

Denials for LOCD Not Complete

Policy: [Michigan Medicaid Provider Manual](#), Nursing Facility Chapter, Nursing Facility Coverages, Section 5 Beneficiary Eligibility and Admission Process, Subsection 5.1.D.1 Michigan Medicaid Nursing Facility Level of Care Determination

If a LOCD is created prior to the LOC02/Provider ID or beneficiary eligibility being updated in CHAMPS, the LOCD may not complete. This may be because the LOCD was created 120 days prior to the LOC02/Provider ID or beneficiary eligibility being updated in CHAMPS.

ONLINE LOCD: The web-based LOCD must be completed as follows:

- Within 14 calendar days from the date of a new admission of a Medicaid-eligible applicant, regardless of primary payer source.
- Within 14 calendar days from the date of a non-emergency transfer of a Medicaid-eligible resident to another nursing facility, including transfers originating from a nursing facility that is undergoing a voluntary facility closure.
- Within 14 calendar days from the date of disenrollment of a beneficiary from a Medicaid Health Plan which has been paying for nursing facility services.
- Within 14 calendar days from the date a Medicaid financial application was registered with MDHHS (i.e., date-stamped by MDHHS on the date the application is received) by a current private-pay nursing facility resident requesting Medicaid as the payer for nursing facility services.

Claim Adjustment Reason Code (CARC) and Remittance Adjustment Remark Code (RARC) will be applied to claims that are being rejected due to the Provider ID/LOC or eligibility not updated within 120 days of the LOCD being created:

- CARC 96 - Non-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.
- RARC 216 - We do not offer coverage for this type of service or the patient is not enrolled in this portion of the benefit package.
- The CARC and RARC is stating the LOCD record is not active/not complete/not met.

When you receive rejections for LOCD's that are not complete, you will need to verify the following information in CHAMPS:

- Beneficiary eligibility is active for dates of service;
- The Level Of Care 02 is active with the correct Provider ID number and dates of service; and
- That the LOCD completed with the correct beneficiary name spelling.

If the Provider ID/LOC or eligibility is updated within 120 days, CHAMPS should automatically update the LOCD to a complete status.

Once this information has been verified, the original Freedom of Choice and 2565 (Facility Admission Notice) will need to be sent to Provider Support. When the information is received by Provider Support, we will verify that all the documentation meets the required criteria prior to forwarding to Policy for review.

When Policy receives the documentation, they will verify all required criteria is met. If it meets all criteria, Policy can complete and/or backdate the LOCD.

There are 3 Ways to Submit Documentation:

1. **Email to Providersupport@michigan.gov**

Include the beneficiary name and ID number, date of service, and TCN. If you spoke with a Medicaid representative and received a service request reference number, please include that in the email. If you are submitting documentation for multiple beneficiaries, send one email with separate attachments for each beneficiary.

2. **Fax to 517-241-8968**

On the cover sheet, include the beneficiary name and ID number, date of service, and TCN. If you spoke with a Medicaid representative and received a service request reference number, please include that on the fax cover sheet. Please include the contact information for the Provider, if follow-up is necessary.

3. **Upload into CHAMPS – Coming Soon!**

This option is coming soon and MDHHS will provide instructions and outreach when available.

Please note, a claim will not adjudicate and pay until the process is complete. Providers are required to keep the claim active to avoid denials for Timely Filing.