Common Denials

Per the Medicaid Provider Manual, Billing and Reimbursement for Professionals, Section 8 Remittance Advice: You should be reviewing your remittance advice, determining why your claim(s) rejected, making the necessary corrections and resubmitting as a new claim or adjusting the original claim. A complete listing of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes can be found on the Washington Publishing Company website.

Michigan Department of Health and Human Services (MDHHS) encourages providers to send claims electronically by file transfer through the File Transfer System (FTS). Claims may also be submitted via Direct Data Entry (DDE) through the Community Health Automated Medicaid Processing System (CHAMPS) free of charge versus submitting a paper claim. If you do not have access to CHAMPS, you may go to CHAMPS webpage to become registered user with CHAMPS or by calling 1-800-292-2550 for assistance.

Below are a list of common denial claim adjustment reason codes and remittance advice remark codes (CARCs and RARCs) with a description on how to resolve the denial.

CARC 22 & RARC N598: Beneficiary has other insurance listed in CHAMPS, the other insurance will need to be reported on the claim. If the insurance policy is no longer active providers should fill out the online DCH-0078 form. Update Other Insurance NOW!

CARC B7 & RARC N570: Billing or rendering provider is not active in CHAMPS on the DOS. Check the enrollment for both NPIs. If this is showing active on the DOS submit a new claim.

CARC 96 & RARC N55: Billing provider is not associated to the billing agent/clearing house in CHAMPS. Provider will need to verify the billing agent or clearing house that the claims are billed through and make sure the information is associated to the group NPI within the groups Provider Enrollment file in CHAMPS.

CARC B13: Attempting to adjust a claim that has already been adjusted. Provider will need to obtain the TCN that has the status of paid.

CARC 16 & RARCM62: The procedure code requires a PA. Please utilize the Medicaid Code and Rate Reference to see if procedures require a PA.

CARC 16 & RARC M136: The rendering provider listed on the claim is a physician assistant or nurse practitioner and no supervising NPI is listed on the claim. Please see policy bulletin MSA 12-42.

CARC 16 & RARC MA04: Secondary claim was submitted without a CARC reported under the other insurance information for the primary payer.

CARC 24: Beneficiary is enrolled in a managed care plan for the DOS. Providers will need to verify eligibility in CHAMPS and bill the managed care plan.

CARC 208 & RARC N265: The ordering provider is not enrolled in CHAMPS or not active on the DOS. Please utilize the Provider Verification tool in CHAMPS to verify if the provider is enrolled and active with Medicaid before submitting a new claim. Provider Verification Tool

CARC 16 & RARC M47: This indicates the claim was submitted as a provider initiated adjustment and the TCN # listed is not valid. This is because the TCN was either incorrect, or it belongs to a denied, voided or already adjusted claim. You can only adjust a claim that has a paid status.

CARC 183 & RARC N767: The referring/ordering NPI must be an individual NPI (type 1 NPI) not a group NPI.

CARC 206 & RARC N286: According to policy bulletin MSA 13-17. The name and NPI of the ordering/referring or attending provider must be reported on all claims for services rendered as a result of an order/referral. Please refer to the Michigan Medicaid Provider Manual for order/referral requirements for specific services. Examples of services that require an order/referral include, but are not limited to:

- Ambulance nonemergency transports;
- Ancillary services for beneficiaries residing in nursing facilities (e.g., chiropractic, dental, podiatry, vision);
- Childbirth/parenting and diabetes self-management education;
- Consultations;
- Diagnostic radiology services, unless rendered by the ordering physician;
- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS);
- Hearing and hearing aid dealer services;
- Home health services;
- Hospice services;
- Laboratory services;
- Certain mental health and substance abuse children's waiver services;
- Certain Maternal Infant Health Program (MIHP) services;
- Pharmacy services;
- Private duty nursing services;
- Certain School based services;
- Therapy services (occupational therapy (OT), physical therapy (PT) and speech); and
- Certain vision supplies.

CARC 183 & RARC N574: The referring/ordering provider has to be an individual provider (type 1 NPI). Ordering/referring providers must be one of the following practitioner types, acting within their scope of practice under State law and MDCH Medicaid policy requirements: Physician, Physician Assistant, Nurse Practitioner, Certified Nurse Midwife, Dentist, Podiatrist, Optometrist, or Chiropractor (limited to spinal x-rays only).

CARC: 96 & RARC: N198: Review the individual provider's enrollment information to make sure their NPI is associated to the group NPI in CHAMPS on the DOS. If the provider is not associated to the group the enrollment will need to be updated. If the billing NPI listed on the claim is a rendering servicing provider in CHAMPS they cannot bill for themselves. Only an individual sole provider can bill for themselves.

CARC 31 & RARC MA61: The beneficiary ID # listed on the claim is not a valid ID #. Providers will need to complete an eligibility inquiry in CHAMPS to obtain the correct ID #. Eligibility Inquiry QR Guide

CARC 16 & RARC N286: The referring provider is not active on the DOS or not enrolled in CHAMPS. Please utilize the Provider Verification tool in CHAMPS to verify if the provider is enrolled and active with Medicaid before submitting a new claim. Provider Verification Tool

CARC 16 & RARC N297: The rendering provider is a nurse practitioner or physician assistant and the supervising NPI is not active on the DOS.

CARC 16 & RARC MA63: Diagnosis code submitted is missing/incomplete/invalid. Provider needs to verify that the diagnosis code is a correct/valid diagnosis code.

CARC 16 & RARC M77- Denying for beneficiary's eligibility and place of service. Verify the eligibility and the place of service on the claim. For example: INCAR-MA only covers inpatient hospital place of service.

CARC 40: The patient is enrolled in emergency services only and the claim does not meet the qualifications for emergent services or is not being reported as an emergent claim correctly.

CARC 236: The procedure code is hitting up against another procedure that was billed on the same day and the code needs a modifier to separate the service. You can find out which code this is hitting up against through the claim limit list function. Please see link for instructions How to use the CHAMPS Claim Limit List.

CARC 198 & RARC 54: The units or dollar amount on the prior authorization have been exceeded. Providers will need to log into CHAMPS to see if there are any units or dollar amounts available on the PA. If they are used contact PA. PA Inquiry QR Guide

CARC 198 & RARC N351: The dates of service on the PA are not matching the DOS listed on the claim. Providers will need to review the dates listed on the PA.

CARC 50 & RARC M76: Billing an emergency transport without and emergency diagnosis code. Biller "B" Aware posted August 9, 2016: Attention Ambulance Providers: MDHHS is seeing an increase of emergency ambulance transport claims denying CARC 50 for a non-supporting emergency ambulance diagnosis code. Providers are not utilizing the highest specificity of the diagnosis code, when possible. For example, using DX S82899A: Unspecified fracture of unspecified lower leg. The more specific DX code could be S82891A: Other fracture of right lower leg or S82892A: Other fracture of left lower leg. The Medicaid Code and Rate Reference Tool can be used to verify which diagnosis codes support Emergency Transport by having an ambulance indicator. Also, many providers are not utilizing the emergency in Loop 2400, SV109 segment or the CMS1500, 24C to indicate emergency services. If left blank, the indicator defaults to N, which indicate no. Providers with further questions can contact Provider Support by phone 1-800-292-2550 or by email ProviderSupport@Michigan.gov
Emergency Transports Diagnosis Codes Database

CARC 96 & RARC N54: Provider will need to verify eligibility coverage for the DOS. If patient is enrolled in CSHCS for the DOS the provider needs to be listed as an authorized provider under the beneficiaries authorized provider list. If provide is not an authorized provider they will need to contact the county the beneficiary lives in to become an authorized provider. Please see link for Local CSHCS Office Contacts

CARC 29: Timely filing is 1 year from the DOS effective January 1, 2017. Please see link for policy bulletin MSA 16-37

CARC 16 & RARC M119: The procedure requires an NDC code and the NDC is missing/incomplete/invalid. A provider is required to report the National Drug Code (NDC) supplemental information in addition to the procedure code (CPT or HCPCS) when billing for a physician administered drug. Coverage of a physician administered drug (except an immunization) is limited to a drug product from a manufacturer who has a signed rebate agreement with the Centers for Medicare & Medicaid Services (CMS). A current listing of the manufacturers who have signed rebate agreements with CMS can be found on the CMS website.

CARC 23: The other insurance information was reported with a CARC that is not payable for Medicaid. Providers will need to review the CARC reported for the other insurance.

CARC 18 & RARC N522: Duplicate claim. Providers need to log into CHAMPS to see what the claim is hitting against. How to use the CHAMPS Claim Limit List.