Other Insurance (OI)

May 24, 2022

"Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time."

-Provider Relations

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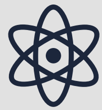

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Federal Regulation

- Michigan Medicaid Provider Manual
  - >> Chapter Coordination of Benefits
  - >> Sections 1 and 3.6

- Federal regulations require that all identifiable financial resources be utilized prior to the expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries.
- Providers must investigate and report the existence of other insurance or liability to Medicaid and must utilize other payment sources to their fullest extent prior to filing a claim with the Michigan Department of Health and Human Services (MDHHS).
- Medicaid is considered the payer of last resort.
  - Exceptions: Crime Victims Compensation Fund, Ryan White Program, Indian Health Services, Women, Infants and Children Program, Grantees under Title V of the Social Security Act (Maternal and Child Health Services Block Grant), Veteran Benefits

Definitions

- Michigan Medicaid Provider Manual
  - >> Chapter Coordination of Benefits
  - >> Section 1
- Third Party Liability (TPL) Coordination of Benefits Website

Coordination of Benefits (COB)

- The mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, the prevention of duplicate payments.

Third Party Liability (TPL)

- Refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a beneficiary's medical coverage.
- The terms "third party liability" and "other insurance" are used interchangeably to mean any source, other than Medicaid, that has a financial obligation for health care coverage.

How to Locate and Update OI

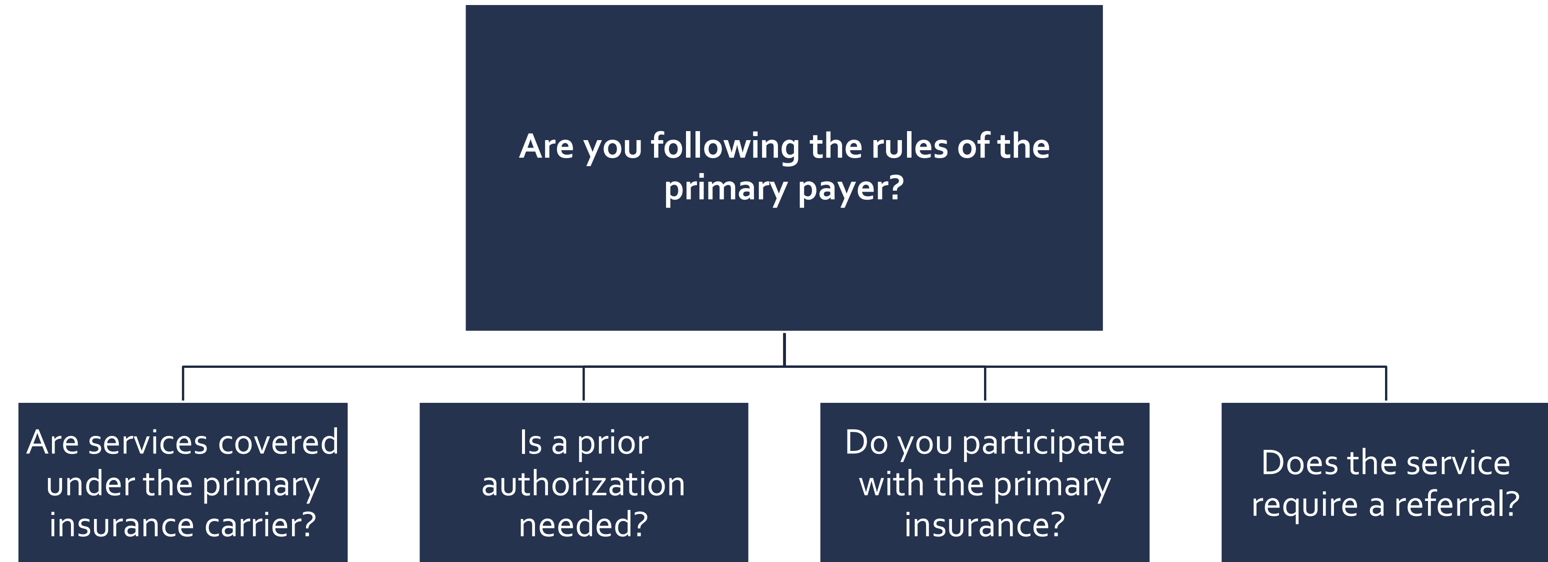
- Michigan Medicaid Provider Manual
  - >> Chapter Coordination of Benefits
  - >> Section 1.3
- Eligibility Quick Reference Guide
- How to Locate Payer ID and Other Health Insurance Information website
- How to Update Third Party Liability Information website

- Information about a beneficiary's other insurance is available through the Community Health Automated Medicaid Processing System (CHAMPS) Eligibility Inquiry and/or vendor that receives eligibility data from the CHAMPS270/271 transaction.
- Providers should always ask the beneficiary if other insurance coverage exists at the time of service.

OI is not listed in CHAMPS	OI is listed in CHAMPS but not correct
• Provider must use the other insurance that the beneficiary indicates and report the coverage to MDHHS by completing the on-line Request to Add, Terminate, or Change Other Insurance (form DCH-0078).	• The beneficiary needs to notify their local MDHHS office or contact the Beneficiary Helpline to report the OI change. • Providers can also elect to fill out the on-line Request to Add, Terminate, or Change Other Insurance (form DCH-0078).

Following the Rules of the Primary

- Per the Provider Manual, Chapter Coordination of Benefits, Section 2.1 Commercial Health Insurance.
- Medicaid Code and Rate Reference Tool



MDHHS
Michigan Department of Health & Human Services

Billing OI to Medicaid

- Michigan Medicaid Provider Manual
  - >> Chapter Coordination of Benefits
  - >> Section 2.1
- Commercial/Other Insurance Coverage Type Codes

- Providers must secure other insurance adjudication response(s) which must include Claim Adjustment Reason Codes (CARCs) prior to billing Medicaid.
  - Washington Publishing Company (WPC)
- Denials do not need to be obtained in cases where the parameters of the carrier would never cover a specific service (e.g., a dental carrier (DO) would never cover a vision service (VO), etc.).
- In cases where the provider renders a service and the carrier indicates it does not cover that specific service, the provider needs only to bill the carrier once for the service and keep a copy of the denial in the beneficiary's file.

Medicaid Responsibility of Payment:

- [Michigan Medicaid Provider Manual]
  - >> Chapter Coordination of Benefits
  - >> Section 3.3

Coinsurance, Copayments, and Deductibles

- Medicaid pays the appropriate coinsurance amounts, copayment amounts, and deductibles up to the beneficiary's financial obligation to pay or the Medicaid allowable amount (less other insurance payments), whichever is less.
- If the other insurance has negotiated a rate for a service that is lower than the Medicaid allowable amount, that amount must be accepted as payment in full and Medicaid cannot be billed.

Medicaid services not covered by another insurance

- If the other insurance does not cover a service that is a Medicaid-covered service, Medicaid reimburses the provider up to the Medicaid allowable amount if all the Medicaid coverage rules are followed.

Medicaid-covered services

- Beneficiaries cannot be charged for Medicaid-covered services, except for approved copays or deductibles, whether they are enrolled as a FFS beneficiary, MDHHS is paying the HMO premiums to a contracted health plan, or services are provided under PIHP/CMHSP capitation.

Medicaid Responsibility of Payment

- Example: Primary insurance PAID the claim. Secondary coverage adjudicates the claim as appropriate. Medicaid FFS may pay up to the allowable amount minus any other insurance payment.

Medicaid is Secondary	
Primary Submission (P)	
Provider Submitted Charges	$ 80.00
P Pays	$ 10.00
P applies to Coinsurance/Deductable	$ 50.00
Contractual Write off	$ 20.00
Medicaid allowable	$ 40.00
MA allowable Minus P payment	$40 - $10
MA Pays	$ 30.00

MDHHS
Michigan Department of Health & Human Services

Claim Adjustment Reason Codes (CARC) Breakdown

- 2 – Coinsurance
- 3 – Co-payment
- 23 – Impact of prior payer(s) adjudication
- 96 – Non-covered
- 119 – Benefit max

For a further breakdown visit the Other Insurance CARC Codes Resource

MDHHS Michigan Department of Health & Human Services

CARC 2 - Coinsurance

Original Claim

Amount Paid	Responsibility	Remittance Date (mm/dd/yyyy)		Quantity	Amount	Adj. Reason Code
$2,273.21	P-Primary	07/22/2019				
$2,273.21	P-Primary	07/22/2019				
			Adj:	1	$1,021.89	45
			Adj:	1	$579.90	2

Final Claim

Amount Paid	Responsibility	Remittance Date (mm/dd/yyyy)		Quantity	Amount	Adj. Reason Code
$2,273.21	P-Primary	07/22/2019				
$2,273.21	P-Primary	07/22/2019				
			Adj:	1	$975.50	45
	Added 253 →		Adj:	1	$46.39	253
			Adj:	1	$579.90	2

EOB

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PROV                          SERV DATE        POS  NOS  PROC   MODS          BILLED  ALLOWED  DEDUCT   COINS       GRP/RC-AMT      PROV PD

NAME                          MBR                         ACNT:                        ICN
CORRECTED:                    HICN
CLM Status:1                  MRN:
                                               12   1    K0606  KFRR          3875.00  2899.50   0.00   579.90   CO-45        975.50  2273.21
                                                                                                                  CO-253        46.39
PT RESP 0.00                                                    SUB TOTALS    3875.00  2899.50   0.00   579.90              1021.89  2273.21
ADJ TO TOTALS:                                 PREV PD 0.00     INTEREST 0.00        LATE FILING CHARGE
                                                                                     0.00
                                                                                                                               NET 2273.21

   TOTALS:   # OF CLAIMS   BILLED AMT   ALLOWED AMT   DEDUCT AMT   COINS AMT    RC-AMT      PROV PAID   PROV ADJ   CHECK AMT
                  1          3875.00      2899.50        0.00        579.90     1021.89      2273.21     -4.75     9097.59
PROVIDER ADJ DETAILS:                        PLB REASON CODE       FCN / Other Identifier              AMOUNT
                                                   L6                                                   -4.75

GLOSSARY:   Adjustment, Group, Reason, MOA, and Remark codes
CO-         Contractual obligations. The patient may not be billed for this amount
         45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment
            amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts
            (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group
            Codes PR or CO depending upon liability)
→        253Sequestration - reduction in federal spending.
PR-         Patient Responsibility
         2  Coinsurance Amount
L6          Use this monetary amount for the interest paid on claims in this 835. Support the amounts related to this
            adjustment by 2-062 AMT amounts, where AMT01 is "I. "Medicare Part A will provide code "IN" in PLB03-2.
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Medicaid Denial Explanation

Coinsurance amount should equal primary payment + CARC 2 + CARC 253 x 20%

MDHHS
Michigan Department of Health & Human Services

CARC 2 - Coinsurance

Original Claim

			Adj:		$346.50	45
$0.00	P-Primary	02/08/2021				
			Adj:		$51.00	45
$0.00	P-Primary	02/08/2021				
			Adj:		$534.00	45
$0.00	P-Primary	02/08/2021				
			Adj:		$391.00	1
			Adj:		$175.00	2
			Adj:		$826.00	45
$0.00	P-Primary	02/08/2021				
			Adj:		$735.00	45

EOB

Service Dates: 01/11/2021 - 01/11/2021

Payment Information

Charge Amount:	4398.00	Payment Amt:	0.00	Blood Deductible:	0.00	DRG Code:	
Covered:	4398.00	Deductible:	391.00	Interest:	0.00	DRG Amount:	0.00
Non-Covered:	0.00	Coinsurance:	0.00	Contractual Adj:	3832.00	DSH Amount:	0.00
Denied:	0.00	Copayment:	175.00	Allowed Amt:	566.00	MSP Pri Payer	0.00

Claim Level Information

Group & Reason Code	Amount	Units	Remark Codes
CO45	3832.00	0	
PR3	175.00	0	
PR1	391.00	0	

Line Level Information

RCC	HCPCS/ Modifier	Units	DOS	Charges	Allowed	Paid	Remark Code	Group & Reason Code	Reason Code Amt	Reason Code Units
				0.00	0.00	0.00				

*Claim was adjudicated by payer at claim Level, please refer to Payment Information

Reason/Remark Summation

Group/ Reason Code	Amount	Units	Description
CO45	3832.00	0	CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. USAGE: THIS ADJUSTMENT AMOUNT CANNOT EQUAL THE TOTAL SERVICE OR CLAIM CHARGE AMOUNT; AND MUST NOT DUPLICATE PROVIDER ADJUSTMENT AMOUNTS (PAYMENTS AND CONTRACTUAL REDUCTIONS) THAT HAVE RESULTED FROM PRIOR PAYER(S) ADJUDICATION. (USE ONLY WITH GROUP CODES PR OR CO DEPENDING UPON LIABILITY)
PR3	175.00	0	CO-PAYMENT AMOUNT
PR1	391.00	0	DEDUCTIBLE AMOUNT

Medicaid Denial Explanation

The claim was denied because coinsurance was billed without a payment from the primary reflected on the claim. EOB shows that the primary applied the $175.00 to the copay and not to coinsurance.

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CARC 3 - Copayment

Original Claim

Amount Paid	Responsibility	Remittance Date (mm/dd/yyyy)		Quantity	Amount	Adj. Reason Code
$0.00	P-Primary					
$0.00	P-Primary	11/04/2021				
			Adj:		$62.59	3
			Adj:		$105.41	45

EOB

NAME:
ACCOUNT #:
CCN #:
SVC DATE: 2021-10-19 - 2021-10-19
INSRD ID:
CLM STATUS:
REMARK:
NETWORK ID:
REND PROV:
TOB:

TOTAL CHARGE:	$168.00
TOTAL PAYMENT:	$0.00
TOTAL CONTRACTUAL:	$105.41
TOTAL DEDUCTIBLE AMT:	$0.00
TOTAL COINSURANCE AMT:	$0.00
TOTAL CO-PAYMENT AMT:	$62.59
ADJ AMT:	$168.00
ADJ CODE:	
INTEREST:	0.00

S	FROM	THRU	PROC	MD	REV	UNT	CHARGE AMT	ALLOWED	PAYMENT	ADJ AMOUNT	GRP	RSN	REM
1	2021-10-19		99213			1.0	$168.00	$62.59	$0.00	$105.41	CO	45	
										$62.59	PR	3	
CLAIM TOTALS							$168.00	$62.59	$0.00	$168.00			

Codes/Description:

3 Co-payment Amount

45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)

CO Contractual Obligations

PR Patient Responsibility

Explanation from Provider

Primary confirmed the copay CARC 3 for a specialty provider is $65

Medicaid Denial Explanation

The claim was denied questioning the copay amount of $62.59 for CPT 99213. The provider verified with the primary that the copay for a specialty provider was 65.00. ….

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CARC 3 - Copayment

Original Claim

Amount Paid	Responsibility	Remittance Date (mm/dd/yyyy)		Quantity	Amount	Adj. Reason Code
$0.00	P-Primary					
$0.00	P-Primary	11/01/2021				
			Adj:		$67.87	45
			Adj:		$132.13	3

Medicaid Denial Explanation

Primary EOB shows $132.13 was applied to the deductible (CARC 1), not copay (CARC 3).

EOB

Claim Detail

Billed Amount	Account Number	Medical Plan	Provider
$200.00		--	

Provider Id	Tax Id	Service Date	Claim Received
	--	10-15-2021	10-26-2021

Paid Date	DRG	Voucher #	Check #
10-31-2021	--		--

Total Check Amount
$0

Line Billed Detail

Code	Description	Units	Billed Amount
99214	Physician Eval & Management Regular	1	$200.00

Deductible

Line Paid Detail

Allowed	Other Insurance	Capitation	Withheld
$132.13	$0.00	$0.00	$0.00

Total Patient Liability	Copays	Deductible	Coinsurance
$132.13	$0.00	$132.13	$0.00

Provider Liability	Clinical Edits	Priority Health Paid
$0.00	--	$0.00

Claim Line Explanation

MDHHS
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CARC 96 – Non-Covered

Original Claim

Amount Paid	Responsibility	Remittance Date (mm/dd/yyyy)		Quantity	Amount	Adj. Reason Code
$0.00	P-Primary					
$0.00	P-Primary	12/17/2021				
			Adj:	114	$769.39	96
$0.00	P-Primary	12/17/2021				
			Adj:	14	$700.00	96

EOB

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PROV                     SERV DATE    POS  NOS  PROC   MODS          BILLED  ALLOWED  DEDUCT  COINS    GRP/RC-AMT      PROV PD

NAME:                    MBR                         ACNT:                        ICN:
CORRECTED:               HIC
CLM Status:1             MRN:
GRP/POL NUM:
                         1018 103121  12   0    B4161                769.39     0.00    0.00   0.00  PR-96    769.39     0.00
                                  SUB NOS:114   REM: N216
                         1018 103121  12   0    S9342                700.00     0.00    0.00   0.00  PR-96    700.00     0.00
                                  SUB NOS:14    REM: N216
PT RESP 1469.39                                  SUB TOTALS   1469.39     0.00    0.00   0.00           1469.39     0.00
ADJ TO TOTALS:                    PREV PD 0.00   INTEREST 0.00   LATE FILING CHARGE 0.00
                                                                                                                 NET 0.00

   TOTALS:   # OF CLAIMS  BILLED AMT  ALLOWED AMT  DEDUCT AMT  COINS AMT   RC-AMT   PROV PAID  PROV ADJ   CHECK AMT
                  1        1469.39       0.00         0.00        0.00     1469.39     0.00       0.00     381405.06
PROVIDER ADJ DETAILS:                   PLB REASON CODE      FCN / Other Identifier        AMOUNT
                                              WO                                            -280.00
                                              WO                                             280.00

GLOSSARY:  Adjustment, Group, Reason, MOA, and Remark codes
PR-        Patient Responsibility
       96Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject
           Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy
           Identification Segment (loop 2110 Service Payment Information REF), if present.
N216       We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit
           package
WO         Use this for the recovery of previous overpayment. An identifying number should be provided in PLB03-2. See the
           notes on codes 72 and B3 for additional information about balancing against a provider refund. Medicare Part A will
           provide code "OR" in PLB03-2.
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Medicaid Denial Explanation

Claim was denied for the reason "covered by primary". The provider responded that the services were not covered by primary because they do not pay enteral services for patients under the age of 1 year. Claim was reprocessed by OICU and paid.

MDHHS
Michigan Department of Health & Human Services

CARC 96 – Non-Covered

Original Claim

Amount Paid	Responsibility	Remittance Date (mm/dd/yyyy)		Quantity	Amount	Adj. Reason Code
$0.00	P-Primary					
$0.00	P-Primary	08/25/2020				
			Adj:		$264.00	96
$0.00	P-Primary	08/25/2020				
			Adj:		$61.00	96

EOB

EXPLANATION OF BENEFITS - MEDICARE PART A AND B
Remittance Date: 08/26/2020
MICHIGAN MEDICINE
Provider Number:

Patient Name:
DOB:
Insured's Name:
Policy Number:

Admission Date: 08/12/2020
Discharge Date: 08/12/2020

Invoice Number:
ICN/DCN:

Insurance Carrier Information
MEDICARE PART A AND B
PO BOX 8604
MADISON, WI 53708-8604

MEDICAID MICHIGAN
PO BOX 30043
LANSING, MI 48909

Total Charges:	$ 325.00	**Not Allowed:**	$ 0.00
Allowed:	$ 325.00	**Deductible:**	$ 0.00
Payment:	$ 0.00	**Coinsurance:**	$ 0.00
Adjustment:	$ 0.00	**Copay:**	$ 0.00

Reason Codes
1. N174-N174-THIS IS NOT A COVERED SERVICE/PROCEDURE/ EQUIPMENT/BED, HOWE
2. MA01-MA01-ALERT: YOU MAY APPEAL SERVICE APPROVAL, BUT ONLY WITH AN IND
3. 96-NON-COVERED SERVICES PER INSURANCE

#	Date	HCPC	Mod	Units	Revenue	Billed	Cov. Units	Non-Cov.	Reason & Remark	
1	08/12/2020	90750	PO	1.0	0636	$264.00		**$264.00**	PR 96 N174 31992	More Info
2	08/12/2020	90471	PO	1.0	0771	$61.00		**$61.00**	PR 96 N174 31992	More Info
Total					0001	$325.00		**$325.00**		

Reason & Remark Code Descriptions

96 - NON-COVERED CHARGE(S). USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF),IF PRESENT.
PR - PATIENT RESPONSIBILITY
N174 - THIS IS NOT A COVERED SERVICE/PROCEDURE/ EQUIPMENT/BED, HOWEVER PATIENT LIABILITY IS LIMITED TO AMOUNTS SHOWN IN THE ADJUSTMENTS UNDER GROUP 'PR'.
31992 - CHARGES ON THIS LINE WERE SUBMITTED AS NONCOVERED BY THE PROVIDER THE TOB IS EQUAL TO INPATIENT (11X, 18X, 21X, OR 41X), THE NON-COVERED CHARGES ARE GREATER THAN ZERO AND ARE EQUAL TO THE TOTAL CHARGES, AND SPAN CODE 79 OR M1 IS NOT PRESENT OR A DDE/EMC NON-INPATIENT CLAIM HAS LINE(S) WITH PROVIDER SUBMITTED NON-COVERED CHARGES GREATER THAN ZERO AND IS EQUAL TO THE TOTAL CHARGES, AND CONDITION CODE 20 OR 21 IS PRESENT

Medicaid Denial Explanation

EOB is from Medicare Part A and B. Vaccine & Administration codes that were billed (90750, 90471) are covered under Medicare Part D.

MDHHS Michigan Department of Health & Human Services

CARC 119 – Benefits Maxed

Original Claim

Amount Paid	Responsibility	Remittance Date (mm/dd/yyyy)		Quantity	Amount	Adj. Reason Code
$0.00	P-Primary	10/13/2021				
$0.00	P-Primary	10/13/2021				
			Adj:		$51.00	119

EOB for current DOS

SERVICE DATES FROM/TO	PROCEDURE CODE CVD/NCVD	TOTAL CHARGES	ALLOWED AMOUNT	OTHER INSURANCE DOLLARS	OTHER AMOUNTS NOT COVERED	SUBSCRIBER'S LIABILITY	APPROVED TO PAY	AMOUNT PAID	RSN CODE
* P P O N O N P A I D C L A I M S *									
SUBMITTED SUB ID: CLAIM#:	PATIENT	FINALIZED SUB ID: ACCT/PRESCRIPTION#:				PATIENT:			
10/27/21 10/27/21	3 9 98941	$51.00	$.00	$.00	$.00	$51.00	$.00	$.00	A
CLAIM TOTAL----		$51.00	$.00	$.00	$.00	$51.00	$.00	$.00	
A-MAXIMUM DAYS EXCEEDED. (M007)									

EOB for last paid by primary DOS 7/22/2021

A-WE APPROVED THE APPLICABLE FEE SCHEDULE AMOUNT, OF WHICH $2.49 IS THE PGIP ALLOCATION AMOUNT. THE MEMBER'S LIABILITY IS SHOWN ABOVE.(Z587)

SERVICE DATES FROM/TO	PROCEDURE CODE CVD/NCVD	TOTAL CHARGES	ALLOWED AMOUNT	OTHER INSURANCE DOLLARS	OTHER AMOUNTS NOT COVERED	SUBSCRIBER'S LIABILITY	APPROVED TO PAY	AMOUNT PAID	RSN CODE
SUBMITTED SUB ID: CLAIM#	PATIENT	FINALIZED SUB ID: ACCT/PRESCRIPTION#:				PATIENT:			
07/22/21 07/22/21	3 9 98941	$51.00	$41.50	$.00	$.00	$.00	$41.50	$39.01	A
CLAIM TOTAL----		$51.00	$41.50	$.00	$.00	$.00	$41.50	$39.01	

EOB where benefits were maxed DOS 7/29/2021

SERVICE DATES FROM/TO	PROCEDURE CODE CVD/NCVD	TOTAL CHARGES	ALLOWED AMOUNT	OTHER INSURANCE DOLLARS	OTHER AMOUNTS NOT COVERED	SUBSCRIBER'S LIABILITY	APPROVED TO PAY	AMOUNT PAID	RSN CODE
A-MAXIMUM DAYS EXCEEDED. (M007)									
SUBMITTED SUB ID: CLAIM#:	PATIENT	FINALIZED SUB ID: ACCT/PRESCRIPTION#:				PATIENT:			
07/29/21 07/29/21	3 9 98941	$51.00	$.00	$.00	$.00	$51.00	$.00	$.00	A
CLAIM TOTAL----		$51.00	$.00	$.00	$.00	$51.00	$.00	$.00	
A-MAXIMUM DAYS EXCEEDED. (M007)									

Medicaid Denial Explanation

Claim denied for covered by primary. For CARC 119 Benefits maxed OICU needs EOBs uploaded in DMP for the last DOS that the primary paid for the service, and DOS when benefits were maxed.

MDHHS Michigan Department of Health & Human Services

Original Claim

Amount Paid	Responsibility	Remittance Date (mm/dd/yyyy)		Quantity	Amount	Adj. Reason Code
$0.00	P-Primary					
$0.00	P-Primary	11/15/2021				
			Adj:		$110.00	119
$0.00	P-Primary	11/15/2021				
			Adj:		$60.00	119

EOB for current claim and benefits maxed 11/09/2021

Payer Name:
Tax ID #:
Check/EFT #:
Date Issued: 11/15/2021
Check Amount: $.00

Patient Name | HIC (Insured ID #) | Claim - Acct # | ICN (Payer Claim #) | Rendering Provider #

Date From	Date Thru	POS	Procedure	Modifier(s)	Total Billed	Allowed	Deductible	Coinsurance	Grp-Rsn Code	Adjust Amount	Payment Amount
11/9/2021	11/9/2021	3	G0101	GA---	$110.00				PR-119	$110.00	
11/9/2021	11/9/2021	3	Q0091	GA---	$60.00				PR-119	$60.00	
			Claims Totals		$170.00	$.00	$.00	$.00		$170.00	$.00

PR-119 --> Benefit maximum for this time period or occurrence has been reached.
Scenario --> # 3 - Billed Service Not Covered by Health Plan
Scenario --> # 3 - Billed Service Not Covered by Health Plan
M38 --> Alert: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges.
M83 --> Service is not covered unless the patient is classified as at high risk.

EOB for last paid by primary DOS 10/07/2020

Payer Name:
Tax ID #:
Check/EFT #:
Date Issued: 10/22/2020
Check Amount: $129.24

Patient Name | HIC (Insured ID #) | Claim - Acct # | ICN (Payer Claim #) | Rendering Provider #

Date From	Date Thru	POS	Procedure	Modifier(s)	Total Billed	Allowed	Deductible	Coinsurance	Grp-Rsn Code	Adjust Amount	Payment Amount
10/7/2020	10/7/2020	3	G0101	GA---	$110.00	$42.53			CO-45	$67.47	$42.53
10/7/2020	10/7/2020	3	Q0091	GA---	$60.00	$44.18			CO-45	$15.82	$44.18
			Claims Totals		$170.00	$86.71	$.00	$.00		$83.29	$86.71

CO-45 --> Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual

Medicaid Denial Explanation

11/9/2021 Provider explanation-Primary only pays for the G and Q code every other year. Primary paid DOS 10/7/20 so they would not pay in 2021.

CARC 23 – Prior Payer(s) Adjudication

Claim Example

Amount Paid	Responsibility	Remittance Date (mm/dd/yyyy)		Quantity	Amount	Adj. Reason Code
$0.00	P-Primary					
$0.00	S-Secondary					
$0.00	P-Primary					
			Adj:		$84.11	45
			Adj:		$175.89	1
$0.00	S-Secondary					
			Adj:		$175.89	3
			Adj:		$84.11	23

Acceptable Use of CARC 23

CARC 23 must equal the Primary OI payment plus any write-off amount that is included in a reduced CARC (ex. 45, 97, 144, 253, 237)

CARC 23 – Prior Payer(s) Adjudication

Claim Example

Amount Paid	Responsibility	Remittance Date (mm/dd/yyyy)		Quantity	Amount	Adj. Reason Code
$0.00	P-Primary					
$0.00	S-Secondary					
$0.00	P-Primary					
			Adj:		$94.02	45
			Adj:		$95.98	1
$0.00	S-Secondary					
			Adj:		$95.98	204
			Adj:		$94.02	23

Acceptable Use of CARC 23

CARC 23 is equal to primary OI payment $0.00 and CARC 45 $94.02

CARC 23 – Prior Payer(s) Adjudication

Claim Example

$100.66	P-Primary	04/02/2021					
			A	Adj:		$34.18	45
				Adj:		$25.16	2
$20.13	S-Secondary	06/21/2021					
				Adj:		$134.84	23
				Adj:		$5.03	2
$31.42	P-Primary	04/02/2021					
			B	Adj:		$60.73	45
				Adj:		$7.85	2
$6.28	S-Secondary	06/21/2021					
				Adj:		$92.15	23
				Adj:		$1.57	2
$0.00	P-Primary	04/02/2021					
			C	Adj:		$50.00	96
$0.00	S-Secondary	…21					
				Adj:		$50.00	23

Acceptable and Denied Use of CARC 23

CARC 23 is equal to primary OI payment and CARC 45 for lines 1-2

A. $134.84= $100.66 + $34.18

B. $92.15= $31.42 + $60.73

C. CARC 96 is not appropriate to bill with a 23.

CARC 23 – Prior Payer(s) Adjudication

Claim Example

$74.65	P-Primary	10/13/2021				
$18.35	S-Secondary	10/27/2021				
$74.65	P-Primary	10/13/2021				
			Adj:		$28.23	45
			Adj:		-$1.23	144
			Adj:		$18.35	3
$18.35	S-Secondary	10/27/2021				
			Adj:		$101.65	23
$0.00	P-Primary	10/13/2021				
			Adj:		$90.00	96
$0.00	S-Secondary	10/27/2021				
			Adj:		$90.00	96

Acceptable Use of CARC 23

CARC 23 is equal to primary OI payment + CARC 45 – CARC 144 (this is ONLY when a negative amount is acceptable

$101.65= $74.65 + $28.23 - $1.23

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Claim Example

		Date (mm/dd/yyyy)				Reason Code
$6.92	P-Primary					
$0.00	S-Secondary					
$6.92	P-Primary					
			Adj:		$84.92	45
			Adj:		$104.16	1
$0.00	S-Secondary					
			Adj:		$91.84	23
			Adj:		$104.16	1

Acceptable Use of CARC 23

CARC 23 is equal to primary OI payment and CARC 45

$91.84= $84.92 + $6.92

Claim Example

		(mm/dd/yyyy)				Code
$68.59	P-Primary					
$0.00	S-Secondary					
$68.59	P-Primary	06/18/2021				
			Adj:		$8.18	144
			Adj:		$43.23	45
			Adj:		$40.00	3
$0.00	S-Secondary	06/29/2021				
			Adj:		$108.59	1
			Adj:		$51.41	23

Denied Use of CARC 23

CARC 23 is NOT equal to primary OI payment, CARC 45 and CARC 144

$51.41 not = $68.59 + $43.23 + $8.18

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Reminders for Successful Claim Submission

- Overview
- Prior Authorization
- CHAMPS Claim Screen Error Messages
- Getting your DDE Claim to Balance

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Overview

- Professional/Dental claim type:
  - OI is reported at both the header and service line level.
- Institutional claim type:
- Outpatient - OI is added at the header and service line level
  - Inpatient - OI is added only at the header level
- Important to note:
  - When submitting a DDE claim, the Payer ID listed in CHAMPS is required for claim processing.
  - Coverage types DO (dental only), VO (vision only), and RX (pharmacy) are not required on the claim unless billing for those specific services. All other coverage types are required to be listed on the claim.

- When would a provider add or adjust other insurance to a claim?
  - To add other insurance coverage to a new claim submission.
  - To add other insurance coverage to an already paid claim due to finding coverage later on.
  - To adjust other insurance coverage to an already paid claim due to correction by primary payer (e.g., takebacks, reprocessing, TPL void, etc.).
    - How to Access TPL Void Reports
- Prior to adding or adjusting OI coverage to a paid claim through DDE in CHAMPS, have the following available:
  - Primary payer Explanation of Benefits (EOB);
  - Verify the Group or Policy number and the Payer ID within the CHAMPS member eligibility screen; and
  - Verify the TCN is in a paid status and has been issued to a remittance advice (RA) or shows a pay cycle date within CHAMPS claim inquiry.
- Resources:
  - Step-by-Step Instructions for Verifying Eligibility
  - How to Adjust a DDE Claim with Other Insurance
  - How to Locate Payer ID and Other Health Insurance Information website
  - Commercial/Other Insurance Coverage Type Codes
  - Other Insurance CARC Codes Resource

Prior Authorization

PA is not necessary for situations of OI* coverage if all the following apply:	PA is required for the following:
• The beneficiary is eligible for the OI and the primary insurer rules are followed; • The provider is billing a standard HCPCS* code that Medicaid covers, and the primary insurer makes payment or applies the service to the deductible; and • The service/item complies with Michigan Medicaid standards.	• The OI benefit has been exhausted or the service/item is not a covered benefit. • PA is necessary for all other situations, including not otherwise classified (NOC) codes.

- *OI – Other Insurance; HCPCS – Healthcare Common Procedure Coding System
- Prior Authorization Website

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CHAMPS DDE Claim Screen Error Messages

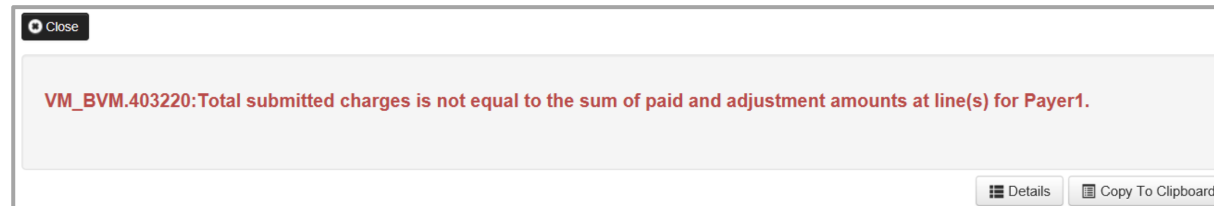
- If attempting to exit the other payers screen without saving:

Please save the information to complete the data validation after adding or updating data.

  - *To correct, ensure you are clicking save prior to exiting the other payer's screen.*
- If both the header and service line is selected at the same time and edit is clicked:

Multiple selections not allowed, only one record can be edited at a time.

  - *To correct, ensure you are only selecting one line to edit at a time.*
- If the submitted charges on the claim header and the other payer amounts do not balance:



  - *To correct, ensure all other payer information balances to the submitted charges.*

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Getting your DDE Claim to Balance

- A - Line one submitted charges are $235.
- 235 = 66.65 (primary payment) + 66.66 (CARC 2) + 101.69 (CARC 45).
- B - Line two submitted charges are $270.
- 270 ≠ 66.65 (primary payment) + 66.92(CARC 2) + 136.16 (CARC 45) (this equals 269.73 versus the 270 that was submitted for charges.

	Submitted Charges ▲▼	Approved Amount ▲▼	Claim Status ▲▼
A	$235.00	$0.00	Denied
B	$270.00	$0.00	Denied

« First ‹ Prev › Next » Last

Amount Paid	Responsibility	Remittance Date (mm/dd/yyyy)		Quantity	Amount	Adj. Reason Code
$133. 30	P-Primary					
$66.65	P-Primary					
			Adj:		$66.66	2
			Adj:		$101.69	45
$66.65	P-Primary					
			Adj:		$66.92	2
			Adj:		$136.16	45

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Provider Resources

MDHHS website: www.michigan.gov/medicaidproviders

We continue to update our Provider Resources:

- CHAMPS Resources
- Listserv Instructions
- Provider Alerts
- Medicaid Provider Training Sessions

Provider Support:

ProviderSupport@Michigan.gov

1-800-292-2550

Thank you for participating in the Michigan Medicaid Program

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