

Top 25 Pends/Rejects

By # of Claims

Reason Code	If Paired with Remark Code	<i>Why we are looking at this?</i> What you should look for.	If Paired with Remark Code	<i>Why we are looking at this?</i> What you should look for.
B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N198 - Rendering provider must be affiliated with the pay-to provider.	<i>We do not show this rendering provider.</i> Is the rendering provider associated to the billing provider properly?	N95 - This provider type/provider specialty may not bill this service.	<i>We show that this provider is not valid in our system on the Date of Service (DOS).</i> Have you enrolled this provider in CHAMPS?
8 - The procedure code is inconsistent with the provider type/specialty (taxonomy).	N65 - Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	<i>Specific providers are allowed to bill only certain codes.</i> Are you certain you have identified the right specialty in CHAMPS for your provider?		
18 - Duplicate claim/service.	N30 - Recipient ineligible for this service.	<i>Our history shows this claim has already been paid.</i> Did you already get paid for this service?	M86 - Service denied because payment already made for similar procedure within set time frame.	<i>This appears to be a duplicate of a previously paid claim.</i> Did you use the proper modifier to identify this was not the same claim as previously paid?
133 - The disposition of this claim/service is pending further review.	N198 - Rendering provider must be affiliated with the pay-to provider.	<i>You are enrolled as a rendering only provider.</i> Rendering providers cannot bill for their services are you enrolled properly in CHAMPS?	N65 - Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	<i>We cannot find a way to pay this claim.</i> We are working internally to identify which account within MDCH this claim should be paid out of. Be patient we are working on a solution.
24 - Charges are covered under a capitation agreement/managed care plan.	N130 - Consult plan benefit documents for information about restrictions for this service.	<i>We show this beneficiary is enrolled in an HMO or a Capitated Rate Plan.</i> Did you bill us in error? Do you need to be the Managed Care Plan?		
204 - This service/equipment/drug is not covered under the patient's current benefit plan	N30 - Recipient ineligible for this service.	<i>We show this service is not covered by MDCH on the DOS.</i> Did you bill with the correct DOS?		

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31 - Patient cannot be identified as our insured.	N130 - Consult plan benefit documents for information about restrictions for this service.	<i>We cannot tell if this is our beneficiary or not. Did you use the proper beneficiary ID?</i>		
97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	<i>We show that another service was paid on this claim or another claim that includes this service. We follow CCI guidelines. Double check to see if like services were billed properly. Some services are included in other services.</i>		
17 - Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N379 - Claim level information does not match line level information.	<i>Beneficiary is seeking services not covered because they were eliminated by the program for those over 21 years of age. Improper mapping during conversion from legacy we're working on it. Be sure you are not billing for services no longer covered for those over 21 years old. See Bulletin MSA 09-28.</i>		
59 - Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	<i>The combination of services billed is being reviewed. We follow CCI guidelines. Be sure you are billing in accordance with multiple surgery/lab/radiology rules. Some services cannot be billed with each other or may be included in other services.</i>		

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29 - The time limit for filing has expired.	N59 - Please refer to your provider manual for additional program and provider information.	<i>This claim has been billed greater than 1 year from the DOS.</i> Make sure you are billing in a timely fashion and are keeping your claim active.		
11 - The diagnosis is inconsistent with the procedure.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	<i>We do not believe that this diagnosis is appropriate for this procedure.</i> Make sure you are billing to the highest level of specificity for both the diagnosis and the procedure code. Often this is a simple mistake of missing the 5th digit on the diagnosis code.		
150 - Payer deems the information submitted does not support this level of service.		<i>This is missing the remark code. Conversion issue we are working on it.</i> Be sure you are billing properly for the claim format and services you are submitting.		
22 - This care may be covered by another payer per coordination of benefits.	MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	<i>We are the payer of last resort we cannot pay if we show the beneficiary has other insurance or Medicare that may cover the service.</i> Does the beneficiary have other insurance or Medicare? Have you completed the proper information concerning Third Party Liability?		

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B9 - Patient is enrolled in a Hospice.	N143 - The patient was not in a hospice program during all or part of the service dates billed.	<i>This is a Hospice claim but we don't show the beneficiary as being in Hospice.</i> Are you waiting for Hospice eligibility? Is the beneficiary enrolled in a Hospice program?		
15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62 - Missing/incomplete/invalid treatment authorization code.	<i>We show this service requires prior authorization and the prior authorization on file does not match the information on the submitted claim.</i> Did you bill the wrong procedure code or use the wrong prior authorization number for the service provided?		
9 - The diagnosis is inconsistent with the patient's age.	N129 - This amount represents the dollar amount not eligible due to the patient's age.	<i>Diagnosis codes can be age specific, we show the beneficiary 's age does not meet the requirements for the diagnosis code.</i> Did you take into account the beneficiary's age when you billed the claim? Is there a more appropriate diagnosis that would match with the beneficiary's age?		
16 - Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	M119 - Missing/incomplete/invalid National Drug Code (NDC).	<i>This is an injectable drug and requires an NDC code.</i> Make sure you are submitting the appropriate NDC code within the correct field.		

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133 - The disposition of this claim/service is pending further review.	M17 - Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar circumstances.	<i>The mapping of the reason & remark code is in error, will be corrected in the near future.</i> We are unable to determine the beneficiary information. Review the beneficiary information on the claim.		
31 - Patient cannot be identified as our insured.	MA61 - Missing/incomplete/invalid social security number or health insurance claim number.	<i>The beneficiary ID number is either missing or invalid.</i> Review the beneficiary information to make sure you have used the Medicaid ID number correctly.		
133 - The disposition of this claim/service is pending further review.	M47 - Missing/incomplete/invalid internal or document control number.	<i>We are looking at the original TCN on a claim replacement or void/cancel claim.</i> Verify the original TCN.		
109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N193 - Specific federal/state/local program may cover this service through another payer.	<i>We understand this is a claim that should be paid by a capitated program.</i> Verify eligibility and send claim to proper program.		

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A8 - Ungroupable DRG.	MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	<i>We are not able to determine which DRG this should be paid under.</i> Verify the appropriate inpatient DRG and rebill.		
4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	M20 - Missing/incomplete/invalid HCPCS.	<i>We believe there should have been a modifier supplied or the modifier that was supplied was inappropriate for the service.</i> Verify the service and rebill with the modifier that is appropriate.		
96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N65 - Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	<i>This provider is not allowed to bill this procedure code. Note: This may be setting on Medicare payment related claims in error we are working on fixing this problem.</i> Double check that the service is covered for the provider that is billing.		
16 - Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	MA120 - Missing/incomplete/invalid CLIA certification number.	<i>We are expecting a valid CLIA number to be on the claim.</i> Verify the CLIA number for the service provided and rebill.		