Program Integrity's Goal

Through vigilance and unyielding dedication, Program Integrity will strive to safeguard taxpayer dollars that are utilized to care for our nation's Veterans and their families.

Office of Integrated Veteran Care Program Integrity Tools score and reject medical claims in a prepayment environment. Claims or individual claim lines that are rejected will be assigned a score and an explanation. Use this document to compare the rejection code and explanation found on the explanation of benefits you received from the Department of Veterans Affairs. In most cases, the claim or claim line is not payable under any circumstances and should not be resubmitted. If a claim is resubmitted using alternative CPT/HCPCS codes, the submission may be considered fraudulent under
31 U.S.C. §3729.

Additionally, all medical providers and medical facilities that are aware of any overpayment made to them by the s Affairs are obligated by law (31 U.S.C. §3729) to return the overpayment amount.

Table 1: Explanation of Rejection Codes

| Rejection Code | Rejection Explanation | What Should the Provider Do? |
| --- | --- | --- |
| RL00110 | Provider is listed on the current active "LEIE List" and the claim line service date is within the LEIE exclusion dates.  | The rendering provider must contact the HHS-OIG to have their name removed or data modified by the HHS-OIG. If the provider's information was incorrect, they must attach a cover letter to the claim(s) explaining the circumstances and request that the claim(s) be reprocessed.\*\*Under no circumstances shall the provider balance bill the Veteran or beneficiary. Any adverse action taken against the Veteran or beneficiary will be reported to the appropriate authorities such as, but not limited to, State Licensing Board, HHS-OIG, District Attorney, etc. |
| RL00210 | Modifier -26 Duplicate Payment Rule - claim line score and reason indicate that either the professional component or the global service was paid on a previous claim based on a unique combination of the following: Patient ID, Service Date Range, and Procedure Code.  | If you or your affiliate were not paid, please contact the office that processed your claim with a cover letter of explanation.  |
| RL00220 | Modifier -TC Duplicate Payment Rule - claim line score and reason indicate that either the technical component or the global service was paid on a previous claim based on a unique combination of the following: Patient ID, Service Date Range, and Procedure Code.  | If you or your affiliate were not paid, please contact the office that processed your claim with a cover letter of explanation.  |
| RL00230 | Global Diagnostic Service Component Duplicate Payment Rule - claim line score and reason indicate that either the professional component, technical component or the global service were paid on a previous claim based on a unique combination of the following: Patient ID, Service Date Range, and Procedure Code. | If you or your affiliate were not paid, please contact the office that processed your claim with a cover letter of explanation.  |
| RL00410 | Duplicate Professional Medical Claim - the claim line matched a previously paid claim line based on the unique combination of the following: Provider ID, Patient ID, Service Date, Place of Service, Procedure Code, and Modifier(s).  | If you are submitting a corrected claim or if there was a payment and/or billing error initially, please contact the office that processed your claim with supporting medical documentation that validates a change in coding/billing with a cover letter of explanation.  |
| RL00420 | Duplicate Institutional Inpatient Claim - the claim matched a previously paid inpatient claim based on the unique combination of the following: Provider ID, Patient ID, Principal Diagnosis, and Type of Bill.  | If you are submitting a corrected claim or if there was a payment and/or billing error initially, please contact the office that processed your claim with supporting medical documentation that validates a change in coding/billing with a cover letter of explanation. |
| RL00430 | Duplicate Institutional Outpatient Claim - the claim line matched a previously paid claim line based on the unique combination of the following: Provider ID, Patient ID, Service Date, Billed Amount, Procedure Code, Modifier(s), and Type of Bill.  | If you are submitting a corrected claim or if there was a payment and/or billing error initially, please contact the office that processed your claim with supporting medical documentation that validates a change in coding/billing with a cover letter of explanation. |
| RL00450 | Pharmacy Duplicate Claim Multiple Providers (CHAMPVA claims ONLY) - the claim line matched a previously paid claim line based on the unique combination of the following: Patient ID, Service Date (Fill Date), National Drug Code, and Quantity. | If you are submitting a corrected claim or if there was a payment and/or billing error initially, please contact the office that processed your claim with supporting medical documentation that validates a change in coding/billing with a cover letter of explanation. |
| RL00460 | Pharmacy Duplicate Claim Same Provider (CHAMPVA claims ONLY) - the claim line matched a previously paid claim line based on a unique combination of the following: Provider ID, Patient ID, Service Date (Fill Date), National Drug Code, and Quantity. | If you are submitting a corrected claim or if there was a payment and/or billing error initially, please contact the office that processed your claim with supporting medical documentation that validates a change in coding/billing with a cover letter of explanation. |
| RL00470 | Pharmacy Duplicate Claim Same Provider & Script (CHAMPVA claims ONLY) - the claim line matched a previously paid claim line based on a unique combination of the following: Provider ID, Patient ID, Service Date (Fill Date), National Drug Code, Quantity, and Prescription Number. | If you are submitting a corrected claim or if there was a payment and/or billing error initially, please contact the office that processed your claim with supporting medical documentation that validates a change in coding/billing with a cover letter of explanation. |
| RL00480 | Duplicate Dental Claim (CHAMPVA claims ONLY) - the claim line matched a previously paid claim line based on a unique combination of the following: Provider ID, Patient ID, Service Date, Procedure Code, Modifier(s), and Tooth Number.  | If you are submitting a corrected claim or if there was a payment and/or billing error initially, please contact the office that processed your claim with supporting medical documentation that validates a change in coding/billing with a cover letter of explanation. |
| RL00610 | Inconsistent Procedure Code and Diagnosis Code Inclusive Rule - claim line score and reason indicate the diagnosis is inconsistent with the procedure code. The service is not covered for the submitted diagnosis code. | If this is a coding error or you believe the claims was rejected in error, contact the office that processed your claim with supporting medical documentation that validates a change in coding/billing with a cover letter of explanation. |
| RL00620 | Inconsistent Procedure Code and Diagnosis Code Exclusive Rule - claim line score and reason indicate the diagnosis is inconsistent with the procedure code. The service is not covered for the submitted diagnosis code. | If this is a coding error or you believe the claims was rejected in error, contact the office that processed your claim with supporting medical documentation that validates a change in coding/billing with a cover letter of explanation. |
| RL00710 | Inconsistent Place of Service and Procedure Code Inclusive Rule - claim line score and reason indicate the procedure code is inconsistent with the place of service. | If this is a coding error or you believe the claims was rejected in error, contact the office that processed your claim with supporting medical documentation that validates a change in coding/billing with a cover letter of explanation. |
| RL00720 | Inconsistent Place Of Service and Procedure Code Exclusive Rule - claim line score and reason indicate the procedure code is inconsistent with the place of service. | If this is a coding error or you believe the claims was rejected in error, contact the office that processed your claim with supporting medical documentation that validates a change in coding/billing with a cover letter of explanation. |
| RL00810 | Inconsistent Provider Specialty Licensure and Procedure Code Inclusive Rule - claim line score and reason indicate the specialty licensure is inconsistent with the procedure code. | If this is a coding error or you believe the claims was rejected in error, contact the office that processed your claim with supporting medical documentation that validates a change in coding/billing with a cover letter of explanation. |
| RL00820 | Inconsistent Provider Specialty Licensure and Procedure Code Exclusive Rule - claim line score and reason indicate the specialty licensure is inconsistent with the procedure code. | If this is a coding error or you believe the claims was rejected in error, contact the office that processed your claim with supporting medical documentation that validates a change in coding/billing with a cover letter of explanation. |
| FB….. | The claim was rejected by the Program Integrity Tools. | Based on multiple Fraud Abuse Management System Rules the claim or claim lines have scored extremely high and must be reviewed prior to resubmission. If you dispute this finding, please contact the office that processed your claim with a cover letter explaining the reason(s) you feel you should be paid. |
| FBG623 (RL00310) | Billing Excessive Hours - claim line score and reason score indicate that an excessive amount of hours were billed by the rendering provider the service date. | The provider billed an excessive amount of hours, based on the relative value units and quantify for each procedure code for this service date. If you can justify the excessive hours, please provide medical documentation supporting the hours billed. Please contact the office that processed your claim with a cover letter explaining the reason(s) you feel you should be paid. |