MDHHS
Michigan Department of Health & Human Services

Provider Relations

Resubmssion of Claim Based on Claim Adjustment Reason Code

CARC Code	Short Description	Why did my Claim Deny?	Steps for Claim Resubmission
2	Coinsurance Amount	Claim denied, provider is reporting coinsurance without payment. When coinsurance is reported payment is expected to be on the claim from the primary. Coinsurance represents a percentage of something and in some cases, it is implied an OI payment should be reported. For example, Medicare has a 20% coinsurance, therefore of the 100% of the submitted charges, 20% of that would be applied to CARC 2.	1. Verify if the CARC on the EOB from the primary was a CARC 2 for coinsurance or if it was a CARC 3 for co-payment. 2. Email provider support with why coinsurance was reported from the primary with no payment. Upload the EOB in DMP for review.
3	Co-payment Amount	Claim denied, provider is reporting a copay less than what the primary is showing. Typically, what the primary is reporting for the co-pay is the same amount to be listed on the claim. A copay amount should be a straight dollar amount listed within the benefits. If the provider is reporting an amount lower than the verified copay it would typically be related to a lower level procedure code and/or the benefits state the beneficiary is 100% responsible for the allowed amount of the code.	1. Verify the primary copay amount for the service being billed. For example, if billing for x-rays determines the copay amount for x-rays. This amount will not include the write-off amount. 2. Email provider support with the verified co-pay amount from the primary for that particular service along with the breakdown of how the primary EOB was reported. Upload the EOB in DMP for review.
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	Claim denied, CARC 23 amount does not equal primary OI payment plus any write-off amount that is included in a reduced CARC. CARC 23 is not appropriate to bill except when the CARC 23 amount is equal to the primary payment plus any reduced CARCs (e.g., 45, 97, 144, 253, or 237).	1. Check the claim to confirm CARC 23 amount balances correctly. 2. If the claim balances, email provider support for a second review. Upload the EOB in DMP for review. 3. If the claim does not balance, follow up with primary and/or fix the error if appropriate and submit a new claim.
96	Non-covered charge	Claim denied, provider is reporting that the service is noncovered by the primary. Verification of the primary policy shows this service is a covered benefit.	1. Email provider support for a second review. As a reminder, if the rules of the primary were not followed Medicaid will not pay the claim. Upload EOB to DMP for review.
119	Benefit maximum for this time period or occurrence has been reached.	Claim denied, provider reporting patient benefits are maxed with the primary. If reporting a CARC 119 for exhausting benefits it is always recommended to upload the remittance advice at the same time as submitting the claim.	1. Verify your EOB(s) indicate the date of when the benefits were maxed, the date of the last time the service was paid and/or the denials from the primary of the benefits maxed denial. Upload the EOBs that show the needed information in DMP for review. 2. Email provider support about the denial. If unable to get this information such as new patient, haven't billed service before, etc. Please indicate this in the email to provider support.