Common Hospital Claim Denials

Policy: Medicaid Provider Manual (MPM), Chapter Billing and Reimbursement for Institutional Providers, Section 12- Remittance Advice

In the event, that MDHHS denies a claim there are claim adjustment reason codes (CARC) and remittance advice remark codes (RARC) appended that explain why the claim was denied. These codes can be located on the weekly paper remittance advice (RA) or electronically within the CHAMPS system by doing a claim inquiry. For providers that have elected to receive the 835 Electronic Remittance Advice (835 ERA) claim denial information can also be found within this report. Definitions for the CARC and RARC codes can be found on the Washington Publishing Company website (WPC).

Providers are expected to review the editing on each claim to determine why a claim was denied, make the necessary corrections, and resubmit as a new claim or adjust the original.

Top Denials:

CARC 22 and RARC N598: Beneficiary has other insurance listed in CHAMPS that was not reported on the claim. Medicaid is the payer of last resort and all identifiable payers must be reported on the claim. It is suggested that providers review the TPL coverage file in CHAMPS for accuracy. If changes need to be made then the online DCH 0078 request to add/change/update other insurance should be completed.

MPM Chapter Coordination of Benefits

Online DCH 0078

Other Insurance Reporting Requirements Tip

CARC 23: The other insurance information reported on the claim includes a CARC that is considered a denial, suspend, or otherwise not reimbursable. It is suggested that providers report the other insurance processing information on the service line to prevent the entire claim from being denied.

BBA posted on June 13, 2017

CARC A8 and RARC N657: Un-groupable DRG. Reporting invalid information can cause claims to be denied as ungroupable IE: procedure code, diagnosis, patient gender, missing or invalid modifiers can cause claims to be denied.

A8 Outpatient Hospital Claims Denials Provider TIP

A8 Inpatient Hospital Claim Denial Provider Tip

CARC 16 & RARC M76: Missing/incomplete/invalid diagnosis or condition. This means that the benefit plan does not cover the services being billed. Check eligibility via CHAMPS, the eligibility may have been updated after the claim was submitted or the current benefit plan doesn't cover the services billed.

MPM Chapter Beneficiary Eligibility - Section 2.1 BENEFIT PLANS

CARC 96 & RARC M2: Not paid separately when the patient is an inpatient, claim is denied due to a paid Outpatient claim billed within three days of your Inpatient stay.

Outpatient Services Prior to Inpatient Admission

CARC 97 and RARC M86: Split billing. There is a previously paid claim in the system with the same dates of service and the services being billed are not allowed for repetitive billing as defined by CMS. Providers can use the claim limit list function in CHAMPS to view the previously paid claim.

CHAMPS Claim Inquire Claim Limit List

MM 3633 Hospital Billing for Repetitive Services

MPM Chapter Billing and Reimbursement for Institutional Providers Section 7.1.E Date of Service

CARC 197: Missing Precertification/authorization, review the provider tips to see if the claim requires authorization/PACER.

PACER Requirements

Prior Authorization Tip

Prior Authorization

CARC 24: Beneficiary is enrolled in a managed care plan for the date(s) of service. Providers should review beneficiaries' eligibility within in CHAMPS and bill the correct payer.

Eligibility Inquiry

CARC 16 & RARC M47: Missing/incomplete/invalid Payer Claim Control Number. Invalid parent/adjusted TCN. Only claims with a PAID status can be adjusted. To locate the paid claim, utilize the claim inquiry function in CHAMPS.

Claims and Encounters

Manage Claims – Adjust/Void

Claim Inquiry

CARC 204 and RARC N448: A QMB beneficiary and services are not covered by Medicare. MDHHS reimburses for co-insurance and deductible when a beneficiary is enrolled in the QMB program. If Medicare does not cover Medicaid does not have liability.

MPM Chapter Coordination of Benefits Section 2.6.E Medicare Buy-In/Medicare Savings Program

MLN SE1128 Prohibition on Billing Dual Eligible Individuals in the QMB Program

CARC 204 and RARC N130: Benefit plan assigned receives no payment. The beneficiary has a Medicaid deductible / spenddown that has not been met.

Eligibility Inquiry

CARC 204 and N448: Beneficiary has emergency services only Medicaid and the services and or diagnosis codes being billed are not considered an emergency.

MPM Chapter Emergency Services Only Medicaid

CARC 109 and RARC N130: Claim or service is not payable by MDHHS. Mental health or substance abuse services are the responsibility of the beneficiary's county PIHP.

Inpatient Hospital Psychiatric Admissions Billing Tip

MPM Chapter Hospital Section 3.22 Mental Health and Substance Abuse