



Claim Denial Reasons and Resolutions (1945)

Executive Office of Health & Human Services

Edit Resolution Overview

This module provides an overview of common claim denial reasons and how to avoid them.

We will review how in the Provider Online Service Center (POSC), providers may verify a member's eligibility or check a claim status to determine the next steps to make claim corrections.

Common Edit Denials

After analysis of call reasons, some common denial themes were identified

- Claim was submitted incorrectly to account for previous submissions of the claim or coordination of benefit information
 - 4021 Member benefit plan does not cover procedure
 - 2502 Member covered by other insurance
 - 2020 Treatment not allowed for Limited benefit plan
 - 850 90-Day billing deadline exceeded
- There was a provider coding error
 - 4801 Procedure not covered by provider contract
 - 2020 Treatment not allowed for Limited benefit plan

Common Edit Denials 2

The common denial themes Identified could be for the following reasons:

- Provider file needs to be reviewed updated
 - 1010 Rendering Provider Not A Member of Billing Group
 - 1945 Billing provider is mapped to multiple service locations
- Provider misinterpreted member eligibility data
 - 4021 Member benefit plan does not cover procedure
 - 2502 Member covered by other insurance
 - 2020 Treatment not allowed for Limited benefit plan
- Member information was updated after the provider had checked eligibility
 - 4021 Member benefit plan does not cover procedure
 - 2502 Member covered by other insurance
 - 2020 Treatment not allowed for Limited benefit plan
- The claim was not submitted in the accepted time frames
 - 850 90-Day billing deadline exceeded

* These are the MassHealth EOB codes and not the HIPAA CARC and RARC codes. You may find these codes on the MassHealth PDF remittance advice available from the POSC. <https://www.mass.gov/doc/claim-adjustment-reason-codes-and-remittance-advice-remark-codes-carcs-and-rarcs-effective-112022/download>

Provider File Updates

Provider File Updates Information

- If submitting via paper, email or fax, include your MassHealth provider number or NPI on all correspondence
- Keep all information accurate, including:
 - Addresses: legal entity, doing business as and check mailing
 - Telephone numbers
 - Licensure and certifications
- All updates must be submitted using the POSC system or in writing to:

MassHealth

ATTN: Provider Enrollment and Credentialing

PO Box 278

Quincy MA 02171-0005

fax: 617-988-8974 (must have a cover sheet with: ATTN: Provider Enrollment and Credentialing)

Provider File Updates - POSC

A provider can verify current information or update their profile in the POSC by clicking

1. Manage Provider Information
2. Update Your MassHealth Profile



Health and Human Services Mass.Gov 

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« Collapse Services

» Provider Services

- > Home
- > Provider Search
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» MassHealth Provider Online Service Center ?

List of Providers

Please select the provider you wish to update.

Name	Provider ID	City	State
		QUINCY	MA

1945 Edit 1



- The 1945 edit sets in MMIS when a claim is submitted with the billing provider NPI and MassHealth is not able to crosswalk the NPI to a PIDSL
- This happens when the NPI is linked to multiple PIDSLs on the and there is no unique identifier on the provider's file and/or the provider's claims submission that would allow the claim to crosswalk the NPI to the appropriate PID/SL
 - This includes NPIs with an end date that are not displayed in the Provider Search screen, but were active on the claim DOS

Edit Denial Code 1945

These Explanation of Benefit (EOB) codes may appear because the billing provider’s NPI is linked to multiple Provider ID/Service Locations (PIDSL) and MassHealth cannot route to the correct PIDSL. Claims deny to the first PIDSL with the NPI.

Edit Code Type	Description
EOB	Billing Provider NPI Is Mapped To Multi Serv Loc
CARC	Information Requested From Billing/Rendering Provider Was Not Provided Or Not Provided Timely Or Was Insufficient/Incomplete.
RARC	N/A

- **Common Occurrences:**
 - The address listed in the 837, 2010AA segment is not the DBA address in your provider file
 - Zip Code, including +4 billed on the claim(s) does not match your provider file with MassHealth
 - A new provider location has been added with the same NPI and you need to bill with the DBA address and/or taxonomy code
- **Recommended Guidance:**
 - Confirm the address listed in the 2010AA segment is correctly listed as the DBA address of the location being billed
 - Confirm zip code, including the +4 entered on the claim(s) match provider file
 - You may need to bill with taxonomy code to crosswalk the NPI

Provider File 1



There are times when a provider may have an NPIs listed on multiple PIDSLs at the same address for different provider types, like PT 26 & 28. In these cases, you can use the provider type specific taxonomy code to crosswalk the NPI. This includes 1946 and 1952 denials for individuals enrolled under different PIDSLs with the same NPI as with PTs 01 & 10.

If the provider is enrolled with the same provider type at the same address with the same NPI with multiple PIDSLs, then an NPI crosswalk taxonomy would be required.

Changes to an address, or address verification in the address panel can change the address and start to cause 1945 issues.

Correcting a 1945 Denial

How to correct a 1945 denial?

- Does the provider have multiple service location addresses? Do they need to bill with the specific DBA address?
- Is the provider enrolled with different provider types? Do they need to bill with the provider type specific taxonomy code?
- Is the provider enrolled with the same provider type/address? Do we need to add an NPI crosswalk taxonomy code?
- Does the provider have an administrative PIDSL that does all the billing? Do we need to end date an NPI from a non-billing PIDSL?
- Has the provider changed the information sent in the 837 2010AA segment?
- Be sure your crossover claims are billed to Medicare the way you bill to MassHealth

Checking Member's MassHealth Eligibility

Edit Denial Codes

- Common edit denial codes associated with eligibility include:
 - 4021 not covered by benefit plan*
 - 2502 Member covered by other insurance
 - 2020 Service not allowed for limited benefit plan

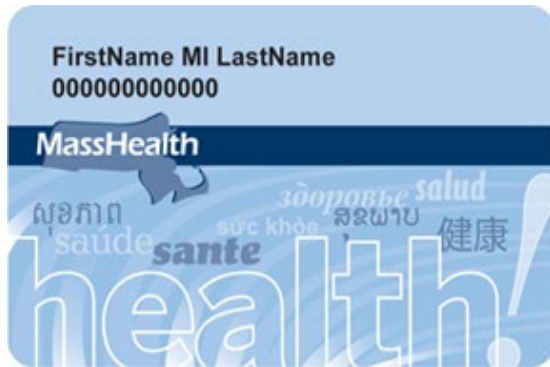
Checking member eligibility could avoid these kinds of errors

* For a comprehensive listing of all the various coverage types please see the link below. [MassHealth Coverage Types](#)

Eligibility Verification

Member Identification Card:

Each member is issued a MassHealth ID card, which includes the individual and their system-generated 12-digit ID number.



Members enrolled in managed care plans may have additional cards issued by their managed care plan.

Eligibility Verification Information

The Eligibility Verification System (EVS) is:

- Accessible through the Provider Online Service Center (POSC)
- Available 24 hours a day, 7 days a week
- Easy access to the most current and complete member eligibility information

Where you go to check eligibility?

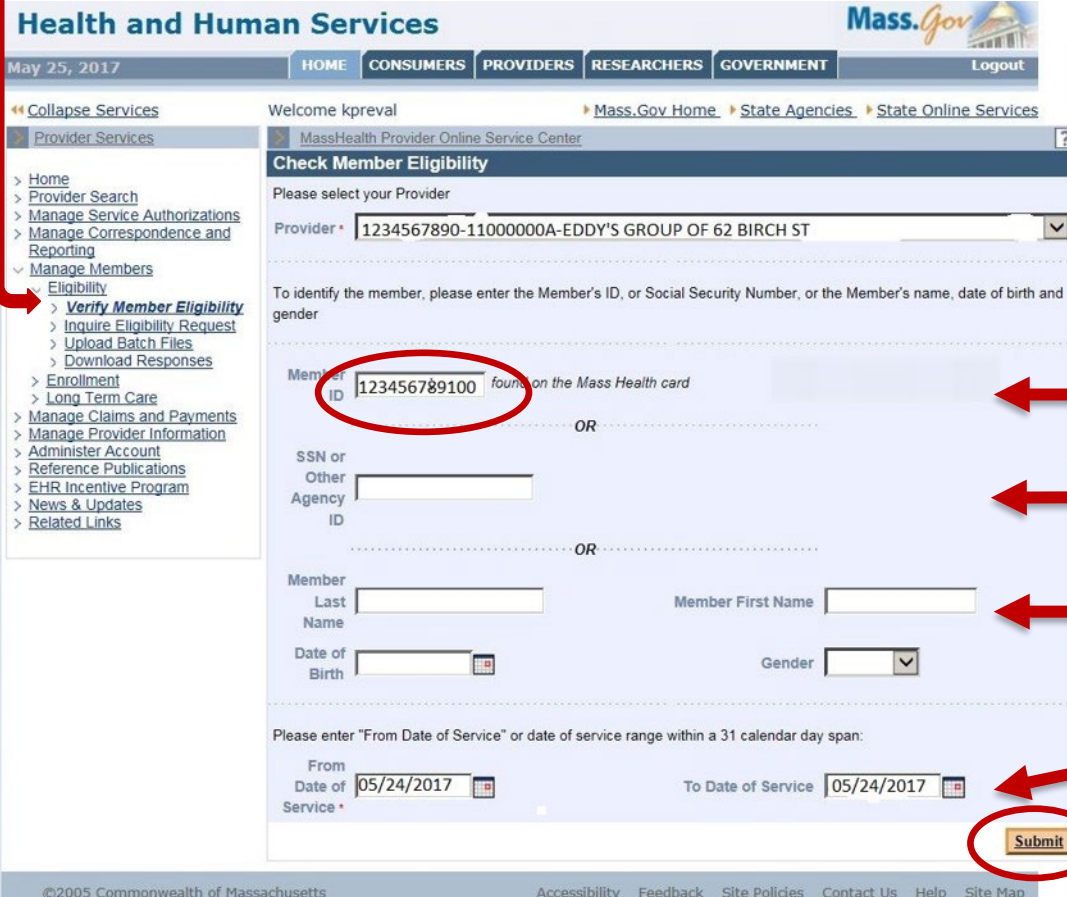
- **Eligibility Verification System (EVS):** The EVS is accessed through the POSC at www.mass.gov/masshealth/provider-service-center
- For additional information, see the [Submit Eligibility Inquiry job aid](#)

What you need when checking eligibility?

- POSC User ID & Password
- MMIS Provider ID/Service Location
- Dates of Service
- Member ID Number or Member Name and DOB

Eligibility Verification POSC

The Check Member Eligibility page can be accessed by clicking *Manage Members* from the menu then click *Verify Member Eligibility*.



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MassHealth Provider Online Service Center

Check Member Eligibility

Please select your Provider

Provider *

To identify the member, please enter the Member's ID, or Social Security Number, or the Member's name, date of birth and gender

Member ID found on the Mass Health card

OR

SSN or Other Agency ID

OR

Member Last Name Member First Name

Date of Birth Gender

Please enter "From Date of Service" or date of service range within a 31 calendar day span:

From Date of Service * To Date of Service

1. Select the provider from the drop-down menu

2. Search for the member either by MassHealth ID

Or Social Security Number, or Agency ID

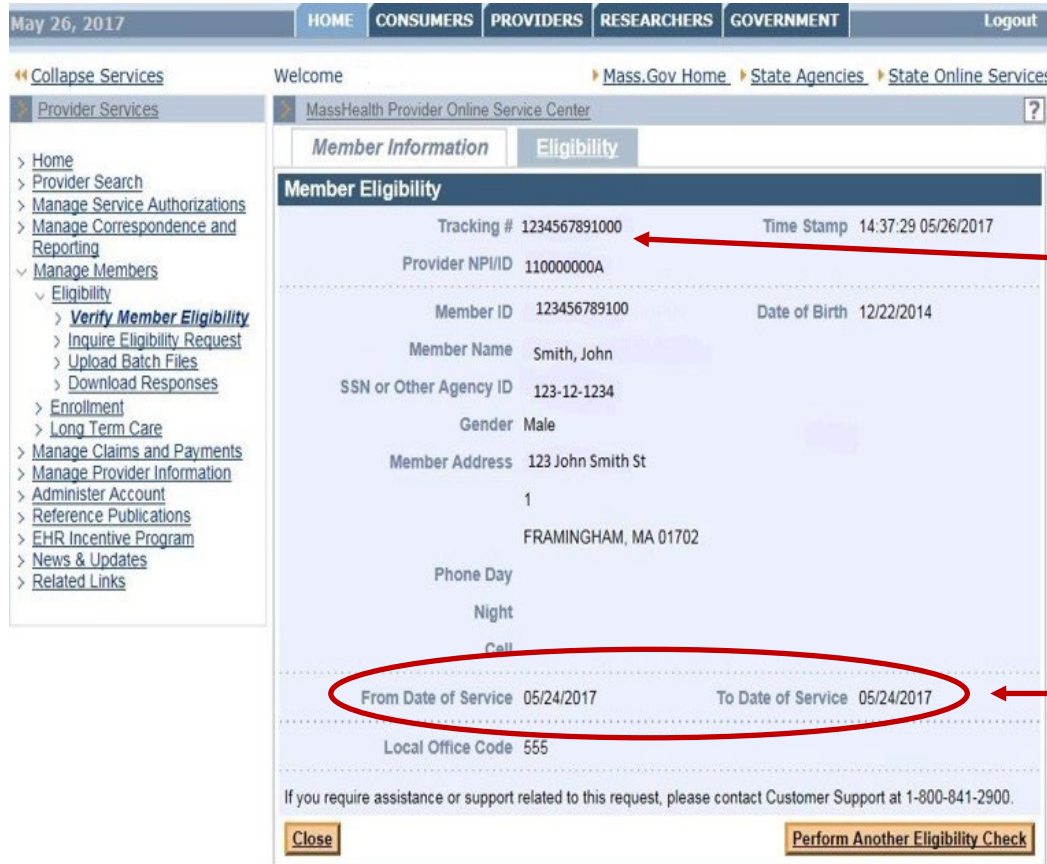
Or Member's Last Name, First name, DOB & Gender

3. Enter the date of service (date range needs to be equal to or before the current date)

4. And finally Click **Submit**

Eligibility Verification POSC 2

From the Member Information Tab ensure that you have the correct member by verifying all of his or her Information as indicated in the example below (which includes the member's name, social or Agency ID and address) are correct.



The screenshot shows the 'Member Eligibility' section of the POSC. The tracking number 1234567891000 is highlighted with a red arrow. The member's name is John Smith, and the date of birth is 12/22/2014. The address is 123 John Smith St, Framingham, MA 01702. The 'From Date of Service' and 'To Date of Service' are both 05/24/2017, which is circled in red. The interface includes a navigation menu on the left, a top navigation bar with 'HOME', 'CONSUMERS', 'PROVIDERS', 'RESEARCHERS', and 'GOVERNMENT', and a 'Logout' button. At the bottom, there are buttons for 'Close' and 'Perform Another Eligibility Check'.

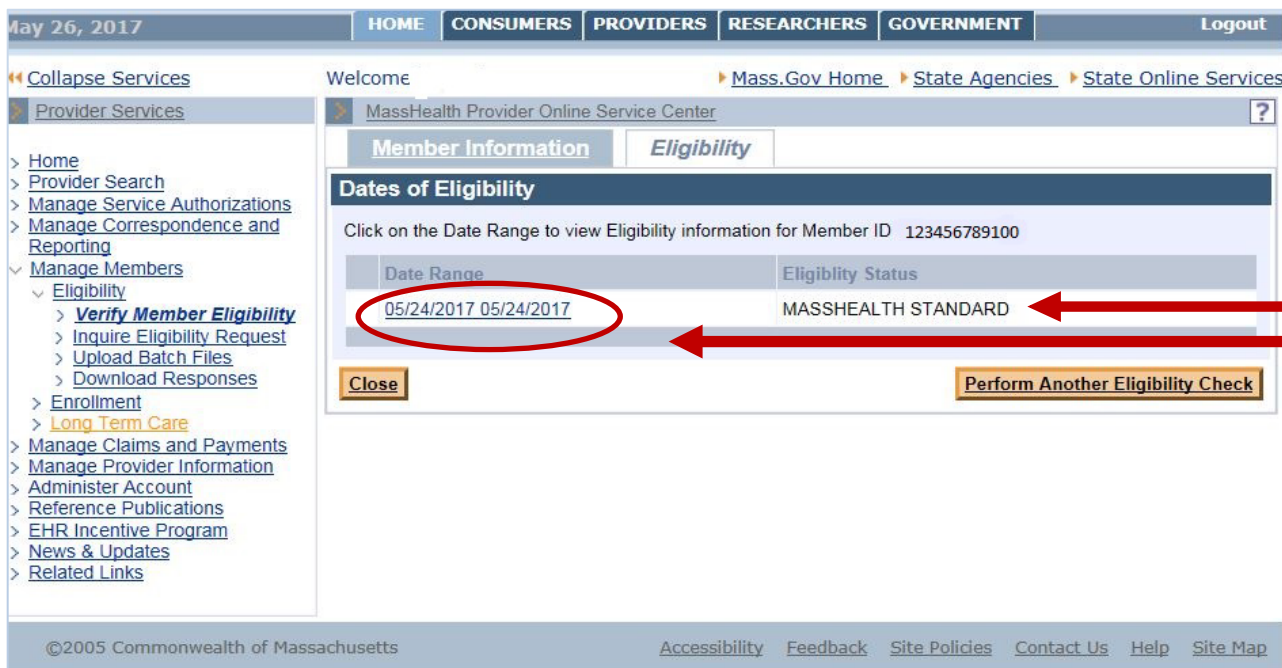
Note the tracking number to verify eligibility verification

Note: Member eligibility information is specific to the date of service entered and also as a reminder, no future dates are allowed

Eligibility Verification POSC 3

Eligibility Tab.

From the *Eligibility* Tab you will see which coverage type the member is enrolled in



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MassHealth Provider Online Service Center

Member Information Eligibility

Dates of Eligibility

Click on the Date Range to view Eligibility information for Member ID 123456789100

Date Range	Eligibility Status
05/24/2017 05/24/2017	MASSHEALTH STANDARD

Close Perform Another Eligibility Check

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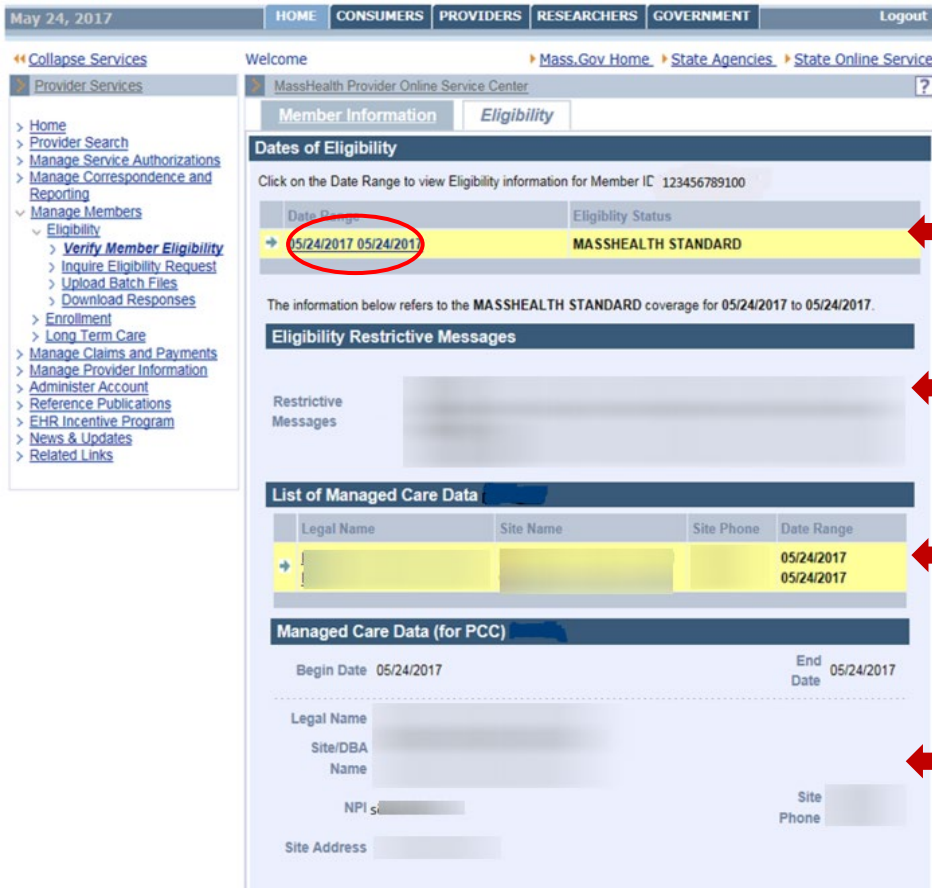
Click on the Date Range for more descriptive information regarding the Plan type (if any) (more than one coverage type may be listed)

The example above indicate the member's coverage as **MassHealth Standard** (which is one of the coverage types), but for a more comprehensive listing of all the various coverage types please see the link below.

[MassHealth Coverage Types](#)

Eligibility Verification POSC 4

Eligibility tab for member



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MassHealth Provider Online Service Center

Member Information | Eligibility

Dates of Eligibility

Click on the Date Range to view Eligibility information for Member IC 123456789100

Date Range	Eligibility Status
05/24/2017 05/24/2017	MASSHEALTH STANDARD

The information below refers to the MASSHEALTH STANDARD coverage for 05/24/2017 to 05/24/2017.

Eligibility Restrictive Messages

Restrictive Messages

List of Managed Care Data

Legal Name	Site Name	Site Phone	Date Range
			05/24/2017 05/24/2017

Managed Care Data (for PCC)

Begin Date 05/24/2017 | End Date 05/24/2017

Legal Name
Site/DBA Name
NPI
Site Address | Site Phone

1. Click on the Date Range for additional information such as the *Eligibility Restrictive Messages* pertaining to the coverage type

2. *Eligibility Restrictive messages* show any and all information pertaining to the member's **coverage type**.

3. *List of Managed Care Data* Indicates, as applicable, if the member is enrolled in PCC, MCO or ACO plan

4. *Managed Care Data details* provides the contact information, DBA address, telephone number for the site (if PCC) or the Health Plan's (if MCO or ACO).

The example above indicate the member's coverage as **MassHealth Standard** (which is one of the coverage types), but for a more comprehensive listing of all the various coverage types please see the link below. [MassHealth Coverage Types](#)

Edit Code 4021

These EOB codes often appear when the services delivered to the member are not covered under their benefit plan.

Edit Code Type	Description
EOB	Procedure Not Covered For Benefit Plan
CARC	This Service/Equipment/Drug Is Not Covered Under The Patient's Current Benefit Plan
RARC	Consult Plan Benefit Documents/Guidelines For Information About Restrictions For This Service.

- Common Occurrences:
 - Not checking for member’s active coverage
 - Code not applicable for the member’s coverage type
- Recommended Guidance:
 - Check member eligibility to know coverage type on DOS
 - Review of [MassHealth Coverage Types](#) available on Mass.gov or to the [Administrative and Billing Regulations](#), at 450.105

Edit Code 2502

These EOB codes may appear when the member has another insurance listed on file

Edit Code Type	Description
EOB	Member Is Covered By Other Insurance - Deny
CARC	This Care May Be Covered By Another Payer Per Coordination Of Benefits.
RARC	Secondary Payment Cannot Be Considered Without The Identity Of Or Payment Information From The Primary Payer. The Information Was Either Not Reported Or Was Illegible.

❖ Common Occurrences:

- Not checking for member’s active coverage for other insurance
- Not including member’s other insurance carrier code on claim

❖ Recommended Guidance:

- Checking Eligibility Verification System (EVS)
- Checking administrative guidelines
 - Provider Manual - [Appendix C](#) lists common third party liability carrier codes
- Entering TPL carrier code on claim (displayed on the eligibility response) and the full COB information on the claim

Edit Code 2020

These EOB codes may appear The service is not allowed for a member in the Limited Benefit Plan

Edit Code Type	Description
EOB	Treatment Not Allowed For Limited Benefit Plan
CARC	This Service/Equipment/Drug Is Not Covered Under The Patient's Current Benefit Plan
RARC	Consult Plan Benefit Documents/Guidelines For Information About Restrictions For This Service

❖ Common Occurrences:

- Not checking for member’s active coverage
- Not listing emergency diagnosis as primary, secondary or at all, as applicable

❖ Recommended Guidance:

- Checking Eligibility Verification System (EVS)
- Checking administrative guidelines [MassHealth Coverage Types](#)
- Review Documentation and billing instructions for the MassHealth Limited Program listed in [All Provider 251](#)

Eligibility Verification Reminders

- Always check eligibility on the date(s) of service
- Review full eligibility response to verify restrictive message pertaining to coverage types or Third-Party Liability
- Follow procedures for reprocessing or updating a claim

Timely Filing

Claims Submission Timely Filing

- In accordance with [Subchapters 1-3 of the Provider Manual](#), all claims must be received by the MassHealth agency within 90 days from the date of service or the date of the explanation of benefits from another insurer
- When a service is provided continuously on consecutive dates, the date from which the 90-day deadline is measured is the latest date of service
- For claims that are not submitted within the 90-day period but that meet one of the exceptions specified below, a provider must request a waiver of the billing deadline (a 90-day waiver) pursuant to the billing instructions provided by the MassHealth agency. The exceptions are as follows:
 - (1) a medical service was provided to a person who was not a member on the date of service, but was later enrolled as a member for a period that includes the date of service;
 - (2) a medical service was provided to a member who failed to inform the provider in a timely fashion of the member's eligibility for MassHealth; and
 - (3) other exceptions that are expressly authorized by the MassHealth agency pursuant to a MassHealth transmittal letter or provider bulletin

Claims Submission Timeline

90 Days: Initial claims must be received by MassHealth within 90 days of the service date. If another insurance was billed before MassHealth, claims must be received within 90 days from the date of the explanation of benefits (EOB) of the primary insurer.

12 Months: Final submission deadline to resolve claims that were initially submitted within 90 days of the date of service (DOS). Claims that exceed this deadline will be denied.

18 Months: Final submission deadline to resolve claims submitted to another insurance carrier prior to MassHealth. Claims must be initially submitted within 90 days from the date of the explanation of benefits (EOB) of the primary insurer. Claims that exceed this deadline will be denied.

36 Months: Final submission deadline for all claims

For more information, please see <https://www.mass.gov/service-details/billing-timelines-and-appeal-procedures>; also, in *All Provider Regulations 130 CMR 450.309, 450.319 and 450.314*

Common Timely Filing Edit

If the provider originally bills a claim to MassHealth after 90 days from the date of service or the date of the explanation of benefits from another insurer, the claim may deny for one or more of the following edits:

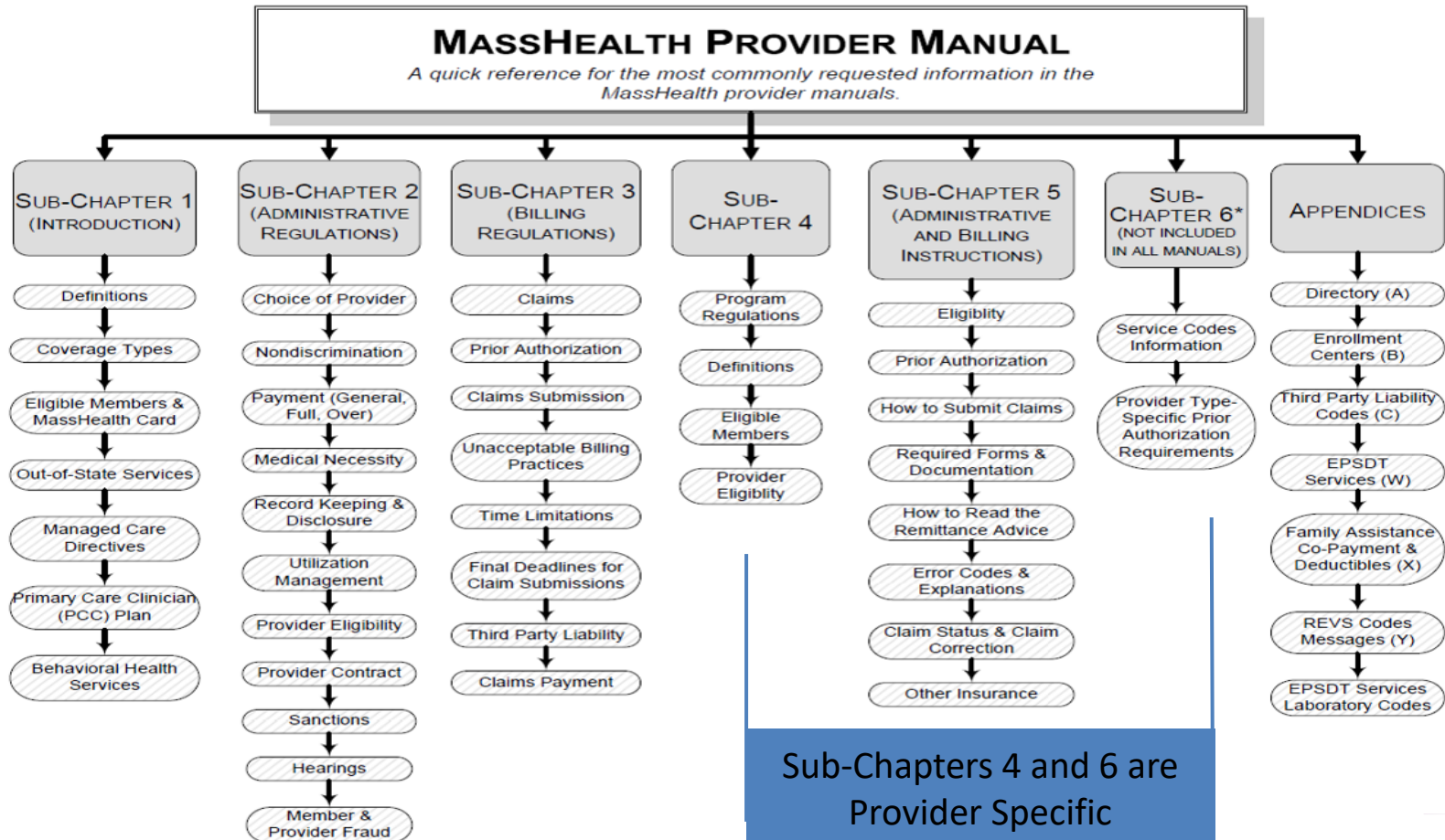
Edit Code	Description
850	The claim date of service at the claim detail level is over 90 days from the bill date.
851	The original claim was not received within the appropriate timely filing limit.
852	The claim date of service at the claim header level is over 90 days from the bill date.

- Common Occurrences:
 - Not checking member’s active coverage
 - Provider or billing intermediary not submitting claim timely
 - Billing with incorrect or no primary insurance information (remittance date, carrier code, etc.)
 - Billed original claim incorrectly
- Recommended Guidance:
 - Checking EVS on date of service prior to rendering the service
 - Check claim status or HIPAA 999 to verify submission was successful
 - Checking administrative guidelines [Billing timelines and appeal procedures for providers](#)

Provider Manual

MassHealth Provider Manual

The MassHealth Provider Manual guides providers to the regulations, administrative and billing instructions, and service codes they need. Providers should refer to the provider manual that is specific to their provider type. Below is a quick reference chart showing the contents of each section.



MassHealth Provider Manual

Subchapter 6



[Subchapter 6](#) of each provider manual contains information about billable procedure codes applicable to each specific provider type. Claims submitted by providers that do not follow the subchapter 6 guidelines may deny with one or more of the following edits:

Edit Code	Description
4033	Invalid Proc Mod Combination
4801	Procedure Not Covered By Provider Contract
4014	No Pricing Segment On File

- Common Occurrences:
 - The provider did not bill with a MassHealth accepted procedure code/modifier for their provider type
 - MassHealth system not updated (contact the appropriate customer service vendor as needed)
- Recommended Guidance:
 - Check specific [Provider Manual](#) subchapter 6
 - Check payment and [Provider Payment Rates](#)

Claim Correction via Direct Data Entry on the Provider Online Service Center

Claim Correction Overview



Only those claims that were originally submitted by the billing provider either through DDE or 837 batch can be copied, replaced, resubmitted or voided.

- Corrections to a Paid claims are done by voiding and replacing the original claim with the corrected or additional information.



- Corrections to a Denied claims are done by resubmitting the original claim with the corrected or additional information.



Paid Claim Correction



- Use the former ICN to replace the claim if one or more of the following items are changing: Service date, revenue code, service code charge amount, etc.
- Void the claim If you are changing the following: Member ID, Pay-to-Provider number, or Claim Type, then submit a new claim with correct information.
 - A 90 Day Waiver will be needed to submit the corrected claim if over 90 days from the day of service or the date on the Explanation of Benefits (EOB)Date If you are changing the following: Member ID, Pay-to-Provider number, or Claim Type
 - Please note if claim if over a year from the day of service or the date on the Explanation of Benefits (EOB) a Final Deadline Appeal should be followed.

Claim Replacement/Void



- **Replace Option:** This option is only available to providers when a claim Pays. It allows the provider to modify ALL fields that were populated on the original claim, including member information.

- **Void Option:** This option is only available to providers when a claim Pays. It allows the provider to void the paid claim.
 - The voided claim will be displayed on a future remittance advice. The total amount originally paid will appear as a negative amount and that amount will be deducted from payments until the overpayment is recovered.

Denied Claims Resolution



- Use the former ICN to resubmit the claim if one or more of the following items are changing: Service date, revenue code, service code

- Submit a new claim if you are changing the following: Member ID, Pay-to-Provider number, or Claim Type

- A former ICN is NOT required if the claim meets the following criteria:
 - If claim is still within 90 days from the date of service, or the date on the Explanation of Benefits (EOB)

OR

- If claim is over 90 days from the date of service, but within a year or 18 months from the date of service for TPL claims and does not meet the exception criteria above

Claim Resubmission



- **Resubmit Option:** This option is only available to providers when a claim DENIES. ALL fields that were populated on the original claim, including attachments, COB data, and member information will be transferred to a new claim.
- This feature is like the copy feature, however, it allows for the repopulation of ALL fields, rather than just some of them, as done through the copy feature.
- This option is available to providers immediately upon submitting a claim via DDE and receiving a denial
- It is also available when the provider submits a claim via 837 batch. If the provider searches for a claim that they submitted via the 837 batch through the claim status inquiry feature, one of the action options available to them upon selecting the claim will be to resubmit

How to Adjust a Paid Claim

Paid Claim Adjustment



Available Actions: Adjustment Options

- **Void Option:** Only use this option if you want to remove all history of a given claim from the system. This will cause the claim and any associated payments to be retracted.
- **Replace Option:** Use this option if you want to adjust a paid claim. This one transaction involves two processes: the voiding of the original claim and the reprocessing of the adjusted claim.
 - The ICN will automatically be associated with the claim

Available Actions: Non-Adjustment Options

- **Copy Option:** Use this option if you want a copy of the claim to be created in order that you can edit the data included in the fields.
 - **Note:** This is not an adjustment function. It is only a function to create a duplicate claim using the same data as identified on the original claim.

How to Adjust a Paid Claim



From the **Claims Search Results** panel:

- View the claim **status**
- Select the claim that needs to be adjusted
- The **Claim Detail** panel will appear
 - Review information to ensure correct claim is being resubmitted for correction.
- Click on **Replace**

Claim Search Results

Click on the Internal Control Number (ICN) link to view the Claim Details.

ICN	Member Name	Status	Payments	Charges	FDOS
2208044600001	[REDACTED]		\$0.00	\$100.00	02/13/2008
2208044600002	[REDACTED]		\$0.00	\$100.00	02/13/2008
2208044600003	[REDACTED]		\$0.00	\$125.00	01/25/2008

Claim Detail

Provider	[REDACTED]	Provider NPI	
Billing Provider	[REDACTED]	Billing Provider NPI	0
Member ID	[REDACTED]		
Patient Account #	[REDACTED]		
Member Name	[REDACTED]		
Date of Birth	[REDACTED]		
Gender	[REDACTED]		
		ICN	2208064600001
Charged Amount	\$250.00	Payment Amount	\$250.00
Status Date	03/04/2008		
Adjudication Date		Service Date(s)	12/18/2007 - 12/18/2007
Check Issue Date			
Claim Status	FINALIZED/PAYMNT-THE CLAIMLINE HAS BEEN PAID		

List Of Services

Detail	Service Code	Units	Charges	Paid Amount	Status
1	20962	1.00	250.00	\$250.00	Paid

[Close](#)
[Return to Search Results](#)
[Void](#)
[Copy](#)
[Replace](#)
[Resubmit](#)

General Reminders on Adjusting a Claim



General Reminders

You can review information in the tabs in any order you need to verify the information and make the correction

- However, once you open a tab and begin filling it out, you cannot leave the tab until all the required fields (identified by red asterisk) are completed or click on cancel item. Do not click on **Cancel Service**, this will cancel the whole claim.

A screenshot of the "MassHealth Provider Online Service Center" interface. The "Billing and Service Confirmation" tab is selected. The "Billing Information" section is active, showing various fields for editing. A blue callout box with white text says "Now you can make the necessary corrections" and points to the "Billing Provider ID" field. Another blue callout box with white text says "Note: ALL fields will be populated that were included on the original claim, including member information." and points to the "Member ID" field. The form includes fields for "Previous ICN", "Billing Provider ID", "Billing Provider Taxonomy", "Member ID", "Patient Account #", "Last Name", "First Name", "DOB", "Member Date of Death", "Member Address 1", "Member Address 2", "Member City", and "Member Zip". Fields with a red asterisk indicate required information.

Claim Replacement Information



Adjusted (Replace) Claims

- When a claim is adjusted, a new ICN will be assigned and it will begin with a **59** or **58** region code, i.e. **59**xxxxxxxxxxx
 - This new ICN should appear on the confirmation tab within the DDE interface, if the adjustment claim was entered through DDE.
- Should you inquire through the claim status feature on this ICN, the system will still report both the old and the newly adjusted ICN as “PAID.”
 - **Only the ICN that begins with 59 will truly be “PAID” if the resubmission doesn’t result in denial.**
- If you check your PDF RA, the claim should be correctly identified as adjusted
 - It will be found on the Adjusted Claims page and, if money is being returned to MassHealth, also on the Financial Transactions page.

Claim Replacement RA example



Replacement transactions will appear on the ADJUSTED CLAIMS PAGE

COMMONWEALTH OF MASSACHUSETTS
 MEDICAID MANAGEMENT INFORMATION SYSTEM
~~PROFESSIONAL CLAIMS ADJUSTED~~
 PROFESSIONAL CLAIMS ADJUSTED

PAYEE N

\$497.41 is what we previously paid but retracted as a result of the adjustment. \$593.81 is what is being paid towards the replacement claim.

PL
 SERV ST PR
 12 PD H3
 12 PD H3

T DE'
 O
 O

2009217745695		072009	072909	(593.81)	(497.41)	(-0.00)	(-0.00)	(497.41)
5909266001221		072009	072909	593.81	593.81	0.00	0.00	593.81

MEMBER NAME: [REDACTED] MEMBER ID: [REDACTED] OTH INS CD: PA: [REDACTED]

DIAG: 7818

ADJUSTMENT EOBS: 9702 HEADER EOBS:

Old and New ICN

S	ICN	UNITS	DIAG	SEQ	SERVICE FROM	DATES THRU	SERVICING PROV/ NPI	BILLED AMOUNT	ALLOWED AMOUNT	CO
		6.00	01		072009	07200	[REDACTED]	44.40	44.40	0
		3.00	01		072109	07210	[REDACTED]	48.51	48.51	0

Replacement Payment

How to Resubmit a Denied Claim

How to Resubmit a Denied Claim after Submitting via DDE



Resubmit option is available to providers immediately upon submitting a claim via DDE, at the point where they are on the confirmation tab.

- To resubmit claim, Click on **Resubmit**.
 - Review the claim information and enter the corrected information for the resubmitted claim then go to confirmation tab to resubmit claim.

For a List of Edit Code Summary and Corrective Action visit [Edit Codes Summary of Corrections](#)

MassHealth Provider Online Service Center

Confirmation

You have submitted a Professional Claim for [REDACTED]. The status of the claim listed below should be retained for your records.

Claim Status: Denied
Claim ICN: 2216179600001
Adjudication Date: [REDACTED]
Paid Amount: \$0.00

Explanation of Benefits (EOB)

Detail	EOB Code	Description
00	2001	MEMBER ID NUMBER NOT ON FILE
00	1927	NPI REQUIRED HEALTHCARE=Y BILLING PROV
00	1209	MULT SAK PROV LOCS FOR REFERRING PROVIDER - HDR
00	1217	REFERRING PROVIDER NOT AUTHORIZED TO REFER - HDR
00	900	PROVIDER TYPE/SPEC GROUP EMPTY
00	1032	BILLING PROVIDER NOT ELIGIBLE TO BILL THIS CLM TYP
1	1085	ORDERING PROVIDER NOT AUTHORIZED TO ORDER SERVICES
1	1010	RENDERING PROVIDER NOT A MEMBER OF BILLING GROUP

If you require assistance or support related to this request, please contact Customer Support at 1-800-841-2900.

Close Void Resubmit Replace Copy

How Search a Denied Claim

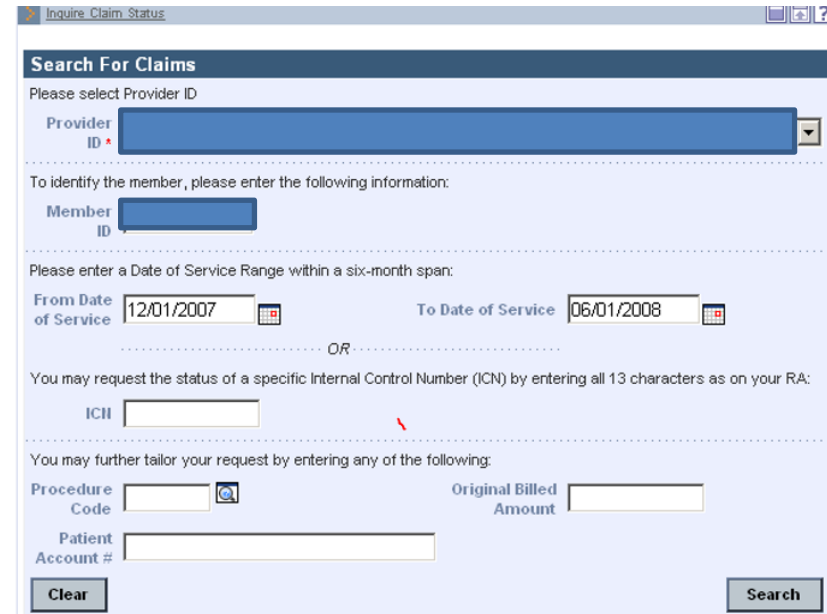
To resubmit claim, locate denied claim via the Provider Online Service Center panel:

- Click **Manage Claims and Payments**
- Click **Inquire Claim Status**. The **Search for Claims** panel is displayed.

- ▼ [Manage Claims and Payments](#)
 - > [Enter Single Claim](#)
 - > [Inquire Claim Status](#)
 - > [Batch Process Claims](#)
 - > [View PACE Payments](#)
 - > [View SCO Payments](#)
 - > [Download Capitation Information](#)

From the **Search for Claims** panel:

- Select **Provider ID** from the drop-down list.
- Enter the **Member ID** and enter **From Date of Service** and **To Date of Service**.
- Or enter the **ICN#**
- Click **Search**.



Inquire Claim Status

Search For Claims

Please select Provider ID

Provider ID *

To identify the member, please enter the following information:

Member ID

Please enter a Date of Service Range within a six-month span:

From Date of Service To Date of Service

OR

You may request the status of a specific Internal Control Number (ICN) by entering all 13 characters as on your RA:

ICN

You may further tailor your request by entering any of the following:

Procedure Code Original Billed Amount

Patient Account #

How Resubmit a Denied Claim



From the **Claims Search Results** panel:

- View the claim status.
- Select the claim that needs to be resubmitted
- The **Claim Detail** panel will appear
 - Review information to ensure correct claim is being resubmitted for correction.
- Click on **Resubmit**

Claim Search Results

Click on the Internal Control Number (ICN) link to view the Claim Details.

ICN	Member Name	Status	Payments	Charges	FDOS
2208044600001	[REDACTED]		\$0.00	\$100.00	02/13/2008
2208044600002	[REDACTED]		\$0.00	\$100.00	02/13/2008
2208044600003	[REDACTED]		\$0.00	\$125.00	01/25/2008

Claim Detail

Provider [REDACTED] Provider ID [REDACTED]

Member ID [REDACTED]

Patient Account # [REDACTED]

Member Name [REDACTED]

Date of Birth [REDACTED]

Gender [REDACTED]

ICN 2209324500029

Charged Amount \$1,750.00 Payment Amount \$0.00

Status Date 11/20/2009

Adjudication Date 11/20/2009 Service Date(s) 06/26/2009 - 06/30/2009

Check Issue Date

Claim Status FINALIZED/DENIAL-THE CLM LINE HAS BEEN DENIED

List Of Services

Detail	Service Code	Units	Charges	Paid Amount	Status
01	120	5.00	\$1,750.00	\$0.00	Denied

[Close](#) [Return to Search Results](#) [Void](#) [Copy](#) [Replace](#) [Resubmit](#)

DDE Resubmission Information



Available Actions:

- **Resubmit Option:** Use this option if you want to resubmit a denied claim. All data is copied from the original claim, including attachments, COB data, and member information. Make the necessary corrections to the claim and resubmit.
- **Copy Option:** Use this option as a template, if you want a copy of the claim to be created in order that you can edit the data included in the fields.
- **Note:** When copying a claim, attachments included in the original transaction will be not be reattached, nor will the member or COB information

General Reminders on Resubmitting a Claim



General Reminders

You can review information in the tabs in any order you need to verify the information and make the correction

- However, once you open a tab and begin filling it out, you cannot leave the tab until all the required fields (identified by red asterisk) are completed or click on cancel item. Do not click on **Cancel Service**, this will cancel the whole claim.

A screenshot of the "MassHealth Provider Online Service Center" interface. The "Billing and Service Confirmation" tab is selected, with other tabs like "Extended Services", "Coordination of Benefits", "Procedure", and "Attachments" visible. The "Billing Information" section is active, showing various input fields for member and provider information. A blue callout box with white text says "Now you can make the necessary corrections" and is positioned over the "Billing Provider ID" field. Another blue callout box with white text says "Note: ALL fields will be populated that were included on the original claim, including member information." and is positioned over the "Member Address 1" field. The form includes fields for "Previous ICN", "Billing Provider ID", "Billing Provider Taxonomy", "Member ID", "Patient Account #", "Last Name", "First Name", "DOB", "Member Date of Death", "Member Address 1", "Member Address 2", "Member City", and "Member Zip".

Resources

Resources



Provider Manuals- See Subchapter 6 for payable/non-payable code based on your provider type

- <https://www.mass.gov/lists/masshealth-provider-manuals>

Billing Timelines and Appeal Procedures

<https://www.mass.gov/service-details/billing-timelines-and-appeal-procedures>

90-day Claim Waiver information

- <https://www.mass.gov/how-to/submit-a-90-day-claim-waiver-request-form>

MassHealth Claim Information for Direct Date Entry (DDE)

- <https://www.mass.gov/service-details/masshealth-claims-information-for-direct-data-entry-dde>

Resources



MassHealth Billing Tips

<https://www.mass.gov/service-details/billing-tips>

How to View Remittance Advice Reports

<https://www.mass.gov/doc/new-mmis-job-aid-view-remittance-advice-reports/download>

List of Explanation of Benefit Codes Appearing on the Remittance Advice

<https://www.mass.gov/service-details/list-of-explanation-of-benefit-codes-appearing-on-the-remittance-advice>

Claim Adjustment Reason Codes and Remittance Advice remark Codes CARCs and RARCS

<https://www.mass.gov/doc/claim-adjustment-reason-codes-and-remittance-advice-remark-codes-carcs-and-rarcs-posted-01262023-0/download>

MassHealth Customer Service

Phone: (800) 841-2900; TTY: (800) 497-4648

Email: provider@masshealthquestions.com

Fax: (617) 988-8974

Other Training Available



Related Courses

How to Direct Data Entry a Professional Claim Submission with Other Insurance Information-Coordination of Benefit (COB Balancing)

Professional Claim Correction via Direct Data Entry on the Provider Online Service Center

Courses available on MassHealth Learning Management System (LMS)

- <https://masshealth.inquisiqlms.com/Default.aspx>
- Sign in or create an account to access courses

