

Magellan Healthcare of Idaho

Claims – Denial Codes Crosswalk

Overview

The purpose of this guide is to help Idaho Behavioral Health Plan (IBHP) providers determine the reason for a claim denial. On the explanation of payment (EOP), there will be a standardized code. This code is the claim adjustment reason code (CARC). Most times there is also a remittance advice remark code (RARC), but not always. If there is a denial code on the EOP, use the below crosswalk to find the CARC/RARC code and then the corresponding denial code we use at Magellan with the reason for denial.

CARC and RARC codes are defined by the government. To see a full list of codes, visit the [CARC codes list](#) or [RARC codes list](#).

CARC Denial Code	RARC Denial Code	Magellan Denial Code	Magellan Code Meaning	Magellan Code Description/Direction
4	N519	K9	Invalid CPT procedure code/modifier code	The procedure code/modifier combination submitted is not in the correct order for the multiple modifiers or is not appropriate or is not covered for the diagnosis/service billed. If there is information that documents that the services rendered meet the benefit plan requirements for reimbursable mental health or substance abuse services, please resubmit that information.
11	M76	2C	Diagnosis does not match the procedure code billed	Diagnosis does not match the procedure code billed. Resubmit with correct procedure code.
11		L4	Mismatched diagnosis codes	Based on the ICD-10-CM official guidelines for coding and reporting, two or more diagnosis codes associated with this service are mismatched.
16	N152	3Y	EDI Adjustment-missing information	The information received is not sufficient for us to determine which claim(s) requires adjustment for this electronic adjustment request. Please resubmit this adjustment request and provide the Original Reference Number, including claim line number on the EDI file.

CARC Denial Code	RARC Denial Code	Magellan Denial Code	Magellan Code Meaning	Magellan Code Description/Direction
16	N479	05	COB requested primary carrier's EOB	The Coordination of Benefits (COB) section of the member's plan booklet requires that claims for members covered under multiple plans first be submitted to the primary plan(s). According to our records, or the information reflected on the claim, the member's primary coverage is through another carrier or health plan(s). To process this claim, we require the Explanation of Benefits (EOB) of the primary plan(s) and/or Medicare. If there is information that documents that the claim should be processed as originally submitted, please submit that information for consideration.
18	N522	IW	Corrected claim received and adjusted original claim	We have received the corrected claim and have adjusted the original claim that was submitted. Please reference the original claim submission.
18	N522	C3	Duplicate, previous submit and processed or still in process	Our records indicate the charge for these services was previously submitted and was processed or is still in process. As a result, this claim is not eligible for payment. If there is information that documents that this claim has not been previously processed, please submit that information.
18	N522	3Z	Adjusted claim exact match to original claim	The information received is an exact match to the previously submitted claim and therefore no adjustment can be made. If you intended for this claim to be adjusted, please submit this adjustment with amended information along with the Original Reference Number on the EDI file if applicable. Be sure to include the reason(s) for requesting this adjustment.
26	N30	G8	Prior to PLAN effective date	The member was not eligible for coverage on this date of service. Under our guidelines, claims are considered only for members who are eligible under this plan on the date(s) of service. Submit your claim to the insurance carrier or plan under which the individual was eligible on the date of service. If there is information that documents that the person was eligible on the date services were rendered, please submit that information for consideration.
39		42	Case deny UM Review-Par-Member not responsible	Our records indicate a non-authorization was issued for these dates of service. Please refer to the non-authorization notice regarding these services. If there is information that documents that the date(s) of service was authorized, please submit that information.

CARC Denial Code	RARC Denial Code	Magellan Denial Code	Magellan Code Meaning	Magellan Code Description/Direction
49	N390	AB	Code cannot be billed alone	In accordance with correct billing procedures, this code cannot be considered unless billed in conjunction with an appropriate primary procedure code. If there is information that documents that this code was billed in conjunction with an appropriate primary procedure code, please submit that information for consideration.
96	N130	K8	The service not covered for the patient's age	The member does not meet the criteria for this service because of member age and/or eligibility criteria. If there is information that supports and/or documents that the services rendered meet the benefit plan requirements for reimbursable mental health services, please submit that information.
96	N428	BL	Services provided in this location are not covered	The service rendered is not covered when rendered at this location. If there is information that documents that services for this location meet the plan guidelines, please submit that information.
96	N643	RX	CPT/HCPCS is not covered under the member's plan	The code billed is not covered under the member's plan. If there is information that documents that the service is covered under the member's plan, please submit that information for consideration.
96	N665	QD	Degree level modifier missing/does not match provider degree	The required license level modifier was not provided on the claim submission and/or does not match the provider degree level. Therefore, payment cannot be made for this service. For consideration of these charges, please resubmit the claim to include the license level modifier of the servicing provider. If there is information that supports and/or documents that the information was included in the original claim submission, please submit that information.
109	N130	53	Non-covered/medical service	The service billed is not covered as a mental health or substance abuse benefit under the plan but may be covered as a medical benefit. If you believe this to be the case, submit the claim to the medical health plan. If there is information that documents that the services are covered as a mental health or substance abuse benefit under the plan, please submit that information.
109	N569	EE	Non-covered behavioral health diagnosis	The service rendered is not covered for this diagnosis under the plan. Please refer to member materials for benefit guidelines. If there is information which documents that the services rendered for this diagnosis meet the benefit plan requirements for reimbursable mental health or substance abuse services, please submit that information.

CARC Denial Code	RARC Denial Code	Magellan Denial Code	Magellan Code Meaning	Magellan Code Description/Direction
131		KN	This code/service is inclusive in the Special Program	This code/service is inclusive in the special program payment.
177	N30	E8	Patient not eligible	The member was not eligible for coverage on this date of service. Claims are considered only for members who are eligible under this plan on the date(s) of service. Submit your claim to the insurance carrier or plan under which the individual was eligible on the date of service. If there is information that documents that the person was eligible on the date services were rendered, please submit that information for consideration.
197		54	Par prov- no authorization on file	There is no authorization available for this date of service with this participating provider. The member is responsible only for applicable deductibles, co-pay and/or co-insurance. The provider should not balance bill the member. If there is information that documents that the services were authorized, please submit that information for consideration.
204	N569	IA	Diagnosis not covered for the service	The service rendered is not covered for this diagnosis under the program. If there is information that documents that the services rendered for this diagnosis meet the program requirements for reimbursable services, please submit the information. An example is the primary diagnosis listed is medical, but the provider and CPT codes are behavioral health.
243	M115	I6	Non-par provider- no authorization on file	Per the benefit schedule for this plan, coverage is only provided for services rendered by providers who participate in the provider network.
250	M49	KD	Encounter data missing/invalid	There are missing and/or invalid values for the encounter value payment of your facility type. For consideration of these charges, please resubmit the claim with the required information.
251	M127	GD	PI denial-request medical record	The appropriate medical records and all supporting documentation for the date(s) of service is needed in order to review. Please submit the documentation within 45 days of receipt of notification to facilitate prompt review of the submitted claim(s) to: PIRecordsReview@MagellanHealth.com . It is important to note that the processing of the claim(s) cannot be completed until the requested documentation is received.