Special Meeting of The All Payer Claims Database Policy & Procedure Enhancement Subcommittee

NOTICE OF MEETING AND AGENDA

Date:	Thursday, May 8, 2014
Time:	9:00 a.m. to 11:00 a.m.
Location:	Legislative Office Building, Room 1D 300 Capitol Avenue Hartford, CT 06103
Conference:	1-877-716-3135 Participant Code: 23333608
Directions:	http://www.cga.ct.gov/asp/menu/DrivingDirections.asp#LOB

I. Call to Order and Introductions

II. Public Comment

III. Review and Approval of Minutes for February 21, 2014 Meeting

IV. Overview of Claims Adjustment Reason Codes and Remittance Advice Codes

V. Review of Denied Claims Data Use Cases

VI. Discussion of Dental Data Collection and Stakeholder Engagement

VII. Next Steps

VIII. Future Meetings

IX. Adjournment

Public comment of the agenda is limited to two minutes per person and is not to exceed the first 15 minutes of each meeting. A sign-in sheet will be provided.

Access Health CT is pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify Christen Orticari at (860) 241-8444.

Meeting materials will become available at: www.ct.gov/hix following each meeting.

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Connecticut's Health Insurance Marketplace

All-Payer Claims Database Policy & Procedures Enhancements Subcommittee Meeting

May 8, 2014

Agenda

- Call to Order and Introductions
- Public Comment
- Approval of Minutes for the February 21, 2014 Meeting
- Overview of Claims Adjustment Reason Codes and Remittance Advice Codes
- Review of Denied Claims Data Use Cases
- Discussion of Dental Data Collection and Stakeholder Engagement
- Next Steps
- Future Meetings

Overview of Claims Adjustment Reason Codes and Remittance Advice Codes

Denial and Adjustment Code Sets

	Claim Adjustment Group Codes (CAGC)	Claim Adjustment Reason Codes (CARC)	Remittance Advice Remark Codes (RARC)	NCPDP Reject Code
Purpose:	Assigns financial responsibility for the Claims Adjustment Reason Code (CARC).	Offers a reason for the positive/negative financial adjustment specific to particular claim or service referenced	Delivers supplemental information (in addition to a CARC) about why a claim or service line is not paid in full	Provides information regarding a retail pharmacy claim rejection
Code Set Steward:	ASC X12 Standards Committee	Codes Maintenance Committee (BCBSA)	Centers for Medicare & Medicaid Services (CMS)	National Council for Prescription Drug Programs (NCPDP)
Count:	5	~268	~930	NA
Example:	**CO -** *Contractual Obligation* **CR -** *Corrections and Reversal* **OA -** *Other Adjustment* **PI -** *Payer Initiated Reductions* **PR -** *Patient Responsibility*	**26** - *Expenses incurred prior to coverage.*	**N19** - *Procedure code incidental to primary procedure.*	NA
Reference:	http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/	http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/	http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/	https://www.ncpdp.org/

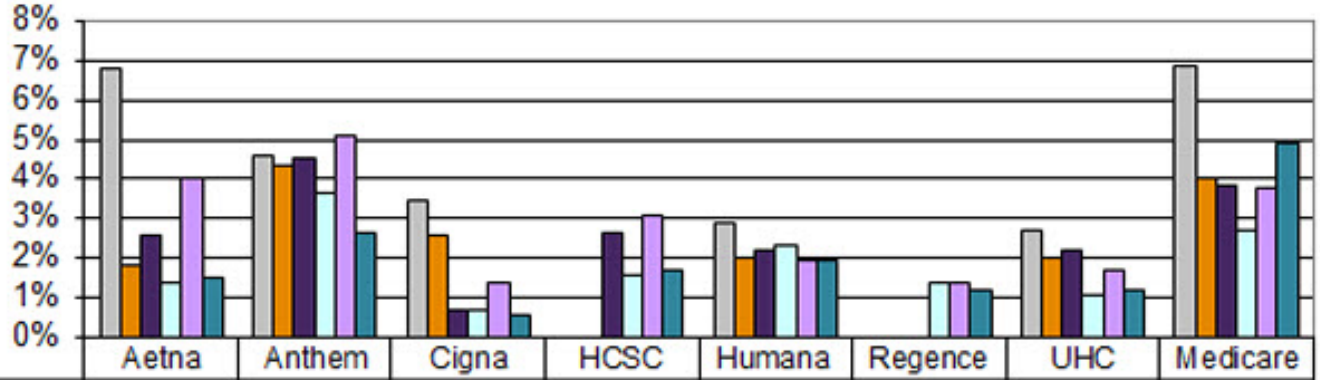
Denial and Adjustment Code Set Values Examples[1]

CARC	CARC Description[2]	RARC	RARC Description[3]	ASC X12 CAGC
163	Attachment/other documentation referenced on the claim was not received.	N678	Missing post-operative images/visual field results.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N679	Incomplete/Invalid post-operative images/visual field results.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N680	Missing/Incomplete/Invalid date of previous dental extractions.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N681	Missing/Incomplete/Invalid full arch series.	CO or PI
24	Charges are covered under a capitation agreement/managed care plan.			CO, PI or PR
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO, PI or PR

1. ***CAQH CORE 360 Rule:*** *http://www.caqh.org/CORECodeCombinations.php*
2. ***Washington Publishing Company:*** *http://www.wpc-edi.com/reference/*
3. ***Washington Publishing Company:*** *http://www.wpc-edi.com/reference/*

AMA National Health Insurer Report Card Findings (Years 2008 – 2013)*

Metric 11 - Percentage of claim lines denied



	Aetna	Anthem	Cigna	HCSC	Humana	Regence	UHC	Medicare
2008	6.80%	4.62%	3.44%		2.90%		2.68%	6.85%
2009	1.81%	4.34%	2.56%		2.03%		2.02%	4.00%
2010	2.57%	4.50%	0.67%	2.67%	2.18%		2.21%	3.82%
2011	1.38%	3.62%	0.68%	1.59%	2.33%	1.36%	1.05%	2.73%
2012	4.00%	5.07%	1.39%	3.06%	1.97%	1.38%	1.71%	3.78%
2013	1.50%	2.64%	0.54%	1.70%	1.97%	1.18%	1.18%	4.92%

**American Medical Association:* *http://www.ama-assn.org/ama/pub/advocacy/topics/administrative-simplification-initiatives/national-health-insurer-report-card/denials.page*

*** The AMA NHRIC results are based on data pulled from the nationally mandated Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic health care transactions. Metrics are self-reported and provided by NHXS, based in Sacramento, CA.*

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AMA National Health Insurer Report Card Findings*

Most Frequently Reported Reason Codes For a Denial (2008 – 2013)

Aetna		Anthem		Cigna		HCSC		Humana		Regence		UHC	
CARC	%	CARC	%	CARC	%	CARC	%	CARC	%	CARC	%	CARC	%
96	37.18%	204	29.40%	96	29.17%	16	40.37%	125	23.66%	16	29.41%	16	30.19%
49	10.12%	16	19.95%	197	22.77%	96	17.47%	96	21.86%	204	23.23%	96	23.43%
227	9.84%	96	10.46%	204	13.12%	227	11.21%	94	19.43%	50	9.79%	B20	8.46%
55	9.59%	45	9.10%	49	11.65%	B5	6.85%	16	12.88%	167	6.94%	38	5.58%
226	7.67%	38	4.79%	55	5.77%	179	5.94%	197	8.09%	51	5.98%	15	4.76%
119	5.84%	227	4.32%	50	4.30%	49	5.64%	165	3.94%	226	4.61%	56	4.06%
197	5.56%	other	21.97%	51	3.78%	197	4.04%	204	3.36%	49	4.45%	197	3.88%
165	3.68%			other	9.44%	other	8.47%	other	6.78%	227	4.17%	227	3.23%
other	10.52%									other	11.40%	49	3.23%
												204	3.10%
												other	10.08%

**American Medical Association:* *http://www.ama-assn.org/ama/pub/advocacy/topics/administrative-simplification-initiatives/national-health-insurer-report-card/denials.page*

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AMA National Health Insurer Report Card Findings*

Most Frequently Reported Reason Codes For a Denial

CARC	CARC Description	# Payers	Cumulative % of Denials	Average % Per Payer
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.	6	140%	23.3%
197	Precertification/authorization/notification absent.	5	44%	8.9%
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	5	35%	7.0%
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. 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.)	5	33%	6.6%
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.	5	133%	26.6%
204	This service/equipment/drug is not covered under the patient's current benefit plan	4	69%	17.2%
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. 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.)	2	12%	6.1%
55	Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2	15%	7.7%
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2	10%	4.9%
165	Referral absent or exceeded.	2	8%	3.8%
Grand Total		**38**	**498%**	**13.1%**

****American Medical Association:*** *http://www.ama-assn.org/ama/pub/advocacy/topics/administrative-simplification-initiatives/national-health-insurer-report-card/denials.page*

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AMA National Health Insurer Report Card Findings*

Most Frequently Reported Remark Codes For a Denial (2008 – 2013)

Aetna		Anthem		Cigna		HCSC		Humana		Regence		UHC	
RARC	%	RARC	%	RARC	%	RARC	%	RARC	%	RARC	%	RARC	%
N130	33.89%	N29	13.22%	N130	58.23%	N130	22.45%	N22	24.83%	N29	33.81%	N115	31.06%
N179	12.22%	N193	11.87%	N30	12.03%	MA100	20.50%	N115	21.74%	N429	10.60%	N174	14.57%
M41	9.99%	N179	9.29%	M118	8.54%	N366	16.24%	N130	9.54%	N179	9.93%	M77	8.05%
N56	8.72%	N221	7.66%	N175	6.65%	M127	10.38%	N4	5.92%	N517	9.46%	N54	7.86%
N20	7.51%	N155	6.45%	N216	4.11%	N4	9.29%	M77	4.65%	N130	7.45%	N429	6.14%
N54	7.16%	MA92	6.05%	other	10.44%	N225	7.44%	N489	4.55%	N102	6.69%	N386	5.75%
N517	5.92%	N161	4.28%			N202	5.46%	MA130	3.36%	M135	4.49%	N179	5.27%
N429	5.01%	N174	3.99%			M29	3.24%	M62	3.29%	N463	4.30%	M51	4.70%
other	9.58%	N301	3.92%			other	4.99%	N386	3.13%	N30	3.63%	M86	4.22%
		N232	3.84%					M53	3.03%	other	9.65%	other	12.37%
		M127	3.68%					other	15.96%				
		other	25.75%										

American Medical Association: *http://www.ama-assn.org/ama/pub/advocacy/topics/administrative-simplification-initiatives/national-health-insurer-report-card/denials.page*

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AMA National Health Insurer Report Card Findings*

Most Frequently Reported Remark Codes For a Denial

RARC	RARC Description	# Payers	Cumulative % of Denials	Average % Per Payer
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	5	132%	26.4%
N29	Missing documentation/orders/notes/summary/report/chart.	2	59%	29.4%
N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	2	52%	26.0%
N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	4	34%	8.6%
N30	Patient ineligible for this service.	2	34%	17.1%
N429	Not covered when considered routine.	3	32%	10.6%
N22	This procedure code was added/changed because it more accurately describes the services rendered.	1	24%	23.7%
N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.	2	23%	11.7%
N161	This drug/service/supply is covered only when the associated service is covered.	1	22%	22.0%
N193	Specific federal/state/local program may cover this service through another payer.	1	20%	20.0%
Grand Total		**23**	**432%**	**18.8%**

**American Medical Association:* *http://www.ama-assn.org/ama/pub/advocacy/topics/administrative-simplification-initiatives/national-health-insurer-report-card/denials.page*

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Future Changes to CARC and RARC Submissions

- Two primary problems in the reporting of claim payment adjustments:
  1. Existence of individual health plan approaches to mapping the plan's internal proprietary codes to CARCs/RARCs
  2. Adjustment/denial code combinations are based on proprietary, health plan-specific business scenarios

- An industry mandate for the use of operating rules to support implementation of the HIPAA standards included in Section 1104 of the ACA.
- Operating Rules and standards for ERA and EFT in the process of being implemented.

Review of Denied Claims Data Use Cases

Denied Claims in CT: High Volume Procedures

High Volume Denied Procedures Within CT[1,2]

Service Count/% Denied by Masked Payer

Time Span: 10/1/2012 – 11/1/2013

		Payer A		Payer B		Payer D		Grand Total	
CPT / HCPCS	Procedure Description	Service Count	% Denied	Service Count	% Denied	Service Count	% Denied	Total Service Count	Total % Denied
99213	Office Outpt Low to Moderate Severity (15 Min)	-	0.0%	16,519	1.6%	15,058	1.1%	31,577	1.4%
99214	Office Outpt Moderate to High Severity (25 Min)	12,562	1.1%	10,416	1.2%	-	0.0%	22,978	1.1%
99232	Subsequent Hospital Care	4,344	2.4%	1,767	8.6%	8,875	3.0%	14,986	3.5%
81002	Urinalysis Nonauto W/O Scope	3,944	22.0%	-	0.0%	3,819	10.2%	7,763	16.2%
90471	Immunization Admin	-	0.0%	-	0.0%	1,801	31.3%	1,801	31.3%
90658	Flu Vaccine, 3 Yrs, Im	-	0.0%	-	0.0%	1,040	30.8%	1,040	30.8%
76499	Radiographic Procedure	266	92.9%	205	97.1%	242	62.4%	713	83.7%
G0202	Screening Mammography Digital	-	0.0%	679	24.4%	-	0.0%	679	24.4%
77052	Computer Aided Detection Screening Mammography	-	0.0%	679	24.3%	-	0.0%	679	24.3%
76645	Us Exam, Breast(S)	-	0.0%	522	24.5%	-	0.0%	522	24.5%
Grand Total		**21,116**	**6.4%**	**30,787**	**3.9%**	**30,835**	**6.0%**	**82,738**	**5.3%**

1) *Source: MDEdge, product of the Physicians Advocacy Institute (PAI) Inc.*
2) *Claims and denial information derived from a repository containing information for approximately 5% of physicians in CT and for more than 5,700 physicians across NY, NJ, MA and CT*

Denied Claims Across Regional States: High Volume Procedures

High Volume Denied Procedures Across States[1,2]

% of Services Denied by Procedure

Time Span: 5/1/2012 – 11/1/2013

CPT / HCPCS	Procedure Description	CT	MA	NJ	NY	Grand Total
70450	Ct Head/Brain W/O Dye	5.9%	4.0%	6.8%	5.6%	**6.2%**
71010	Chest X-Ray	7.9%	3.5%	6.6%	5.1%	**5.8%**
71020	Chest X-Ray	5.7%	2.8%	5.6%	8.3%	**6.2%**
77052	Computer-Aided Detection Screening Mammography	5.4%	1.6%	2.7%	2.9%	**2.8%**
93000	Electrocardiogram, Complete	2.1%	2.9%	3.1%	1.8%	**2.7%**
93010	Electrocardiogram Report	0.0%	4.2%	9.9%	3.8%	**5.2%**
99213	Office Outpt Low to Moderate Severity (15 Min)	2.0%	2.3%	4.0%	3.0%	**2.8%**
99214	Office Outpt Moderate to High Severity (25 Min)	1.7%	2.3%	3.3%	1.9%	**2.6%**
99232	Subsequent Hospital Care	4.3%	5.4%	7.3%	3.5%	**5.8%**
99233	Subsequent Hospital Care	3.9%	4.6%	6.7%	5.6%	**5.1%**
Grand Total		**2.8%**	**3.2%**	**4.9%**	**4.9%**	**4.1%**

1) *Source: MDEdge*
2) *Claims and denial information derived from a repository containing information for approximately 5% of physicians in CT and for more than 5,700 physicians across NY, NJ, MA and CT*

Denied Claims Data Use Cases

Use Case #1

Effective for dates of service on or after January 1, 2007, Medicare will pay for BMM services for *dual-energy x-ray absorptiometry (*CPT code 77080) when this procedure is used to monitor osteoporosis drug therapy. New CPTs have also been assigned to BMMs.

In Connecticut, using this code and other available information Payer E has a denial rate of 33% in the last 12 months, while Payer A, Payer B, and Payer D all have denial rates below 5%. This causes the denial rate for Payer E to be 6 times higher, a rate based on information from a selection of Connecticut physicians during this time period.

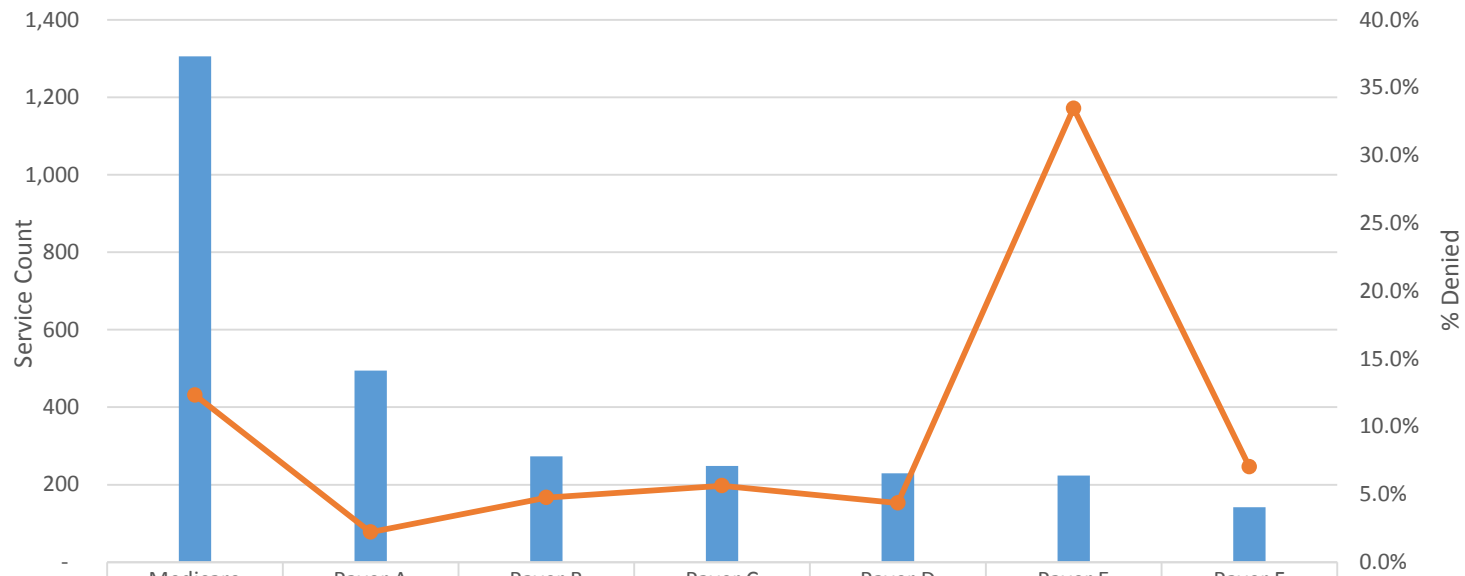
This example highlights the variation in insurers' interpretation of medical necessity in the context of this diagnostic study. If a patient had a particular need for the nature of this procedure due to their personal and family history of bone mass loss, this data in combination with other information would support the patient's ability to make an informed decision.

Denied Claims Data Use Cases

Case #1: % Denied Claims for DXA Bone Density Scan[1,2]

Service Count/% Denied by Masked Payer

Time Span: 5/1/2012 – 11/1/2013



	Medicare	Payer A	Payer B	Payer C	Payer D	Payer E	Payer F
CT - Service Count	1,306	495	273	248	229	224	142
CT - % Denied	12.3%	2.2%	4.8%	5.6%	4.4%	33.5%	7.0%

1) *Source: MDEdge*
2) *Claims and denial information derived from a repository containing information for approximately 5% of physicians in CT and for more than 5,700 physicians across NY, NJ, MA and CT*

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Denied Claims Data Use Cases

Use Case #2

In Connecticut, a simple X-ray exam of the foot had a significant denial by Payer J by nearly 60%, while Payer C, Payer B and Payer D demonstrated a denial rate below 2.5%.

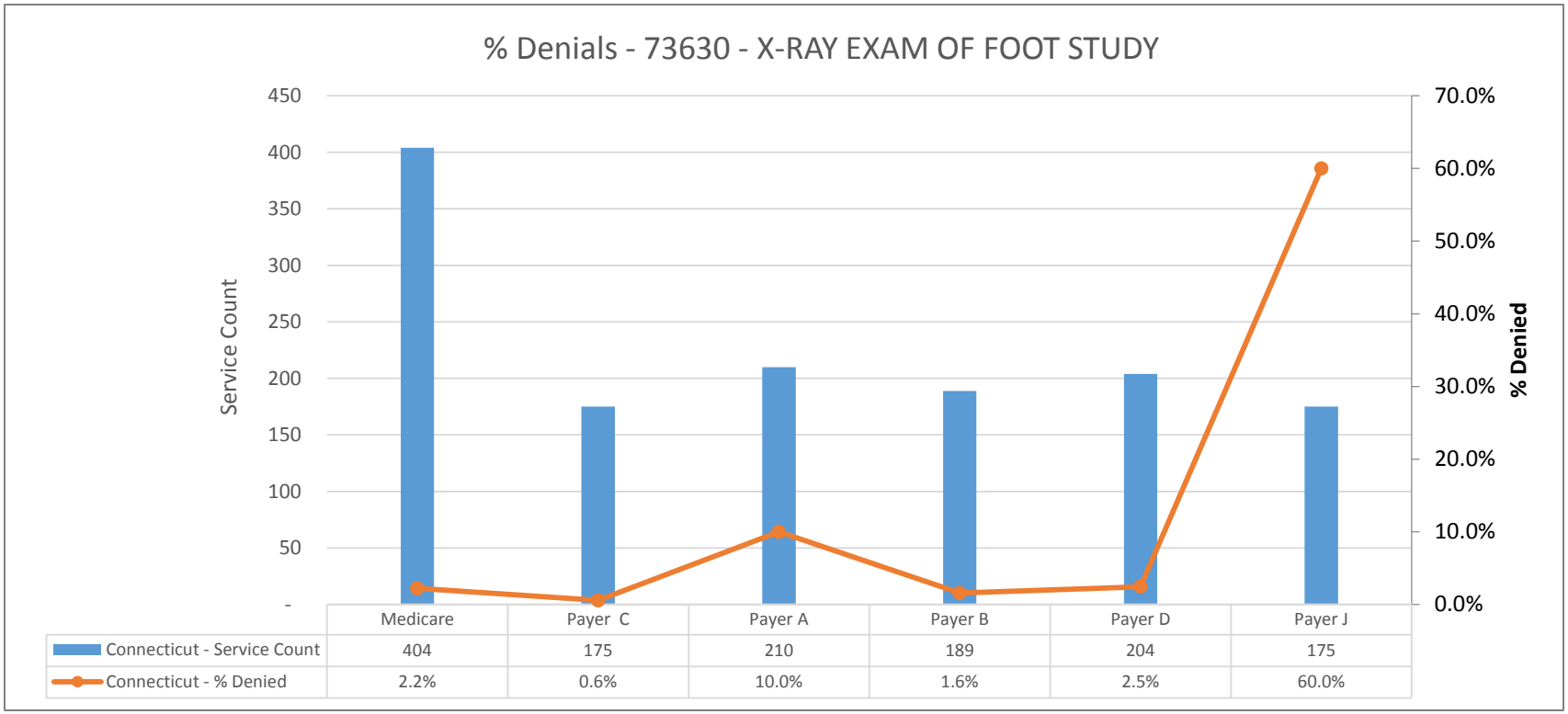
This rate becomes important when a patient has need for an X-ray exam of their foot due to an injury. The denied claims information may be more likely used in the context of a general case of inquiry, rather than tied to a particular condition, chronic or otherwise, however, this information continues to demonstrate profound differences in denial rates by insurer by service/procedure (CPT code).

Denied Claims Data Use Cases:

Use Case #2: % Denied Claims for X-Ray Exam of Foot[1,2]

Service Count/% Denied by Masked Payer

Time Span: 5/1/2012 – 11/1/2013



	Medicare	Payer C	Payer A	Payer B	Payer D	Payer J
Connecticut - Service Count	404	175	210	189	204	175
Connecticut - % Denied	2.2%	0.6%	10.0%	1.6%	2.5%	60.0%

1) *Source: MDEdge*
2) *Claims and denial information derived from a repository containing information for approximately 5% of physicians in CT and for more than 5,700 physicians across NY, NJ, MA and CT*

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Denied Claims Data Use Cases

Use Case #3

Jane is a 40 year old independent IT consultant. She wishes to directly purchase health insurance and is evaluating multiple insurance companies. She has a family history of colorectal cancer and wants to know which insurers may more often deny the medically necessary diagnostic procedures provided that she has a family history and need for frequent colonoscopies. She would like additional information through her assessment to indicate the process to demonstrate the importance of having a colonoscopy, as a 40 year old female. She asks "Is there any place this information is available?"

If Connecticut were to maintain information on denied claims, which included data on denied medical services and procedures, frequency of denial, which insurers denied the procedure more often, and other relevant data, Jane would have a wealth of information to support an informed decision in her determination of which insurance company would be best for her given her family history and current medical condition.

Denied Claims Data Use Cases

Use Case #4

A patient sees their doctor and the doctor orders an expensive diagnostic procedure. The insurance company has not published their denial rules and the doctor is unaware that they will be denying the charge for the procedure already provided. More than two weeks after the diagnostic procedure is completed the insurance company informs the doctor that they have denied the claim.

When the doctor informs the patient that he is financially liable, the patient conveys upset and confusion as he repeatedly asks, "Why couldn't someone tell me there was a substantial risk that the insurance company would deny the procedure? Is this a common thing that happens and which insurance company in Connecticut would pay for the procedure, so I can determine if I need to change insurance companies?"

Denied Claims Data Use Cases

Use Case #5

Ruth is the Human Resources manager with a small employer in Connecticut and is reviewing their insurance coverage. They are a tight knit group and have just lost one of the staff to cancer. This has made the staff keenly aware of cancer screening. Being a small company she is using an Insurance Broker to help her evaluate Insurance companies.

While she likes her broker, she is also aware that insurance companies compensate brokers based on volume, which can bias their recommendations. She asks "Is there anywhere that I can independently research how often insurance companies are denying cancer screenings?

Next Steps

Discussion of Dental Data Collection and Stakeholder Engagement

Dental Data Background/Current Stats

Acceptance and Integration of Dental Claims

- *"The Administrator shall establish a similar schedule for the reporting of Dental Claims Data by Reporting Entities in the future. Said schedule and detailed reporting specifications shall be incorporated into a future revised version of the Submission Guide. Notification of such changes shall be provided to Reporting Entities through written notice and posted on the APCD website."* **- CT APCD Policy and Procedure**
- Dental claims data included within the current CT APCD data submission guide (DSG). Data layout and components mirror dental format found in other APCD states.

- Highly similar to collection of medical claims data.

Dental Data Background/Current Stats

Not Registered or Estimated Lives Not Provided

- Humana Dental Insurance Company
- United Concordia Insurance Company
- Aetna Life Insurance Company
- Mega Life & Health Insurance Company
- Renaissance Life & Health Insurance Company Of America
- Security Life Insurance Company Of America
- Starmount Life Insurance Company (Alwayscare)
- Stonebridge Life Insurance Company (Encore Dental)
- Ameritas Life Insurance Corporation
- Anthem Health Plans Inc.
- Connecticut General Life Insurance Company
- The Chesapeake Life Insurance Company

Registered and Provided Covered Lives Estimate

- Delta Dental of New Jersey, Inc.
- Chesapeake Life Insurance Company
- Connecticare Insurance Company
- Dentegra Insurance Company
- The Lincoln National Life Insurance Company
- Lincoln Life & Annuity Company of New York
- First Penn-Pacific Life Insurance Company

Dental Data Background/Current Stats

Dental Data Current Data Components

- **Service/Paid Dates**
- **Provider IDs**
- **Diagnosis/Procedure Codes:**
  - Common Dental Terminology (CDT)
  - Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes
  - ICD Diagnosis Codes
- **Financial Information:**
  - Charged, Allowed, Paid, and Consumer Out-of-Pocket amounts
- **Dental Specific Fields:**
  - Tooth Number/Letter Identification
  - Dental Quadrant
  - Tooth Surface

Dental Data Discussion

Discussion Topics:

1. **Requirements, Enforcement, and Compliance to Billing Standards For Dental Health Care Claims (2012 ADA Dental Claim Form & 837/835 EDI):**
   - Industry Acceptance Rate of Billing Standards (Paper vs. EDI)
   - Billing Variations Across Providers (Dentists and Other Providers)
   - Data Collection Variations Across Payers
   - Demarcation Between Services Billed to Medical Benefit vs. Dental Benefit
   - Barriers to Capturing Dental Service Utilization Information
   - Barriers to Capturing Dental Clinical Information
2. **Opportunities to Improve The Dental Data Submission Guide (DSG) Requirements:**
   - Potential Additions To The Dental DSG Contents
   - Potential Exclusions/Redundancies To The Dental DSG Contents
3. **Opportunities For Dental Data Usage:**
   - Topics of Research Interest and Usage Within CT

APCD Policies and Procedures Implications

- APCD legislation definition of reporting entity includes dental carriers (CGS 38a-1091)
- Policies and Procedures require submission of dental data in the future, based on a schedule to be established by APCD Administrator as part of a revised Data Submission Guide (DSG)
- DSG revisions require 30 public comment period, effective 90 days after final revisions posted

Next Steps

Policy and Procedure Enhancement Subcommittee Meeting

Meeting Minutes

Date: February 21, 214
Time: 1:00 p.m. EST
Location: Hilton Hotel – Ethan Allen Room
315 Trumbull St, Hartford, CT 06103

Members Present: Olga Armah, Demian Fontanella, Matthew Katz, Jean Rexford, Brenda Shipley, Mary Taylor (Phone)

Members Absent: None

Other Participants: Tamim Ahmed, Robert Blundo, Matthew Salner

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I. Call to Order and Introductions

Matthew Katz called the meeting to order at 1:00 p.m. Mr. Katz provided a brief update to the subcommittee. Members introduced themselves.

II. Public Comment

There was no public comment.

III. Discussion of Challenges, Benefits, and Opportunities for Denied Claims Acceptance

Mary Taylor asked for the subcommittee to consider developing a criteria for data prioritization and making decisions. Ms. Taylor expressed that the criteria take into account APCD legislation, support by federal funding, and the development of parameters to guide committee's discussions. Ms. Taylor motioned for the subcommittee develop a criteria for data elements proposed for inclusion in the APCD.

Brenda Shipley asked for clarification with regard to whether the proposed criteria would cause the committee to reconsider the data elements for inclusion in the APCD. Ms. Taylor indicated that the guidelines were proposed for the purpose of creating a structured approach for prioritizing discussions on data elements requested for DSG addition in the future.

Olga Arma seconded the motion by Ms. Taylor. Mr. Katz indicated he believes the enhancements committee should not be limited from reviewing and evaluating the enhancement request from the APCD committee. Ms. Shipley indicated she would like to understand data enhancement requests before developing criteria. Jean Rexford expressed her disagreement with the need for the development of a process since the group is tasked with reporting back to the larger committee. Ms. Taylor noted the potential for the submission of a large number of data requests depending on the individual making the request. However, the carrier community may not collect

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the types of information to support requests and knowledge of the less frequently collected data components would aid the subcommittee in prioritization of their discussions. To effectively handle these requests, the creation of guidelines for prioritizing discussion would improve the efficiency of subcommittee deliberation and consideration. Mr. Katz responded by suggesting group discussion incorporate a vetting process to ensure the state maximizes cost and effectiveness of the requests. Mr. Katz proposed that the potential motion could be for the committee to review proposed criteria in the next subcommittee meeting before voting whether criteria and parameters should be implemented. Ms. Taylor agreed with Mr. Katz. Ms. Taylor rescinded the motion. Ms. Rexford made a motion to the effect of Mr. Katz's proposal. The motion was seconded by Ms. Shipley. The motion passed unanimously.

Mr. Katz introduced the agenda topic that addressed the challenges, benefits, and opportunities for denying claims acceptance by the APCD. Mr. Katz provided the present language for the claims denial process in the Data Submission Guide (DSG). Mr. Katz clarified that a claim is denied for incompleteness, errors or other administrative reasons, alternatively are referred to as soft claims, and should not be submitted until the claim has been paid. Mr. Katz provided support for the importance of collecting and assessing as much denied claims data as possible to illustrate the way consumers, providers, and payers are represented in the denial of claims. Mr. Katz opined that the analysis of denied claims hold the purpose of indicating trends in administrative and medical errors throughout an episode of care as well as information missing from current data sets. Mr. Katz stated the public is entitled to a transparent and fair outlining of the reasons claims are denied to clearly indicate whether these reasons vary by insurer, types of services provided, patient demographics, types of plans, payers and the frequency at which each factor led to claim denial. Policy makers would benefit from the data reported from an angle that contrasts a population health perspective to a care access perspective, which indicates policy makers want to know which services are being paid for and which are denied, the issues of disparities that are causing denial, and to take a more broad look at claim denial trends. Mr. Katz recommended the committee investigate denied claims data to understand and help others learn about the opportunities and issues that affect public health, and to determine whether reasons for denial vary across payers, region and patient population in conclusion of his commentary. Ms. Shipley supported the initiative in her comment about making claims denial data accessible to assist the newly insured public with the comprehension of their own denied claims.

Ms. Taylor urged the inclusion of insurance companies in this discussion in reference to their interaction with the consumer, carrier and policy information. The providers can provide critical insight since their role requires policy forms to be filed with changes in language, assessed through procedures including utilization reporting, identification of outlier carriers through statistical reports, determination of care discrepancies, and then approved by the department. The Office of Consumer Advocates has a great window into whether issues are occurring with certain carriers across the industry that might impact factors related to population.

Ms. Taylor requested clarification with regard to what data is being collected and the solution being sought from intake and aggregation of denied claims data. Mr. Katz responded that the purpose is to extract critical information that can be obtained through assessment. Demian Fontanella asked whether any denied claims outside of the definition provided by Mr. Katz would be collected. Robert Blundo replied by explaining that the prior DSG maintained that if a claim was partially denied, all components of the partially denied claim would be received by the APCD. Mr. Blundo stated that in a circumstance wherein all services are denied coverage or when there is a soft denial, claims data would not be received by the APCD. Mr. Fontanella asked how a full medical necessity denial fits in this definition as it does not seem to meet the definition of a soft denial, if this full denial is not administrative, incomplete, or without error. Mr. Blundo explained that the Connecticut APCD is functioning in accordance with the data submission guidelines, which states a claim is not submitted until it is paid. Mr. Fontanella disagreed with the premise that denied data is unimportant and does not understand how a medically

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necessity denial fits into the DSG denial definition. Mr. Blundo explained that medical necessity may fall under the definition's "other administrative reasons" category, and since that claim is not paid it should not be submitted by DSG request. Mr. Katz requested more detail on how the DSG language would be applied for denied claims, and that this may need to wait for the data management contractor. Tamim Ahmed discussed from the perspective of analytic complexity, what is denied in one time period may be overruled in the next period, which highlights the APCD challenge of collecting old claims in the context of new rules and the need to maintain continuity when considering DSG reconstruction to address this issue.

Mr. Salner supported the fact that the current Policies and Procedures and DSG are limited to the collection of paid claims by reading the definition of medical claims files in the Policies and Procedures text (passed by the board December, 2013). Mr. Salner addressed the question by Mr. Damian by explaining that the current language in the policies and procedures do not permit unpaid claims, but can be revised to permit the collection of unpaid claims data. Mr. Blundo presented a graphical representation to illustrate the denied claims topic and to identify best practices by observing current processes, reports and initiatives for handling this type of data reporting and challenges that may be encountered. Mr. Blundo presented two graphics comparing EDI methods versus a proposed APCD post adjudicated method and suggested consideration of the annual AMA national health insurance report based on 835 data from various large carriers including response time for a claim to be adjudicated as factual support. Mr. Blundo recommended that the subcommittee review the available CARC and RARC codes in future meetings to ensure their values meet the goals of the subcommittee. Mr. Katz indicated that the presentation by Mr. Blundo was included in the meeting to enhance member understanding of the data collection and transmission process between provider, payer and APCD.

Mr. Blundo introduced slide eight, which contained data components within the data submission guide and explained the components serve as tools in the APCD processing of a post-adjudicated claim or denied claim. Mr. Ahmed raised the question regarding the ability to determine whether a claim has been fully denied if all claim lines were denied. Mr. Blundo explained that could be conceivable, however the inclusion of a data manager and submitter at the table would be needed to ensure the proposed assumption is correct. Mr. Ahmed posed a question asking whether the subcommittee could request submitters to propose scenarios for denied claims. Mr. Blundo recommended an iterative approach in which the first step is to on-board a data manager, and then work with submitters to determine if the current DSG facilitates collection. Mr. Katz agreed with Mr. Blundo, and commented that if denied claims data were to be incorporated into the APCD in the future, modifications to the DSG and consensus amongst stake holders would be needed.

Mr. Blundo initiated the discussion of slide nine, which illustrated Mr. Katz's recommendation on a proposed cycle with which the AHA would take on the challenges and opportunities of building and working with denied claims. An iterative process was outlines which steps for determining, requesting, analyzing, assessing and then evaluating progress. Mr. Blundo stated that the request phase would require an assessment of the best practices and feasibility of denied claims would be necessary in their consideration for APCD inclusion. Ms. Taylor expressed her interest in learning how the collection and analysis of denied claims data align with the priorities and goals of the APCD and its committee. A discussion ensued regarding the manner in which a report would be provided to the APCD committee. It was agreed that the topic was still fluid, and for the short-term a briefing during the regular APCD committee meetings would suffice. Mr. Katz reiterated that the proposed recommendation should be feasible and practical. In an effort to support this, a motion was made to continue evaluate denied claims collection and incorporate data submitters into the dialogue in the future. The motion was seconded by Ms. Shipley. Discussion ensued about the manner in which denied claims would be evaluated in future meetings. Ms. Taylor requested advanced notice to submitters so they could prepare educational materials regarding denied

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claims. A vote on the motion was passed unanimously. Mr. Katz proposed a list of questions be developed by the subcommittee to provide to submitters.

IV. Discussion of Dental Data Submission Plans and Status

Mr. Katz introduced the agenda item concerning the integration of dental claims through the use of the DSG amendment and reporting methods characterized in the denied claims discussion. Mr. Katz stated the committee should move forward with the development, composition and inclusion of a schedule and approach in the policy and procedure guide to capture dental claims data. Ms. Rexford asked about the availability and use of dental in CT and by other states. Mr. Katz indicated various dental insurance models exist in Connecticut, and the data would support oral health initiatives. Mr. Blundo explained the components contained within the dental data submission guide and the data components specific to the dental community. Mr. Blundo also opined that including the dental community to ensure all useful data components have been included prior to requesting the data from submitters. In addition, Mr. Blundo indicated the identification of dental submitters is still a work in progress. Ms. Rexford opined the data collection proposed by Mr. Blundo would be useful in oral public health initiatives. Mr. Ahmed included that communication with the Connecticut Oral Health Initiative was already underway.

Mr. Blundo announced the structured approach maintained by Access Health Analytics in taking on different types of claims data. Mr. Ahmed noted the implicit understanding that the incorporation of dental claims data will take place 2015. Mr. Blundo contributed to this statement by explaining the need to develop a timeline for the necessary data collection steps in the near future. Mr. Salner added the need for legal consultation regarding the requisite notice, policy and procedure revision to indicate the start date, and DSG revision prior to moving forward. Mr. Blundo clarified that the policy and procedures guide must be changed to include the dental claims protocol at least and ideally more than 90 days before implementation to provide submitters adequate preparation time.

Ms. Taylor noted large carriers who already provide dental to other states can produce the information relatively easily, while small dental only carriers may find the process more challenging. Mr. Katz identified the need to decide the dental submission elements and logistics within the next three months to allow for dental data submission in the timeline leading up to 2015. Mr. Salner demonstrated his agreement the need to get started in making these considerations with Ms. Taylor by describing the process leading up to dental claims submission from the APCD Advisory group approval of policy and procedure revisions, to the Access Health Board evaluation for approval, and then be presented for public comment in the law journal for thirty days. This succession would take approximately three months and revision to the DSG would potentially lengthen this period of time. Mr. Salner indicated that the organization currently requires dental carrier registration and noted that the committee would need to formalize language in the Policies and Procedures, and submit the new content for board approval.

Mr. Katz requested that the committee deliberate the intent and timing for the addition of elements including dental claims data elements, submission guidelines and APCD integration. Ms. Shipley asked for clarification on the requirements for revising the Policy and Procedures and whether the completion of formalized language to characterize dental data elements would be part of the process. Mr. Blundo indicated that the data elements have been determined in the section of the DSG that describes the requested dental claims fields and how to handle them. Mr. Blundo differentiated the Policies and Procedures from the DSG by stating that the Policy and Procedures makes reference to the DSG and indicated the need to develop formal language that characterizes a timeline for the incorporation of dental claims data within the Policies and Procedures. Mr. Blundo suggested that the creation of policy and procedure language could occur in parallel with the coordination of DSG dental components with the community.

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Ms. Shipley requested that a motion be made for Mr. Salner to work with legal to provide the committee the modified policy and procedure language to promote the initiative to incorporate dental claims data by mid-2015. The motion was seconded and passed unanimously.

V. Next Steps

Mr. Katz requested that the subcommittee draft any DSG revisions necessary to comprehensively capture dental claims data and asked that members communicate with the commercial carriers and payers in the Dental Association to facilitate proceedings at the upcoming subcommittee meeting.

Ms. Shipley asked that the next agenda allow for discussion of the de-identification algorithms and the Policies and Procedures concerning the data use agreements and process. Mr. Katz clarified that the Data Privacy and Security Subcommittee would discuss de-identification and permissible data use guidelines.

VI. Future Meetings

Mr. Katz proposed that the subcommittee meet in April to deliberate next steps for the incorporation of dental claims and to seek resolution to issues associated with the denied claims

VII. Adjournment

Mr. Katz made the motion to adjourn the meeting. The motion was seconded and passed unanimously. The meeting was adjourned at 3:00 p.m.

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TO: Tamim Ahmed, Executive Director, Access Health Analytics
CC: Kevin Counihan, CEO, Access Health CT
Matthew Salner, Policy Analyst, Access Health CT
FROM: Joanna Douglass BDS, DDS, Associate Professor of Pediatric Dentistry, UConn School of Dental Medicine and Oral Health Consultant to the Connecticut Health Foundation
Patricia Baker, President & CEO, Connecticut Health Foundation
Elizabeth Krause, VP of Policy and Communications, Connecticut Health Foundation
DATE: May 5, 2014
RE: Oral Health and the All Payer Claims Database

The Connecticut Health Foundation (CT Health), an organization that has been advancing policy solutions that improve access to quality oral health services for Connecticut's low income families for 15 years, respectfully requests the inclusion of robust dental payer data in the All Payer Claims Database (APCD). This would give oral health stakeholders important insights about cost and quality, while if done in a linked way, bridging the medical-dental divide.

In this memo, we provide some background followed by specific suggestions that we hope will prove useful in implementation. CT Health VP of Policy and Communications, Elizabeth Krause, will share key points during the public comment period at the May 8, 2014 Access Health Analytics Policies and Procedures subcommittee meeting. Additionally, CT Health would be pleased to offer you a phone or in-person briefing with Joanna Douglass BDS, DDS, CT Health's oral health consultant.

Premise

Oral health is critical to overall health. As Connecticut continues to innovate towards the triple aim of achieving improved population health through higher quality care at lower costs, the collection of dental-specific data necessary to measure the impact of the state's efforts should be a priority. Connecticut has seen significant improvements in expanding access to oral health care for children in Medicaid and is a model for how to successfully ensure access to pediatric dental benefits under the Affordable Care Act. However, without the inclusion of robust dental payer data in the APCD, it will remain difficult to truly demonstrate the effectiveness of these programs.

The Need for and Utility of Linked/Amalgamated Dental and Medical Claims Data

Oral health is directly related to overall health and the costs of delivering medical care. While examining dental care via dental billing allows us to draw conclusions about oral health care, it fails to allow us to examine dental care's impact on overall health and the places where significant cost savings can be realized. Most of these health and cost issues are embedded into the Medical plans. Examples include, but are not limited to, the following:

- Operating room costs for general anesthesia to treat aggressive dental disease in children only appear in the medical plan, but account for millions in the Connecticut Medicaid budget.
- Emergency room and inpatient costs secondary to poorly controlled diabetes, which is partly related to untreated gum disease, only appear in the medical plan.
- Medical care of children with special health care needs can be compromised and end up costing more due to extensive dental disease. These costs need to be tracked in both dental and medical plans to fully understand cost and health complications.

It is critically important, therefore, that medical and dental claims databases be linked, or ideally amalgamated into one database, to help us understand the interplay between oral health and overall health, as well as the cost implications on insurances as a whole, and not just on one segment of the market. Only when this integration is achieved can we help move people towards complete health in a cost effective manner.

Suggested Guiding Framework for Developing the Dental Component of the APCD

1. *We should plan for the future and not be constrained by what the data inadequacies might be at present*
2. *The framework for what is requested in the medical part of the database, in terms of demographics, plan information etc., should be mirrored in dental*
3. *We should not worry about what the statistical analyses might be at present. The data will initially require exploration for validity and understanding. This will be an iterative process in the first few years. See below for measures that have already been developed for children.*
4. *Dental and medical APCDs should be linked or amalgamated. This can only be achieved by Medicaid number or social security number (for non Medicaid beneficiaries)*
5. *Race/ethnicity should be included in the dental APCD so we can continue to promote health equity. While race/ethnicity is not always collected by dental carriers (similar to medical carriers), APCDs around the country are increasingly requiring payers to provide this information.*
6. *We should use information from existing dental APCDs to help frame the dataset. States with existing dental APCDs include: Kansas, Maine, Massachusetts, New Hampshire, and West Virginia.*

Dental Data and Quality of Care

The collection of dental data to assess quality of care poses unique challenges, because unlike medical treatment, there are no diagnostic codes used in dentistry, only procedural codes. For example, when a dentist submits a procedure code for a filling, we know that the patient received a filling, and most of the time we can correctly infer that they had a cavity. However, in some cases they may have had an old fractured filling that merely needed replacement. While some measures of quality are relatively easy to determine using procedural codes, others are not and require a more indirect use of selective codes to ascertain quality.

Below are some other areas of dental claims differences to be aware of.

1. *The rendering provider is not consistently reported on dental claims, often only the senior partner's name is on the claim*
2. *Location of care in multi-site offices is typically not determined. There may be no separate NPI for each different service site. Offices often only report billing NPI*
3. *Most dental plans have benefit limitations. When dollar threshold is reached dentists will not submit to insurers. As such, the dental APCD can only report on covered services and will never capture as much information as the medical APCD.*
4. *Certain providers (e.g. FQHCs and capitated providers) may only submit one covered code for a visit when they may do multiple codes. With regards to FQHCs this is an issue that is currently being rectified within the Medicaid system.*
5. *Dentists vary in the charges they submit. Some submit usual and customary, some submit what they know the plan will cover.*

Many of these issues can be rectified over time by holding dentists and payers to consist standards of claims submission.

Measures Recommended by the Dental Quality Alliance

The Centers on Medicaid and Medicare Services initiated the development of the national Dental Quality Alliance (DQA), an organization that is managed by the American Dental Association. The goal of DQA is "to advance performance measurement as a means to improve oral health, patient care and safety through a consensus-building process"[1] and they are intimately familiar with the challenges of working with dental data and their work reflects this knowledge.

Dental measures chosen that help address issues of quality need to be:[2], [3]

1. Important:
    a. Healthcare systems should be able to affect action and be accountable for the measure
    b. The cost of the issue should be significant
    c. The extent of the quality problem should be significant
    d. Variation and disparity in the measures should exist
2. Reliable and Valid
3. Feasible:
    a. Data should be readily available
4. Aligned:
    a. The measure should appear in other federal, state or private sector quality reporting programs

DQA has developed a series of measures for children (measures for adults are currently being developed, and will build off of the same quality data[4]) that can[5]:

1. Uniformly assess quality of care across private/public sectors and across state/community and national levels;
2. Uniformly assess utilization of certain services that are not supported by evidence that they indicate better or worse care, but which may be important in the context of providing a standard of care;
3. Inform performance improvement projects longitudinally and monitor improvements in care;
4. Identify variations in care; and
5. Develop benchmarks for comparison.

Quality can be considered for prevention and treatment results over the short term and long term. For example, fluoride intensity (measuring number of fluoride treatments over a specified interval) is a longer term measure whereas an annual oral evaluation is a short term measure.

Cost helps us understand in the long term the cost-benefit of various preventive/treatment options.

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[1] http://www.ada.org/5105.aspx
[2] http://www.ada.org/sections/dentalPracticeHub/pdfs/042213_Measure_development_Procedure_Manual.pdf
[3] Department Of Health And Human Services, Centers for Medicare & Medicaid Services.
Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework Measures and Methodology. Federal Register / Vol. 78, No. 223 / Tuesday, November 19, 2013
[4] http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/Adult_Measures_under_consideration.ashx
[5] http://www.ada.org/sections/dentalPracticeHub/pdfs/User_Guide(1).pdf

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Current recommended children's measures by the DQA include:

Evaluation Domain	Measure	AHRQ Domain
Utilization	Use of Any Services	Use of Services
	Use of Preventive Services	Use of Services
	Use of Treatment Services	Use of Services
Quality of Care	Oral Evaluation annually	Access/Process
	Topical Fluoride Intensity	Access/Process
	Sealant use in 6-9 years	Access/Process
	Sealant use in 10-14 years	Access/Process
	Care Continuity	Access/Process
	Usual Source of Services	Access/Process
Cost of Care	Per-Member Per-Month Cost	Cost

Data Required

Certain data elements must be captured in order to use the measures listed above. The data necessary to examine these measures and the contextual issues behind variation include:

- Paid and Unpaid claims for all procedure codes and visits including:
  - CDT and CPT codes
  - Tooth numbers and tooth surfaces (as necessary for specific CDT code)
- Rendering provider type, including:
  - dental versus non-dental
  - office setting (private, FQHC, safety net, hospital etc).
- Providers such as FQHCs using encounter paying and those using capitated models should be required to submit codes for all services rendered
- Individuals with elevated risk should be identified as outlined in the DQA materials based on presence of specific codes in the reporting year
- Stratification information including:
  - Age
  - Race/ethnicity
  - Geographic location
  - Payer type
  - Program plan type
  - Primary language
  - Disability status

Exact data points required can be seen in the DQA report[6]

In closing, please do not hesitate to contact elizabeth@cthealth.org or 860-724-1580 x14 if you would be interested in scheduling a briefing with Dr. Douglass at your convenience to elaborate on or answer any questions about this memo. Thank you for your consideration and partnership.

[6] http://www.ada.org/sections/dentalPracticeHub/pdfs/User_Guide(1).pdf

Reasons for the Collection of Denied Claims Information

Background

Payer-specific denials have always been of high interest to medical providers and patients, especially those in need of services or procedures that are often difficult to receive due to challenges associated with their availability and accessibility of service. In the case of many payers, they simply do not do a good job of publishing denial rules, especially for patients who seek this information when making decisions regarding insurers, providers and services they intend to obtain. Both known and unknown edits vary greatly between payers. Provided these discrepancies, a main goal in the initiative to collect and identify both partial and fully denied claims is to promote greater transparency within the health care system and health insurance industry. Transparent health care information is critical when making decisions as a consumer or provider, and would help state agencies and policy makers better to better understand the health care climate in the state as they consider the provision and payment of medical services in Connecticut. Please consider the following additional information in support of APCD inclusion of denied claims:

- Connecticut has more than 20 mandated benefits (that are to be provided or covered when medically necessary, or to be covered regardless of an insurer's interpretation of medical necessity. For this reason, insurer-specific information on denials would allow for a better assessment of whether state mandated benefits are being provided or more specifically covered by insurers.

- Similar to the evaluation of state covered and required mandates, information by insurer on denials of service would allow for a better evaluation of qualified health plans and if they actually providing the full benefit package required under the Accountable Care Act (ACA), within the Health Insurance Exchange, and outside of the Exchange, as well as if there were any identified difference in coverage or benefit coverage. If a high percentage of "covered" benefits was denied, the state, resident enrollees, and likely the federal government would appreciate this information.

- Denied claims information would facilitate our ability to track certain procedures and services, which are often identified by some insurers as investigational or experimental. This would allow stakeholders to better understand the frequency of service provision in Connecticut and the differences in coverage determinations by insurers tied to these particular services and procedures.

- Certain services and procedures may not be considered covered benefits in Connecticut, regardless of insurer and for a variety of reasons, but are commonly provided services in Connecticut. It would be important to track the volume or frequency of these services that may be important to patients and policy makers, especially if there are high denial rates.

- Tracking high-frequency services with a large numbers of denials incurred for various reasons, which also may require tracking due to public safety concerns. A reason for the nature of this tracking might be to observe the provision of compounding agents through injection when

medications are defective or worse, because we will need to know more than just who received it, and from whom in the event of a mass recall or problem. In the case of this circumstance, we would need information of all cases or times of per the given provision, regardless of whether or not a service or procedure was denied. In cases of tracking of provision of services or procedures that include medications, there is great need to identify all cases and claims, not just those processed for payment. It is important to note that the provision of compounding agents is generally viewed as being denied more frequently than when those same agents are provided in successive injections or injections on different dates.

- With new technology and new approaches to certain procedures, understanding the denial rates in general and by specific payer would be helpful for patients, especially those in need of the particular procedure, to have another data point for evaluation or comparison of insurers tied to the selection of insurance product and design. An example would be a new surgical device that reduces the time of the surgery and length of recovery, which some patients may deem extremely beneficial tied to their treatment and long term prognosis, while other patients may be more comfortable with a traditional method or surgical approach. Without understanding the likelihood of medical procedure denial, a patient would miss a critical piece of understanding needed for an informed decision tied to insurance selection.

- Denied claims information would be necessary to fully evaluate or compare insurers from a perspective of frequency of denied claims. Though it appears locally and nationally the overall claims denial rate is between 1 and 3 percent (with higher percentages of initial claims denied- or upon initial submission prior to resubmission or appeal), there is some great variability across claim category (services or procedures) and across and among insurers, including governmental payers such as traditional Medicare and Medicaid.

- Denied claims could be used by patients to comprehensively evaluate or compare insurers from a perspective of frequency of denial of certain services or procedures (that may be of interest to someone purchasing insurance who may have a defined and chronic condition, such as diabetes, COPD, asthma, etc.).

- Denied claim information could be used by the State of Connecticut to identify insurers who may be outliers with regards to claims denials for certain procedures or services.

- Denied claim information could be used to evaluate if there is any difference in general (or in aggregate) in claims denials of certain or all services and procedures between commercial insurers and governmental payers, especially Medicare and Medicaid.

- Denied claim information could be used to determine if certain patient populations (by race, ethnicity, gender or geographic location) experience more denials in general (aggregate) or more denials for certain procedures and services, especially procedures or services associated with specific conditions that may have a genetic disposition or have a geographic link in Connecticut.

- Denied claim information could be used to determine if certain geographic locations in Connecticut, regardless of patient populations, experience more denials in general and in aggregate and by certain or select services and procedures (or certain mandated benefits).

- Denied claims information could be used to determine if there is any site of service differential in denials of services and procedures (more or less in the hospital, in nursing homes, physician office, etc.). It would also be important to capture denied claims when looking at overall volume of certain services or procedures by site of service, especially when there are significant differences in the cost (provider charges and insurer payments) by the various sites for those services and procedures.

- Denied claims information could be used to determine if it is the professional component or all aspects of particular procedures and services that are denied (since the APCD will be collecting partial claims, having information on the same services and procedures that are totally denied would permit a comparison of what aspect or in what situation is a particular service or claim partially denied or fully denied, and if it is a component of the service or all aspects of the service or procedure that is often or always denied).

- Denied claims information will help determine exactly how many services or procedures a particular physician, provider or institution is actually providing and what percentage of the care they provide is denied. There is no suggestion that the provider or institution is wrong in the identification, documentation or reporting of the particular service or procedure, but the differential of denial would be something to look closely at and could lead to the determination of certain positive or negative trends tied to the providers of care or the insurers.

- There is interest in understanding how often insurers deny the entire claim for medical care the first time (or even second time) before eventually making payment on a high level and also for specific services and procedures. It would be interesting to see if there is any variability by specific service and procedure and if these claims are for large payments or small payments, or if there is a specific or associated medical condition associated with the services that are most often denied but later paid and tied to claims that are always and repeatedly denied after resubmission. It would be interesting to see if the frequency of resubmission is correlated with the percentage of eventual payment- do insurers change positions tied to the approval or denial of claims.

- The collection of denied claims information would allow for an analysis of payer lag time or more specifically prompt payment of claims as a function of claims denial. For instance, are cases where something is denied associated with a quicker response time than claims that are paid in full? Is there any association between denied claim and timeliness of payment? Are claims being denied quickly and then later paid after the statutory time frame has expired suggesting that the state prompt payment law is causing insurers to have to deny claims that do not have sufficient information rather than delay payment or potentially suggesting that the state law may be causing insurers to inappropriately or unnecessarily deny claims because they can’t meet the statutory time frame for timely payment?

Summary of Intent

This presentation of denied claims use cases aimed to simulate conversation between subcommittee members and stakeholders. Although these use cases were presented in a hypothetical context, the challenges presented in them have not been uncommon to both patient and provider, and are often a product of variability in reporting throughout the industry. Payers could also serve to benefit from their inclusion in the APCD with regard to information that could be derived from the analysis of denied claims to support future composition and revision of their health plans. On the whole, denied claims in the Connecticut APCD could provide a reliable cornerstone on which stakeholders could base their collaborations in the development of a common ground for reporting and interpreting denied claims.

Claim Adjustment Reason Codes (CARCs)

http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

CARC	Message
1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	This injury/illness is covered by the liability carrier.
21	This injury/illness is the liability of the no-fault carrier.
22	This care may be covered by another payer per coordination of benefits.
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
24	Charges are covered under a capitation agreement/managed care plan.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
29	The time limit for filing has expired.
31	Patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Insured has no dependent coverage.
34	Insured has no coverage for newborns.
35	Lifetime benefit maximum has been reached.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
44	Prompt-pay discount.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

55	Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.
61	Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
66	Blood Deductible.
69	Day outlier amount.
70	Cost outlier - Adjustment to compensate for additional costs.
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
78	Non-Covered days/Room charge adjustment.
85	Patient Interest Adjustment (Use Only Group code PR)
89	Professional fees removed from charges.
90	Ingredient cost adjustment. Note: To be used for pharmaceuticals only.
91	Dispensing fee adjustment.
94	Processed in Excess of charges.
95	Plan procedures not followed.
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.
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
100	Payment made to patient/insured/responsible party/employer.
101	Predetermination: anticipated payment upon completion of services or claim adjudication.
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount).
104	Managed care withholding.
105	Tax withholding.
106	Patient payment option/election not in effect.
107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Service not furnished directly to the patient and/or not documented.
114	Procedure/product not approved by the Food and Drug Administration.
115	Procedure postponed, canceled, or delayed.
116	The advance indemnification notice signed by the patient did not comply with requirements.
117	Transportation is only covered to the closest facility that can provide the necessary care.
118	ESRD network support adjustment.
119	Benefit maximum for this time period or occurrence has been reached.
121	Indemnification adjustment - compensation for outstanding member responsibility.
122	Psychiatric reduction.
128	Newborn's services are covered in the mother's Allowance.
129	Prior processing information appears incorrect. 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.)

130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
133	The disposition of the claim/service is pending further review. (Use only with Group Code OA). This change effective 11/01/2014: The disposition of this service line is pending further review. (Use only with Group Code OA). NOTE: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).
134	Technical fees removed from charges.
135	Interim bills cannot be processed.
136	Failure to follow prior payer's coverage rules. (Use only with Group Code OA)
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
138	Appeal procedures not followed or time limits not met.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
140	Patient/Insured health identification number and name do not match.
142	Monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	Incentive adjustment, e.g. preferred product/service.
146	Diagnosis was invalid for the date(s) of service reported.
147	Provider contracted/negotiated rate expired or not on file.
148	Information from another provider was not provided or was insufficient/incomplete. 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.)
149	Lifetime benefit maximum has been reached for this service/benefit category.
150	Payer deems the information submitted does not support this level of service.
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
152	Payer deems the information submitted does not support this length of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
153	Payer deems the information submitted does not support this dosage.
154	Payer deems the information submitted does not support this day's supply.
155	Patient refused the service/procedure.
157	Service/procedure was provided as a result of an act of war.
158	Service/procedure was provided outside of the United States.
159	Service/procedure was provided as a result of terrorism.
160	Injury/illness was the result of an activity that is a benefit exclusion.
161	Provider performance bonus
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.
163	Attachment/other documentation referenced on the claim was not received.
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.
165	Referral absent or exceeded.
166	These services were submitted after this payers responsibility for processing claims under this plan ended.
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.
169	Alternate benefit has been provided.
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
171	Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
172	Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
173	Service/equipment was not prescribed by a physician.
174	Service was not prescribed prior to delivery.
175	Prescription is incomplete.
176	Prescription is not current.
177	Patient has not met the required eligibility requirements.

178	Patient has not met the required spend down requirements.
179	Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
180	Patient has not met the required residency requirements.
181	Procedure code was invalid on the date of service.
182	Procedure modifier was invalid on the date of service.
183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
186	Level of care change adjustment.
187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)
188	This product/procedure is only covered when used according to FDA recommendations.
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF)
192	Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.
195	Refund issued to an erroneous priority payer for this claim/service.
197	Precertification/authorization/notification absent.
198	Precertification/authorization exceeded.
199	Revenue code and Procedure code do not match.
200	Expenses incurred during lapse in coverage
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR)
202	Non-covered personal comfort or convenience services.
203	Discontinued or reduced service.
204	This service/equipment/drug is not covered under the patient’s current benefit plan
205	Pharmacy discount card processing fee
206	National Provider Identifier - missing.
207	National Provider identifier - Invalid format
208	National Provider Identifier - Not matched.
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)
210	Payment adjusted because pre-certification/authorization not received in a timely fashion
211	National Drug Codes (NDC) not eligible for rebate, are not covered.
212	Administrative surcharges are not covered
213	Non-compliance with the physician self referral prohibition legislation or payer policy.
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only
215	Based on subrogation of a third party settlement
216	Based on the findings of a review organization
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only)
218	Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only

219	Based on extent of injury. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).
220	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Property and Casualty only)
221	Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (Note: To be used by Property & Casualty only)
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. 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.)
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. 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.)
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)
230	No available or correlating CPT/HCPCS code to describe this service. Note: Used only by Property and Casualty.
231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
232	Institutional Transfer Amount. Note - Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
234	This procedure is not paid separately. 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.)
235	Sales Tax
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.
237	Legislated/Regulatory Penalty. 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.)
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
241	Low Income Subsidy (LIS) Co-payment Amount
242	Services not provided by network/primary care providers.
243	Services not authorized by network/primary care providers.
244	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.
245	Provider performance program withhold.
246	This non-payable code is for required reporting only.
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.
249	This claim has been identified as a readmission. (Use only with Group Code CO)
250	The attachment/other documentation content received is inconsistent with the expected content.
251	The attachment/other documentation content received did not contain the content required to process this claim or service.
252	An attachment/other documentation is required to adjudicate this claim/service. 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).
253	Sequestration - reduction in federal payment
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.
255	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA)
256	Service not payable per managed care contract.
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)

258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
259	Additional payment for Dental/Vision service utilization.
260	Processed under Medicaid ACA Enhanced Fee Schedule
A0	Patient refund amount.
A1	Claim/Service denied. 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.)
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
A7	Presumptive Payment Adjustment
A8	Ungroupable DRG.
B1	Non-covered visits.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Only one visit or consultation per physician per day is covered.
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
B16	'New Patient' qualifications were not met.
B20	Procedure/service was partially or fully furnished by another provider.
B22	This payment is adjusted based on the diagnosis.
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.
B4	Late filing penalty.
B5	Coverage/program guidelines were not met or were exceeded.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
B8	Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
B9	Patient is enrolled in a Hospice.
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.
P10	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only.
P11	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA)
P12	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.
P15	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only.
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA)
P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only.
P18	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only.
P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.
P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.

P22	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.
P23	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.
P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR)
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.
P6	Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.
P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.
P8	Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.
P9	No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only.
W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply.
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.
W3	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. For use by Property and Casualty only.
W4	Workers' Compensation Medical Treatment Guideline Adjustment.
W5	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA)
W6	Referral not authorized by attending physician per regulatory requirement.
W7	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.
W8	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.
W9	Service not paid under jurisdiction allowed outpatient facility fee schedule.
Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.
Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.
Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.

Remittance Advice Remark Codes (RARCs)

http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/

RARC	Supplemental/Informational Message
M1	X-ray not taken within the past 12 months or near enough to the start of treatment.
M10	Equipment purchases are limited to the first or the tenth month of medical necessity.
M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
M102	Service not performed on equipment approved by the FDA for this purpose.
M103	Information supplied supports a break in therapy. However, the medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.
M104	Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service.
M105	Information supplied does not support a break in therapy. The medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.
M107	Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.
M109	We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring practitioner.
M11	DME, orthotics and prosthetics must be billed to the DME carrier who services the patient's zip code.
M111	We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken.
M112	Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
M113	Our records indicate that this patient began using this item/service prior to the current contract period for the DMEPOS Competitive Bidding Program.
M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.
M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
M116	Processed under a demonstration project or program. Project or program is ending and additional services may not be paid under this project or program.
M117	Not covered unless submitted via electronic claim.
M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
M12	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.
M121	We pay for this service only when performed with a covered cryosurgical ablation.
M122	Missing/incomplete/invalid level of subluxation.
M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
M124	Missing indication of whether the patient owns the equipment that requires the part or supply.
M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.
M126	Missing/incomplete/invalid individual lab codes included in the test.
M127	Missing patient medical record for this service.
M129	Missing/incomplete/invalid indicator of x-ray availability for review.
M13	Only one initial visit is covered per specialty per medical group.
M130	Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
M131	Missing physician financial relationship form.
M132	Missing pacemaker registration form.
M133	Claim did not identify who performed the purchased diagnostic test or the amount you were charged for the test.
M134	Performed by a facility/supplier in which the provider has a financial interest.
M135	Missing/incomplete/invalid plan of treatment.
M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.
M137	Part B coinsurance under a demonstration project or pilot program.
M138	Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.
M139	Denied services exceed the coverage limit for the demonstration.
M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.
M141	Missing physician certified plan of care.
M142	Missing American Diabetes Association Certificate of Recognition.
M143	The provider must update license information with the payer.
M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.
M17	Alert: Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.
M18	Certain services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home.
M19	Missing oxygen certification/re-certification.
M2	Not paid separately when the patient is an inpatient.
M20	Missing/incomplete/invalid HCPCS.
M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.
M22	Missing/incomplete/invalid number of miles traveled.
M23	Missing invoice.
M24	Missing/incomplete/invalid number of doses per vial.

M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice.
M27	Alert: The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.
M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
M29	Missing operative note/report.
M3	Equipment is the same or similar to equipment already being used.
M30	Missing pathology report.
M31	Missing radiology report.
M32	Alert: This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.
M36	This is the 11th rental month. We cannot pay for this until you indicate that the patient has been given the option of changing the rental to a purchase.
M37	Not covered when the patient is under age 35.
M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.
M39	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.
M4	Alert: This is the last monthly installment payment for this durable medical equipment.
M40	Claim must be assigned and must be filed by the practitioner's employer.
M41	We do not pay for this as the patient has no legal obligation to pay for this.
M42	The medical necessity form must be personally signed by the attending physician.
M44	Missing/incomplete/invalid condition code.
M45	Missing/incomplete/invalid occurrence code(s).
M46	Missing/incomplete/invalid occurrence span code(s).
M47	Missing/incomplete/invalid internal or document control number.
M49	Missing/incomplete/invalid value code(s) or amount(s).
M5	Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.
M50	Missing/incomplete/invalid revenue code(s).
M51	Missing/incomplete/invalid procedure code(s).
M52	Missing/incomplete/invalid “from” date(s) of service.
M53	Missing/incomplete/invalid days or units of service.
M54	Missing/incomplete/invalid total charges.
M55	We do not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug.
M56	Missing/incomplete/invalid payer identifier.
M59	Missing/incomplete/invalid “to” date(s) of service.
M6	Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment.
M60	Missing Certificate of Medical Necessity.
M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.
M62	Missing/incomplete/invalid treatment authorization code.
M64	Missing/incomplete/invalid other diagnosis.
M65	One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each interpreting physician.
M66	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.
M67	Missing/incomplete/invalid other procedure code(s).
M69	Paid at the regular rate as you did not submit documentation to justify the modified procedure code.
M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.
M70	Alert: The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.
M71	Total payment reduced due to overlap of tests billed.
M73	The HPSA/Physician Scarcity bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components.
M74	This service does not qualify for a HPSA/Physician Scarcity bonus payment.
M75	Multiple automated multichannel tests performed on the same day combined for payment.
M76	Missing/incomplete/invalid diagnosis or condition.
M77	Missing/incomplete/invalid/inappropriate place of service.
M79	Missing/incomplete/invalid charge.
M8	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.

M80	Not covered when performed during the same session/date as a previously processed service for the patient.
M81	You are required to code to the highest level of specificity.
M82	Service is not covered when patient is under age 50.
M83	Service is not covered unless the patient is classified as at high risk.
M84	Medical code sets used must be the codes in effect at the time of service.
M85	Subjected to review of physician evaluation and management services.
M86	Service denied because payment already made for same/similar procedure within set time frame.
M87	Claim/service(s) subjected to CFO-CAP prepayment review.
M89	Not covered more than once under age 40.
M9	Alert: This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.
M90	Not covered more than once in a 12 month period.
M91	Lab procedures with different CLIA certification numbers must be billed on separate claims.
M93	Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.
M94	Information supplied does not support a break in therapy. A new capped rental period will not begin.
M95	Services subjected to Home Health Initiative medical review/cost report audit.
M96	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.
M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
M99	Missing/incomplete/invalid Universal Product Number/Serial Number.
MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
MA02	Alert: If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice.
MA04	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.
MA07	Alert: The claim information has also been forwarded to Medicaid for review.
MA08	Alert: Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.
MA09	Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.
MA10	Alert: The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.
MA100	Missing/incomplete/invalid date of current illness or symptoms.
MA103	Hemophilia Add On.
MA106	PIP (Periodic Interim Payment) claim.
MA107	Paper claim contains more than three separate data items in field 19.
MA108	Paper claim contains more than one data item in field 23.
MA109	Claim processed in accordance with ambulatory surgical guidelines.
MA110	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.
MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.
MA112	Missing/incomplete/invalid group practice information.
MA113	Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.
MA114	Missing/incomplete/invalid information on where the services were furnished.
MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).
MA116	Did not complete the statement 'Homebound' on the claim to validate whether laboratory services were performed at home or in an institution.
MA117	This claim has been assessed a $1.00 user fee.
MA118	Coinsurance and/or deductible amounts apply to a claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. No Medicare payment issued.
MA12	You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).
MA120	Missing/incomplete/invalid CLIA certification number.
MA121	Missing/incomplete/invalid x-ray date.
MA122	Missing/incomplete/invalid initial treatment date.
MA123	Your center was not selected to participate in this study, therefore, we cannot pay for these services.
MA125	Per legislation governing this program, payment constitutes payment in full.
MA126	Pancreas transplant not covered unless kidney transplant performed.
MA128	Missing/incomplete/invalid FDA approval number.
MA13	Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
MA131	Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.
MA132	Adjustment to the pre-demonstration rate.
MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.
MA14	Alert: The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.
MA15	Alert: Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.
MA16	The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.

MA17	We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.
MA18	Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
MA19	Alert: Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.
MA20	Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.
MA21	SSA records indicate mismatch with name and sex.
MA22	Payment of less than $1.00 suppressed.
MA23	Demand bill approved as result of medical review.
MA24	Christian Science Sanitarium/ Skilled Nursing Facility (SNF) bill in the same benefit period.
MA25	A patient may not elect to change a hospice provider more than once in a benefit period.
MA26	Alert: Our records indicate that you were previously informed of this rule.
MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.
MA28	Alert: Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.
MA30	Missing/incomplete/invalid type of bill.
MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
MA32	Missing/incomplete/invalid number of covered days during the billing period.
MA33	Missing/incomplete/invalid noncovered days during the billing period.
MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.
MA35	Missing/incomplete/invalid number of lifetime reserve days.
MA36	Missing/incomplete/invalid patient name.
MA37	Missing/incomplete/invalid patient's address.
MA39	Missing/incomplete/invalid gender.
MA40	Missing/incomplete/invalid admission date.
MA41	Missing/incomplete/invalid admission type.
MA42	Missing/incomplete/invalid admission source.
MA43	Missing/incomplete/invalid patient status.
MA44	Alert: No appeal rights. Adjudicative decision based on law.
MA45	Alert: As previously advised, a portion or all of your payment is being held in a special account.
MA46	The new information was considered but additional payment will not be issued.
MA47	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.
MA48	Missing/incomplete/invalid name or address of responsible party or primary payer.
MA50	Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number.
MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.
MA54	Physician certification or election consent for hospice care not received timely.
MA55	Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
MA56	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
MA57	Patient submitted written request to revoke his/her election for religious non-medical health care services.
MA58	Missing/incomplete/invalid release of information indicator.
MA59	Alert: The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
MA60	Missing/incomplete/invalid patient relationship to insured.
MA61	Missing/incomplete/invalid social security number or health insurance claim number.
MA62	Alert: This is a telephone review decision.
MA63	Missing/incomplete/invalid principal diagnosis.
MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
MA65	Missing/incomplete/invalid admitting diagnosis.
MA66	Missing/incomplete/invalid principal procedure code.
MA67	Correction to a prior claim.
MA68	Alert: We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim.
MA69	Missing/incomplete/invalid remarks.
MA70	Missing/incomplete/invalid provider representative signature.
MA71	Missing/incomplete/invalid provider representative signature date.
MA72	Alert: The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice.
MA73	Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.
MA74	This payment replaces an earlier payment for this claim that was either lost, damaged or returned.
MA75	Missing/incomplete/invalid patient or authorized representative signature.
MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.
MA77	Alert: The patient overpaid you. You must issue the patient a refund within 30 days for the difference between the patient’s payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice.
MA79	Billed in excess of interim rate.

MA80	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
MA81	Missing/incomplete/invalid provider/supplier signature.
MA83	Did not indicate whether we are the primary or secondary payer.
MA84	Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.
MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.
MA89	Missing/incomplete/invalid patient's relationship to the insured for the primary payer.
MA90	Missing/incomplete/invalid employment status code for the primary insured.
MA91	This determination is the result of the appeal you filed.
MA92	Missing plan information for other insurance.
MA93	Non-PIP (Periodic Interim Payment) claim.
MA94	Did not enter the statement “Attending physician not hospice employee” on the claim form to certify that the rendering physician is not an employee of the hospice.
MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number.
MA99	Missing/incomplete/invalid Medigap information.
N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract, plan benefit documents or jurisdiction statutes.
N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.
N100	PPS (Prospect Payment System) code corrected during adjudication.
N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.
N103	Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/ Local Authority as appropriate.
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.
N105	This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.
N106	Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.
N107	Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.
N108	Missing/incomplete/invalid upgrade information.
N109	This claim/service was chosen for complex review and was denied after reviewing the medical records.
N11	Denial reversed because of medical review.
N110	This facility is not certified for film mammography.
N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
N112	This claim is excluded from your electronic remittance advice.
N113	Only one initial visit is covered per physician, group practice or provider.
N114	During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.
N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.
N116	This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency’s (HHA’s) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.
N117	This service is paid only once in a patient’s lifetime.
N118	This service is not paid if billed more than once every 28 days.
N119	This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or Skilled /nursing Facility (SNF) within those 28 days.
N12	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.
N120	Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.
N121	Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered Skilled Nursing Facility (SNF) stay.
N122	Add-on code cannot be billed by itself.
N123	This is a split service and represents a portion of the units from the originally submitted service.
N124	Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.
N125	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice.
N126	Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.
N127	This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them.

N128	This amount represents the prior to coverage portion of the allowance.
N129	Not eligible due to the patient's age.
N13	Payment based on professional/technical component modifier(s).
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.
N131	Total payments under multiple contracts cannot exceed the allowance for this service.
N132	Alert: Payments will cease for services rendered by this US Government debarred or excluded provider after the 30 day grace period as previously notified.
N133	Alert: Services for predetermination and services requesting payment are being processed separately.
N134	Alert: This represents your scheduled payment for this service. If treatment has been discontinued, please contact Customer Service.
N135	Record fees are the patient's responsibility and limited to the specified co-payment.
N136	Alert: To obtain information on the process to file an appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548.
N137	Alert: The provider acting on the Member's behalf, may file an appeal with the Payer. The provider, acting on the Member's behalf, may file a complaint with the State Insurance Regulatory Authority without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The address may be obtained from the State Insurance Regulatory Authority.
N138	Alert: In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.
N139	Alert: Under the Code of Federal Regulations, Chapter 32, Section 199.13 a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
N140	Alert: You have not been designated as an authorized OCONUS provider therefore are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.
N142	The original claim was denied. Resubmit a new claim, not a replacement claim.
N143	The patient was not in a hospice program during all or part of the service dates billed.
N144	The rate changed during the dates of service billed.
N146	Missing screening document.
N147	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.
N148	Missing/incomplete/invalid date of last menstrual period.
N149	Rebill all applicable services on a single claim.
N15	Services for a newborn must be billed separately.
N150	Missing/incomplete/invalid model number.
N151	Telephone contact services will not be paid until the face-to-face contact requirement has been met.
N152	Missing/incomplete/invalid replacement claim information.
N153	Missing/incomplete/invalid room and board rate.
N154	Alert: This payment was delayed for correction of provider's mailing address.
N155	Alert: Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.
N156	Alert: The patient is responsible for the difference between the approved treatment and the elective treatment.
N157	Transportation to/from this destination is not covered.
N158	Transportation in a vehicle other than an ambulance is not covered.
N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.
N16	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.
N160	The patient must choose an option before a payment can be made for this procedure/ equipment/ supply/ service.
N161	This drug/service/supply is covered only when the associated service is covered.
N162	Alert: Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Your failure to correct the laboratory certification information will result in a denial of payment in the near future.
N163	Medical record does not support code billed per the code definition.
N167	Charges exceed the post-transplant coverage limit.
N170	A new/revised/renewed certificate of medical necessity is needed.
N171	Payment for repair or replacement is not covered or has exceeded the purchase price.
N172	The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.
N173	No qualifying hospital stay dates were provided for this episode of care.
N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.
N175	Missing review organization approval.
N176	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.
N177	Alert: We did not send this claim to patient’s other insurer. They have indicated no additional payment can be made.
N178	Missing pre-operative images/visual field results.
N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
N180	This item or service does not meet the criteria for the category under which it was billed.
N181	Additional information is required from another provider involved in this service.
N182	This claim/service must be billed according to the schedule for this plan.
N183	Alert: This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits.
N184	Rebill technical and professional components separately.
N185	Alert: Do not resubmit this claim/service.

N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.
N187	Alert: You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
N188	The approved level of care does not match the procedure code submitted.
N189	Alert: This service has been paid as a one-time exception to the plan's benefit restrictions.
N19	Procedure code incidental to primary procedure.
N190	Missing contract indicator.
N191	The provider must update insurance information directly with payer.
N192	Patient is a Medicaid/Qualified Medicare Beneficiary.
N193	Specific federal/state/local program may cover this service through another payer.
N194	Technical component not paid if provider does not own the equipment used.
N195	The technical component must be billed separately.
N196	Alert: Patient eligible to apply for other coverage which may be primary.
N197	The subscriber must update insurance information directly with payer.
N198	Rendering provider must be affiliated with the pay-to provider.
N199	Additional payment/recoupment approved based on payer-initiated review/audit.
N2	This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.
N20	Service not payable with other service rendered on the same date.
N200	The professional component must be billed separately.
N202	Additional information/explanation will be sent separately.
N203	Missing/incomplete/invalid anesthesia time/units.
N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months
N205	Information provided was illegible.
N206	The supporting documentation does not match the information sent on the claim.
N207	Missing/incomplete/invalid weight.
N208	Missing/incomplete/invalid DRG code.
N209	Missing/incomplete/invalid taxpayer identification number (TIN).
N21	Alert: Your line item has been separated into multiple lines to expedite handling.
N210	Alert: You may appeal this decision.
N211	Alert: You may not appeal this decision.
N212	Charges processed under a Point of Service benefit .
N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.
N214	Missing/incomplete/invalid history of the related initial surgical procedure(s).
N215	Alert: A payer providing supplemental or secondary coverage shall not require a claims determination for this service from a primary payer as a condition of making its own claims determination.
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.
N217	We pay only one site of service per provider per claim.
N218	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for the time period specified in the contract or coverage manual.
N219	Payment based on previous payer's allowed amount.
N22	This procedure code was added/changed because it more accurately describes the services rendered.
N220	Alert: See the payer's web site or contact the payer's Customer Service department to obtain forms and instructions for filing a provider dispute.
N221	Missing Admitting History and Physical report.
N222	Incomplete/invalid Admitting History and Physical report.
N223	Missing documentation of benefit to the patient during initial treatment period.
N224	Incomplete/invalid documentation of benefit to the patient during initial treatment period.
N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.
N226	Incomplete/invalid American Diabetes Association Certificate of Recognition.
N227	Incomplete/invalid Certificate of Medical Necessity.
N228	Incomplete/invalid consent form.
N229	Incomplete/invalid contract indicator.
N23	Alert: Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.
N230	Incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.
N231	Incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
N232	Incomplete/invalid itemized bill/statement.
N233	Incomplete/invalid operative note/report.
N234	Incomplete/invalid oxygen certification/re-certification.
N235	Incomplete/invalid pacemaker registration form.
N236	Incomplete/invalid pathology report.
N237	Incomplete/invalid patient medical record for this service.
N238	Incomplete/invalid physician certified plan of care.
N239	Incomplete/invalid physician financial relationship form.
N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.
N240	Incomplete/invalid radiology report.
N241	Incomplete/invalid review organization approval.
N242	Incomplete/invalid radiology film(s)/image(s).
N243	Incomplete/invalid/not approved screening document.
N244	Incomplete/Invalid pre-operative images/visual field results.
N245	Incomplete/invalid plan information for other insurance .

N246	State regulated patient payment limitations apply to this service.
N247	Missing/incomplete/invalid assistant surgeon taxonomy.
N248	Missing/incomplete/invalid assistant surgeon name.
N249	Missing/incomplete/invalid assistant surgeon primary identifier.
N25	This company has been contracted by your benefit plan to provide administrative claims payment services only. This company does not assume financial risk or obligation with respect to claims processed on behalf of your benefit plan.
N250	Missing/incomplete/invalid assistant surgeon secondary identifier.
N251	Missing/incomplete/invalid attending provider taxonomy.
N252	Missing/incomplete/invalid attending provider name.
N253	Missing/incomplete/invalid attending provider primary identifier.
N254	Missing/incomplete/invalid attending provider secondary identifier.
N255	Missing/incomplete/invalid billing provider taxonomy.
N256	Missing/incomplete/invalid billing provider/supplier name.
N257	Missing/incomplete/invalid billing provider/supplier primary identifier.
N258	Missing/incomplete/invalid billing provider/supplier address.
N259	Missing/incomplete/invalid billing provider/supplier secondary identifier.
N26	Missing itemized bill/statement.
N260	Missing/incomplete/invalid billing provider/supplier contact information.
N261	Missing/incomplete/invalid operating provider name.
N262	Missing/incomplete/invalid operating provider primary identifier.
N263	Missing/incomplete/invalid operating provider secondary identifier.
N264	Missing/incomplete/invalid ordering provider name.
N265	Missing/incomplete/invalid ordering provider primary identifier.
N266	Missing/incomplete/invalid ordering provider address.
N267	Missing/incomplete/invalid ordering provider secondary identifier.
N268	Missing/incomplete/invalid ordering provider contact information.
N269	Missing/incomplete/invalid other provider name.
N27	Missing/incomplete/invalid treatment number.
N270	Missing/incomplete/invalid other provider primary identifier.
N271	Missing/incomplete/invalid other provider secondary identifier.
N272	Missing/incomplete/invalid other payer attending provider identifier.
N273	Missing/incomplete/invalid other payer operating provider identifier.
N274	Missing/incomplete/invalid other payer other provider identifier.
N275	Missing/incomplete/invalid other payer purchased service provider identifier.
N276	Missing/incomplete/invalid other payer referring provider identifier.
N277	Missing/incomplete/invalid other payer rendering provider identifier.
N278	Missing/incomplete/invalid other payer service facility provider identifier.
N279	Missing/incomplete/invalid pay-to provider name.
N28	Consent form requirements not fulfilled.
N280	Missing/incomplete/invalid pay-to provider primary identifier.
N281	Missing/incomplete/invalid pay-to provider address.
N282	Missing/incomplete/invalid pay-to provider secondary identifier.
N283	Missing/incomplete/invalid purchased service provider identifier.
N284	Missing/incomplete/invalid referring provider taxonomy.
N285	Missing/incomplete/invalid referring provider name.
N286	Missing/incomplete/invalid referring provider primary identifier.
N287	Missing/incomplete/invalid referring provider secondary identifier.
N288	Missing/incomplete/invalid rendering provider taxonomy.
N289	Missing/incomplete/invalid rendering provider name.
N29	Missing documentation/orders/notes/summary/report/chart.
N290	Missing/incomplete/invalid rendering provider primary identifier.
N291	Missing/incomplete/invalid rendering provider secondary identifier.
N292	Missing/incomplete/invalid service facility name.
N293	Missing/incomplete/invalid service facility primary identifier.
N294	Missing/incomplete/invalid service facility primary address.
N295	Missing/incomplete/invalid service facility secondary identifier.
N296	Missing/incomplete/invalid supervising provider name.
N297	Missing/incomplete/invalid supervising provider primary identifier.
N298	Missing/incomplete/invalid supervising provider secondary identifier.
N299	Missing/incomplete/invalid occurrence date(s).
N3	Missing consent form.
N30	Patient ineligible for this service.
N300	Missing/incomplete/invalid occurrence span date(s).
N301	Missing/incomplete/invalid procedure date(s).
N302	Missing/incomplete/invalid other procedure date(s).
N303	Missing/incomplete/invalid principal procedure date.
N304	Missing/incomplete/invalid dispensed date.
N305	Missing/incomplete/invalid accident date.

N306	Missing/incomplete/invalid acute manifestation date.
N307	Missing/incomplete/invalid adjudication or payment date.
N308	Missing/incomplete/invalid appliance placement date.
N309	Missing/incomplete/invalid assessment date.
N31	Missing/incomplete/invalid prescribing provider identifier.
N310	Missing/incomplete/invalid assumed or relinquished care date.
N311	Missing/incomplete/invalid authorized to return to work date.
N312	Missing/incomplete/invalid begin therapy date.
N313	Missing/incomplete/invalid certification revision date.
N314	Missing/incomplete/invalid diagnosis date.
N315	Missing/incomplete/invalid disability from date.
N316	Missing/incomplete/invalid disability to date.
N317	Missing/incomplete/invalid discharge hour.
N318	Missing/incomplete/invalid discharge or end of care date.
N319	Missing/incomplete/invalid hearing or vision prescription date.
N32	Claim must be submitted by the provider who rendered the service.
N320	Missing/incomplete/invalid Home Health Certification Period.
N321	Missing/incomplete/invalid last admission period.
N322	Missing/incomplete/invalid last certification date.
N323	Missing/incomplete/invalid last contact date.
N324	Missing/incomplete/invalid last seen/visit date.
N325	Missing/incomplete/invalid last worked date.
N326	Missing/incomplete/invalid last x-ray date.
N327	Missing/incomplete/invalid other insured birth date.
N328	Missing/incomplete/invalid Oxygen Saturation Test date.
N329	Missing/incomplete/invalid patient birth date.
N33	No record of health check prior to initiation of treatment.
N330	Missing/incomplete/invalid patient death date.
N331	Missing/incomplete/invalid physician order date.
N332	Missing/incomplete/invalid prior hospital discharge date.
N333	Missing/incomplete/invalid prior placement date.
N334	Missing/incomplete/invalid re-evaluation date.
N335	Missing/incomplete/invalid referral date.
N336	Missing/incomplete/invalid replacement date.
N337	Missing/incomplete/invalid secondary diagnosis date.
N338	Missing/incomplete/invalid shipped date.
N339	Missing/incomplete/invalid similar illness or symptom date.
N34	Incorrect claim form/format for this service.
N340	Missing/incomplete/invalid subscriber birth date.
N341	Missing/incomplete/invalid surgery date.
N342	Missing/incomplete/invalid test performed date.
N343	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial start date.
N344	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial end date.
N345	Date range not valid with units submitted.
N346	Missing/incomplete/invalid oral cavity designation code.
N347	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.
N348	You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.
N349	The administration method and drug must be reported to adjudicate this service.
N35	Program integrity/utilization review decision.
N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.
N351	Service date outside of the approved treatment plan service dates.
N352	Alert: There are no scheduled payments for this service. Submit a claim for each patient visit.
N353	Alert: Benefits have been estimated, when the actual services have been rendered, additional payment will be considered based on the submitted claim.
N354	Incomplete/invalid invoice.
N355	Alert: The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.
N356	Not covered when performed with, or subsequent to, a non-covered service.
N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
N358	Alert: This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted.
N359	Missing/incomplete/invalid height.
N36	Claim must meet primary payer's processing requirements before we can consider payment.
N360	Alert: Coordination of benefits has not been calculated when estimating benefits for this pre-determination. Submit payment information from the primary payer with the secondary claim.
N362	The number of Days or Units of Service exceeds our acceptable maximum.
N363	Alert: in the near future we are implementing new policies/procedures that would affect this determination.
N364	Alert: According to our agreement, you must waive the deductible and/or coinsurance amounts.

N365	This procedure code is not payable. It is for reporting/information purposes only.
N366	Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.
N367	Alert: The claim information has been forwarded to a Consumer Spending Account processor for review; for example, flexible spending account or health savings account.
N368	You must appeal the determination of the previously adjudicated claim.
N369	Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.
N37	Missing/incomplete/invalid tooth number/letter.
N370	Billing exceeds the rental months covered/approved by the payer.
N371	Alert: title of this equipment must be transferred to the patient.
N372	Only reasonable and necessary maintenance/service charges are covered.
N373	It has been determined that another payer paid the services as primary when they were not the primary payer. Therefore, we are refunding to the payer that paid as primary on your behalf.
N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required.
N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.
N376	Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE.
N377	Payment based on a processed replacement claim.
N378	Missing/incomplete/invalid prescription quantity.
N379	Claim level information does not match line level information.
N380	The original claim has been processed, submit a corrected claim.
N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.
N382	Missing/incomplete/invalid patient identifier.
N383	Not covered when deemed cosmetic.
N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.
N385	Notification of admission was not timely according to published plan procedures.
N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
N387	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.
N388	Missing/incomplete/invalid prescription number.
N389	Duplicate prescription number submitted.
N39	Procedure code is not compatible with tooth number/letter.
N390	This service/report cannot be billed separately.
N391	Missing emergency department records.
N392	Incomplete/invalid emergency department records.
N393	Missing progress notes/report.
N394	Incomplete/invalid progress notes/report.
N395	Missing laboratory report.
N396	Incomplete/invalid laboratory report.
N397	Benefits are not available for incomplete service(s)/undelivered item(s).
N398	Missing elective consent form.
N399	Incomplete/invalid elective consent form.
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
N40	Missing radiology film(s)/image(s).
N400	Alert: Electronically enabled providers should submit claims electronically.
N401	Missing periodontal charting.
N402	Incomplete/invalid periodontal charting.
N403	Missing facility certification.
N404	Incomplete/invalid facility certification.
N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service.
N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service.
N407	You are not an approved submitter for this transmission format.
N408	This payer does not cover deductibles assessed by a previous payer.
N409	This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident.
N410	Not covered unless the prescription changes.
N418	Misrouted claim. See the payer's claim submission instructions.
N419	Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change.
N42	No record of mental health assessment.
N420	Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery.
N421	Claim payment was the result of a payer's retroactive adjustment due to a review organization decision.
N422	Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program.
N423	Claim payment was the result of a payer's retroactive adjustment due to a non standard program.
N424	Patient does not reside in the geographic area required for this type of payment.
N425	Statutorily excluded service(s).
N426	No coverage when self-administered.
N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery.
N428	Not covered when performed in this place of service.
N429	Not covered when considered routine.
N43	Bed hold or leave days exceeded.

N430	Procedure code is inconsistent with the units billed.
N431	Not covered with this procedure.
N432	Adjustment based on a Recovery Audit.
N433	Resubmit this claim using only your National Provider Identifier (NPI).
N434	Missing/Incomplete/Invalid Present on Admission indicator.
N435	Exceeds number/frequency approved /allowed within time period without support documentation.
N436	The injury claim has not been accepted and a mandatory medical reimbursement has been made.
N437	Alert: If the injury claim is accepted, these charges will be reconsidered.
N438	This jurisdiction only accepts paper claims.
N439	Missing anesthesia physical status report/indicators.
N440	Incomplete/invalid anesthesia physical status report/indicators.
N441	This missed/cancelled appointment is not covered.
N442	Payment based on an alternate fee schedule.
N443	Missing/incomplete/invalid total time or begin/end time.
N444	Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation.
N445	Missing document for actual cost or paid amount.
N446	Incomplete/invalid document for actual cost or paid amount.
N447	Payment is based on a generic equivalent as required documentation was not provided.
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.
N449	Payment based on a comparable drug/service/supply.
N45	Payment based on authorized amount.
N450	Covered only when performed by the primary treating physician or the designee.
N451	Missing Admission Summary Report.
N452	Incomplete/invalid Admission Summary Report.
N453	Missing Consultation Report.
N454	Incomplete/invalid Consultation Report.
N455	Missing Physician Order.
N456	Incomplete/invalid Physician Order.
N457	Missing Diagnostic Report.
N458	Incomplete/invalid Diagnostic Report.
N459	Missing Discharge Summary.
N46	Missing/incomplete/invalid admission hour.
N460	Incomplete/invalid Discharge Summary.
N461	Missing Nursing Notes.
N462	Incomplete/invalid Nursing Notes.
N463	Missing support data for claim.
N464	Incomplete/invalid support data for claim.
N465	Missing Physical Therapy Notes/Report.
N466	Incomplete/invalid Physical Therapy Notes/Report.
N467	Missing Tests and Analysis Report.
N468	Incomplete/invalid Report of Tests and Analysis Report.
N469	Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).
N47	Claim conflicts with another inpatient stay.
N470	This payment will complete the mandatory medical reimbursement limit.
N471	Missing/incomplete/invalid HIPPS Rate Code.
N472	Payment for this service has been issued to another provider.
N473	Missing certification.
N474	Incomplete/invalid certification.
N475	Missing completed referral form.
N476	Incomplete/invalid completed referral form.
N477	Missing Dental Models.
N478	Incomplete/invalid Dental Models.
N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
N48	Claim information does not agree with information received from other insurance carrier.
N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
N481	Missing Models.
N482	Incomplete/invalid Models.
N483	Missing Periodontal Charts.
N484	Incomplete/invalid Periodontal Charts.
N485	Missing Physical Therapy Certification.
N486	Incomplete/invalid Physical Therapy Certification.
N487	Missing Prosthetics or Orthotics Certification.
N488	Incomplete/invalid Prosthetics or Orthotics Certification.
N489	Missing referral form.
N49	Court ordered coverage information needs validation.
N490	Incomplete/invalid referral form.
N491	Missing/Incomplete/Invalid Exclusionary Rider Condition.

N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge.
N493	Missing Doctor First Report of Injury.
N494	Incomplete/invalid Doctor First Report of Injury.
N495	Missing Supplemental Medical Report.
N496	Incomplete/invalid Supplemental Medical Report.
N497	Missing Medical Permanent Impairment or Disability Report.
N498	Incomplete/invalid Medical Permanent Impairment or Disability Report.
N499	Missing Medical Legal Report.
N5	EOB received from previous payer. Claim not on file.
N50	Missing/incomplete/invalid discharge information.
N500	Incomplete/invalid Medical Legal Report.
N501	Missing Vocational Report.
N502	Incomplete/invalid Vocational Report.
N503	Missing Work Status Report.
N504	Incomplete/invalid Work Status Report.
N505	Alert: This response includes only services that could be estimated in real time. No estimate will be provided for the services that could not be estimated in real time.
N506	Alert: This is an estimate of the member's liability based on the information available at the time the estimate was processed. Actual coverage and member liability amounts will be determined when the claim is processed. This is not a pre-authorization or a guarantee of payment.
N507	Plan distance requirements have not been met.
N508	Alert: This real time claim adjudication response represents the member responsibility to the provider for services reported. The member will receive an Explanation of Benefits electronically or in the mail. Contact the insurer if there are any questions.
N509	Alert: A current inquiry shows the member's Consumer Spending Account contains sufficient funds to cover the member liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.
N51	Electronic interchange agreement not on file for provider/submitter.
N510	Alert: A current inquiry shows the member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.
N511	Alert: Information on the availability of Consumer Spending Account funds to cover the member liability on this claim/service is not available at this time.
N512	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.
N513	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time with a change to the adjudication.
N516	Records indicate a mismatch between the submitted NPI and EIN.
N517	Resubmit a new claim with the requested information.
N518	No separate payment for accessories when furnished for use with oxygen equipment.
N519	Invalid combination of HCPCS modifiers.
N52	Patient not enrolled in the billing provider's managed care plan on the date of service.
N520	Alert: Payment made from a Consumer Spending Account.
N521	Mismatch between the submitted provider information and the provider information stored in our system.
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.
N523	The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid.
N524	Based on policy this payment constitutes payment in full.
N525	These services are not covered when performed within the global period of another service.
N526	Not qualified for recovery based on employer size.
N527	We processed this claim as the primary payer prior to receiving the recovery demand.
N528	Patient is entitled to benefits for Institutional Services only.
N529	Patient is entitled to benefits for Professional Services only.
N53	Missing/incomplete/invalid point of pick-up address.
N530	Not Qualified for Recovery based on enrollment information.
N531	Not qualified for recovery based on direct payment of premium.
N532	Not qualified for recovery based on disability and working status.
N533	Services performed in an Indian Health Services facility under a self-insured tribal Group Health Plan.
N534	This is an individual policy, the employer does not participate in plan sponsorship.
N535	Payment is adjusted when procedure is performed in this place of service based on the submitted procedure code and place of service.
N536	We are not changing the prior payer's determination of patient responsibility, which you may collect, as this service is not covered by us.
N537	We have examined claims history and no records of the services have been found.
N538	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.
N539	Alert: We processed appeals/waiver requests on your behalf and that request has been denied.
N54	Claim information is inconsistent with pre-certified/authorized services.
N540	Payment adjusted based on the interrupted stay policy.
N541	Mismatch between the submitted insurance type code and the information stored in our system.
N542	Missing income verification.
N543	Incomplete/invalid income verification.
N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless corrected this will not be paid in the future.
N545	Payment reduced based on status as an unsuccessful eprescriber per the Electronic Prescribing (eRx) Incentive Program.
N546	Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.
N547	A refund request (Frequency Type Code 8) was processed previously.

N548	Alert: Patient's calendar year deductible has been met.
N549	Alert: Patient's calendar year out-of-pocket maximum has been met.
N55	Procedures for billing with group/referring/performing providers were not followed.
N550	Alert: You have not responded to requests to revalidate your provider/supplier enrollment information. Your failure to revalidate your enrollment information will result in a payment hold in the near future.
N551	Payment adjusted based on the Ambulatory Surgical Center (ASC) Quality Reporting Program.
N552	Payment adjusted to reverse a previous withhold/bonus amount.
N554	Missing/Incomplete/Invalid Family Planning Indicator.
N555	Missing medication list.
N556	Incomplete/invalid medication list.
N557	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the specimen was collected.
N558	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the equipment was received.
N559	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the Ordering Physician is located.
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
N560	The pilot program requires an interim or final claim within 60 days of the Notice of Admission. A claim was not received.
N561	The bundled claim originally submitted for this episode of care includes related readmissions. You may resubmit the original claim to receive a corrected payment based on this readmission.
N562	The provider number of your incoming claim does not match the provider number on the processed Notice of Admission (NOA) for this bundled payment.
N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.
N564	Patient did not meet the inclusion criteria for the demonstration project or pilot program.
N565	Alert: This non-payable reporting code requires a modifier. Future claims containing this non-payable reporting code must include an appropriate modifier for the claim to be processed.
N566	Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed.
N567	Not covered when considered preventative.
N568	Alert: Initial payment based on the Notice of Admission (NOA) under the Bundled Payment Model IV initiative.
N569	Not covered when performed for the reported diagnosis.
N57	Missing/incomplete/invalid prescribing date.
N570	Missing/incomplete/invalid credentialing data.
N571	Alert: Payment will be issued quarterly by another payer/contractor.
N572	This procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted.
N573	Alert: You have been overpaid and must refund the overpayment. The refund will be requested separately by another payer/contractor.
N574	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.
N575	Mismatch between the submitted ordering/referring provider name and the ordering/referring provider name stored in our records.
N576	Services not related to the specific incident/claim/accident/loss being reported.
N577	Personal Injury Protection (PIP) Coverage.
N578	Coverages do not apply to this loss.
N579	Medical Payments Coverage (MPC).
N58	Missing/incomplete/invalid patient liability amount.
N580	Determination based on the provisions of the insurance policy.
N581	Investigation of coverage eligibility is pending.
N582	Benefits suspended pending the patient's cooperation.
N583	Patient was not an occupant of our insured vehicle and therefore, is not an eligible injured person.
N584	Not covered based on the insured's noncompliance with policy or statutory conditions.
N585	Benefits are no longer available based on a final injury settlement.
N586	The injured party does not qualify for benefits.
N587	Policy benefits have been exhausted.
N588	The patient has instructed that medical claims/bills are not to be paid.
N589	Coverage is excluded to any person injured as a result of operating a motor vehicle while in an intoxicated condition or while the ability to operate such a vehicle is impaired by the use of a drug.
N59	Please refer to your provider manual for additional program and provider information.
N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.
N591	Payment based on an Independent Medical Examination (IME) or Utilization Review (UR).
N592	Adjusted because this is not the initial prescription or exceeds the amount allowed for the initial prescription.
N593	Not covered based on failure to attend a scheduled Independent Medical Exam (IME).
N594	Records reflect the injured party did not complete an Application for Benefits for this loss.
N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.
N596	Records reflect the injured party did not complete a Medical Authorization for this loss.
N597	Adjusted based on a medical/dental provider's apportionment of care between related injuries and other unrelated medical/dental conditions/injuries.
N598	Health care policy coverage is primary.
N599	Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon 200% of the Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered.

N6	Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B.
N600	Adjusted based on the applicable fee schedule for the region in which the service was rendered.
N601	In accordance with Hawaii Administrative Rules, Title 16, Chapter 23 Motor Vehicle Insurance Law payment is recommended based on Medicare Resource Based Relative Value Scale System applicable to Hawaii.
N602	Adjusted based on the Redbook maximum allowance.
N603	This fee is calculated according to the New Jersey medical fee schedules for Automobile Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage.
N604	In accordance with New York No-Fault Law, Regulation 68, this base fee was calculated according to the New York Workers' Compensation Board Schedule of Medical Fees, pursuant to Regulation 83 and / or Appendix 17-C of 11 NYCRR.
N605	This fee was calculated based upon New York All Patients Refined Diagnosis Related Groups (APR-DRG), pursuant to Regulation 68.
N606	The Oregon allowed amount for this procedure is based upon the Workers Compensation Fee Schedule (OAR 436-009). The allowed amount has been calculated in accordance with Section 4 of ORS 742.524.
N607	Service provided for non-compensable condition(s).
N608	The fee schedule amount allowed is calculated at 110% of the Medicare Fee Schedule for this region, specialty and type of service. This fee is calculated in compliance with Act 6.
N609	80% of the provider's billed amount is being recommended for payment according to Act 6.
N61	Rebill services on separate claims.
N610	Alert: Payment based on an appropriate level of care.
N611	Claim in litigation. Contact insurer for more information.
N612	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.
N613	Alert: Although this was paid, you have billed with an ordering provider that needs to update their enrollment record. Please verify that the ordering provider information you submitted on the claim is accurate and if it is, contact the ordering provider instructing them to update their enrollment record. Unless corrected, a claim with this ordering provider will not be paid in the future.
N614	Alert: Additional information is included in the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information).
N615	Alert: This enrollee receiving advance payments of the premium tax credit is in the grace period of three consecutive months for non-payment of premium. Under the Code of Federal Regulations, Title 45, Part 156.270, a Qualified Health Plan issuer must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.
N616	Alert: This enrollee is in the first month of the advance premium tax credit grace period.
N617	This enrollee is in the second or third month of the advance premium tax credit grace period.
N618	Alert: This claim will automatically be reprocessed if the enrollee pays their premiums.
N619	Coverage terminated for non-payment of premium.
N62	Dates of service span multiple rate periods. Resubmit separate claims.
N620	Alert: This procedure code is for quality reporting/informational purposes only.
N621	Charges for Jurisdiction required forms, reports, or chart notes are not payable.
N622	Not covered based on the date of injury/accident.
N623	Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.
N624	The associated Workers' Compensation claim has been withdrawn.
N625	Missing/Incomplete/Invalid Workers' Compensation Claim Number.
N626	New or established patient E/M codes are not payable with chiropractic care codes.
N627	Service not payable per managed care contract.
N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.
N629	Reviews/documentation/notes/summaries/reports/charts not requested.
N63	Rebill services on separate claim lines.
N630	Referral not authorized by attending physician.
N631	Medical Fee Schedule does not list this code. An allowance was made for a comparable service.
N632	According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due.
N633	Additional anesthesia time units are not allowed.
N634	The allowance is calculated based on anesthesia time units.
N635	The Allowance is calculated based on the anesthesia base units plus time.
N636	Adjusted because this is reimbursable only once per injury.
N637	Consultations are not allowed once treatment has been rendered by the same provider.
N638	Reimbursement has been made according to the home health fee schedule.
N639	Reimbursement has been made according to the inpatient rehabilitation facilities fee schedule.
N64	The “from” and “to” dates must be different.
N640	Exceeds number/frequency approved/allowed within time period.
N641	Reimbursement has been based on the number of body areas rated.
N642	Adjusted when billed as individual tests instead of as a panel.
N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.
N644	Reimbursement has been made according to the bilateral procedure rule.
N645	Mark-up allowance.
N646	Reimbursement has been adjusted based on the guidelines for an assistant.
N647	Adjusted based on diagnosis-related group (DRG).
N648	Adjusted based on Stop Loss.
N649	Payment based on invoice.
N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
N650	This policy was not in effect for this date of loss. No coverage is available.
N651	No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.
N652	The date of service is before the date of loss.
N653	The date of injury does not match the reported date of loss.

N654	Adjusted based on achievement of maximum medical improvement (MMI).
N655	Payment based on provider's geographic region.
N656	An interest payment is being made because benefits are being paid outside the statutory requirement.
N657	This should be billed with the appropriate code for these services.
N658	The billed service(s) are not considered medical expenses.
N659	This item is exempt from sales tax.
N660	Sales tax has been included in the reimbursement.
N661	Documentation does not support that the services rendered were medically necessary.
N662	Alert: Consideration of payment will be made upon receipt of a final bill.
N663	Adjusted based on an agreed amount.
N664	Adjusted based on a legal settlement.
N665	Services by an unlicensed provider are not reimbursable.
N666	Only one evaluation and management code at this service level is covered during the course of care.
N667	Missing prescription.
N668	Incomplete/invalid prescription.
N669	Adjusted based on the Medicare fee schedule.
N67	Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient’s admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.
N670	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.
N671	Payment based on a jurisdiction cost-charge ratio.
N672	Alert: Amount applied to Health Insurance Offset.
N673	Reimbursement has been calculated based on an outpatient per diem or an outpatient factor and/or fee schedule amount.
N674	Not covered unless a pre-requisite procedure/service has been provided.
N675	Additional information is required from the injured party.
N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.
N677	Alert: Films/Images will not be returned.
N678	Missing post-operative images/visual field results.
N679	Incomplete/Invalid post-operative images/visual field results.
N68	Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for your payment. Prior payment made to you by the patient or another insurer for this claim must be refunded to the payer within 30 days.
N680	Missing/Incomplete/Invalid date of previous dental extractions.
N681	Missing/Incomplete/Invalid full arch series.
N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.
N683	Missing/Incomplete/Invalid prior treatment documentation.
N684	Payment denied as this is a specialty claim submitted as a general claim.
N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.
N686	Missing/incomplete/Invalid questionnaire needed to complete payment determination.
N687	Alert: This reversal is due to a retroactive disenrollment.
N688	Alert: This reversal is due to a medical or utilization review decision.
N689	Alert: This reversal is due to a retroactive rate change.
N69	PPS (Prospective Payment System) code changed by claims processing system.
N690	Alert: This reversal is due to a provider submitted appeal.
N691	Alert: This reversal is due to a patient submitted appeal.
N692	Alert: This reversal is due to an incorrect rate on the initial adjudication.
N693	Alert: This reversal is due to a cancellation of the claim by the provider.
N694	Alert: This reversal is due to a resubmission/change to the claim by the provider.
N695	Alert: This reversal is due to incorrect patient financial responsibility information on the initial adjudication.
N696	Alert: This reversal is due to a Coordination of Benefits or Third Party Liability Recovery retroactive adjustment.
N697	Alert: This reversal is due to a payer's retroactive contract incentive program adjustment.
N698	Alert: This reversal is due to non-payment of the Health Insurance Exchange premiums by the end of the premium payment grace period, resulting in loss of coverage.
N699	Payment adjusted based on the Physician Quality Reporting System (PQRS) Incentive Program.
N7	Alert: Processing of this claim/service has included consideration under Major Medical provisions.
N70	Consolidated billing and payment applies.
N700	Payment adjusted based on the Electronic Health Records (EHR) Incentive Program.
N701	Payment adjusted based on the Value-based Payment Modifier.
N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
N703	This service is incompatible with previously adjudicated claims or claims in process.
N704	Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.
N705	Incomplete/invalid documentation.
N706	Missing documentation.
N707	Incomplete/invalid orders.
N708	Missing orders.
N709	Incomplete/invalid notes.
N71	Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims.

N710	Missing notes.
N711	Incomplete/invalid summary.
N712	Missing summary.
N713	Incomplete/invalid report.
N714	Missing report.
N715	Incomplete/invalid chart.
N716	Missing chart.
N717	Incomplete/Invalid documentation of face-to-face examination.
N718	Missing documentation of face-to-face examination.
N719	Penalty applied based on plan requirements not being met.
N72	PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical records.
N720	Alert: The patient overpaid you. You may need to issue the patient a refund for the difference between the patient's payment and the amount shown as patient responsibility on this notice.
N721	This service is only covered when performed as part of a clinical trial.
N722	Patient must use Workers' Compensation Set-Aside (WCSA) funds to pay for the medical service or item.
N723	Patient must use Liability set-aside (LSA) funds to pay for the medical service or item.
N724	Patient must use No-Fault set-aside (NFSA) funds to pay for the medical service or item.
N725	A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.
N726	A conditional payment is not allowed.
N727	A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.
N728	A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.
N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
N75	Missing/incomplete/invalid tooth surface information.
N76	Missing/incomplete/invalid number of riders.
N77	Missing/incomplete/invalid designated provider number.
N78	The necessary components of the child and teen checkup (EPSDT) were not completed.
N79	Service billed is not compatible with patient location information.
N8	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.
N80	Missing/incomplete/invalid prenatal screening information.
N81	Procedure billed is not compatible with tooth surface code.
N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.
N83	No appeal rights. Adjudicative decision based on the provisions of a demonstration project.
N84	Alert: Further installment payments are forthcoming.
N85	Alert: This is the final installment payment.
N86	A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered.
N87	Home use of biofeedback therapy is not covered.
N88	Alert: This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care.
N89	Alert: Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
N9	Adjustment represents the estimated amount a previous payer may pay.
N90	Covered only when performed by the attending physician.
N91	Services not included in the appeal review.
N92	This facility is not certified for digital mammography.
N93	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.
N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
N95	This provider type/provider specialty may not bill this service.
N96	Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.
N97	Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.
N98	Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement through test stimulation. Improvement is measured through voiding diaries.
N99	Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.

Dental Claims Data Contents Guide

12/5/2013

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
HD - DC	HD001	Record Type	10/7/2013	Text	char[2]	Header Record Identifier	Report HD here. Indicates the beginning of the Header Elements of the file.	Mandatory	100%	n/a
HD - DC	HD002	Submitter	10/7/2013	Integer	varchar[6]	Header Submitter / Carrier ID defined by AHCT	Report unique Submitter ID here. AHCT will provide this unique identifier to the carrier. TR002 must match the Submitter ID reported here. This ID is linked to other elements in the file for quality control.	Mandatory	100%	n/a
HD - DC	HD003	National Plan ID	10/7/2013	Integer	int[10]	Header CMS National Plan Identification Number (PlanID)	Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	Situational	0%	n/a
HD - DC	HD004	Type of File	10/7/2013	Text	char[2]	Defines the file type and data expected.	Report **DC** here. Indicates that the data within this file is expected to be MEDICAL CLAIM-based. This must match the File Type reported in TR004.	Mandatory	100%	n/a
HD - DC	HD005	Period Beginning Date	10/7/2013	Full Date - Integer	int[8]	Header Period Start Date	Report the Year and Month of the reported submission period in YYYYMMDD format. This date period must be repeated in HD006, TR005 and TR006. This same date must be selected in the upload application for successful transfer.	Mandatory	100%	n/a
HD - DC	HD006	Period Ending Date	10/7/2013	Full Date - Integer	int[8]	Header Period Ending Date	Report the Year and Month of the reporting submission period in YYYYMMDD format. This date period must match the date period reported in HD005 and be repeated in TR005 and TR006.	Mandatory	100%	n/a
HD - DC	HD007	Record Count	10/7/2013	Integer	varchar[10]	Header Record Count	Report the total number of records submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters.	Mandatory	100%	n/a
HD - DC	HD008	Comments	10/7/2013	Text	varchar[80]	Header Carrier Comments	May be used to document the submission by assigning a filename, system source, compile identifier, etc.	Optional	0%	n/a

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
HD - DC	HD009	APCD Version Number	10/7/2013	Decimal - Numeric	char[3]	Submission Guide Version	Report the version number as presented on the APCD Medical Claim File Submission Guide in 0.0 Format. Sets the intake control for editing elements. Version must be accurate else file will drop. EXAMPLE: 3.0 = Newest Version	Mandatory	100%	n/a
						Code	**Description**			
						1.2	Current Version; required for reporting periods as of October 2013			
1	DC001	Submitter	7/2/2013	Integer	varchar[6]	CT APCD defined and maintained unique identifier	Report the Unique Submitter ID as defined by CT APCD here. This must match the Submitter ID reported in HD002	All	100%	Loop 1000A Segment NM109
2	DC002	National Plan ID	7/2/2013	Text	int[10]	CMS National Plan Identification Number (PlanID)	Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	All	0%	n/a
3	DC003	Insurance Type Code / Product	7/2/2013	Lookup Table - Text	char[2]	Type / Product Identification Code	Report the code that defines the type of insurance under which this patient's claim line was processed. **EXAMPLE:** 17 = Dental Maintenance Organization	All	100%	n/a
						Code	***Description***			
						9	Self-pay			
						11	Other Non-Federal Programs * (use of this value requires disclosure to Data Manager prior to submission)			
						12	Preferred Provider Organization (PPO) *			
						13	Point of Service (POS) *			
						14	Exclusive Provider Organization (EPO) *			
						15	Indemnity Insurance *			
						16	Health Maintenance Organization (HMO) Medicare Risk *			
						17	Dental Maintenance Organization (DMO) *			
						96	Husky Health A			
						97	Husky Health B			
						98	Husky Health C			
						99	Husky Health D			
						AM	Automobile Medical *			
						CH	Champus (now TRICARE) *			
						CI	Commercial Insurance			
						DS	Disability *			
						HM	Health Maintenance Organization *			
						LM	Liability Medical *			
						MA	Medicare Part A *			
						MB	Medicare Part B *			
						MC	Medicaid *			
						OF	Other Federal Program * (use of this value requires disclosure to Data Manager prior to submission)			

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
						TV	Title V *			
						VA	Veterans Affairs Plan *			
						WC	Workers' Compensation *			
						ZZ	Mutually Defined * (use of this value requires disclosure to Data Manager prior to submission)			
4	DC004	Payer Claim Control Number	7/2/2013	Text	varchar[35]	Payer Claim Control Identification	Report the Unique identifier within the payer's system that applies to the entire claim.	All	100%	Loop 2300 Segment CLM01
5	DC005	Line Counter	7/2/2013	Integer	varchar[4]	Incremental Line Counter	Report the line number for this service within the claim. Start with 1 and increment by 1 for each additional line. Do not start with 0, include alphas or special characters.	All	100%	Loop 2400 Segment LX01
6	DC005A	Version Number	7/2/2013	Integer	varchar[4]	Claim Service Line Version Number	Report the version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line. No alpha or special characters.	All	100%	n/a
7	DC006	Insured Group or Policy Number	7/2/2013	Text	varchar[30]	Group / Policy Number	Report the number that defines the insured group or policy. Do not report the number that uniquely identifies the subscriber or member.	All	98%	n/a
8	DC007	Subscriber SSN	7/2/2013	Numeric	char[9]	Subscriber's Social Security Number	Report the Subscriber's SSN here; used to validate Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here.	All	75%	Loop 2010BA Segment REF02 where REF01 - SY
9	DC008	Plan Specific Contract Number	7/2/2013	Text	varchar[30]	Contract Number	Report the Plan assigned contract number. Do not include values in this element that will distinguish one member of the family from another. This should be the contract or certificate number for the subscriber and all of the dependents.	All	98%	Loop 2300 Segment CN104
10	DC009	Member Suffix or Sequence Number	7/2/2013	Text	varchar[20]	Member/Patient's Contract Sequence Number	Report the unique number / identifier of the member / patient within the contract	All	98%	n/a
11	DC010	Member SSN	7/2/2013	Numeric	char[9]	Member/Patient's Social Security Number	Report the patient's social security number here; used to validate Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here	All	75%	Loop 2010BA Segment REF02 where REF01 = SY when Segment SBR02 = 18 - ELSE - Loop 2010CA Segment REF02 where REF01 = SY
12	DC011	Individual Relationship Code	10/30/2013	Lookup Table - Text	varchar[2]	Patient to Subscriber Relationship Code	Report the value that defines the Patient's relationship to the Subscriber. **EXAMPLE:** 1 = Spouse	All	98%	When present Loop 2000B SBR02 = 18 - ELSE - Loop 2000C Segment PAT01
						Code	***Description***			
						1	Spouse			
						4	Grandfather or Grandmother			
						5	Grandson or Granddaughter			
						7	Nephew or Niece			
						10	Foster Child			
						12	Other Adult			
						15	Ward			
						17	Stepson or Stepdaughter			
						19	Child			

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
						20	Self / Employee			
						21	Unknown			
						22	Handicapped Dependent			
						23	Sponsored Dependent			
						24	Dependent of a Minor Dependent			
						29	Significant Other			
						32	Mother			
						33	Father			
						34	Other Adult			
						36	Emancipated Minor			
						39	Organ Donor			
						40	Cadaver Donor			
						41	Injured Plaintiff			
						43	Child Where Insured Has No Financial Responsibility			
						53	Life Partner			
						76	Dependent			
13	DC012	Member Gender	7/2/2013	Lookup Table - Text	char[1]	Patient's Gender	Report patient gender as found on the claim in alpha format. Used to validate clinical services when applicable and Unique Member ID. **EXAMPLE:** F = Female	All	100%	Loop 2010BA Segment DMG03 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment DMG03
						Code	***Description***			
						F	Female			
						M	Male			
						O	Other			
						U	Unknown			
14	DC013	Member Date of Birth	7/2/2013	Full Date - Integer	int[8]	Member/Patient's date of birth	Report the date the member / patient was born in YYYYMMDD Format. Used to validate Unique Member ID.	All	99%	Loop 2010BA Segment DMG02 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment DMG02
15	DC014	Member City Name	7/2/2013	Text	varchar[50]	City name of the Member/Patient	Report the city name of the member / patient. Used to validate Unique Member ID	All	99%	Loop 2010BA Segment N401 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment N401
16	DC015	Member State	7/2/2013	External Code Source - USPS	char[2]	State / Province of the Patient	Report the state of the patient as defined by the US Postal Service. Report Province when Country Code does not = USA	All	100%	Loop 2010BA Segment N402 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment N402
17	DC016	Member ZIP Code	7/2/2013	External Code Source - USPS	varchar[9]	Zip Code of the Member / Patient	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	100%	Loop 2010BA Segment N403 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment N403
18	DC017	Date Service Approved (AP Date)	7/2/2013	Full Date - Integer	int[8]	Date Service Approved by Payer	Report the date that the payer approved this claim line for payment in YYYYMMDD Format. This element was designed to capture date other than the Paid date. If Approved Date and Paid Date are the same, then the date here should match Paid Date.	All	100%	n/a
19	DC018	Service Provider Number	7/2/2013	Text	varchar[30]	Service Provider Identification Number	Report the carrier / submitter assigned service provider number. This number should be the identifier used for internal identification purposes, and does not routinely change. The value in this element must match a record in the provider file in PV002.	All	100%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment REF02 where REF01 = G2

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
20	DC019	Service Provider Tax ID Number	7/2/2013	Numeric	char[9]	Service Provider's Tax ID number	Report the Federal Tax ID of the Service Provider here. Do not use hyphen or alpha prefix.	All	99%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment REF02 where REF01 = EI or SY
21	DC020	National Provider ID - Service	7/2/2013	External Code Source - NPPES	int[10]	National Provider Identification (NPI) of the Service Provider	Report the Primary National Provider ID (NPI) here. This ID should be found on the Provider File in the NPI element (PV039)	All	99%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM109
22	DC021	Service Provider Entity Type Qualifier	7/2/2013	Lookup Table - integer	int[1]	Service Provider Entity Identifier Code	Report the value that defines the provider entity type. Only individuals should be identified with a 1. Facilities, professional groups and clinic sites should all be identified with a 2. **EXAMPLE:** 1 = Person	All	98%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM102 - sets this value = 2 always
						Value	***Description***			
						1	Person			
						2	Non-person entity			
23	DC022	Service Provider First Name	7/2/2013	Text	varchar[25]	First name of Service Provider	Report the individual's first name here. If provider is a facility or organization , do not report any value here	All	98%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM104 when present
24	DC023	Service Provider Middle Name	7/2/2013	Text	varchar[25]	Middle initial of Service Provider	Report the individual's middle name here. If provider is a facility or organization , do not report any value here	All	2%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM105 when present
25	DC024	Service Provider Last Name or Organization Name	7/2/2013	Text	varchar[60]	Last name or Organization Name of Service Provider	Report the name of the organization or last name of the individual provider. DC021 determines if this is an Organization or Individual Name reported here.	All	98%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM103
26	DC025	Carve Out Vendor CT APCD ID	7/2/2013	Integer	varchar[6]	CT APCD defined and maintained Org ID for linking across submitters	Report the CT APCD ID of the Carve Out Vendor here. This element contains the CT APCD assigned organization ID for the Vendor. Contact the CT APCD for the appropriate value. If no Vendor is affiliated with this claim line do not report any value here: i.e., do not repeat the CT APCD ID from MC001	All	98%	n/a
27	DC026	Service Provider Taxonomy	7/2/2013	External Code Source - WPC	varchar[10]	Taxonomy Code	Report the standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of hygienists, assistants and laboratory technicians, where applicable, as well as Dentists, Orthodontists, etc.	All	98%	Assuming Service Provider = Billing Provider: Loop 2000A Segment PRV03
28	DC027	Service Provider City Name	7/2/2013	Text	varchar[30]	City name of the Provider	Report the Providers practice city location	All	98%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment N401
29	DC028	Service Provider State	7/2/2013	External Code Source - USPS	char[2]	State of the Service Provider	Report the state of the service providers as defined by the US Postal Service	All	98%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment N402
30	DC029	Service Provider ZIP Code	7/2/2013	External Code Source - USPS	varchar[9]	Zip Code of the Service Provider	Report the 5 or 9 digit Zip Code as defined by the US Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	98%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment N403
31	DC030	Facility Type - Professional	7/2/2013	External Code Source - CMS	char[2]	Place of Service Code	Report the code the defines the location code where services were performed by the provider referenced on the claim	All	80%	Loop 2300 CLM05-01 where CLM05-02 = B
32	DC031	Claim Status	10/7/2013	Lookup Table - integer	varchar[2]	Claim Line Status	Report the value that defines the payment status of this claim line	All	98%	n/a
						Value	***Description***			

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
						1	Processed as primary			
						2	Processed as secondary			
						3	Processed as tertiary			
						4	Denied			
						19	Processed as primary, forwarded to additional payer(s)			
						20	Processed as secondary, forwarded to additional payer(s)			
						21	Processed as tertiary, forwarded to additional payer(s)			
						22	Reversal of previous payment			
						23	Not our claim, forwarded to additional payer(s)			
						25	Predetermination Pricing Only - no payment			
33	DC032	CDT Code	7/2/2013	External Code Source - ADA	char[5]	HCPCS / CDT Code	Report the Common Dental Terminology code here	All	99%	As Sent by Provider - Loop 2400 Segment SV301-02 -OR- As Adjudicated - Loop 2430 Segment SVD03-02
34	DC033	Procedure Modifier - 1	7/2/2013	External Code Source - AMA	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (DC032).	All	0%	As Sent by Provider - Loop 2400 Segment SV301-03 - OR- As Adjudicated - Loop 2430 Segment SVD03-03
35	DC034	Procedure Modifier - 2	7/2/2013	External Code Source - AMA	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (DC032).	All	0%	As Sent by Provider - Loop 2400 Segment SV301-04 - OR- As Adjudicated - Loop 2430 Segment SVC03-04
36	DC035	Date of Service - From	7/2/2013	Full Date - Integer	int[8]	Date of Service	Report the date of service for this claim line in YYYYMMDD Format.	All	99%	Loop 2300 Segment DTP03 when DTP02 = D8 where DTP01 = 472; Else first eight digits of Loop 2300 Segment DTP03 when DTP02 = RD8 where DTP01 = 4 72 - OR - Loop 2400 Segment DTP03 when DTP02 = D8 where DTP01 = 472
37	DC036	Date of Service - To	7/2/2013	Full Date - Integer	int[8]	Date of Service	Report the end service date for the claim line in YYYYMMDD Format; it can equal DC035 when a single date of service is being reported.	All	0%	Loop 2300 Segment DTP03 when DTP02 = D8 where DTP01 = 472; Else last eight digits of Loop 2300 Segment DTP03 when DTP02 = RD8 where DTP01 = 4 72 - OR - Loop 2400 Segment DTP03 when DTP02 = D8 where DTP01 = 472
38	DC037	Charge Amount	7/2/2013	Integer	±varchar[10]	Amount of provider charges for the claim line	Report the amount the provider billed the insurance carrier for this claim line service. Report 0 for services rendered in conjunction with other services on the claim. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%	Loop 2400 Segment SV302
39	DC038	Paid Amount	7/2/2013	Integer	±varchar[10]	Amount paid by the carrier for the claim line	Report the amount paid for the claim line. Report 0 if line is paid as part of another procedure / claim line. Do not report any value if the line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%	Loop 2430 Segment SVD02

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
40	DC039	Copay Amount	7/2/2013	Integer	±varchar[10]	Amount of Copay member/patient is responsible to pay	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Copay applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	100%	Loop 2430 Segment CAS03, 06, 09, 12, 15 or 18 where CAS01 = PR and CAS02 = 3
41	DC040	Coinsurance Amount	7/2/2013	Integer	±varchar[10]	Amount of coinsurance member/patient is responsible to pay	Report the amount that defines a calculated percentage amount for this claim line service that the patient is responsible to pay. Report 0 if no Coinsurance applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	100%	Loop 2430 Segment CAS03, 06, 09, 12, 15 or 18 where CAS01 = PR and CAS02 = 2
42	DC041	Deductible Amount	7/2/2013	Integer	±varchar[10]	Amount of deductible member/patient is responsible to pay on the claim line	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Deductible applies to service. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	100%	Loop 2430 Segment CAS03, 06, 09, 12, 15 or 18 where CAS01 = PR and CAS02 = 1
43	DC042	Filler	7/2/2013	Filler	char[0]	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0%	n/a
44	DC043	Member Street Address	7/2/2013	Text	varchar[50]	Street address of the Member/Patient	Report the patient / member's address. Used to validate Unique Member ID.	All	90%	Loop 2010BA Segment N301 when Loop 2000B SBR02 = 18 - ELSE - Loop 2010CA Segment N301
45	DC044	Billing Provider Tax ID Number	7/2/2013	Numeric	char[9]	The Billing Provider's Federal Tax Identification Number (FTIN)	Report the Federal Tax ID of the Billing Provider here. Do not use hyphen or alpha prefix.	All	90%	Loop 2010AA Segment REF02 when REF01 = EI
46	DC045	Paid Date	7/2/2013	Integer	int[8]	Paid date of the claim line	Report the date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment in YYYYMMDD Format. This can be the same date as Processed Date. EXAMPLE: Claims paid in full, partial or zero paid.	Required when DC031 = 01, 02, 03, 19, 20, or 21	100%	Loop 2430 Segment DTP03
47	DC046	Allowed Amount	7/2/2013	Integer	±varchar[10]	Allowed Amount	Report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often it is less than or equal to the fee charged by the provider. Report 0 when the claim line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when DC031 does not = 4, 22, or 23	99%	n/a
48	DC047	Tooth Number/Letter	7/2/2013	External Code Source - ADA	varchar[2]	Tooth Number or Letter Identification	Report the tooth identifier(s) when DC032 is within the given range. Report one tooth per line when DC032 = D2000 thru D2999	Required when DC032 = D2000 thru D2999	100%	Loop 2400 Segment TOO02

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
49	DC048	Dental Quadrant	7/2/2013	External Code Source - ADA	char[10]	Dental Quadrant	Report the standard quadrant identifier from the External Code Source here. Provides further detail on procedure(s).	Required when DC032 indicates procedures of 3 or more consecutive teeth	100%	Loop 2400 Segment SV304-01, and/or SV304-02 and/or SV304-03 and/or SV304-04 and/or SVC304-05
50	DC049	Tooth Surface	7/2/2013	External Code Source - ADA	varchar[5]	Tooth Service Identification	Report the tooth surface(s) that this service relates to per tooth. Provides further detail on procedure.	Required when DC047 is populated	100%	Loop 2400 Segment TOO03-01 and/or TOO03-02 and/or TOO03-03 and/or TOO03-04 and/or TOO03-05
51	DC050	Subscriber Last Name	7/2/2013	Text	varchar[60]	Last name of Subscriber	Report the last name of the subscriber. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. **EXAMPLE:** O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	100%	Loop 2010BA Segment NM103
52	DC051	Subscriber First Name	7/2/2013	Text	varchar[25]	First name of Subscriber	Report the first name of the subscriber here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. **EXAMPLE:** Anne-Marie becomes ANNEMARIE	All	100%	Loop 2010BA Segment NM104
53	DC052	Subscriber Middle Initial	7/2/2013	Text	char[1]	Middle initial of Subscriber	Report the Subscriber's middle initial here. Used to validate Unique Member ID.	All	2%	Loop 2010BA Segment NM105
54	DC053	Member Last Name	7/2/2013	Text	varchar[60]	Last name of Member/Patient	Report the last name of the patient / member here. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. **EXAMPLE**: O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	100%	Loop 2010BA Segment NM103 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment NM103
55	DC054	Member First Name	7/2/2013	Text	varchar[25]	First name of Member/Patient	Report the first name of the patient / member here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. **EXAMPLE:** Anne-Marie becomes ANNEMARIE	All	100%	Loop 2010BA Segment NM104 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment NM104
56	DC055	Member Middle Initial	7/2/2013	Text	char[1]	Middle initial of the Member/Patient	Report the middle initial of the patient / member when available. Used to validate Unique Member ID.	All	2%	Loop 2010BA Segment NM105 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment NM105
57	DC056	Carrier Specific Unique Member ID	7/2/2013	Text	varchar[50]	Member's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to validate Unique Member ID and link back to Member Eligibility (ME107)	All	100%	Loop 2010BA Segment NM109 when Loop 2000B SBR02 = 18 - ELSE - Loop 2010CA Segment NM109
58	DC057	Carrier Specific Unique Subscriber ID	7/2/2013	Text	varchar[50]	Subscriber's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to validate Unique Member ID and link back to Member Eligibility (ME117)	All	100%	Loop 2010BA Segment NM109

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
59	DC058	Member Street Address 2	7/2/2013	Text	varchar[50]	Secondary Street Address of the Member/Patient	Report the address of member which may include apartment number or suite, or other secondary information besides the street. Used to validate Unique Member ID.	All	2%	Loop 2010BA Segment N302 when Loop 2000B SBR02 = 18 - ELSE - Loop 2010CA Segment N302
60	DC059	Claim Line Type	7/2/2013	Lookup Table - Text	char[1]	Claim Line Activity Type Code	Report the code that defines the claim line status in terms of adjudication. **EXAMPLE:** O = Original	All	98%	n/a
						Code	***Description***			
						O	Original			
						V	Void			
						R	Replacement			
						B	Back Out			
						A	Amendment			
61	DC060	Former Claim Number	7/2/2013	Text	varchar[35]	Previous Claim Number	Report the Claim Control Number (DC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own DC004. Use of "Former Claim Number" to version claims can **only** be used if approved by the APCD. Contact the APCD for conditions of use.	All	0%	n/a
62	DC061	Diagnosis Code	7/2/2013	External Code Source - ICD	varchar[7]	ICD Diagnosis Code	Report the ICD Diagnosis Code when applicable	Required when DC032 is within the ranges of D7000-D7999 or D9220 or D9221	75%	Loop 2300 Segment HI01-02
63	DC062	ICD Indicator	7/2/2013	Lookup Table - Integer	int[1]	International Classification of Diseases version	Report the value that defines whether the diagnoses on claim are ICD9 or ICD10. **EXAMPLE:** 9 = ICD9	Required when DC061 is populated	100%	Set value here based upon value in Loop 2300 Segment HI01-01 starting with the letter A
						Value	***Description***			
						9	ICD-9			
						0	ICD-10			
64	DC063	Denied Flag	7/2/2013	Lookup Table - Integer	int[1]	Denied Claim Line Indicator	Report the value that defines the element. **EXAMPLE:** 1 = Yes, Claim Line was denied.	Required when DC031 = 04	100%	Loop 2430 CAS identification will set APCD value to 1 or 2 - THIS REQUIRES PAYER BY PAYER MAPPING
						Value	***Description***			
						1	Yes			
						2	No			
						3	Unknown			
						4	Other			
						5	Not Applicable			
65	DC064	Denial Reason	7/2/2013	External Code Source - HIPAA **- OR-** Carrier Lookup Table	varchar[20]	Denial Reason Code	Report the code that defines the reason for denial of the claim line. Carrier must submit denial reason codes in separate table to the APCD.	Required when DC063 = 1	100%	Loop 2430 CAS/Carrier Defined Table identification will set APCD value to 1 or 2 - THIS REQUIRES PAYER BY PAYER MAPPING
66	DC065	Payment Arrangement Type	7/2/2013	Lookup Table - Numeric	char[2]	Payment Arrangement Type Value	Report the value that defines the contracted payment methodology for this claim line. **EXAMPLE:** 02 = Fee for Service	All	98%	n/a
						Value	***Description***			
						1	Capitation			

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
						2	Fee for Service			
						3	Percent of Charges			
						4	DRG			
						5	Pay for Performance			
						6	Global Payment			
						7	Other			
						8	Bundled Payment			
67	DC066	Filler	7/2/2013	Filler	char[0]	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0%	n/a
68	DC067	APCD ID Code	7/2/2013	Lookup Table - Integer	int[1]	Member Enrollment Type	Report the value that describes the member's / subscriber's enrollment into one of the predefined categories; aligns enrollment to appropriate editing and thresholds. **EXAMPLE:** 1 = FIG - Fully Insured Commercial Group Enrollee.	All	100%	n/a
						Value	***Description***			
						1	FIG - Fully-Insured Commercial Group Enrollee			
						2	SIG - Self-Insured Group Enrollee			
						3	State or Federal Employer Enrollee			
						4	Individual - Non-Group Enrollee			
						5	Supplemental Policy Enrollee			
						6	ICO - Integrated Care Organization			
						0	Unknown / Not Applicable			
69	DC068	Bill Frequency Code	7/2/2013	External Code Source - NUBC	char[1]	Bill Frequency	Report the valid frequency code of the claim to indicate version, credit/debit activity and/or setting of claim.	All	100%	Loop 2300 Segment CLM05-03
70	DC899	Record Type	7/2/2013	Text	char[2]	File Type Identifier	Report **DC** here. This validates the type of file and the data contained within the file. This must match HD004	All	100%	n/a
TR-DC	TR001	Record Type	10/7/2013	Text	char[2]	Trailer Record Identifier	Report TR here. Indicates the end of the data file.	Mandatory	100%	n/a
TR-DC	TR002	Submitter	10/7/2013	Integer	varchar[6]	Trailer Submitter / Carrier ID defined by AHCT	Report unique Submitter ID here. AHCT will provide this unique identifier to the carrier. This must match the Submitter ID reported in HD002.	Mandatory	100%	n/a
TR-DC	TR003	National Plan ID	10/7/2013	Integer	int[10]	CMS National Plan Identification Number (PlanID)	Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	Situational	0%	n/a
TR-DC	TR004	Type of File	10/7/2013	Text	char[2]	Validates the file type defined in HD004.	Report **DC** here. This must match the File Type reported in HD004.	Mandatory	100%	n/a
TR-DC	TR005	Period Beginning Date	10/7/2013	Full Date - Integer	int[8]	Trailer Period Start Date	Report the Year and Month of the reported submission period in YYYYMMDD format. This date period must match the date period reported in HD005 and HD006.	Mandatory	100%	n/a

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
TR-DC	TR006	Period Ending Date	10/7/2013	Full Date - Integer	int[8]	Trailer Period Ending Date	Report the Year and Month of the reporting submission period in YYYYMMDD format. This date period must match the date period reported in TR005 and HD005 and HD006.	Mandatory	100%	n/a
TR-DC	TR007	Date Processed	10/7/2013	Full Date - Integer	int[8]	Trailer Processed Date	Report the full date that the submission was compiled by the submitter in YYYYMMDD Format.	Mandatory	100%	n/a