D89	Documentation does not support icd9
D90	Procedure incompatible for gender
D91	Procedure code and patient age incompatible
D92	Claim not authorized per retro review
D94	Please bill ccs directly w/reports
D95	Submit admission records
D96	Submit to kern county mental health
D97	Primary insurance denied for add'l info
D98	Send appeal to ccs regarding denial
D99	Criteria for reimbursement not met
DAC	See CPT book for appropriate/specific code
DAT	Actual time spent w/patient needed
DBP	Attending physician on billing form does not match attending physician on supporting medical records
DCD	Surgical CPT code not billed by surgeon. (used for facility claims w/extra codes not matching surgeon's claim)
DCP	Denied for incorrect CPT code on ub04 form
DDA	Auto duplicate denial
DDC	Denied – submit claim to Denti-Cal w/reports
DDD	2nd level review denied – explanation letter sent separately
DDR	Code x1500 requires documentation of item, quantity and cost
DEN	Denti-Cal service
DES	Description does not match CPT/HCPCS code
DFL	Denied for frequency limit
DFT	Denied-failure to transfer to participating facility
DGD	Denied – please bill to CA.AFP screening program
DGM	Gender does not match patient