Medicaid Denial Diagnosis & Resolution Guide

A practical field guide for Medicaid HCBS/LTSS revenue-cycle professionals

THE CORE RULE

A denial code is a signal, not a root cause. Diagnose the failure before you correct, resubmit, or appeal.

VERIFY → ACT / HOLD / ESCALATE

Use this guide to move from remittance message to verified cause, correct resolution path, retained evidence, and recurrence prevention. It is intentionally national in scope: state Medicaid agencies, MCOs, fiscal agents, and program-specific authorities may impose additional or different requirements.

Important

Do not treat a denial as a billing-department problem by default. Many denials are downstream symptoms of eligibility, provider enrollment, authorization, EVV, documentation, or payer-routing failures that occurred earlier in the revenue cycle.

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1. Start Here: The Six-Step Denial Response

The fastest resolution is usually the one that correctly identifies where the revenue cycle failed. Do not begin by asking, “How do I rebill this?” Begin by asking, “What condition was not satisfied?”

1 READ	Read the full remittance message, including group code, CARC, RARC, payer text, claim/line status, and any portal detail.
2 VERIFY	Verify the controlling facts in the authoritative system: eligibility, payer, authorization, provider status, EVV, claim data, documentation, or filing history.
3 DIAGNOSE	Identify the earliest point in the revenue cycle where the facts stopped supporting payment. That is usually closer to the root cause than the denial code itself.
4 CHOOSE	Select the correct path: corrected claim, replacement/void, resubmission, requested documentation, payer correction, appeal/dispute, or escalation.
5 DOCUMENT	Retain the denial, evidence reviewed, action taken, submission/confirmation evidence, and follow-up date in the approved system of record.
6 PREVENT	If the issue is repeatable, correct the upstream control. A denial resolved without prevention is only half resolved.

Quick decision rule

CORRECT IT when the payer is right and the claim can be fixed.

Examples: invalid or missing claim data, wrong payer routing, correctable modifier/code issue, duplicate created by billing workflow, or missing requested information.

APPEAL OR DISPUTE when the payer decision appears wrong after verification.

Examples: valid authorization not recognized, timely filing proven, contract/rate applied incorrectly, or documentation supports the billed service and the payer maintained an adverse decision.

HOLD when a required fact is still unresolved.

Do not submit another claim merely to “try again.” Repeated submissions can create duplicates, confuse the claim history, and weaken the audit trail.

2. Diagnose the Denial by Failure Category

Use the denial message to choose a starting point, then verify against the source that actually controls the issue. The same CARC can have different operational causes in different states or payer environments.

Denial signal	Verify first	Likely action	Evidence to retain	Prevention
Eligibility / coverage	Eligibility and coverage on the date of service; program/benefit; spend-down or other applicable status; retroactive changes.	Correct payer/coverage data, rebill when permitted, or escalate eligibility discrepancies.	Eligibility response or portal evidence, dates checked, payer confirmation.	Pre-service eligibility verification and exception workflow.
Wrong payer / routing	Member plan assignment, MCO effective dates, FFS vs managed care lane, payer ID/routing.	Route to correct payer; correct claim routing; coordinate payer corrections if assignment is wrong.	Eligibility/payer evidence, original submission, corrected routing confirmation.	Payer-lane verification before claim release.
Provider enrollment / network	Provider enrollment effective date, service/location/NPI linkage, taxonomy if applicable, MCO credentialing/network status.	Correct enrollment/configuration issue or escalate payer/state mismatch before rebilling.	Enrollment confirmation, effective dates, network/contract evidence.	Provider readiness review and revalidation monitoring.
Authorization	Authorization number, service, member, provider, dates, units, frequency, modifiers and payer applicability.	Correct claim if authorization exists and data mismatched; obtain payer correction; appeal if valid authorization was not honored.	Authorization record, portal screenshot/export, payer communication, corrected claim confirmation.	Authorization-to-service-to-claim reconciliation before billing.
EVV / visit match	EVV applicability; visit date/time; caregiver/member; service; location; aggregator acceptance; exception resolution; claim-to-visit match.	Resolve legitimate EVV exception or transmission/matching issue, then follow payer/state resubmission rules.	Visit record, exception history, aggregator/payer status, correction evidence.	Pre-bill EVV reconciliation and unresolved-exception hold.

Denial signal	Verify first	Likely action	Evidence to retain	Prevention
Claim construction	Member/provider identifiers, dates, code/modifier, units, place/service fields, diagnosis when required, authorization linkage, payer-specific fields.	Correct or replace claim according to payer instructions; do not appeal a valid edit.	Original claim, edit/error response, corrected submission acknowledgment.	Claim scrub rules tied to payer/state requirements.
Duplicate	Claim history, replacement/void indicators, prior acceptance/adjudication, whether services are truly duplicate.	Do not resubmit blindly. Correct duplicate workflow or use replacement/void process if appropriate.	Claim history, original ICN/DCN/TCN where available, replacement submission.	Prevent repeated manual rebilling; use claim-status verification.
Timely filing	Original submission date, acceptance evidence, payer receipt, resubmission history, contract/state deadline, exceptions.	Appeal only when filing evidence or an allowed exception supports it; otherwise classify loss/root cause.	Clearinghouse acceptance, payer acknowledgment, claim history, exception evidence.	Aging controls and timely-filing escalation well before deadline.
Documentation / medical necessity / service support	Required service documentation, plan/service authorization, signatures/attestations, payer request, date-specific records.	Submit requested records or appeal when documentation supports payment; correct workflow if records were incomplete.	Requested records, submission proof, payer correspondence, appeal packet.	Documentation readiness control before billing where required.
COB / other insurance	Other coverage, payer sequence, prior payer adjudication, TPL/COB record, member data.	Correct COB/TPL data and follow payer sequence; submit prior payer information as required.	Eligibility/COB evidence, prior payer EOB/ERA, payer confirmation.	COB verification and exception handling before claim release.
Rate / payment amount	Contract/state rate, effective date, units, modifiers, fee schedule, prior payer impacts, recoupment context.	Reconcile calculation; dispute underpayment when payer did not apply controlling rate/contract correctly.	Rate source/contract, claim, ERA, payment calculation, correspondence.	Rate table/configuration validation and payment variance review.

3. Read the Remittance Correctly

Under HIPAA administrative simplification, health plans use standardized Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) to explain payment adjustments. The CARC gives the broad adjustment reason; a RARC may provide more specific context. Treat the code combination as a diagnostic clue, then verify the underlying facts.

Example signal	What it generally says	Revenue-cycle response
CARC 16	Claim/service lacks information or contains a submission/billing error.	Read the accompanying RARC or other detail. Identify the specific missing/invalid element before correcting.
CARC 18	Exact duplicate claim/service.	Verify claim history before any resubmission. Determine whether a replacement/void workflow was required.
CARC 22	Care may be covered by another payer under coordination of benefits.	Verify payer sequence and other coverage rather than repeatedly billing the same payer.
CARC 29	Filing time limit has expired.	Verify original receipt/acceptance evidence and the payer/state deadline before deciding whether an appeal is supportable.
CARC 96	Non-covered charge(s).	Use the related remark/policy detail to determine whether the issue is benefit coverage, service/program fit, or claim construction.
CARC 109	Claim/service is not covered by this payer/contractor; send to the correct payer/contractor.	Verify plan assignment and payer lane for the date of service.

> **Do not diagnose from the CARC alone**
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> Some CARCs explicitly require an accompanying RARC or other detail. Always read the complete ERA/EOB/portal message and verify the payer/state rule that controls the claim.

The resolution pathway

Corrected claim / replacement: Use when the claim data is wrong but the underlying service is billable and payer rules permit correction.

Void + rebill: Use only when the payer/state workflow requires a void of an incorrectly adjudicated claim before replacement.

Resubmission: Use when the payer instructs resubmission after a specific correctable condition is resolved. Avoid duplicate creation.

Documentation response: Use when the payer has requested records or additional information and the service is otherwise supportable.

Appeal / dispute: Use when verification shows the payer decision or payment appears inconsistent with controlling authorization, policy, contract, rate, or documented facts.

Escalation: Use when the issue cannot be resolved within the revenue-cycle professional's authority or the payer/state systems show conflicting controlling information.

4. Three Fast Diagnosis Examples

Example A — Authorization denial

The ERA indicates an authorization-related denial. The authorization exists, but the billed modifier does not match the authorized service configuration.

VERIFY: Authorization record, billed code/modifier, dates, units, provider and payer applicability.

DIAGNOSIS: The authorization is valid; the claim construction does not match it.

ACTION: Correct the claim using the payer's replacement/correction process. Do not appeal a payer edit that is factually correct.

PREVENT: Add authorization-to-claim configuration verification before release.

Example B — Timely filing

The payer denies for filing limit. The clearinghouse shows the original claim was accepted before the deadline, but the payer portal does not show it.

VERIFY: Deadline, clearinghouse acceptance, payer acknowledgment/claim history, any payer-specific proof standard.

DIAGNOSIS: Potential payer-receipt or adjudication-history discrepancy, not automatically a true late filing.

ACTION: Use the payer's reconsideration/appeal path with timely-filing evidence if the rule supports it.

PREVENT: Monitor claims that are accepted by the clearinghouse but do not appear in payer adjudication within the expected window.

Example C — EVV-linked denial

A personal care claim denies after the visit transmitted from the EVV system. The visit exists, but an unresolved exception prevented the visit from reaching the payer/aggregator in matched status.

VERIFY: EVV applicability, visit details, exception status, aggregator/payer acceptance, claim-to-visit match.

DIAGNOSIS: The service may be valid, but the EVV data flow was not complete when the claim was released.

ACTION: Resolve the legitimate exception and follow the state/payer correction or resubmission process.

PREVENT: Hold affected claims until required EVV reconciliation is complete.

> **Pattern to remember**
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> The correct resolution usually follows the earliest verified failure point. A denial that looks like "billing" can be caused by a readiness, authorization, EVV, documentation, or payer-assignment problem upstream.

5. Evidence and Follow-Up Checklist

For each denial worked, retain enough evidence for another qualified person to reconstruct what happened, what was verified, and why the action was taken. Use the agency's approved system of record rather than creating unnecessary shadow logs.

- Denial/remittance message and claim/line identifiers
- CARC/RARC and payer-specific explanation, when present
- Original claim and relevant submission/acceptance evidence
- Eligibility and payer-assignment evidence for the date of service
- Authorization evidence, when applicable
- EVV visit/exception/aggregator evidence, when applicable
- Provider enrollment/network evidence, when applicable
- Relevant service documentation or requested records
- Corrected/replacement/appeal submission confirmation
- Payer communication/reference number, if material
- Next follow-up date and responsible owner
- Root-cause/prevention action when the issue is repeatable

Root-cause prevention: ask one more question

After payment is recovered—or after the loss is correctly classified—ask: "What control should have prevented this from reaching adjudication?" The answer determines whether the issue is truly closed.

If you keep seeing…	Test this upstream control
Repeated eligibility denials	Is eligibility being verified at the right cadence and again when coverage changes are likely?
Authorization denials	Is the authorization reconciled to service delivery and claim configuration before billing?
EVV denials	Are unresolved EVV exceptions held before claim release, and is aggregator acceptance monitored?
Duplicate denials	Are staff verifying claim status before manual resubmission and using replacement/void logic correctly?
Timely filing losses	Are aging thresholds early enough to escalate missing payer acknowledgment before the deadline?
Payment variance	Are expected rates/configuration validated and actual remittance compared to expected payment?

Closed means more than "paid"

For a recurring denial, true closure means the claim is resolved, the evidence is retained, and the upstream control is corrected or explicitly accepted as an exception.

6. Authoritative Reference Points

Use this guide as a diagnostic framework. For the actual rule, filing deadline, appeal path, EVV requirement, claim field, authorization standard, or correction method, use the controlling state/payer authority.

CMS — Health Care Payment and Remittance Advice

Explains ERA/SPR adjustment information and the relationship among group codes, CARCs and RARCs. Open official source

CMS — EFT and Remittance Advice / Administrative Simplification

Confirms that HIPAA-covered health plans use standardized CARCs and RARCs and identifies X12 as the code-set maintainer. Open official source

X12 — Claim Adjustment Reason Codes

Current code descriptions, effective dates and maintenance information for CARCs. Open official source

Medicaid.gov — Electronic Visit Verification

Federal EVV framework for Medicaid personal care and home health services that require an in-home visit. Open official source

Source hierarchy for a real denial

- State Medicaid agency / MMIS or fiscal-agent authority for FFS rules and state program requirements.
- MCO/health plan provider manual, contract, portal, authorization record, and remittance detail for managed-care requirements.
- EVV aggregator or state EVV authority for visit acceptance, exceptions, and matching requirements.
- Clearinghouse acceptance/rejection evidence for transmission history—but not as a substitute for payer adjudication status.
- Agency billing/management system and approved evidence repository for the operational record of work performed.

Professional standard

Never convert a payer example, internal habit, software behavior, or one-state rule into a national Medicaid requirement. Verify the authority that controls the claim in front of you.

About HCRI

The Home Care Revenue Institute develops professional competency, certification, and operating standards for Medicaid-funded HCBS/LTSS revenue-cycle work. HCRI education focuses on the decisions, controls, evidence, escalation, and prevention practices that help revenue-cycle professionals protect earned revenue without confusing HCRI guidance with governing state or payer authority.