Top Line Level Denial Reasons				
Portal	**RA/835 Code**		Link To Confirm CARC/RARC Codes:	
Edit Reason (Reason shown when viewing on the Portal)	**CARC ***	**RARC ^***	**Business Description**	**Troubleshooting Tips**
532/6026	**18**	**N/A**	**Services billed have already been paid on a separate claim**	1. Pull up the claim status screen on Health Pas. Do a search for the member information and the date of service. 2. Check the paid claims for the same date of service. There should be a claim listed that matches the rendering provider, service code, and modifier. 3. If the line on the paid claim denied, the paid claim must first be reversed and then rebilled. 4. If all other claims for that date of service are denied, there may have been a timing issue with more than one claim coming into the system at the same time; this can be rebilled.
238	**16**	**N245**	**MaineCare's reaction to the Medicare denial reasons listed on the Medicare EOB**	1. Check the Medicare EOB to determine if Medicare paid or denied the claim. 2. If Medicare denied the claim, check the member's eligibility to see if there is full Mainecare. QMB will not pay on denied lines from Medicare. 3. Does the denial reason from Medicare indicate that there was a processing issue with their claim? MaineCare will deny appropriately for certain Medicare denials such as: a. "These are non-covered services because this is not deemed a 'medical necessity' by the payer." b. "Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply." c. "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." 4. If the Medicare EOB shows that a payment was paid on the line, the claim can be rebilled with the EOB attached.
524	**97**	**M15**	**The procedure code is considered to be part of a procedure previously billed and paid to the provider.**	1. This edit follows National Correct Coding Initiative (NCCI) guidelines. Be sure the service you are billing is not one that would be considered to be bundled in a different CPT/HCPC.
378	**22**	**MA04**	**The member has a primary insurer other than MaineCare, and payment has not been noted on the claim, or the EOB was not attached, stating the reason for denial by TPL/Medicare.**	1. Similar to edits 216 and 252; for specific lines on the claim that require a primary insurance EOB. A claim can pay some lines that are exempt from billing the primary insurance and deny other lines for this edit. 2. Is there a Coordination of Benefits attached? This is a requirement when MaineCare is secondary to another payer. 3. Ensure the Direct Data Entry and/or X12 COB fields are filled out. 4. Pended claims can be corrected via the Online Portal and the attachments can be uploaded.

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502	**18**	**N/A**	**Identical services billed on two separate lines of one claim.**	1. Denies claim lines when there are multiple lines on the same claim that are the same date of service, revenue code, CPT code, and modifier. 2. Provider needs to check the dates of service and codes to ensure the correct codes are billed. If this is the case, the lines can usually be combined by adding the units together. 3. If the provider needs to separate the lines due to different prior authorization numbers and the line denies, the provider can call Provider Services to have the claim reviewed.
150	**185**	**N/A**	**The CPT/HCPC/REV billed was not active under the provider's profile on the claim date of service.**	1. The code billed is not one the provider can bill for the service location or rendering provider listed on the claim. 2. Provider should check to make sure the correct rendering provider and service location were used. 3. Provider should check Chapter III of the policy they bill under to be sure that the correct codes are being billed.
202/203	**204**	**N/A**	**Service billed is not covered in the member's benefit plan**	1. Verify the member's eligibility for the claim date(s) of service. 2. Verify that the CPT/HCPC being billed is a MaineCare covered code. MaineCare will only reimburse on those claims where Medicare coinsurance/deductible are indicated, following "lesser than" logic. MaineCare will not pay for these codes when MaineCare is the primary payer or when another insurance company is the primary payer.
611	**198**	**N/A**	**The prior authorization (PA) associated with the claim does not have enough units available to apply to the claim.**	1. Ensure that you are not billing for more units than what is available on your PA.
989	**Effective 12/11/2013 - CARC 16 and RARC M51 will be the messages seen for this edit.**		**Outpatient claim billed with revenue code but no CPT/HCPC**	1. Ensure that you are including a revenue code and CPT/HCPC on each line of your outpatient UB04 claim.
205	**197/NA**	**N/A**	**The member's benefit requires a prior authorization (PA). The system will look for a PA to apply to the claim line for a period of 3 days. If, after the last day, a PA that matches the service being billed is not found, the claim line will be denied. If a PA which will apply to the service being billed is found during that time, the edit will be overridden by the system.**	1. Ensure a prior authorization has been received for the service (s) prior to billing the claim. 2. If provider has multiple PAs which overlap dates of service for a member, attach the appropriate PA number to the claim.