Building Blocks for Effective Relationships with Third-Party Payers

LIFE AFTER 40

COMPANION WORKBOOK

National Family Planning & Reproductive Health Association

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Family Planning
& Reproductive Health Association

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Introduction

The National Family Planning & Reproductive Health Association (NFPRHA) is working to assist publicly funded family planning providers adapt to the changes created by the Affordable Care Act (ACA). Grant funding supports the *Life After 40: The Family Planning Network and the ACA* project, which focuses on the sustainability of the family planning service delivery network in the years following the fortieth anniversary of Title X, the federal family planning program, in 2010.

Building Blocks for Effective Relationships with Third-Party Payers, the sixth case study of the *Life After 40* project, presents three family planning providers and their experiences with third-party payers. The following agencies participated in the case study and have generously shared materials for this workbook:

- Alabama Department of Public Health (ADPH);
- Planned Parenthood of the Heartland (PPHeartland); and
- Planned Parenthood of Minnesota, South Dakota, North Dakota (PPMNS).

The goal of this companion workbook is to provide materials that can be adapted for use by an agency to effectively implement and sustain relationships with third-party payers. This workbook includes the tools and resources utilized by the agencies, and is divided into three broad topics:

- discovery;
- implementation; and
- evaluation.

Each document in the workbook includes a brief description to provide context for use. Additionally, many of the documents are discussed in more detail within the case study. The documents that are mentioned will have a page number for cross-reference with the case study.

Section 1: Discovery

Establishing effective and productive relationships with third-party payers is a critical step for family planning providers to ensure that they have the potential to collect revenue that will allow them to continue to provide services. The first phase of this process for any health care agency, whether starting out or renegotiating an existing contract, should be discovery. A successful discovery process includes:

- identifying and contacting third-party payers;
- reviewing and negotiating the terms of the contract;
- credentialing providers; and
- executing the contract.

After identifying a payer to contract with, the next step is developing a strategy to contact the payer. In preparation for contract negotiations or operationalizing the contract, agency staff should review the contract to ensure the proposed provider-payer relationship is fully understood. This review will provide insight into the specific requirements that the agency must fulfill under the contract, and will also reveal the requirements of the payers.

This section presents the following tools and resources related to the discovery process:

Contacting the Payer

- **PPHeartland CEO Letter to Payers** – A letter from the CEO to third-party payers in each state within the agency's service area, identifying PPHeartland as an essential community provider and requesting to be included in the payer's provider network. The goal of this letter was to increase the number of payers for the agency.

Reviewing the Contract

- **PPMNS Contract Review Process** – Key roles and responsibilities for staff in the contract review process.
- **PPMNS Contract Review Summary** – A cover sheet for contracts that summarizes the review process. Includes space to share comments or concerns about the contract language.

Negotiating with the Payer

- **PPMNS Cost versus Reimbursement Analysis** – A spreadsheet to compare costs and reimbursements for most-frequently provided services by CPT code. Used to prepare for contract reimbursement rate negotiation. The following data are used in the spreadsheet:
  - *Total Medicaid and Waiver Visits* – the number of times each service was provided during the time frame of the analysis.
  - *Unit Cost per Visit* – the cost for providing each service using an RVU methodology.
  - *Unit Reimbursement per MD* – the payer's reimbursement rate in dollars for a physician providing a given service.
  - *Unit Reimbursement per APN (90% of Medicaid Rate)* – the payer's reimbursement rate in dollars for an advanced practice nurse providing a given service.
  - *Unit Reimbursement for Waiver (1.25% x APN rate)* – the reimbursement rate in dollars for a service provided under the state's Medicaid family planning waiver, which is set at a rate 25% higher than APN rate schedule of full-benefit Medicaid.
  - *Average Loss per Office Visit* – the average difference between the cost and the reimbursement for each service.
  - *Total Office Costs* – the total cost for providing the service during the timeframe of analysis.
  - *Total Office Visit Reimbursement* – the total reimbursement for services among all provider types during the timeframe of analysis.
  - *Total Office Visit Loss* – the difference between the total cost and the total reimbursement.

The second portion of the spreadsheet analyzes the cost versus reimbursement for insertion of IUDs and implants. This analysis examines the ratio between the cost of the visit by CPT code and the cost of dispensing the device.

Credentialing Providers

- **ADPH Credentialing Application Spreadsheet** – A spreadsheet to track the completion of the credentialing process for each clinician. The spreadsheet is divided into three sections:
  - *Documentation* – specifies each of the documents needed to complete an application.
  - *Correspondence* – tracks the date the payer accepted the application and when notification of approval was received by the agency.
  - *NPI* – tracks a clinician's National Provider Identifier (NPI) and, if the clinician does not have one, the date the application was submitted.
- **Health Care Provider Characteristics Codes** – A set of codes established by CMS to provide details during the provider credentialing application process. The code list is updated periodically and housed on the website of the designated code set registry, Washington Publishing Company, available here: www.wpc-edi.com/reference/codelists/healthcare/provider-characteristics-codes.
- **PPHeartland Credentialing Policy** – The steps for credentialing new providers, as well as approximate timeframes for each step of the policy.
- **PPHeartland Patient Account Clerk Job Description** – A description of the specific roles and responsibilities for the staff member responsible for monitoring provider credentialing.
- **PPHeartland Credentialing Status Log** – A spreadsheet used to track the status for credentialing each provider with each third-party payer. Includes status of credentialing application, as well as the providers' status with CAQH, an online database of credentialing criteria, and ARMS, the agency's malpractice insurance provider. Sample entries are included for "Provider 1" to provide examples of the type of information housed in this document.

Execute the Contract

- **PPMNS New Contract Checklist** – A tool to ensure business contracts include favorable terms for the agency. A staff member completes the checklist, which includes issues related to party responsibilities, renewal, performance, termination, and liability.

1.a.1 PPHeartland CEO Letter to Payers

See companion Case Study, page 8

[DATE]

[THIRD-PARTY PAYER]
[ADDRESS]

RE: Network inclusion as an Essential Community Provider (ECP)

Dear [THIRD-PARTY PAYER]:

[AGENCY NAME] serves nearly [XX,XXX] patients annually by providing a wide range of quality reproductive health care services at our [XX] health centers. We have served women and men of all ages since the 1930s, and our services are provided by licensed health care professionals, including licensed medical doctors, nurse practitioners, and pharmacists.

As you are aware, [APPROPRIATE DATE] is the deadline for private insurance providers to apply to be considered a qualified health plan (QHP) in the State Health Insurance Exchange. In order to be considered a QHP, issuers are required to include in their network a number of Essential Community Providers (ECP) in the service area. [AGENCY NAME], as a Title X provider with 340b status, is classified as an ECP, and our health centers are identified as ECP Family Planning Providers on the Essential Community Providers list released recently by the Centers for Medicare and Medicaid Services.

As a private insurance company, we encourage you to participate in the Health Insurance Exchange to ensure that citizens are provided with a variety of options in the marketplace. Additionally, we strongly encourage you to include [AGENCY NAME] health centers in your provider network, which will assist your company in meeting the standards for ECP inclusion for plans in the Exchange. Including [AGENCY NAME] in your network will also ensure that individuals insured by your plans have access to trusted family planning services in their area.

The [APPROPRIATE DATE] deadline is quickly approaching, so we urge you to contact us to take the next steps to include us in your provider network. The process can easily be started with a simple letter of intent to include [AGENCY NAME] in your network, with additional details worked out in the coming months.

We look forward to hearing from you regarding your decision be a Qualified Health Provider in the State Health Insurance Exchange, and to begin the process of joining your provider network. Please don't hesitate to contact me with any questions.

Regards,

[CEO NAME]
President and CEO
[AGENCY NAME]

1.b.1 PPMNS Contract Review Process

See companion Case Study, page 9

IMPORTANT: The "originator" is the person with ultimate responsibility for ensuring timely turn-around and signing of a contract. This includes making sure that the contract is accurate, contains all appropriate safeguards for [AGENCY NAME], is signed, and returned to the Executive Assistant with all supporting documentation.

Occasionally the Executive Assistant will assume responsibility for getting contracts signed and returned to corporate file – see below.

WHO	WHAT
Originator	1. Obtain contract from vendor. 2. Review contract and complete Contract Review Checklist. 3. If vendor is new to [AGENCY NAME], complete Accounting Department's *New Vendor Request* form. 4. Negotiate with vendor to make changes in the contract as appropriate. 5. Forward the following documents to the Chief Compliance Officer: a. Contract b. Attachments, addenda, etc. c. Completed Contract Review Checklist NOTE: With certain contracts, originator will also be responsible for submitting background check information to vendor. Originator may also be responsible for ensuring that the contract and BAA/CA are signed and returned to the Executive Assistant.
Chief Compliance Officer	1. Review contract. 2. Forward to CFO for review, if appropriate, and track feedback. 3. Return to originator or attorney for further review if necessary. 4. Determine if Business Associate Agreement (BAA) or Confidentiality Agreement (CA) is required. 5. Determine appropriate signer. 6. Complete *Contract Review Summary*. 7. Forward to Executive Assistant for processing. 8. The Chief Compliance Office will also ensure annual contract review. NOTE: Please allow 3 business days for Compliance and/or legal review.
Chief Financial Officer	1. Review contract, if related to banking, finance, etc., and return to Chief Compliance Officer.

Compliance Assistant	1. Log contract onto Contract Tracking Spreadsheet. 2. Determine whether updated BAA or CA already exists. 3. If necessary, prepare BAA (consult with Privacy Officer if necessary) or CA. 4. Present the following to appropriate signer: a. Two copies of contract and accompanying documents b. Two copies of BAA and/or CA c. Chief Compliance Officer's Contract Review Summary 5. After [AGENCY NAME] representative has signed contract, present two copies of contract and BAA/CA to vendor for signature (or to originator, who may secure vendor's signature instead). 6. When both are signed, notify originator that performance of contract may begin. 7. Return one fully executed copy of contract and BAA/CA to vendor. 8. Enter remaining contract information onto spreadsheet. 9. File in Corporate File: a. One copy of original signature contract b. BAA and/or CA c. Other related documents
Signer	1. Signer reviews any unresolved issues with the contract (which will be noted on the cover sheet) and determines whether the contract should be signed in current state or whether further negotiations with vendor are required. 2. If no further negotiations with vendor are required, sign the contract.

1.b.2 PPMNS Contract Review Summary

See companion Case Study, page 9

Date: _____

Name of Contract: _____

Originator: _____

This contract has been reviewed by:

- ☐ Attorney
- ☐ Compliance Officer
- ☐ CFO

Comments:

- ☐ Confidentiality Agreement required
- ☐ Businesss Associate Agreement required

Authorized signer for this contract is: _____

Compliance Office Signature: _____

1.c.1 PPMNS Cost versus Reimbursement Analysis

See companion Case Study, page 8

Date Sources:

1) Practice Management System Charges Report 2) Medicaid Fee Schedule 3) RVU Cost Analysis 4) Reimbursement

Service Dates:_____

Primary Payers: _____

Locations: _____

CPT Code	Office Visit Type	Total Medicaid and Waiver Office Visits	Unit Cost	Unit Medicaid Reimbursement per MD	Unit Reimbursement per APN (90% of MD rate)	Unit Reimbursement for Waiver (1.25% x APN rate)	Avg Loss per Office Visit	Total Office Visit Cost	Total Office Visit Reimbursement	Total Office Visit Loss
99201	NPT PF 10									
99202	NPT EPF 20									
99203	NPT DET 30									
99204	NPT Comp 40									
99212	EPT PF 10									
99213	EPT EPF 15									
99214	EPT DET 25									
99215	EPT Comp 40									
99384	NPT Prevent 12-17									
99385	NPT Prevent 18-39									
99386	NPT Prevent 40-64									
99394	EPT Prevent 12-17									
99395	EPT Prevent 18-39									
99396	EPT Prevent 40-64									

CPT Code	Insertion/ Injection	Total Medicaid and Waiver Units	Unit Cost	Unit Medicaid Reimbursement per MD	Unit Reimbursement per APN	Unit Reimbursement for Waiver	Avg Loss	Total Cost	Total Reimbursement	Total Loss
11981	Insertion – Nexplanon									
58300	IUD Insertion									
58301	IUD Removal									
96372	Injection									

Office Visit to Dispensing Cost Ratio				
CPT Code	**Office Visit Type**	**Office Visit Unit Cost**	**Dispensing Cost for Mirena, Paragard, Nexplanon**	**Ratio Office Visit to Dispensing Cost**
99201	NPT PF 10			
99202	NPT EPF 20			
99203	NPT DET 30			
99204	NPT Comp 40			
99212	EPT PF 10			
99213	EPT EPF 15			
99214	EPT DET 25			
99215	EPT Comp 40			
99384	NPT Prevent 12-17			
99385	NPT Prevent 18-39			
99386	NPT Prevent 40-64			
99394	EPT Prevent 12-17			
99395	EPT Prevent 18-39			
99396	EPT Prevent 40-64			

1.d.1 ADPH Credentialing Application Spreadsheet

See companion Case Study, page 10

Documentation	Clinician 1	Clinician 2	Clinician 3	Clinician 4	Clinician 5	Clinician 6
	Documentation Submitted					
Completed payer application						
Copy of current RN license or NP Board certification						
CV						
Copy of BME Collaborative Practice Card						
Note regarding Electronic Funds Transfer						
Malpractice/liability insurance						
Note regarding NP not having hospital admitting privileges						
W-9 form						
IRS tax exempt document						
IRS letter 147C						
	Clinician 1	**Clinician 2**	**Clinician 3**	**Clinician 4**	**Clinician 5**	**Clinician 6**
	Correspondence Received					
Notice of application acceptance						
Notice of application approval						
	Clinician 1	**Clinician 2**	**Clinician 3**	**Clinician 4**	**Clinician 5**	**Clinician 6**
	NPI https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart					
Applied for NPI (if needed)						
Clinician has NPI						

1.d.2 Health Care Provider Characteristics Codes

See companion Case Study, page 10

Code	Description
10	Provider has a medical condition that impairs or limits him/her to practice Start: 01/01/2004
11	Provider receives public funding Start: 01/01/2004
13	This is a primary care group Start: 01/01/2004
14	Provider has ownership or financial interest in another medical establishment Start: 01/01/2004
15	Professional liability coverage has been restricted/terminated/or modified Start: 01/01/2004
16	This is the provider's primary insurance coverage Start: 01/01/2004
17	This is the provider's excess insurance coverage Start: 01/01/2004
18	Excess insurance coverage exists for this provider Start: 01/01/2004
19	Provider is self-insured Start: 01/01/2004
1A	Provider's self-insurance is funded Start: 01/01/2004
1B	Provider's self-insurance is not funded Start: 01/01/2004
1C	Provider has had adverse action on state license, certificate, or registration Start: 01/01/2004
1D	Provider has had adverse action on DEA or other applicable narcotic registration Start: 01/01/2004
1E	Provider has had adverse action on hospital or other health care facility staff membership for privileges Start: 01/01/2004
1F	Provider has had adverse action on professional organization membership Start: 01/01/2004
1G	Provider has had adverse action on Medicare, Medicaid or other government health programs Start: 01/01/2004
1H	Provider has had adverse action on any prepaid health plan or managed care participation Start: 01/01/2004
1I	Provider has had adverse action with respect to educational or training institution or program Start: 01/01/2004
1J	Provider has had adverse action by professional society or association Start: 01/01/2004

1K	Provider is under health plan administrative sanction Start: 01/01/2004
1L	Provider accepts Workers' Compensation Start: 01/01/2004
1M	Provider accepts Medicare assignment Start: 01/01/2004
1N	Provider accepts Medicaid assignment Start: 01/01/2004
1O	Provider participates in Medicare and accepts assignment Start: 01/01/2004
1P	Provider participates in Medicaid and accepts assignment Start: 01/01/2004
1Q	Provider is not accepting new patients for obstetric care Start: 01/01/2004
1R	This location is handicapped accessible Start: 01/01/2004
1S	This location is less than 1 block from public transportation Start: 01/01/2004
1T	This location is less than 5 blocks from public transportation Start: 01/01/2004
1U	This location is less than 1 mile from public transportation Start: 01/01/2004
1V	This location is 1 or more miles from public transportation Start: 01/01/2004
1W	This location has a full time assistant available Start: 01/01/2004
1X	This location has a part time assistant available Start: 01/01/2004
1Y	This location has Telecommunication Device for the Deaf (TDD) equipment Start: 01/01/2004
1Z	This location is medically fragile equipped Start: 01/01/2004
20	This location employs para-professional staff/employees Start: 01/01/2004
21	This location maintains para-professional credentialing, licensure & malpractice information Start: 01/01/2004
22	This location admits and cares for patients on its own hospital service Start: 01/01/2004
23	The scheduling time for urgent care at this location is more than 24 hours Start: 01/01/2004
24	The scheduling time for symptomatic care at this location is more than 72 hours Start: 01/01/2004
25	The scheduling time for routine visits at this location is more than 7 days Start: 01/01/2004

26	The scheduling time for preventive routine care at this location is more than 30 days Start: 01/01/2004
27	The waiting time at this location is more than 30 minutes from time of scheduled appointment Start: 01/01/2004
28	Allergy skin testing is provided at this location Start: 01/01/2004
29	Asthma treatment is provided at this location Start: 01/01/2004
2A	EKG services are provided at this location Start: 01/01/2004
2B	Flexible sigmoidoscopy is provided at this location Start: 01/01/2004
2C	IV hydration/treatment is provided at this location Start: 01/01/2004
2D	Laceration repair is provided at this location Start: 01/01/2004
2E	Laboratory services/testing is provided at this location Start: 01/01/2004
2F	Massage therapy is provided at this location Start: 01/01/2004
2G	Minor fracture work is provided at this location Start: 01/01/2004
2H	Minor surgery is provided at this location Start: 01/01/2004
2I	Occupational therapy is provided at this location Start: 01/01/2004
2J	Gynecology services are provided at this location Start: 01/01/2004
2K	Obstetric services are provided at this location Start: 01/01/2004
2L	Osteopathic manipulation is provided at this location Start: 01/01/2004
2M	Physical therapy is provided at this location Start: 01/01/2004
2N	Pulmonary function studies are provided at this location Start: 01/01/2004
2O	Speech pathology is provided at this location Start: 01/01/2004
2P	Hearing tests are provided at this location Start: 01/01/2004
2Q	Visual screenings are provided at this location Start: 01/01/2004
2R	Mammography services are provided at this location Start: 01/01/2004

2S	X-rays are provided at this location Start: 01/01/2004
2T	This hospital has a Medicare Prospective Payment System (PPS) exempt rehabilitation unit Start: 01/01/2004
2U	This hospital has a Medicare Prospective Payment System (PPS) exempt psychiatric unit Start: 01/01/2004
2V	Assistive aid information not collected from the provider Start: 10/01/2006
55	Accepted Start: 01/01/2004
56	Unspecified Error Start: 01/01/2004
57	Failed Field Edits Start: 01/01/2004
58	Minimum Fields Missing Start: 01/01/2004
59	Exact Duplicate Start: 01/01/2004
5A	Rejected by NPI Enumerator Start: 01/01/2004
5B	Invalid Taxonomy Code Start: 01/01/2004
5C	Taxonomy Code Mismatch Start: 01/01/2004
5D	SSN Validation Error Start: 01/01/2004
5E	Mailing Address Error Start: 01/01/2004
5F	Location Address Error Start: 01/01/2004
5G	NPI not on File Start: 01/01/2004
5H	Invalid Deactivation Reason Code Start: 01/01/2004
5I	Pended by GateKeeper Start: 01/01/2004
5J	Pended by L/S/T Start: 01/01/2004
5K	Duplicate record Start: 01/01/2004
5L	Schema validation failed Start: 01/01/2004
5M	Individual Verification – Found Start: 01/01/2004

5N	Individual Verification – Not Found Start: 01/01/2004
5O	Individual Verification – Close Match Start: 01/01/2004
5P	Individual Verification – Insufficient Data Start: 01/01/2004
5Q	Organization Verification – Found Start: 01/01/2004
5R	Organization Verification – Not Found Start: 01/01/2004
5S	Organization Verification – Close Match Start: 01/01/2004
5T	Organization Verification – Insufficient Data Start: 01/01/2004
5U	Individual Data Dissemination – Fulfilled Start: 01/01/2004
5V	Individual Data Dissemination – Not Fulfilled Start: 01/01/2004
5W	Organization Data Dissemination – Fulfilled Start: 01/01/2004
5X	Organization Data Dissemination – Not Fulfilled Start: 01/01/2004
5Y	Unspecified Response Start: 01/01/2004

1.d.3 PPHeartland Credentialing Policy

See companion Case Study, page 11

Effective Date:	
Last Reviewed Date:	
Next Scheduled Review Date:	
Errors or changes to:	Director of Revenue Management

Credentialing/Contracting

- The credentialing and contracting process can take anywhere from 45-180 days to complete depending on the payer. Every effort is made by the credentialing staff to ensure timely follow-up on credentialing, re-credentialing, contracting, demographic changes, and attestation requests. All new requests are logged within 24 hours of receipt.
- If a new clinic site is opened, an NPI is applied for within 1 business day of notification. The clinic location is then added to all payer contracts within 30 business days.
- Human Resources (HR) notifies the credentialing team of new hire when the offer has been accepted by the provider. The Credentialing Specialist is required to contact the new hire within 2 business days. All required documents are to be received from the new hire within 1 week from initial credentialing contact. Once all documentation has been received HR is notified and the official start date is provided to the new hire.
- All major payer applications, malpractice liability insurance, and credentialing databases are completed by the credentialing team within the first 2 to 3 weeks after initial credentialing contact.
  - Affiliates Risk Management Services application – including malpractice liability insurance.
  - Medicaid – including Iowa, Oklahoma, Arkansas, and Nebraska.
  - BC/BS – including Iowa, Oklahoma, Arkansas, and Nebraska.
  - United Healthcare (UHC) – including Medicaid Managed Care plans.
  - CAQH – if the provider does not already have CAQH, the credentialing specialist will obtain the CAQH ID for the new hire.
  - Medicare – including Iowa, Oklahoma, Arkansas, and Nebraska.
  - Any state specific insurance payers – including Coventry, Aetna, Community Care, Interplan, Health Smart, etc.
- Requests to existing providers for completion of forms and data requests are expected to be completed by the providers within 7 business days.
- All agreements and contracts are forwarded to the Director of Revenue Management for signature, the Director of Accounting for coding, a Senior Management Team member for signature, and to the legal department for review. Legal has up to 14 calendar days to return the documents to either the credentialing specialist or CEO for final approval and signature. Once all documents are returned with the required signatures it is sent out within 1 business day.
- Requests from Pharmacy Benefit Managers (PBM) for annual Compliance and Fraud, Waste, and Abuse attestations/ agreements are expected to be completed within 30 calendar days of receipt of the request.

1.d.4 PPHeartland Patient Account Clerk Job Description

JOB TITLE: Patient Account Clerk

REPORTS TO: Director of Revenue Management

FUNCTION: Provide support and perform clerical duties for the credentialing and re-credentialing process for all new and existing providers.

ESSENTIAL DUTIES

1. Achieve and maintain established productivity standards and key revenue cycle performance indicators.
2. Assist patient account and credentialing staff with clerical and support duties that may include but are not limited to the following:
   a. Completing credentialing applications and contract forms
   b. Photocopying, filing, labeling, and sorting documents
   c. Performing data entry and word processing functions
   d. Preparing mail to include stuffing and sealing envelopes
   e. Preparing packets of credentialing information
3. Answering and making phone calls while providing excellent customer service
4. Maintaining and updating spreadsheets and lists of credentialing information
5. Other duties as assigned

MINIMUM EDUCATION AND EXPERIENCE

High school diploma or equivalent required. At least one year of clerical or administrative work experience. Ability to access, retrieve, and input information into various computer systems. Strong computer/keyboarding and Microsoft office skills preferred.

REQUIRED COMPETENCIES

Customer Service: Demonstrates concern for meeting internal and external customer needs in a manner that provides satisfaction. Anticipates additional needs of the customer beyond their current use of [AGENCY NAME] services. Understands and finds solutions within the limits of what is available. Can solve problems with minimal disruption. Communicates openly and directly. Able to change communication style according to the needs of the audience and the situation.

Teamwork: Able to gain cooperation from others and work collaboratively toward solutions which generally benefit all involved parties. Proactively identifies opportunities to assist others and ensures that information is communicated accurately and timely to all necessary parties. Behaves honestly and ethically. Communicates openly and directly. Able to change communication style according to the needs of the audience and the situation.

Planning and Organizing: Establishes a systematic course of action to accomplish specific objectives. Determines priorities and uses time effectively. Completes the workload required of the position. Able to change priorities according to the work load and asks for assistance as appropriate.

REQUIRED COMPETENCIES (continued)

Achievement Orientation: Self-starting. Independently demonstrates a desire to set and meet objectives, to find a better or more efficient way to do things, and to compete against a self-defined standard of excellence.

Self Confidence: Demonstrates a strongly positive image of self and own abilities, and a willingness to exercise and trust one's independent judgment.

Expertise (Technical or Procedural): Possesses specialized knowledge or skills to accomplish a result. Picks up on technical things quickly; is good at learning new skills. Often referred to as a quick learner.

Attention To Detail: Thorough in accomplishing a task. Accurately completes all areas involved no matter how small.

SPECIAL REQUIREMENTS

Ability to maintain confidentiality of all [AGENCY NAME] business and activities on and off of the job.

Licenses: Valid driver's license if required to drive on [AGENCY NAME] business.

Revision Date: January 2013

Overtime Exempt: No

Exposure Control Category: 3

_____ _____

Employee's Signature Date

_____

Print Name

1.d.5 PPHeartland Credentialing Status Log

See companion Case Study, page 11

Provider		PROVIDER 1	PROVIDER 2	PROVIDER 3	PROVIDER 4	PROVIDER 5	PROVIDER 6	PROVIDER 7	PROVIDER 8	PROVIDER 9	PROVIDER 10	PROVIDER 11	PROVIDER 12
Affiliates Risk Management Services (ARMS) Application	Status	Uploaded ARMS application											
	Date	5/6/14											
CAQH Registration and Attestation	Status	Registration Successful on 10/02/13											
	CAQH ID #	12345678											
Iowa Medicaid (IME)		05/10/13 Welcome to IME Ordering/ Referring NPI Letter											
Nebraska Medicaid (DHHS)		N/A											
Wellmark BC/BS of Iowa		05/01/13 faxed provider recredentialing summary											
BC/BS of Nebraska		N/A											
UHC		In-Network Participating Provider with Renewal Contract Effective 10/15/12											
UHC Community Plan		In-Network Participating Provider Effective 10/15/12											
Coventry Cares		Provider participation under group											
Aetna													
Cigna		Processed through Midlands Choice											
Midland's Choice		In-Network Effective 06/09/14											
Tricare													
Tricare South													
Medicare WPS		09/24/13 Mailed 855I & 855R application											
First Choice of the Midwest, Inc		In-Network Effective 01/01/14											
Health Alliance		Mailed application 10/07/13											
MultiPlan		Effective date 03/10/14											
IHFS/IL Medicaid		02/05 Does not enroll Physican's Assistants											

1.e.1 PPMNS New Contract Checklist

Contract Title:	
Vendor:	
Vendor Contact & Phone:	
Contract Originator:	
Department:	
Approximate Value:	

The following process is required before any new contract is entered into on behalf of [AGENCY NAME].

1. Contract Originator ([AGENCY NAME] contact: e.g., manager/administrative assistant/associate/director) fills out New Contract Checklist.
2. Contract Originator sends contract and completed checklist to Compliance Director for review.
3. If there are changes, Compliance Director will send edits back to Contract Originator for contract negotiation. A confidentiality agreement (CA) or business associate agreement (BAA) may need to be sent to vendor/contractor.
4. If there are no changes, Compliance Director will send to appropriate [AGENCY NAME] leadership for signature.
5. Once contract is signed, contract is returned to Contract Originator to send to the vendor. After sending, Contract Originator must send a copy of the executed contract, approval letter, and contract checklist, all with appropriate signatures to Executive Assistant.

I. Contract		
This is a new vendor for [AGENCY NAME].	YES ☐	NO ☐
This contract renews automatically.	YES ☐	NO ☐
If contract renews automatically, it renews on (date):		
This contract expires on (date):		
This contract includes all pages, addenda and attachments, including any referenced documents that are available on the vendor's website.	YES ☐	NO ☐
This contract shows our correct legal name.	YES ☐	NO ☐
The contract clearly spells out the effective date.	YES ☐	NO ☐
All costs are clearly itemized and acceptable.	YES ☐	NO ☐
The payment method and schedule are clear and acceptable.	YES ☐	NO ☐
The responsibility for any cost increases is clear and assigned appropriately.	YES ☐	NO ☐
Charges for late payments are clear and reasonable.	YES ☐	NO ☐

Location(s) for service are clear and acceptable.	YES ☐	NO ☐
The method for delivery of service is clear and acceptable.	YES ☐	NO ☐
Description of issues:		
II. Vendor		
Vendor is reputable.	YES ☐	NO ☐
Vendor is adequately insured.	YES ☐	NO ☐
Vendor does not have an unlimited claim to research results (if applicable).	YES ☐	NO ☐
Vendor does not have access to PHI.	YES ☐	NO ☐
If vendor *does* have access to PHI, a BAA has been sent to the Privacy Officer for review/approval.	YES ☐	
Vendor's performance expectations are clear.	YES ☐	NO ☐
Vendor does not have access to the [AGENCY NAME] logo or trade name.	YES ☐	NO ☐
Description of issues:		
III. [AGENCY NAME]		
[AGENCY NAME] will retain exclusive ownership of that data shared.	YES ☐	NO ☐
If not, [AGENCY NAME] and vendor will share ownership of the data shared.	YES ☐	NO ☐
[AGENCY NAME]'s tax exemption status is observed.	YES ☐	NO ☐
Description of issues:		

IV. Indemnification and Liability		
There is a clause that will hold the vendor harmless for negligence, damages, etc.	YES ☐	NO ☐
There is a clause that will hold [AGENCY NAME] harmless for negligence, damages, etc.	YES ☐	NO ☐
It is clear that any damages to [AGENCY NAME]'s property by vendor is the responsibility of the vendor.	YES ☐	NO ☐
Description of issues:		

V. Performance		
A clear timeline for the performance of service is included and acceptable.	YES ☐	NO ☐
Location(s) for service are clear and acceptable.	YES ☐	NO ☐
The expected quality of services is clearly defined.	YES ☐	NO ☐
It is clear how quality will be determined.	YES ☐	NO ☐
It is clear how long [AGENCY NAME] has to assess quality.	YES ☐	NO ☐
[AGENCY NAME]'s rights and remedies if services do not meet expectations are clearly defined and acceptable.	YES ☐	NO ☐
Description of issues:		

VI. Termination		
[AGENCY NAME] may terminate the contract without the approval of the vendor.	YES ☐	NO ☐
[AGENCY NAME] may terminate the contract for "no cause."	YES ☐	NO ☐
It is clear how much notice must be given before a termination. This period of time is acceptable to [AGENCY NAME].	YES ☐	NO ☐
All fees and penalties for termination are clear and acceptable.	YES ☐	NO ☐
Description of issues:		

VII. Confidentiality		
Vendor may have access to donor information.	YES ☐	NO ☐
Vendor may have access to [AGENCY NAME] operation information (Compliance Director will determine if CA is required.)	YES ☐	NO ☐
Vendor may be able to view PHI, either intentionally or unintentionally (Compliance Director will determine if BAA is required).	YES ☐	NO ☐
Description of issues:		

Signature of Contract Originator

I certify that I have reviewed the contract in question and have completed the above checklist. I have done due diligence to ensure that the contract and vendor meet [AGENCY NAME]'s requirements.

_____ _____

Signature of Contract Originator Date

Section 2: Implementation

The discovery process provides the foundation an agency needs to navigate the implementation of the third-party payer contract. The implementation process uses the information gathered during discovery to design the systems necessary to effectively and efficiently bill and collect revenue from third-party payers. This phase involves several important steps:

- developing policies and procedures;
- appropriately hiring and staffing;
- transferring knowledge to staff;
- monitoring payer information;
- submitting claims for payment; and
- collecting reimbursements.

It is important for an agency to develop standardized policies and procedures to successfully gather the information necessary to submit claims for services and maximize the collection of revenue from the payer. Transferring this knowledge to staff is critical to ensuring a smooth transition when implementing third-party payer contract requirements.

This section will present the following tools and resources related to the implementation process:

Policies and Procedures

- **ADPH Commercial Insurance Billing Process** – The steps for adding a commercial payer into the health centers' processes. This includes activities during appointment scheduling, when the patient arrival at the center, and weekly summary activities.
- **ADPH Authorization and Encounter Forms** – To meet payer and HIPAA requirements, the authorization and encounter forms were re-designed to include space to denote patient's acceptance of billing.

Transferring Knowledge

- **ADPH BC/BS Implementation Training** – A comprehensive training used to prepare staff for the additional activities required to bill commercial insurance. This is intended to provide an example of what was included in the training. For closer viewing of slide content, access slide deck here: www.nationalfamilyplanning.org/file/la40resources.org/case-studies-workbook/third-party-payers/14.-ADPH-BCBS-Implementation-Training.pdf?erid=0.
- **ADPH Processing Encounter Form Job Aid** – A tool to assist staff when entering insurance information from the encounter form into the practice management system. The aid also includes steps for entering visits when confidentiality is needed.
- **ADPH Completing Financial Intake Job Aid** – Outlines the information needed during financial intake per each payer, as well as how to enter the data into the practice management system.
- **PPHeartland Provider In-Network Spreadsheet** – A summary of the agency's providers' network status with each of the third-party payers. This tool is used to ensure patients are seen by an in-network provider, as a claim may be denied or paid at a lower reimbursement rate if the provider is not in network.
- **PPMNS Funding Cascade Chart** – A tool to assist staff with assigning a specific method of payment for a given visit. A staff member selects the appropriate funding for the visit by considering the patient's eligibility for each source, beginning with private insurance and moving across the columns of payment sources. Sample entries are included for to provide examples of the type of information housed in this document.

Submitting Claims and Collecting Reimbursements

- **Claims Adjustment Reason Codes** – A set of codes established by CMS to be used by third-party payers to communicate the reason a claim was not paid at the billed amount. The code list is updated periodically and housed on the website of the designated code set registry, Washington Publishing Company, available here: www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes.
- **Health Care Claim Status Codes** – A set of codes developed by CMS to be used by third-party payers to identify the status of a claim in the submission and payment process. The code list is updated periodically and housed on the website of the designated code set registry, Washington Publishing Company, available here: www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes.

2.a.1 ADPH Commercial Insurance Billing Process

1. When scheduling the appointment over the phone:
   a. Ask the patient if she has insurance coverage, and if so, would she agree to [AGENCY NAME] filing claims for her when she comes in for services. Encourage her to bring a copy of the insurance card with her to the appointment.

2. At the time of the appointment:
   a. Perform the intake process in the usual manner, including: the collection of the demographic information; income assessment as appropriate; and the collection of insurance information. Enter as much insurance information as possible into the practice management system (PMS) (policy and group number, etc.).
   b. Complete the new Authorization for Services form. Ask the patient to initial beside the section for "Permission to Bill" if she agrees to allow [AGENCY NAME] to submit insurance claims. **Make sure she is aware that this will include future claims unless she lets us know otherwise**. If she declines, indicate "Refused" on the form.
   c. Access the payer's website to verify eligibility for those who have given permission to file a claim: Each health center is to set up its User IDs and passwords on the websites for its staff in order to verify coverage. Once the IDs are loaded for the applicable staff, the health center can verify coverage when a patient indicates that she has coverage and has provided all the required information to populate the fields. This is not intended to verify if the services are all covered, but to verify if the patient has the insurance. Finance will attempt billing for all eligible services. Some will be covered, some not. If the health center is able to verify the insurance coverage, make a copy of the verification screen and put it in the medical record.
   d. Make a copy of the insurance card if available. See #3 below for instructions on filing these copies.
   e. For those patients who give permission to allow [AGENCY NAME] to file a claim, print and attach the patient's label to the "Worksheet." Continue to compile these labels throughout the week. REMEMBER: IF THE PATIENT DOES NOT GIVE PERMISSION, DO NOT ADD HER LABEL TO THIS FORM. FIRST PRIORITY IS PROTECTING HER CONFIDENTIALITY. WE DO NOT WANT HER TO RECEIVE AN EOB FROM THE PAYER IN THE MAIL BY ACCIDENT.

3. At the end of the work week, the designated employee will collect all the worksheets and enter the data into the "Insurance Spreadsheet." Once all is entered, hit "Send File" and it will be sent electronically to Finance. Keep the worksheets and copies of insurance cards batched by the week in a separate file for each month.

4. Health centers need to enter the encounter into PMS so Finance can pull the applicable data for billing.

5. The third-party payer will notify the health center regarding payment or denial of the claim. If denied, the health center is to go back and charge the patient for the visit and method as appropriate.

2.a.2 ADPH Authorization Form

See companion Case Study, page 12

AUTHORIZATION FOR SERVICES AND BILLING

FOR ALL SERVICES RENDERED

To Receive Services:

I give permission for myself or the above named child to receive health services as indicated. I understand that my or the above named child's medical records are strictly confidential. I hereby authorize use of these records in the provision of services by [AGENCY NAME]. I understand that these records may be used for statistical audit purposes without using the name of the patient. I understand that interpretation services are available to me at no cost if I need them.

Permission to Bill:

I authorize the release of any medical information necessary to process a claim and request that payment of eligible medical coverage benefits be provided to [AGENCY NAME]. I understand that I am financially responsible to [AGENCY NAME] for charges not covered by this agreement; and for any charges that may occur if I do not want a claim submitted to my medical coverage carrier. _____ *(initial required)*

For Routine Testing:

I understand that routine testing, including that for HIV (the virus that causes AIDS), is needed to determine what treatment, counseling, or referral may be required. I understand that testing is voluntary and I hereby give my consent for testing for myself or the above named child. I may withdraw my consent for testing at any time during this visit by notifying my nurse.

Medicaid Services (if applicable):

I chose Medicaid services through [AGENCY NAME] and was informed of other private physicians who provide Medicaid screening services. I was also advised that all other services are available regardless of whom I choose to provide Medicaid screening services.

Healthcare Professionals (if applicable):

[AGENCY NAME] supports training of healthcare professionals. I understand and agree to be interviewed, examined, or counseled with a student present when receiving services.

FOR FAMILY PLANNING SERVICES

I understand that Family Planning services are confidential and my information may not be disclosed without my consent except as required by law. I understand that [AGENCY NAME] offers services for me to accept on a voluntary basis and that I cannot be coerced (pressured) in any way to receive services or to use any particular method of family planning.

By signing below, I certify I have read and understand the above information and give consent to and authorize the above-listed services for myself/this child.

Privacy Notice

I have received notice of my privacy rights and I have been given or offered a copy of [AGENCY NAME] "Notice of Privacy Practices."

X _____ Date _____ Age _____

(Patient/Parent/Legal Representative)

2.a.3 ADPH Encounter Form

See companion Case Study, page 12

ALABAMA DEPARTMENT OF PUBLIC HEALTH
CLINICAL SERVICES ENCOUNTER FORM

LOCATION
- 1. CLINIC
- 2. HOME
- 3. SCHOOL
- _____
- _____
- 4. OTHER

PRIVATE INSURANCE
- 1. BILL INSURANCE
- 2. NOT APPLICABLE
- 3. DO NOT BILL INSURANCE

CH-CHILD HEALTH Provider
- 01 INITIAL
- 02 PERIODIC
- 13 INTERPERIODIC
- 32 SINGLE SERVICE

PCCM # _____

AH-ADULT HEALTH Provider
- 01 INITIAL
- 02 REVISIT
- 26 DIS DET

CD-CANCER DETECTION Provider
- 01 INITIAL
- 02 REVISIT
- 05 ANNUAL

MAT-MATERNITY Provider
- 07 POSTPARTUM

FP-FAMILY PLANNING
- 01 INITIAL
- 02 PERIODIC/REVISIT
- 05 ANNUAL
- 33 DEFERRED PHYSICAL
- 34 PP HOME VISIT
- 35 EXTENDED COUNS/PP
- 36 GYN PROBLEM/LAB/COUNS
- ☒ Problem/Lab/Counseling Services
- ☐ BP Recheck Only / Repeat Pap for technical reasons
- ☐ Pregnancy Test Only (regardless of result)

PROVIDER

FEMALE CONTRACEPTIVE METHOD
- 0. IMPLANT INSERTED TODAY Y___ N___
- 1. OCs PACKS _____
- 2. IUD
- 3. DIAPHRAGM/CERVICAL CAP
- 4. MALE CONDOM
- 5. NAT/RHY
- 6. INJECTION GIVEN TODAY Y___ N___
- 7. OTHER METHOD
- 8. NO METHOD (OTHER REASON)
- 9. CONTRACEPTIVE PATCH MONTHLY CYCLES _____
- 10. VAGINAL RING MONTHLY CYCLES _____
- 11. FEMALE CONDOM
- 12. SPERMICIDE (USED ALONE)
- 13. ABSTINENCE
- 14. PARTNER PREG OR SEEKING PREG
- 15. RELY ON MALE METHOD (VASECTOMY)
- 17. PREGNANT
- ECP PACKS OF ECPs_____

MALE CONTRACEPTIVE METHOD
- 4. MALE CONDOM
- 5. NAT/RHY
- 7. OTHER METHOD
- 8. NO METHOD (OTHER REASON)
- 13. ABSTINENCE
- 14. PARTNER PREG OR SEEKING PREG
- 16. RELY ON FEMALE METHOD

Lab Entry for FP
- Y N NEW PARTNER
- Y N MULTIPLE PARTNER
- Y N CONDOMS USED
- Y N U PREGNANT
- Y N U URO S/S

1. Volunteer/MP
2. Initial visit
3. Annual visit
4. Sex partner referral
5. Prenatal
6. Other
7. Unknown

SERVICES PERFORMED
- 01. BREAST EXAM (CBE) Presumptive P N Drug
- 03. CHLAMYDIA — Specimen Site: Cervix Urethra Urine Vaginal
- 04. CHOLESTEROL P N Drug
- 05. DARKFIELD
- 07. DCS TREATED
- 08. DCT TREATED
- 10. FIT Test Presumptive P N Drug
- 12. GC — Specimen Site: Cervix Urethra Urine Vaginal
- 13. GLUCOSE (VENOUS)
- 15. Hgb (FINGER STICK)
- 16. HIV POST-TEST COUNS
- 17. HIV PRE-TEST COUNS P N Indeterminate
- 18. HIV-AB TEST
- 19. IMPLANT INSERTION
- 20. IMPLANT REMOVAL
- 22. IUD INSERTION
- 23. IUD (MIRENA)
- 24. IUD (PARAGARD)
- 25. IUD REMOVAL
- 26. LEAD (CAPILLARY)
- 27. LEAD (VENOUS)
- 28. LIPID PROFILE
- 29. MALE TREATED FOR TRICH
- 31. LIVER PROFILE
- 32. PAP SMEAR
- 34. PREG TEST (URINE)
- 35. RENAL PROFILE WR R NR Drug
- 36. RPR
- 37. STERILIZATION REFERRAL
- 38. THYROID PROFILE R NR Unsat
- 39. TPPA
- 40. URINE DIPSTICK
- 41. VDRL — Lab Results Value — WR R NR Drug
- 44. WET PREP P N Drug
- 45. Syphilis-EIA WR R NR Indeterminate Unsat Drug
- 46. TV Presumptive P N Drug — Specimen Site: Cervix Urethra Urine Vaginal

IMM-IMMUNIZATION

PROVIDER

- 01 INITIAL
- 02 REVISIT

- 202. DT
- 204. DTAP
- 228. DTAP-HEP B-IPV
- 205. DTAP-HIB
- 237. DTAP-IPV
- 238. DTAP-IPV-HIB
- 214. TD (ADULT)
- 230. TDAP
- 207. HIB
- 206. HEP B - HIB
- 209. IPV
- 212. MMR
- 213. VAR
- 241. PCV13
- 217. HEP A
- 210. HEP B
- 227. HEP A - HEP B
- 240. HPV (Cervarix)
- 233. HPV (Gardasil)
- 229. MCV4P (Menactra)
- 239. MCV4O (Menveo)
- 216. PPV23
- 236. ROTA (Rotarix)
- 232. ROTA (Rotateq)
- 218. Influenza
- 234. Zoster
- 219. Yellow Fever
- 220. Cholera
- 221. Typhoid
- 222. MPSV4
- 224. IM Rabies
- 226. IG
- 235. JE

DC-DISEASE CONTROL
- 01. Azithromycin 2G PO
- 02. Azithromycin 1G PO
- 03. Bicillin 2.4 Million Units IM
- 06. Ceftriaxone 125 MG IM
- 07. Ceftriaxone 250 MG IM
- 08. Doxy 100 MG PO Bid x 7 days
- 09. Doxy 100 MG PO Bid x 10 days
- 10. Doxy 100 MG PO Bid x 14 days
- 11. Doxy 100 MG PO Bid x 28 days
- 12. Eryth Base 500 MG PO QID x 7 days
- 14. Metronidazol 2 GM PO
- 15. Metronidazol 250 MG PO TID x 7 days
- 16. Metronidazol 500 MG PO BID x 7 days
- 17. Metronidazol 500 MG PO BID x 14 days
- 18. HPV/Wart Treatment
- 19. Other _____
- _____

DCS Provider
- 01 INITIAL
- 02 REVISIT
- 18 LAB REVISIT
- 33 DEFERRED PHYSICAL

- Y N NEW PARTNER
- Y N MULTIPLE PARTNER
- Y N CONDOMS USED
- Y N U PREGNANT
- Y N U URO S/S

CLASSIFICATION
- VOLUNTEER
- REFERRAL

DCT Provider
- 01 INITIAL
- 02 REVISIT

CLASSIFICATION
- CASE
- SUSPECT
- CONTACT
- REACTOR
- CONVERTOR

PATIENT REFERRAL

TO:_____

CONDITION: _____

TO:_____

CONDITION: _____

ADPH-ENC-300/Rev 021412

2.b.1 ADPH BC/BS Implementation Training

See companion Case Study, page 12

BC/BS Billing for the Alabama Family Planning Program

Why is Third Party Collections Important?

- Reductions in State and Federal funding
- Escalating operating costs
- We are not a free clinic- we are a confidential, non-profit entity
- Because the Title X Feds says so
- Because the Affordable Care Act says so

What's in it For Me?

- Maintains your facility
- Provides services to everyone who needs them
- Pays staff
- Purchases medical supplies/contraceptives
- Educates others

The Mission vs. The Business

Data Accuracy

- Accurate data entry into practice management system of all required screens is a critical component to your billing success

It Starts at the First Contact

- When scheduling an appointment – tell the client that we are now billing BC/BS and if they do not need confidentiality, we plan to bill their insurance. Ask them to bring their insurance card.
- People are more compliant in providing information before they see the provider

Intake

- Perform the intake process in the usual manner
  - Demographic info
  - Income assessment
  - Insurance information
- MUST obtain permission to bill
  - Because private insurance billing is a new concept for many of our clients, make sure they review the "permission to bill" on the Authorization Form
- Prior to entering insurance information validate their BC/BS coverage through the web portal

AUTHORIZATION FOR SERVICES AND BILLING

Confidentiality – Do Not Bill Insurance

- We MUST protect those clients who have requested confidentiality
  - Don't want an Explanation of Benefits (EOB) going to the home
- Charge these clients in the usual manner according to the sliding fee scale utilizing the E-Day sheet with receipt

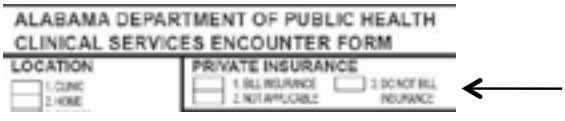
What will Trigger BC/BS Billing?

- Encounter form
  - To bill the service select:
    - Bill Insurance
  - To NOT bill the service select:
    - Do not bill Insurance

Critical Function in Order to Bill BC/BS

- If you do not check on the encounter form to "Bill Insurance" and if this isn't entered into PMS the visit *WILL NOT* be billed to BC/BS
  - This box <u>does not</u> influence Medicaid billing. All family planning visits are automatically bounced against a Medicaid file and billed to Medicaid if they have coverage

Clinical Services Encounter Form



Select "Bill Insurance" when the client has BC/BS, has given us the OK to bill and it is a billable visit/service. (We will bill all NP visits; and Depo injections during RN supply visit or Deferred Physical visit)

Select "Do Not Bill Insurance" when the client has BC/BS and <u>does not</u> want an EOP going to the home

Select "Not Applicable" when the client has either no private insurance, has Medicaid only, has private insurance other than BC/BS or has a visit that is unbillable such as non NP visits (i.e., supply visits where the client receives pills).

Blue Cross and Blue Shield of Alabama Providers

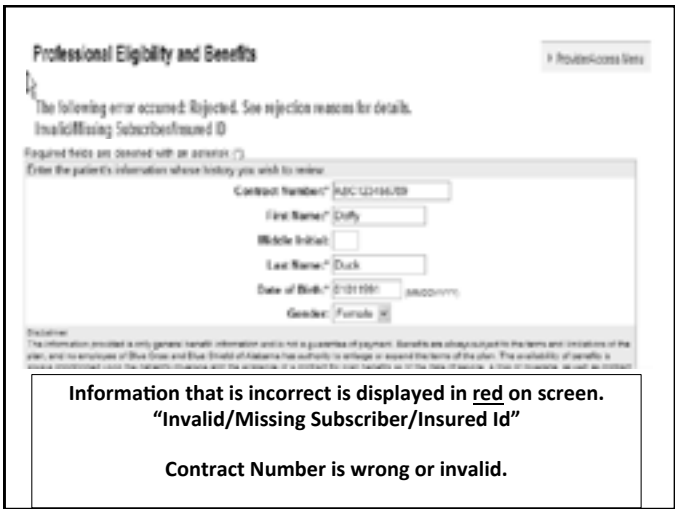
- **Sign-On Screen**
  https://www.bcbsal.org/providers/index.cfm

Select Provider Functions

Choose Location NPI

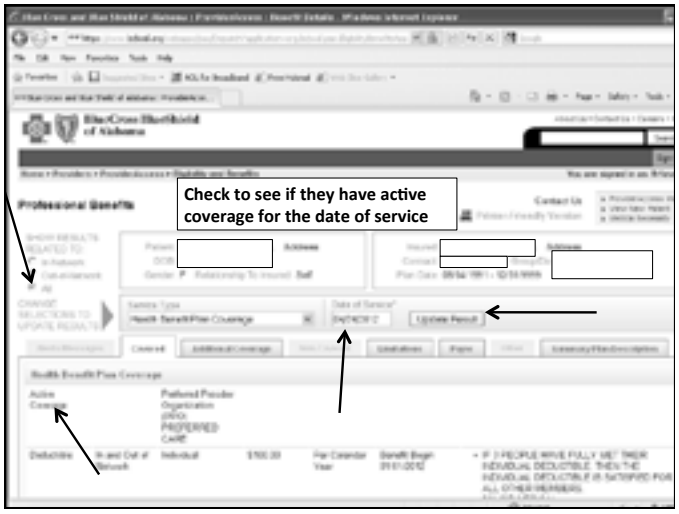
NOTE: This does not have to be a specific Provider. You are just trying to gain access to patient eligibility and benefits.

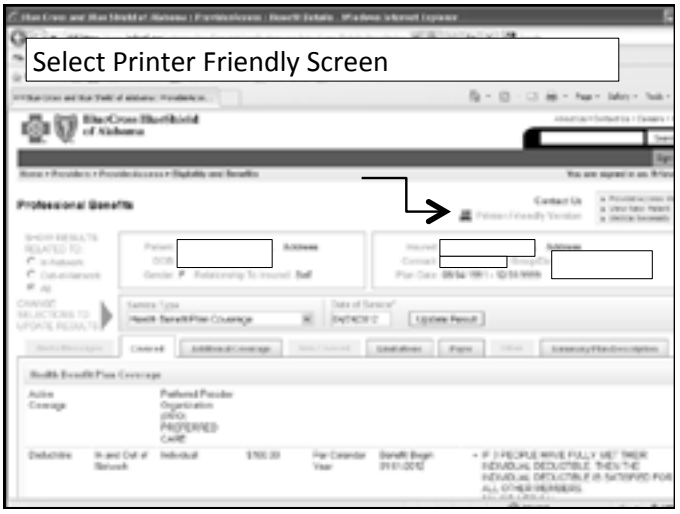
Eligibility and Benefits



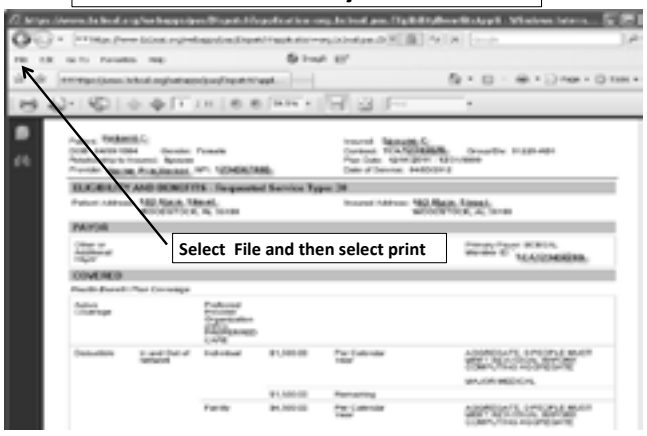
Information that is incorrect is displayed in red on screen.
"Invalid/Missing Subscriber/Insured Id"

Contract Number is wrong or invalid.

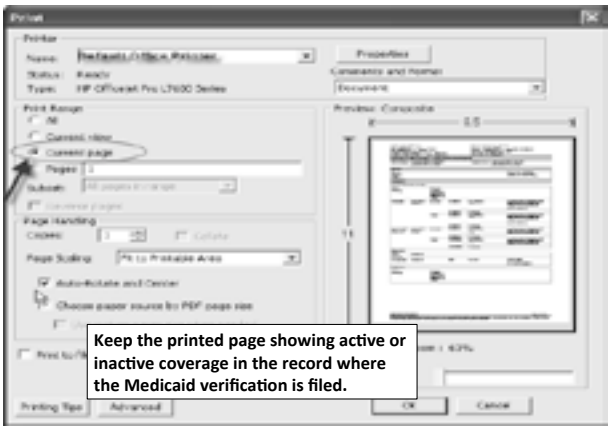




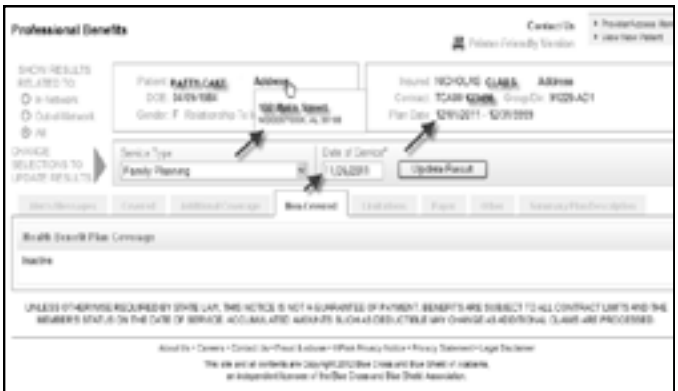
Printer Friendly Version



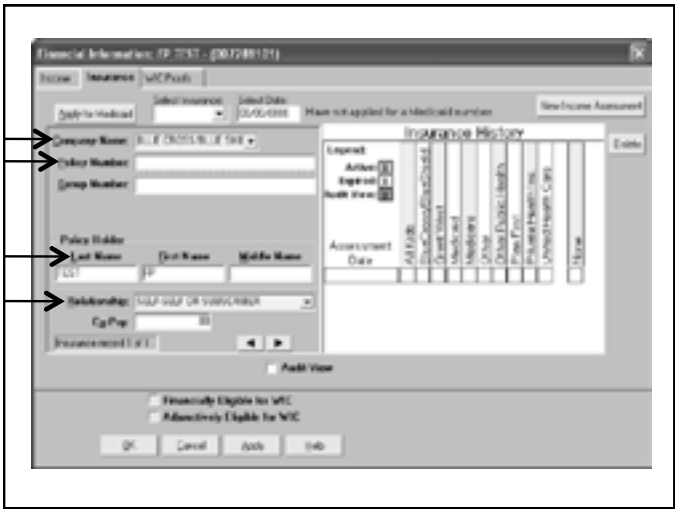
Select Current Page or Current View to Print



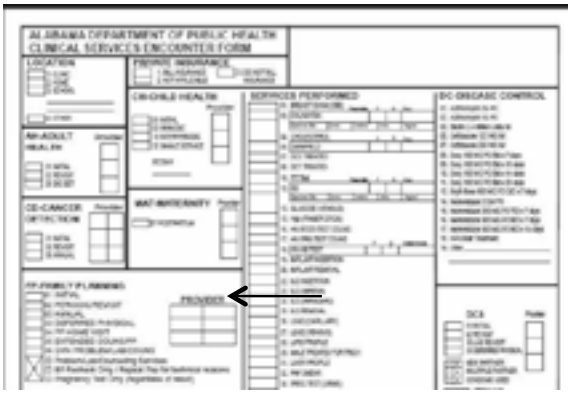
Patient has no Active Coverage



NOTE: Patient has Active Coverage on 12/01/2011 but not on Date of Service entered. See Plan Date.



Encounter Form



NP Provider Number

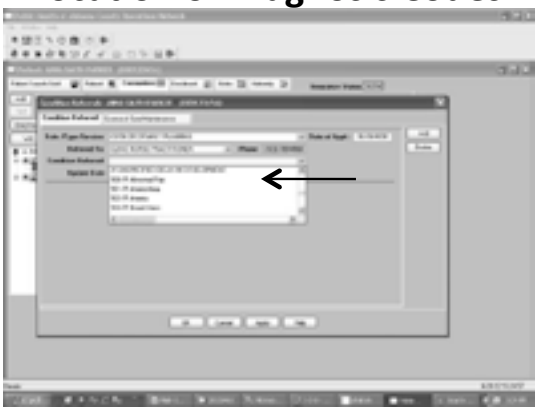
- Prior to May 1, **change (Do not delete the old number)** the NP provider number to the last 4 digits of their social security number (or a 4 digit number approved by the NP Director at the Central Office) at all county locations where they provide services

NP Provider Number

Billing OB/GYN Problem Visit

- Blessed are the diagnostic codes for they shall get us paid!
- Must be identified in the record
  - If the service (and the diagnostic code) isn't written in the record then you cannot bill for it.

Location of Diagnosis Codes



Adding "Clinic Nurse Practitioner" to "Source of Care"

Entering Diagnosis Codes

Encounter Form

In order for the diagnosis codes to be entered into PHALCON, the NP must write in the condition(s) on the encounter form

At the end of the Visit

- For clients who agree to let us process a BC/BS claim
  - Do not charge them a co-pay
  - Advise them that there will be no charge today
    - If the claim is denied – we will send a bill for services rendered to their home
  - Provide Family Planning Services Receipt
    - This is different from the Day Sheet where the client is charged a fee

Individual Policies

- Public Education Employees' Health Insurance Plan (PEEHIP) will not pay County Health Dept for FP services
  - Advise client, charge according to sliding fee scale, utilize the E-Day sheet with receipt

In Review

- Ask if they have BC/BS insurance
- Accurate/correct data entry
- Validate active coverage
- Must check on the encounter form-BILL INSURANCE
  - If needing confidentiality check DO NOT BILL INSURANCE – charge client per sliding fee scale
- Add any pertinent diagnosis codes on the encounter form
- NP number must be on the encounter form
- If billing denied, charge client appropriately

Other Helpful Hints

- Latest information and updates will be available in the Document Library – FHS-BC/BS
- We do not control the time it takes for BC/BS to process claims
- Clients may receive letters from BC/BS

In the Future

- Adding BC/BS to the Production Management Report in Ensemble
- Possible billing of Nurse visits
- Charging client for non-covered contraceptives

2.b.2 ADPH Processing Encounter Form Job Aid

BC/BS Enter "Bill Insurance"	**Medicaid** Enter "N/A"	**Confidential Services** Enter "Do Not Bill"
• If patient agrees to [AGENCY NAME] filing an eligible BC/BS claim. • Includes ALL Kids recipients. • Enter Policy #. • Enter Group # if available. • Enter Policy Holder Name (as listed on BC/BS web portal). • Enter Relationship to insured. Typical response is "Self" or "Child." • Enter 4 digit NP #. • Enter diagnosis code(s) assigned by NP/MD if applicable. • Issue FP Receipt.	• If no insurance coverage; • If patient has other private insurance besides BC/BS; • If patient has Medicaid coverage only; • If patient has BC/BS but the visit is not eligible for filing. • Issue FP Receipt.	• Patient does not want home contact. • Charge patient using Fee System. • Issue Fee System Receipt.

2.b.3 ADPH Completing Financial Intake Job Aid

BC/BS	• Verify active status through web portal. May use SS# to search for patient. • Print BC/BS screen verifying active status. • Obtain approval from patient to file claim for services (Authorization for Services). • Enter policy #, group # if available, name of insured, and relationship of patient to insured into PMS (most common entry is "self" or "child.") • Copy card for record. • Enter "bill insurance" on the encounter form. • At completion of services, enter the 4 digit # for NP or MD into PMS; and diagnosis code(s) if any are assigned by NP/MD. • Nurse or clerk to provide patient with FP receipt. • NOTE: If the visit is not eligible for filing to BC/BS, enter "N/A" on encounter form.
Medicaid	• Ask if patient has private insurance. • Verify active status through web portal. • Print proof if active coverage. • Initiate application if needed. • Enter Medicaid # into EMR. • Enter "N/A" on encounter form. • Nurse or clerk to provide patient with FP Receipt.
Fee Patient	• Enter family size and income into EMR. • Establish income pay bracket per agency protocol. • At completion of visit, charge according to applicable service codes using. • E-Day Sheet. Print receipt for patient.

2.b.4 PPHeartland Provider In-Network Spreadsheet

PROVIDERS	AETNA	COVENTRY OF IA	CIGNA	FIRST CHOICE	HEALTH ALLIANCE	MEDICAID (IA)	MEDICAID (NE) DHHS	MIDLANDS CHOICE	UHC	BC/BS IA	BC/BS NE	COVENTRY OF NE	MULTIPLAN	MERIDIAN HEALTH PLAN	MEDICARE (IA)	MEDICARE (NE)
PROVIDER 1	X	X		X	X	X			X	X			X	X	X	
PROVIDER 2	X	X	X	X	X	X		X								
PROVIDER 3	X	X	X	X	X	X		X	X	X			X	X	X	
PROVIDER 4	X	X	X	X	X	X		X	X	X				X		
PROVIDER 5	X	X	X	X	X	X		X	X	X			X	X		
PROVIDER 6	X	X		X	X	X	X		X	X	X	X	X	X	X	X
PROVIDER 7	X	X	X	X	X	X		X		X			X	X		
PROVIDER 8	X	X	X	X	X	X		X		X			X	X	X	
PROVIDER 9	X	X	X	X	X	X		X	X	X			X	X	X	
PROVIDER 10				X	X	X	X		X	X	X	X	X	X		X
PROVIDER 11	X			X	X		X	X	X	X	X	X	X	X		X
PROVIDER 12	X	X	X	X	X	X	X	X	X	X	X		X	X	X	
PROVIDER 13	X	X				X										
PROVIDER 14	X	X				X										
PROVIDER 15	X	X				X										
PROVIDER 16	X	X				X										
PROVIDER 17	X	X				X										

2.b.5 PPMNS Funding Cascade Chart

See companion Case Study, page 13

		FUNDING PRIORITY LEVEL – Assess patients in this order							
		1	2	3	4	5	6	7	8
Sources of Patient Payment and Priority Levels		**Private Insurance**	**Medicaid (Full Benefit)**	**PMAP**	**FP Limited Benefit Medicaid**	**Grant 1**	**Grant 2**	**Grant 3**	**Title X**
Health centers:		All	All	All	All, except Rapid City	Brooklyn Park, Rice Street, Centro	Rochester only	Duluth, Bemidji	All, except Vandalia, Woodbury, Eden Prairie, South Dakota
ELIGIBILITY REQUIREMENTS									
Income requirement:		N/A	N/A	N/A	At or below 200% FPL	At or below 250% FPL	None	None	At or below 250% FPL
Charges based on income (sliding fee schedule used):									
Sex:									
Residency requirement:									
Insurance status:									
Age requirement:									
Can opt out of insurance for confidentiality concerns?									
Must be a family planning visit?									
Pregnant at time of enrollment?									
Other requirements:									
		1	2	3	4	5	6	7	8
CPT CODE	**Procedure Description**	**Private Insurance**	**Medicaid (Full Benefit)**	**PMAP**	**FP Limited Benefit Medicaid**	**Grant 1**	**Grant 2**	**Grant 3**	**Title X**
PREVENTIVE VISITS AND OFFICE VISITS									
99201	New Minimum	Bill insurance and any remaining balance is billed to patient according to income.	OK	OK	OK if FP visit	OK	NO	OK	OK
99202	New Low								

		1	2	3	4	5	6	7	8
CPT CODE	**Procedure Description**	**Private Insurance**	**Medicaid (Full Benefit)**	**PMAP**	**FP Limited Benefit Medicaid**	**Grant 1**	**Grant 2**	**Grant 3**	**Title X**
PREVENTIVE VISITS AND OFFICE VISITS (continued)									
99203	New Moderate	Bill insurance and any remaining balance is billed to patient according to income.							
99204	New High								
99205	New Complex								
99211	Est Minimum								
99212	Est. Low								
99213	Est. Moderate								
99214	Est. High								
99215	Est.Complex								
99384	New CPE (12-17 Yrs)								
99385	New CPE (18-39 Yrs)								
99386	New CPE (40-64 Yrs)								
99387	New CPE (65+ Yrs)								
99394	Est.CPE (12-17 Yrs)								
99395	Est.CPE (18-39 Yrs)								
99396	Est.CPE (40-64 Yrs)								
99397	Est.CPE (65+ Yrs)								
CONTRACEPTIVES METHODS									
J1050	Depo Provera	Bill insurance and any remaining balance is billed to patient according to income.							
J7300	Paragard IUD								
J7301	Skyla IUD								
J7302	Mirena IUD								
J7303	Nuva Ring								
J7304	Ortho Evra Patch								
J7307	Nexplanon								
ORAL CONTRACEPTIVES									
S4993	Alesse	Bill insurance and any remaining balance is billed to patient according to income.							
S4993	Aubra								
S4993	Azurette								
S4993	Brevicon								
S4993	Cryselle								
S4993	Demulen 1/35								
S4993	Demulen 1/50								
S4993	Desogen								
S4993	Ella								

		1	2	3	4	5	6	7	8
CPT CODE	**Procedure Description**	**Private Insurance**	**Medicaid (Full Benefit)**	**PMAP**	**FP Limited Benefit Medicaid**	**Grant 1**	**Grant 2**	**Grant 3**	**Title X**
ORAL CONTRACEPTIVES (continued)									
S4993	Kelnor 1/35	Bill insurance and any remaining balance is billed to patient according to income.							
S4993	Levlite								
S4993	Loestrin 1.5/30								
S4993	Loestrin 1/20								
S4993	LoOvral								
S4993	Lutera								
S4993	Lybrel								
S4993	Lyza								
S4993	Microgestin 1.5/30								
S4993	Microgestin 1/20								
S4993	Micronor								
S4993	Modicon								
S4993	Necon 1/35								
S4993	Nordette								
S4993	Nor-QD								
S4993	Ortho Cept								
S4993	Ortho Cyclen								
S4993	Ortho Novum 1/35								
S4993	Ortho Novum 777								
S4993	Ortho Tricyclen								
S4993	Ortho Tricyclen Lo								
S4993	OrthoCyclen								
S4993	Ovcon								
S4993	Plan B								
S4993	Plan B One Step								
S4993	Reclipsen								
S4993	Tripahsil								
S4993	Yasmine								
S4993	Yaz								
S4993	Zovia 1/35								

		1	2	3	4	5	6	7	8
CPT CODE	**Procedure Description**	**Private Insurance**	**Medicaid (Full Benefit)**	**PMAP**	**FP Limited Benefit Medicaid**	**Grant 1**	**Grant 2**	**Grant 3**	**Title X**
OTHER CONTRACEPTIVE METHODS									
A4261	Cervical cap contraceptive	Bill insurance and any remaining balance is billed to patient according to income.							
A4266	Diaphragm 60MM								
A4266	Diaphragm 65MM								
A4266	Diaphragm 70MM								
A4266	Diaphragm 75MM								
A4267	Condom								
A4267	Skyn/nonlatex condom								
A4269	Spermicide Jelly/Foam								
LABS									
80061	Cholesterol Lipid Panel	Bill insurance and any remaining balance is billed to patient according to income.							
81002	UA Dip Stick								
81025	UPT True 20								
83001	FSH								
84443	TSH								
84702	HCG								
85018	Hemoglobin								
86592	Syphillis								
86695	HSV 1 Serum								
86696	HSV 2 Serum								
86689	HIV confirm by Western Blot								
86701	HIV Mulitspot								
86701	HIV 1/2 + OScreen								
86706	HepB Surf Antibody								
86780	FTA-ABS								
86787	VARICELLA-ZOSTER ANTIBODY								
86803	Hep C								
87086	Urine Cult Routine w/ Reflex								

		1	2	3	4	5	6	7	8
CPT CODE	**Procedure Description**	**Private Insurance**	**Medicaid (Full Benefit)**	**PMAP**	**FP Limited Benefit Medicaid**	**Grant 1**	**Grant 2**	**Grant 3**	**Title X**
LABS (continued)									
87140	Herpes Typing from Reflex	Bill insurance and any remaining balance is billed to patient according to income.							
87252	HSV Culture								
87255	Herpes Culture w/Reflex								
87290	VARICELLA ZOSTER, AG, IF								
87340	Hep B Core Igm/Surf								
87340	Hep B Surf Antigen HBSAG								
87390	HIV-1 AG, EIA								
87491	Chlamydia TRACH, DNA, AMP PROBE								
87491	Chlamydia ANAL								
87491	Chlamydia THROAT								
87591	Gonorrhea								
87591	Gonorrhea ANAL								
87591	Gonorrhea THROAT								
87621	HPV								
88142	Thin Prep Pap								
88164	Conventional Pap								
89321	Semen Analysis								
VACCINES									
90471	Vaccine Admin-First	Bill insurance and any remaining balance is billed to patient according to income.							
90472	Vaccine Admin-Subsequent								
90632	HEP A Vaccine								
90649	Gardasil								

		1	2	3	4	5	6	7	8
CPT CODE	**Procedure Description**	**Private Insurance**	**Medicaid (Full Benefit)**	**PMAP**	**FP Limited Benefit Medicaid**	**Grant 1**	**Grant 2**	**Grant 3**	**Title X**
VACCINES (continued)									
90650	Cervarix	Bill insurance and any remaining balance is billed to patient according to income.							
90710	MMR Vaccine								
90744	HEP B Vaccine, 11-19 Yrs								
90746	HEP B Vaccine, 20+ Yrs								
NON-CONTRA RX									
J0456	Azithromycin	Bill insurance and any remaining balance is billed to patient according to income.							
J0561	Bicillin								
J0696	Ceftriaxone sodium injection								
J3490	Aldara								
J3490	Nystatin								
J3490	Terazol								
J8499	Metronidazole								
PROCEDURES									
11976	Nexplanon Removal	Bill insurance and any remaining balance is billed to patient according to income.							
11977	Nexplanon Removal & Insert								
11981	Nexplanon Insert								
36415	Venipuncture								
36416	Finger Stick								
54050	Wart Tx Simple Male								
54065	Wart Tx Ext Male								
55250	Vasectonomy								
56420	Tx Bartholin's Gland Cyst								
56501	Wart Tx Simple Female								
56515	Wart Tx Ext. Female								
56605	Exc/Biopsy – Vulva 1st								

		1	2	3	4	5	6	7	8
CPT CODE	**Procedure Description**	**Private Insurance**	**Medicaid (Full Benefit)**	**PMAP**	**FP Limited Benefit Medicaid**	**Grant 1**	**Grant 2**	**Grant 3**	**Title X**
PROCEDURES (continued)									
56606	Exc/Biopsy – Vulva Additional	Bill insurance and any remaining balance is billed to patient according to income.							
57100	Exc/Biopsy – Vag Mucosa								
57170	Diaphragm Fit								
57452	Colposcopy Only								
57454	Colposcopy w/Biopsy and ECC								
57455	Colposcopy w/Biopsy Only								
57456	Colposcopy w/ECC Only								
57460	LEEP – Bx Cervix w/ Scope								
57500	Exc/Biopsy – Cervix								
57505	Endocervical Curettage								
58100	Endometrial Sample								
58300	IUD Insert								
58301	IUD Removal								
58565	Hysteroscopy Essure								
76815	Pelvic Limited								
76816	Transabd repeat								
76817	Transvaginal								
76857	Pelvic Limited IUD Check/ Other								
88305	Specimen								
88307	Specimen – Biopsy/LEEP								
96372	Injection Administration								

2.c.1 Claim Adustment Reason Codes

Reason Code	Description
1	Deductible Amount Start: 01/01/1995
2	Coinsurance Amount Start: 01/01/1995
3	Co-payment Amount Start: 01/01/1995
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. Start: 01/01/1995 | Last Modified: 09/20/2009
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. Start: 01/01/1995 | Last Modified: 09/20/2009
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. Start: 01/01/1995 | Last Modified: 09/20/2009
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. Start: 01/01/1995 | Last Modified: 09/20/2009
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. Start: 01/01/1995 | Last Modified: 09/20/2009
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. Start: 01/01/1995 | Last Modified: 09/20/2009
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. Start: 01/01/1995 | Last Modified: 09/20/2009
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. Start: 01/01/1995 | Last Modified: 09/20/2009
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. Start: 01/01/1995 | Last Modified: 09/20/2009
13	The date of death precedes the date of service. Start: 01/01/1995
14	The date of birth follows the date of service. Start: 01/01/1995
15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 01/01/1995 | Last Modified: 09/30/2007

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. Start: 01/01/1995 | Last Modified: 11/01/2013
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 01/01/1995 | Last Modified: 09/21/2008 | Stop: 07/01/2009
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) Start: 01/01/1995 | Last Modified: 06/02/2013
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. Start: 01/01/1995 | Last Modified: 09/30/2007
20	This injury/illness is covered by the liability carrier. Start: 01/01/1995 | Last Modified: 09/30/2007
21	This injury/illness is the liability of the no-fault carrier. Start: 01/01/1995 | Last Modified: 09/30/2007
22	This care may be covered by another payer per coordination of benefits. Start: 01/01/1995 | Last Modified: 09/30/2007
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA) Start: 01/01/1995 | Last Modified: 09/30/2012
24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007
25	Payment denied. Your Stop loss deductible has not been met. Start: 01/01/1995 | Stop: 04/01/2008
26	Expenses incurred prior to coverage. Start: 01/01/1995
27	Expenses incurred after coverage terminated. Start: 01/01/1995
28	Coverage not in effect at the time the service was provided. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Redundant to codes 26&27.
29	The time limit for filing has expired. Start: 01/01/1995
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements. Start: 01/01/1995 | Stop: 02/01/2006
31	Patient cannot be identified as our insured. Start: 01/01/1995 | Last Modified: 09/30/2007
32	Our records indicate that this dependent is not an eligible dependent as defined. Start: 01/01/1995
33	Insured has no dependent coverage. Start: 01/01/1995 | Last Modified: 09/30/2007
34	Insured has no coverage for newborns. Start: 01/01/1995 | Last Modified: 09/30/2007
35	Lifetime benefit maximum has been reached. Start: 01/01/1995 | Last Modified: 10/31/2002

36	Balance does not exceed co-payment amount. Start: 01/01/1995 | Stop: 10/16/2003
37	Balance does not exceed deductible. Start: 01/01/1995 | Stop: 10/16/2003
38	Services not provided or authorized by designated (network/primary care) providers. Start: 01/01/1995 | Last Modified: 06/02/2013 | Stop: 01/01/2013 Notes: CARC codes 242 and 243 are replacements for this deactivated code
39	Services denied at the time authorization/pre-certification was requested. Start: 01/01/1995
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. Start: 01/01/1995 | Last Modified: 09/20/2009
41	Discount agreed to in Preferred Provider contract. Start: 01/01/1995 | Stop: 10/16/2003
42	Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45) Start: 01/01/1995 | Last Modified: 10/31/2006 | Stop: 06/01/2007
43	Gramm-Rudman reduction. Start: 01/01/1995 | Stop: 07/01/2006
44	Prompt-pay discount. Start: 01/01/1995
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability) Start: 01/01/1995 | Last Modified: 07/01/2013
46	This (these) service(s) is (are) not covered. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 96.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid. Start: 01/01/1995 | Stop: 02/01/2006
48	This (these) procedure(s) is (are) not covered. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 96.
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. Start: 01/01/1995 | Last Modified: 11/01/2013
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. Start: 01/01/1995 | Last Modified: 09/20/2009
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. Start: 01/01/1995 | Last Modified: 09/20/2009
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed. Start: 01/01/1995 | Stop: 02/01/2006
53	Services by an immediate relative or a member of the same household are not covered. Start: 01/01/1995
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. Start: 01/01/1995 | Last Modified: 09/20/2009

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. Start: 01/01/1995 | Last Modified: 09/20/2009
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. Start: 01/01/1995 | Last Modified: 09/20/2009
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply. Start: 01/01/1995 | Stop: 06/30/2007 Notes: Split into codes 150, 151, 152, 153 and 154.
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. Start: 01/01/1995 | Last Modified: 09/20/2009
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. Start: 01/01/1995 | Last Modified: 09/20/2009
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services. Start: 01/01/1995 | Last Modified: 06/01/2008
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. Start: 01/01/1995 | Last Modified: 09/20/2009
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Start: 01/01/1995 | Last Modified: 10/31/2006 | Stop: 04/01/2007
63	Correction to a prior claim. Start: 01/01/1995 | Stop: 10/16/2003
64	Denial reversed per Medical Review. Start: 01/01/1995 | Stop: 10/16/2003
65	Procedure code was incorrect. This payment reflects the correct code. Start: 01/01/1995 | Stop: 10/16/2003
66	Blood Deductible. Start: 01/01/1995
67	Lifetime reserve days. (Handled in QTY, QTY01=LA) Start: 01/01/1995 | Stop: 10/16/2003
68	DRG weight. (Handled in CLP12) Start: 01/01/1995 | Stop: 10/16/2003
69	Day outlier amount. Start: 01/01/1995
70	Cost outlier – Adjustment to compensate for additional costs. Start: 01/01/1995 | Last Modified: 06/30/2001
71	Primary Payer amount. Start: 01/01/1995 | Stop: 06/30/2000 Notes: Use code 23.
72	Coinsurance day. (Handled in QTY, QTY01=CD) Start: 01/01/1995 | Stop: 10/16/2003
73	Administrative days. Start: 01/01/1995 | Stop: 10/16/2003

74	Indirect Medical Education Adjustment. Start: 01/01/1995
75	Direct Medical Education Adjustment. Start: 01/01/1995
76	Disproportionate Share Adjustment. Start: 01/01/1995
77	Covered days. (Handled in QTY, QTY01=CA) Start: 01/01/1995 | Stop: 10/16/2003
78	Non-Covered days/Room charge adjustment. Start: 01/01/1995
79	Cost Report days. (Handled in MIA15) Start: 01/01/1995 | Stop: 10/16/2003
80	Outlier days. (Handled in QTY, QTY01=OU) Start: 01/01/1995 | Stop: 10/16/2003
81	Discharges. Start: 01/01/1995 | Stop: 10/16/2003
82	PIP days. Start: 01/01/1995 | Stop: 10/16/2003
83	Total visits. Start: 01/01/1995 | Stop: 10/16/2003
84	Capital Adjustment. (Handled in MIA) Start: 01/01/1995 | Stop: 10/16/2003
85	Patient Interest Adjustment (Use Only Group code PR) Start: 01/01/1995 | Last Modified: 07/09/2007 Notes: Only use when the payment of interest is the responsibility of the patient.
86	Statutory Adjustment. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Duplicative of code 45.
87	Transfer amount. Start: 01/01/1995 | Last Modified: 09/20/2009 | Stop: 01/01/2012
88	Adjustment amount represents collection against receivable created in prior overpayment. Start: 01/01/1995 | Stop: 06/30/2007
89	Professional fees removed from charges. Start: 01/01/1995
90	Ingredient cost adjustment. Note: To be used for pharmaceuticals only. Start: 01/01/1995 | Last Modified: 07/01/2009
91	Dispensing fee adjustment. Start: 01/01/1995
92	Claim Paid in full. Start: 01/01/1995 | Stop: 10/16/2003
93	No Claim level Adjustments. Start: 01/01/1995 | Stop: 10/16/2003 Notes: As of 004010, CAS at the claim level is optional.
94	Processed in Excess of charges. Start: 01/01/1995

95	Plan procedures not followed. Start: 01/01/1995 | Last Modified: 09/30/2007
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. Start: 01/01/1995 | Last Modified: 09/20/2009
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. Start: 01/01/1995 | Last Modified: 09/20/2009
98	The hospital must file the Medicare claim for this inpatient non-physician service. Start: 01/01/1995 | Stop: 10/16/2003
99	Medicare Secondary Payer Adjustment Amount. Start: 01/01/1995 | Stop: 10/16/2003
100	Payment made to patient/insured/responsible party/employer. Start: 01/01/1995 | Last Modified: 01/27/2008
101	Predetermination: anticipated payment upon completion of services or claim adjudication. Start: 01/01/1995 | Last Modified: 02/28/1999
102	Major Medical Adjustment. Start: 01/01/1995
103	Provider promotional discount (e.g., Senior citizen discount). Start: 01/01/1995 | Last Modified: 06/30/2001
104	Managed care withholding. Start: 01/01/1995
105	Tax withholding. Start: 01/01/1995
106	Patient payment option/election not in effect. Start: 01/01/1995
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. Start: 01/01/1995 | Last Modified: 09/20/2009
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 09/20/2009
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. Start: 01/01/1995 | Last Modified: 01/29/2012
110	Billing date predates service date. Start: 01/01/1995
111	Not covered unless the provider accepts assignment. Start: 01/01/1995
112	Service not furnished directly to the patient and/or not documented. Start: 01/01/1995 | Last Modified: 09/30/2007
113	Payment denied because service/procedure was provided outside the United States or as a result of war. Start: 01/01/1995 | Last Modified: 02/28/2001 | Stop: 06/30/2007 Notes: Use Codes 157, 158 or 159.
114	Procedure/product not approved by the Food and Drug Administration. Start: 01/01/1995

115	Procedure postponed, canceled, or delayed. Start: 01/01/1995 | Last Modified: 09/30/2007
116	The advance indemnification notice signed by the patient did not comply with requirements. Start: 01/01/1995 | Last Modified: 09/30/2007
117	Transportation is only covered to the closest facility that can provide the necessary care. Start: 01/01/1995 | Last Modified: 09/30/2007
118	ESRD network support adjustment. Start: 01/01/1995 | Last Modified: 09/30/2007
119	Benefit maximum for this time period or occurrence has been reached. Start: 01/01/1995 | Last Modified: 02/29/2004
120	Patient is covered by a managed care plan. Start: 01/01/1995 | Stop: 06/30/2007 Notes: Use code 24.
121	Indemnification adjustment – compensation for outstanding member responsibility. Start: 01/01/1995 | Last Modified: 09/30/2007
122	Psychiatric reduction. Start: 01/01/1995
123	Payer refund due to overpayment. Start: 01/01/1995 | Stop: 06/30/2007 Notes: Refer to implementation guide for proper handling of reversals.
124	Payer refund amount – not our patient. Start: 01/01/1995 | Last Modified: 06/30/1999 | Stop: 06/30/2007 Notes: Refer to implementation guide for proper handling of reversals.
125	Submission/billing error(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.) Start: 01/01/1995 | Last Modified: 09/20/2009 | Stop: 11/01/2013
126	Deductible – Major Medical Start: 02/28/1997 | Last Modified: 09/30/2007 | Stop: 04/01/2008 Notes: Use Group Code PR and code 1.
127	Coinsurance – Major Medical Start: 02/28/1997 | Last Modified: 09/30/2007 | Stop: 04/01/2008 Notes: Use Group Code PR and code 2.
128	Newborn's services are covered in the mother's Allowance. Start: 02/28/1997
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.) Start: 02/28/1997 | Last Modified: 01/30/2011
130	Claim submission fee. Start: 02/28/1997 | Last Modified: 06/30/2001
131	Claim specific negotiated discount. Start: 02/28/1997
132	Prearranged demonstration project adjustment. Start: 02/28/1997

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). Start: 07/01/2014 | Last Modified: 01/20/2013
134	Technical fees removed from charges. Start: 10/31/1998
135	Interim bills cannot be processed. Start: 10/31/1998 | Last Modified: 09/30/2007
136	Failure to follow prior payer's coverage rules. (Use only with Group Code OA) Start: 10/31/1998 | Last Modified: 07/01/2013
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes. Start: 02/28/1999 | Last Modified: 09/30/2007
138	Appeal procedures not followed or time limits not met. Start: 06/30/1999 | Last Modified: 09/30/2007
139	Contracted funding agreement – Subscriber is employed by the provider of services. Start: 06/30/1999
140	Patient/Insured health identification number and name do not match. Start: 06/30/1999
141	Claim spans eligible and ineligible periods of coverage. Start: 06/30/1999 | Last Modified: 09/30/2007 | Stop: 07/01/2012
142	Monthly Medicaid patient liability amount. Start: 06/30/2000 | Last Modified: 09/30/2007
143	Portion of payment deferred. Start: 02/28/2001
144	Incentive adjustment, e.g. preferred product/service. Start: 06/30/2001
145	Premium payment withholding Start: 06/30/2002 | Last Modified: 09/30/2007 | Stop: 04/01/2008 Notes: Use Group Code CO and code 45.
146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007
147	Provider contracted/negotiated rate expired or not on file. Start: 06/30/2002
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.) Start: 06/30/2002 | Last Modified: 09/20/2009
149	Lifetime benefit maximum has been reached for this service/benefit category. Start: 10/31/2002
150	Payer deems the information submitted does not support this level of service. Start: 10/31/2002 | Last Modified: 09/30/2007
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. Start: 10/31/2002 | Last Modified: 01/27/2008
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. Start: 10/31/2002 | Last Modified: 09/20/2009

153	Payer deems the information submitted does not support this dosage. Start: 10/31/2002 | Last Modified: 09/30/2007
154	Payer deems the information submitted does not support this day's supply. Start: 10/31/2002 | Last Modified: 09/30/2007
155	Patient refused the service/procedure. Start: 06/30/2003 | Last Modified: 09/30/2007
156	Flexible spending account payments. Note: Use code 187. Start: 09/30/2003 | Last Modified: 01/25/2009 | Stop: 10/01/2009
157	Service/procedure was provided as a result of an act of war. Start: 09/30/2003 | Last Modified: 09/30/2007
158	Service/procedure was provided outside of the United States. Start: 09/30/2003 | Last Modified: 09/30/2007
159	Service/procedure was provided as a result of terrorism. Start: 09/30/2003 | Last Modified: 09/30/2007
160	Injury/illness was the result of an activity that is a benefit exclusion. Start: 09/30/2003 | Last Modified: 09/30/2007
161	Provider performance bonus Start: 02/29/2004
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. Start: 02/29/2004 | Stop: 07/01/2014 Notes: Use code P1
163	Attachment/other documentation referenced on the claim was not received. Start: 06/30/2004 | Last Modified: 06/02/2013
164	Attachment/other documentation referenced on the claim was not received in a timely fashion. Start: 06/30/2004 | Last Modified: 06/02/2013
165	Referral absent or exceeded. Start: 10/31/2004 | Last Modified: 09/30/2007
166	These services were submitted after this payers responsibility for processing claims under this plan ended. Start: 02/28/2005
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. Start: 06/30/2005 | Last Modified: 09/20/2009
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan. Start: 06/30/2005 | Last Modified: 09/30/2007
169	Alternate benefit has been provided. Start: 06/30/2005 | Last Modified: 09/30/2007
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. Start: 06/30/2005 | Last Modified: 09/20/2009
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. Start: 06/30/2005 | Last Modified: 09/20/2009
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. Start: 06/30/2005 | Last Modified: 09/20/2009

173	Service/equipment was not prescribed by a physician. Start: 06/30/2005 | Last Modified: 07/01/2013
174	Service was not prescribed prior to delivery. Start: 06/30/2005 | Last Modified: 09/30/2007
175	Prescription is incomplete. Start: 06/30/2005 | Last Modified: 09/30/2007
176	Prescription is not current. Start: 06/30/2005 | Last Modified: 09/30/2007
177	Patient has not met the required eligibility requirements. Start: 06/30/2005 | Last Modified: 09/30/2007
178	Patient has not met the required spend down requirements. Start: 06/30/2005 | Last Modified: 09/30/2007
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. Start: 06/30/2005 | Last Modified: 09/20/2009
180	Patient has not met the required residency requirements. Start: 06/30/2005 | Last Modified: 09/30/2007
181	Procedure code was invalid on the date of service. Start: 06/30/2005 | Last Modified: 09/30/2007
182	Procedure modifier was invalid on the date of service. Start: 06/30/2005 | Last Modified: 09/30/2007
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. Start: 06/30/2005 | Last Modified: 09/20/2009
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. Start: 06/30/2005 | Last Modified: 09/20/2009
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. Start: 06/30/2005 | Last Modified: 09/20/2009
186	Level of care change adjustment. Start: 06/30/2005 | Last Modified: 09/30/2007
187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.) Start: 06/30/2005 | Last Modified: 01/25/2009
188	This product/procedure is only covered when used according to FDA recommendations. Start: 06/30/2005
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service Start: 06/30/2005
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay. Start: 10/31/2005
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) Start: 10/31/2005 | Last Modified: 10/17/2010 | Stop: 07/01/2014 Notes: Use code P2

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. Start: 10/31/2005 | Last Modified: 09/30/2007
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. Start: 02/28/2006 | Last Modified: 01/27/2008
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician. Start: 02/28/2006 | Last Modified: 09/30/2007
195	Refund issued to an erroneous priority payer for this claim/service. Start: 02/28/2006 | Last Modified: 09/30/2007
196	Claim/service denied based on prior payer's coverage determination. Start: 06/30/2006 | Stop: 02/01/2007 Notes: Use code 136.
197	Precertification/authorization/notification absent. Start: 10/31/2006 | Last Modified: 09/30/2007
198	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007
199	Revenue code and Procedure code do not match. Start: 10/31/2006
200	Expenses incurred during lapse in coverage Start: 10/31/2006
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) Start: 10/31/2006 | Last Modified: 06/01/2014 Notes: Not for use by Workers' Compensation payers; use code P3 instead.
202	Non-covered personal comfort or convenience services. Start: 02/28/2007 | Last Modified: 09/30/2007
203	Discontinued or reduced service. Start: 02/28/2007 | Last Modified: 09/30/2007
204	This service/equipment/drug is not covered under the patient's current benefit plan Start: 02/28/2007
205	Pharmacy discount card processing fee Start: 07/09/2007
206	National Provider Identifier – missing. Start: 07/09/2007 | Last Modified: 09/30/2007
207	National Provider identifier – Invalid format Start: 07/09/2007 | Last Modified: 06/01/2008
208	National Provider Identifier – Not matched. Start: 07/09/2007 | Last Modified: 09/30/2007
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) Start: 07/09/2007 | Last Modified: 07/01/2013
210	Payment adjusted because pre-certification/authorization not received in a timely fashion Start: 07/09/2007
211	National Drug Codes (NDC) not eligible for rebate, are not covered. Start: 07/09/2007

212	Administrative surcharges are not covered Start: 11/05/2007
213	Non-compliance with the physician self referral prohibition legislation or payer policy. Start: 01/27/2008
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 Start: 01/27/2008 | Last Modified: 10/17/2010 | Stop: 07/01/2014 Notes: Use code P4
215	Based on subrogation of a third party settlement Start: 01/27/2008
216	Based on the findings of a review organization Start: 01/27/2008
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) Start: 01/27/2008 | Last Modified: 09/30/2012 | Stop: 07/01/2014 Notes: Use code P5
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 Start: 01/27/2008 | Last Modified: 10/17/2010 | Stop: 07/01/2014 Notes: Use code P6
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). Start: 01/27/2008 | Last Modified: 10/17/2010
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) Start: 01/27/2008 | Last Modified: 09/30/2012 | Stop: 07/01/2014 Notes: Use code P7
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) Start: 01/27/2008 | Last Modified: 07/01/2013 | Stop: 07/01/2014 Notes: Use code P8
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. Start: 06/01/2008 | Last Modified: 09/20/2009
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. Start: 06/01/2008
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims. Start: 06/01/2008
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837) Start: 06/01/2008

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.) Start: 09/21/2008 | Last Modified: 07/01/2013
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.) Start: 09/21/2008 | Last Modified: 09/20/2009
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication Start: 09/21/2008
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) Start: 01/25/2009 | Last Modified: 07/01/2013
230	No available or correlating CPT/HCPCS code to describe this service. Note: Used only by Property and Casualty. Start: 01/25/2009 | Stop: 07/01/2014 Notes: Use code P9
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. Start: 07/01/2009 | Last Modified: 09/20/2009
232	Institutional Transfer Amount. Note – Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions. Start: 11/01/2009
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error. Start: 01/24/2010
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.) Start: 01/24/2010
235	Sales Tax Start: 06/06/2010
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. Start: 01/30/2011 | Last Modified: 07/01/2013
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.) Start: 06/05/2011
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR) Start: 03/01/2012 | Last Modified: 07/01/2013
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims. Start: 03/01/2012 | Last Modified: 01/29/2012
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. Start: 06/03/2012
241	Low Income Subsidy (LIS) Co-payment Amount Start: 06/03/2012
242	Services not provided by network/primary care providers. Start: 06/03/2012 | Last Modified: 06/02/2013 Notes: This code replaces deactivated code 38

243	Services not authorized by network/primary care providers. Start: 06/03/2012 | Last Modified: 06/02/2013 Notes: This code replaces deactivated code 38
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. Start: 09/30/2012 | Stop: 07/01/2014 Notes: Use code P10
245	Provider performance program withhold. Start: 09/30/2012
246	This non-payable code is for required reporting only. Start: 09/30/2012
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim. Start: 09/30/2012 Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim. Start: 09/30/2012 Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).
249	This claim has been identified as a readmission. (Use only with Group Code CO) Start: 09/30/2012
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. 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). Start: 09/30/2012 | Last Modified: 06/01/2014
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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). Start: 09/30/2012 | Last Modified: 06/01/2014
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). Start: 09/30/2012 | Last Modified: 06/02/2013
253	Sequestration – reduction in federal payment Start: 06/02/2013 | Last Modified: 11/01/2013
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. Start: 06/02/2013
255	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA) Start: 06/02/2013 | Stop: 07/01/2014 Notes: Use code P11
256	Service not payable per managed care contract. Start: 06/02/2013
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) Start: 11/01/2013 | Last Modified: 06/01/2014 Notes: To be used after the first month of the grace period.

258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service. Start: 11/01/2013
259	Additional payment for Dental/Vision service utilization. Start: 01/26/2014
260	Processed under Medicaid ACA Enhanced Fee Schedule Start: 01/26/2014
261	The procedure or service is inconsistent with the patient's history. Start: 06/01/2014
A0	Patient refund amount. Start: 01/01/1995
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.) Start: 01/01/1995 | Last Modified: 09/20/2009
A2	Contractual adjustment. Start: 01/01/1995 | Last Modified: 02/28/2007 | Stop: 01/01/2008 Notes: Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code.
A3	Medicare Secondary Payer liability met. Start: 01/01/1995 | Stop: 10/16/2003
A4	Medicare Claim PPS Capital Day Outlier Amount. Start: 01/01/1995 | Last Modified: 09/30/2007 | Stop: 04/01/2008
A5	Medicare Claim PPS Capital Cost Outlier Amount. Start: 01/01/1995
A6	Prior hospitalization or 30 day transfer requirement not met. Start: 01/01/1995
A7	Presumptive Payment Adjustment Start: 01/01/1995 | Stop: 07/01/2015
A8	Ungroupable DRG. Start: 01/01/1995 | Last Modified: 09/30/2007
B1	Non-covered visits. Start: 01/01/1995
B2	Covered visits. Start: 01/01/1995 | Stop: 10/16/2003
B3	Covered charges. Start: 01/01/1995 | Stop: 10/16/2003
B4	Late filing penalty. Start: 01/01/1995
B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995 | Last Modified: 09/30/2007
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty. Start: 01/01/1995 | Stop: 02/01/2006
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. Start: 01/01/1995 | Last Modified: 09/20/2009

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. Start: 01/01/1995 | Last Modified: 09/20/2009
B9	Patient is enrolled in a Hospice. Start: 01/01/1995 | Last Modified: 09/30/2007
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. Start: 01/01/1995
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor. Start: 01/01/1995
B12	Services not documented in patients' medical records. Start: 01/01/1995
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment. Start: 01/01/1995
B14	Only one visit or consultation per physician per day is covered. Start: 01/01/1995 | Last Modified: 09/30/2007
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. Start: 01/01/1995 | Last Modified: 09/20/2009
B16	'New Patient' qualifications were not met. Start: 01/01/1995 | Last Modified: 09/30/2007
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current. Start: 01/01/1995 | Stop: 02/01/2006
B18	This procedure code and modifier were invalid on the date of service. Start: 01/01/1995 | Last Modified: 09/21/2008 | Stop: 03/01/2009
B19	Claim/service adjusted because of the finding of a Review Organization. Start: 01/01/1995 | Stop: 10/16/2003
B20	Procedure/service was partially or fully furnished by another provider. Start: 01/01/1995 | Last Modified: 09/30/2007
B21	The charges were reduced because the service/care was partially furnished by another physician. Start: 01/01/1995 | Stop: 10/16/2003
B22	This payment is adjusted based on the diagnosis. Start: 01/01/1995 | Last Modified: 02/28/2001
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test. Start: 01/01/1995 | Last Modified: 09/30/2007
D1	Claim/service denied. Level of subluxation is missing or inadequate. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 16 and remark codes if necessary.
D2	Claim lacks the name, strength, or dosage of the drug furnished. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 16 and remark codes if necessary.
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 16 and remark codes if necessary.

D4	Claim/service does not indicate the period of time for which this will be needed. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 16 and remark codes if necessary.
D5	Claim/service denied. Claim lacks individual lab codes included in the test. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 16 and remark codes if necessary.
D6	Claim/service denied. Claim did not include patient's medical record for the service. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 16 and remark codes if necessary.
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 16 and remark codes if necessary.
D8	Claim/service denied. Claim lacks indicator that 'x-ray is available for review.' Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 16 and remark codes if necessary.
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 16 and remark codes if necessary.
D10	Claim/service denied. Completed physician financial relationship form not on file. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 17.
D11	Claim lacks completed pacemaker registration form. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 17.
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 17.
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 17.
D14	Claim lacks indication that plan of treatment is on file. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 17.
D15	Claim lacks indication that service was supervised or evaluated by a physician. Start: 01/01/1995 | Stop: 10/16/2003 Notes: Use code 17.
D16	Claim lacks prior payer payment information. Start: 01/01/1995 | Stop: 06/30/2007 Notes: Use code 16 with appropriate claim payment remark code [N4].
D17	Claim/Service has invalid non-covered days. Start: 01/01/1995 | Stop: 06/30/2007 Notes: Use code 16 with appropriate claim payment remark code.

D18	Claim/Service has missing diagnosis information. Start: 01/01/1995 | Stop: 06/30/2007 Notes: Use code 16 with appropriate claim payment remark code.
D19	Claim/Service lacks Physician/Operative or other supporting documentation Start: 01/01/1995 | Stop: 06/30/2007 Notes: Use code 16 with appropriate claim payment remark code.
D20	Claim/Service missing service/product information. Start: 01/01/1995 | Stop: 06/30/2007 Notes: Use code 16 with appropriate claim payment remark code.
D21	This (these) diagnosis(es) is (are) missing or are invalid Start: 01/01/1995 | Stop: 06/30/2007
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) – Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code Start: 01/27/2008 | Stop: 01/01/2009
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility. 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.) Start: 11/01/2009 | Stop: 01/01/2012
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only. Start: 11/01/2013 Notes: This code replaces deactivated code 162
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. Start: 11/01/2013 Notes: This code replaces deactivated code 191
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) Start: 11/01/2013 Notes: This code replaces deactivated code 201
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 Start: 11/01/2013 Notes: This code replaces deactivated code 214
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only. Start: 11/01/2013 Notes: This code replaces deactivated code 217
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. Start: 11/01/2013 Notes: This code replaces deactivated code 218

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. Start: 11/01/2013 Notes: This code replaces deactivated code 220
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. Start: 11/01/2013 Notes: This code replaces deactivated code 221
P9	No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only. Start: 11/01/2013 Notes: This code replaces deactivated code 230
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. Start: 11/01/2013 Notes: This code replaces deactivated code 244
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) Start: 11/01/2013 Notes: This code replaces deactivated code 255
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. Start: 11/01/2013 Notes: This code replaces deactivated code W1
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. Start: 11/01/2013 Notes: This code replaces deactivated code W2
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. Start: 11/01/2013 Notes: This code replaces deactivated code W3
P15	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only. Start: 11/01/2013 Notes: This code replaces deactivated code W4
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) Start: 11/01/2013 Notes: This code replaces deactivated code W5
P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only. Start: 11/01/2013 Notes: This code replaces deactivated code W6

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. Start: 11/01/2013 Notes: This code replaces deactivated code W7
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. Start: 11/01/2013 Notes: This code replaces deactivated code W8
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only. Start: 11/01/2013 Notes: This code replaces deactivated code W9
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. Start: 11/01/2013 Notes: This code replaces deactivated code Y1
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. Start: 11/01/2013 Notes: This code replaces deactivated code Y2
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. Start: 11/01/2013 Notes: This code replaces deactivated code Y3
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. Start: 02/29/2000 | Last Modified: 06/02/2013 | Stop: 07/01/2014 Notes: Use code P12
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. Start: 10/17/2010 | Last Modified: 06/02/2013 | Stop: 07/01/2014 Notes: Use code P13

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. Start: 09/30/2012 | Stop: 07/01/2014 Notes: Use code P14
W4	Workers' Compensation Medical Treatment Guideline Adjustment. Start: 09/30/2012 | Stop: 07/01/2014 Notes: Use code P15
W5	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA) Start: 06/02/2013 | Stop: 07/01/2014 Notes: Use code P16
W6	Referral not authorized by attending physician per regulatory requirement. Start: 06/02/2013 | Stop: 07/01/2014 Notes: Use code P17
W7	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. Start: 06/02/2013 | Stop: 07/01/2014 Notes: Use code P18
W8	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. Start: 06/02/2013 | Stop: 07/01/2014 Notes: Use code P19
W9	Service not paid under jurisdiction allowed outpatient facility fee schedule. Start: 06/02/2013 | Stop: 07/01/2014 Notes: Use code P20
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. Start: 09/30/2012 | Last Modified: 06/02/2013 | Stop: 07/01/2014 Notes: Use code P21
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. Start: 09/30/2012 | Last Modified: 06/02/2013 | Stop: 07/01/2014 Notes: Use code P22
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. Start: 09/30/2012 | Last Modified: 06/02/2013 | Stop: 07/01/2014 Notes: Use code P23

2.c.2 Health Care Claim Status Codes

Reason Code	Description
0	Cannot provide further status electronically. Start: 01/01/1995
1	For more detailed information, see remittance advice. Start: 01/01/1995
2	More detailed information in letter. Start: 01/01/1995
3	Claim has been adjudicated and is awaiting payment cycle. Start: 01/01/1995
6	Balance due from the subscriber. Start: 01/01/1995
12	One or more originally submitted procedure codes have been combined. Start: 01/01/1995 | Last Modified: 06/30/2001
15	One or more originally submitted procedure code have been modified. Start: 01/01/1995 | Last Modified: 06/30/2001
16	Claim/encounter has been forwarded to entity. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
17	Claim/encounter has been forwarded by third party entity to entity. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
18	Entity received claim/encounter, but returned invalid status. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
19	Entity acknowledges receipt of claim/encounter. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
20	Accepted for processing. Start: 01/01/1995 | Last Modified: 06/30/2001
21	Missing or invalid information. Note: At least one other status code is required to identify the missing or invalid information. Start: 01/01/1995 | Last Modified: 07/09/2007
23	Returned to Entity. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
24	Entity not approved as an electronic submitter. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
25	Entity not approved. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
26	Entity not found. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
27	Policy canceled. Start: 01/01/1995 | Last Modified: 06/30/2001
29	Subscriber and policy number/contract number mismatched. Start: 01/01/1995

30	Subscriber and subscriber id mismatched. Start: 01/01/1995
31	Subscriber and policyholder name mismatched. Start: 01/01/1995
32	Subscriber and policy number/contract number not found. Start: 01/01/1995
33	Subscriber and subscriber id not found. Start: 01/01/1995
34	Subscriber and policyholder name not found. Start: 01/01/1995
35	Claim/encounter not found. Start: 01/01/1995
37	Predetermination is on file, awaiting completion of services. Start: 01/01/1995
38	Awaiting next periodic adjudication cycle. Start: 01/01/1995
39	Charges for pregnancy deferred until delivery. Start: 01/01/1995
40	Waiting for final approval. Start: 01/01/1995
41	Special handling required at payer site. Start: 01/01/1995
42	Awaiting related charges. Start: 01/01/1995
44	Charges pending provider audit. Start: 01/01/1995
45	Awaiting benefit determination. Start: 01/01/1995
46	Internal review/audit. Start: 01/01/1995
47	Internal review/audit – partial payment made. Start: 01/01/1995
49	Pending provider accreditation review. Start: 01/01/1995
50	Claim waiting for internal provider verification. Start: 01/01/1995
51	Investigating occupational illness/accident. Start: 01/01/1995
52	Investigating existence of other insurance coverage. Start: 01/01/1995
53	Claim being researched for Insured ID/Group Policy Number error. Start: 01/01/1995
54	Duplicate of a previously processed claim/line. Start: 01/01/1995

55	Claim assigned to an approver/analyst. Start: 01/01/1995
56	Awaiting eligibility determination. Start: 01/01/1995
57	Pending COBRA information requested. Start: 01/01/1995
59	Information was requested by a non-electronic method. Note: At least one other status code is required to identify the requested information. Start: 01/01/1995 | Last Modified: 10/17/2010
60	Information was requested by an electronic method. Note: At least one other status code is required to identify the requested information. Start: 01/01/1995 | Last Modified: 10/17/2010
61	Eligibility for extended benefits. Start: 01/01/1995
64	Re-pricing information. Start: 01/01/1995
65	Claim/line has been paid. Start: 01/01/1995
66	Payment reflects usual and customary charges. Start: 01/01/1995
72	Claim contains split payment. Start: 01/01/1995
73	Payment made to entity, assignment of benefits not on file. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
78	Duplicate of an existing claim/line, awaiting processing. Start: 01/01/1995
81	Contract/plan does not cover pre-existing conditions. Start: 01/01/1995
83	No coverage for newborns. Start: 01/01/1995
84	Service not authorized. Start: 01/01/1995
85	Entity not primary. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
86	Diagnosis and patient gender mismatch. Start: 01/01/1995 | Last Modified: 02/28/2000
88	Entity not eligible for benefits for submitted dates of service. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
89	Entity not eligible for dental benefits for submitted dates of service. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
90	Entity not eligible for medical benefits for submitted dates of service. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
91	Entity not eligible/not approved for dates of service. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
92	Entity does not meet dependent or student qualification. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010

93	Entity is not selected primary care provider. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
94	Entity not referred by selected primary care provider. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
95	Requested additional information not received. Start: 01/01/1995 | Last Modified: 07/09/2007 Notes: If known, the payer must report a second claim status code identifying the requested information.
96	No agreement with entity. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
97	Patient eligibility not found with entity. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
98	Charges applied to deductible. Start: 01/01/1995
99	Pre-treatment review. Start: 01/01/1995
100	Pre-certification penalty taken. Start: 01/01/1995
101	Claim was processed as adjustment to previous claim. Start: 01/01/1995
102	Newborn's charges processed on mother's claim. Start: 01/01/1995
103	Claim combined with other claim(s). Start: 01/01/1995
104	Processed according to plan provisions (Plan refers to provisions that exist between the Health Plan and the Consumer or Patient) Start: 01/01/1995 | Last Modified: 06/01/2008
105	Claim/line is capitated. Start: 01/01/1995
106	This amount is not entity's responsibility. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services) Start: 01/01/1995 | Last Modified: 06/01/2008
109	Entity not eligible. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
110	Claim requires pricing information. Start: 01/01/1995
111	At the policyholder's request these claims cannot be submitted electronically. Start: 01/01/1995
114	Claim/service should be processed by entity. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
116	Claim submitted to incorrect payer. Start: 01/01/1995
117	Claim requires signature-on-file indicator. Start: 01/01/1995
121	Service line number greater than maximum allowable for payer. Start: 01/01/1995

123	Additional information requested from entity. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
124	Entity's name, address, phone and id number. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
125	Entity's name. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
126	Entity's address. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
127	Entity's Communication Number. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 06/06/2010
128	Entity's tax id. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
129	Entity's Blue Cross provider id. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
130	Entity's Blue Shield provider id. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
131	Entity's Medicare provider id. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
132	Entity's Medicaid provider id. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
133	Entity's UPIN. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
134	Entity's CHAMPUS provider id. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
135	Entity's commercial provider id. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
136	Entity's health industry id number. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
137	Entity's plan network id. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
138	Entity's site id . Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
139	Entity's health maintenance provider id (HMO). Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
140	Entity's preferred provider organization id (PPO). Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
141	Entity's administrative services organization id (ASO). Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
142	Entity's license/certification number. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
143	Entity's state license number. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
144	Entity's specialty license number. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010

145	Entity's specialty/taxonomy code. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
146	Entity's anesthesia license number. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
147	Entity's qualification degree/designation (e.g. RN,PhD,MD). Note: This code requires use of an Entity Code. Start: 02/28/1997 | Last Modified: 02/11/2010
148	Entity's social security number. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
149	Entity's employer id. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
150	Entity's drug enforcement agency (DEA) number. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
152	Pharmacy processor number. Start: 01/01/1995
153	Entity's id number. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
154	Relationship of surgeon & assistant surgeon. Start: 01/01/1995
155	Entity's relationship to patient. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
156	Patient relationship to subscriber Start: 01/01/1995
157	Entity's Gender. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
158	Entity's date of birth. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
159	Entity's date of death. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
160	Entity's marital status. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
161	Entity's employment status. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
162	Entity's health insurance claim number (HICN). Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
163	Entity's policy number. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
164	Entity's contract/member number. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
165	Entity's employer name, address and phone. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
166	Entity's employer name. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
167	Entity's employer address. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010

168	Entity's employer phone number. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
170	Entity's employee id. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
171	Other insurance coverage information (health, liability, auto, etc.). Start: 01/01/1995
172	Other employer name, address and telephone number. Start: 01/01/1995
173	Entity's name, address, phone, gender, DOB, marital status, employment status and relation to subscriber. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
174	Entity's student status. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
175	Entity's school name. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
176	Entity's school address. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
177	Transplant recipient's name, date of birth, gender, relationship to insured. Start: 01/01/1995 | Last Modified: 02/28/2000
178	Submitted charges. Start: 01/01/1995
179	Outside lab charges. Start: 01/01/1995
180	Hospital s semi-private room rate. Start: 01/01/1995
181	Hospital s room rate. Start: 01/01/1995
182	Allowable/paid from other entities coverage Note: This code requires the use of an entity code. Start: 01/01/1995 | Last Modified: 01/24/2010
183	Amount entity has paid. Note: This code requires use of an Entity Code. Start: 01/01/1995 | Last Modified: 02/11/2010
184	Purchase price for the rented durable medical equipment. Start: 01/01/1995
185	Rental price for durable medical equipment. Start: 01/01/1995
186	Purchase and rental price of durable medical equipment. Start: 01/01/1995
187	Date(s) of service. Start: 01/01/1995
188	Statement from-through dates. Start: 01/01/1995
189	Facility admission date Start: 01/01/1995 | Last Modified: 10/31/2006
190	Facility discharge date Start: 01/01/1995 | Last Modified: 10/31/2006

191	Date of Last Menstrual Period (LMP) Start: 02/28/1997
192	Date of first service for current series/symptom/illness. Start: 01/01/1995
193	First consultation/evaluation date. Start: 02/28/1997
194	Confinement dates. Start: 01/01/1995
195	Unable to work dates/Disability Dates. Start: 01/01/1995 | Last Modified: 09/20/2009
196	Return to work dates. Start: 01/01/1995
197	Effective coverage date(s). Start: 01/01/1995
198	Medicare effective date. Start: 01/01/1995
199	Date of conception and expected date of delivery. Start: 01/01/1995
200	Date of equipment return. Start: 01/01/1995
201	Date of dental appliance prior placement. Start: 01/01/1995
202	Date of dental prior replacement/reason for replacement. Start: 01/01/1995
203	Date of dental appliance placed. Start: 01/01/1995
204	Date dental canal(s) opened and date service completed. Start: 01/01/1995
205	Date(s) dental root canal therapy previously performed. Start: 01/01/1995
206	Most recent date of curettage, root planing, or periodontal surgery. Start: 01/01/1995
207	Dental impression and seating date. Start: 01/01/1995
208	Most recent date pacemaker was implanted. Start: 01/01/1995
209	Most recent pacemaker battery change date. Start: 01/01/1995
210	Date of the last x-ray. Start: 01/01/1995
211	Date(s) of dialysis training provided to patient. Start: 01/01/1995
212	Date of last routine dialysis. Start: 01/01/1995

213	Date of first routine dialysis. Start: 01/01/1995
214	Original date of prescription/orders/referral. Start: 02/28/1997
215	Date of tooth extraction/evolution. Start: 01/01/1995
216	Drug information. Start: 01/01/1995
217	Drug name, strength and dosage form. Start: 01/01/1995
218	NDC number. Start: 01/01/1995
219	Prescription number. Start: 01/01/1995
222	Drug dispensing units and average wholesale price (AWP). Start: 01/01/1995
223	Route of drug/myelogram administration. Start: 01/01/1995
224	Anatomical location for joint injection. Start: 01/01/1995
225	Anatomical location. Start: 01/01/1995
226	Joint injection site. Start: 01/01/1995
227	Hospital information. Start: 01/01/1995
228	Type of bill for UB claim Start: 01/01/1995 | Last Modified: 10/31/2006
229	Hospital admission source. Start: 01/01/1995
230	Hospital admission hour. Start: 01/01/1995
231	Hospital admission type. Start: 01/01/1995
232	Admitting diagnosis. Start: 01/01/1995
233	Hospital discharge hour. Start: 01/01/1995
234	Patient discharge status. Start: 01/01/1995
235	Units of blood furnished. Start: 01/01/1995
236	Units of blood replaced. Start: 01/01/1995

237	Units of deductible blood. Start: 01/01/1995
238	Separate claim for mother/baby charges. Start: 01/01/1995
239	Dental information. Start: 01/01/1995
240	Tooth surface(s) involved. Start: 01/01/1995
241	List of all missing teeth (upper and lower). Start: 01/01/1995
242	Tooth numbers, surfaces, and/or quadrants involved. Start: 01/01/1995
243	Months of dental treatment remaining. Start: 01/01/1995
244	Tooth number or letter. Start: 01/01/1995
245	Dental quadrant/arch. Start: 01/01/1995
246	Total orthodontic service fee, initial appliance fee, monthly fee, length of service. Start: 01/01/1995
247	Line information. Start: 01/01/1995
249	Place of service. Start: 01/01/1995
250	Type of service. Start: 01/01/1995
251	Total anesthesia minutes. Start: 01/01/1995
252	Entity's authorization/certification number. Note: This code requires the use of an Entity Code. Start: 01/01/1995 | Last Modified: 01/30/2011
254	Principal diagnosis code. Start: 01/01/1995 | Last Modified: 01/30/2011
255	Diagnosis code. Start: 01/01/1995
256	DRG code(s). Start: 01/01/1995
257	ADSM-III-R code for services rendered. Start: 01/01/1995
258	Days/units for procedure/revenue code. Start: 01/01/1995
259	Frequency of service. Start: 01/01/1995
260	Length of medical necessity, including begin date. Start: 02/28/1997

261	Obesity measurements. Start: 01/01/1995
262	Type of surgery/service for which anesthesia was administered. Start: 01/01/1995
263	Length of time for services rendered. Start: 01/01/1995
264	Number of liters/minute & total hours/day for respiratory support. Start: 01/01/1995
265	Number of lesions excised. Start: 01/01/1995
266	Facility point of origin and destination – ambulance. Start: 01/01/1995
267	Number of miles patient was transported. Start: 01/01/1995
268	Location of durable medical equipment use. Start: 01/01/1995
269	Length/size of laceration/tumor. Start: 01/01/1995
270	Subluxation location. Start: 01/01/1995
271	Number of spine segments. Start: 01/01/1995
272	Oxygen contents for oxygen system rental. Start: 01/01/1995
273	Weight. Start: 01/01/1995
274	Height. Start: 01/01/1995
275	Claim. Start: 01/01/1995
276	UB04/HCFA-1450/1500 claim form Start: 01/01/1995 | Last Modified: 10/31/2006
277	Paper claim. Start: 01/01/1995
279	Claim/service must be itemized Start: 01/01/1995 | Last Modified: 10/17/2010
281	Related confinement claim. Start: 01/01/1995
282	Copy of prescription. Start: 01/01/1995
283	Medicare entitlement information is required to determine primary coverage Start: 01/01/1995 | Last Modified: 01/27/2008
284	Copy of Medicare ID card. Start: 01/01/1995

286	Other payer's Explanation of Benefits/payment information. Start: 01/01/1995
287	Medical necessity for service. Start: 01/01/1995
288	Hospital late charges Start: 01/01/1995 | Last Modified: 10/17/2010
290	Pre-existing information. Start: 01/01/1995
291	Reason for termination of pregnancy. Start: 01/01/1995
292	Purpose of family conference/therapy. Start: 01/01/1995
293	Reason for physical therapy. Start: 01/01/1995
294	Supporting documentation. Note: At least one other status code is required to identify the supporting documentation. Start: 01/01/1995 | Last Modified: 10/17/2010
295	Attending physician report. Start: 01/01/1995
296	Nurse's notes. Start: 01/01/1995
297	Medical notes/report. Start: 02/28/1997
298	Operative report. Start: 01/01/1995
299	Emergency room notes/report. Start: 01/01/1995
300	Lab/test report/notes/results. Start: 02/28/1997
301	MRI report. Start: 01/01/1995
305	Radiology/x-ray reports and/or interpretation Start: 01/01/1995 | Last Modified: 01/30/2011
306	Detailed description of service. Start: 01/01/1995
307	Narrative with pocket depth chart. Start: 01/01/1995
308	Discharge summary. Start: 01/01/1995
310	Progress notes for the six months prior to statement date. Start: 01/01/1995
311	Pathology notes/report. Start: 01/01/1995
312	Dental charting. Start: 01/01/1995

313	Bridgework information. Start: 01/01/1995
314	Dental records for this service. Start: 01/01/1995
315	Past perio treatment history. Start: 01/01/1995
316	Complete medical history. Start: 01/01/1995
318	X-rays/radiology films Start: 01/01/1995 | Last Modified: 10/17/2010
319	Pre/post-operative x-rays/photographs. Start: 02/28/1997
320	Study models. Start: 01/01/1995
322	Recent Full Mouth X-rays Start: 01/01/1995 | Last Modified: 10/17/2010
323	Study models, x-rays, and/or narrative. Start: 01/01/1995
324	Recent x-ray of treatment area and/or narrative. Start: 01/01/1995
325	Recent fm x-rays and/or narrative. Start: 01/01/1995
326	Copy of transplant acquisition invoice. Start: 01/01/1995
327	Periodontal case type diagnosis and recent pocket depth chart with narrative. Start: 01/01/1995
329	Exercise notes. Start: 01/01/1995
330	Occupational notes. Start: 01/01/1995
331	History and physical. Start: 01/01/1995 | Last Modified: 08/01/2007
333	Patient release of information authorization. Start: 01/01/1995
334	Oxygen certification. Start: 01/01/1995
335	Durable medical equipment certification. Start: 01/01/1995
336	Chiropractic certification. Start: 01/01/1995
337	Ambulance certification/documentation. Start: 01/01/1995
339	Enteral/parenteral certification. Start: 01/01/1995

340	Pacemaker certification. Start: 01/01/1995
341	Private duty nursing certification. Start: 01/01/1995
342	Podiatric certification. Start: 01/01/1995
343	Documentation that facility is state licensed and Medicare approved as a surgical facility. Start: 01/01/1995
344	Documentation that provider of physical therapy is Medicare Part B approved. Start: 01/01/1995
345	Treatment plan for service/diagnosis Start: 01/01/1995
346	Proposed treatment plan for next 6 months. Start: 01/01/1995
352	Duration of treatment plan. Start: 01/01/1995
353	Orthodontics treatment plan. Start: 01/01/1995
354	Treatment plan for replacement of remaining missing teeth. Start: 01/01/1995
360	Benefits Assignment Certification Indicator Start: 01/01/1995 | Last Modified: 10/17/2010
363	Possible Workers' Compensation Start: 01/01/1995 | Last Modified: 10/17/2010
364	Is accident/illness/condition employment related? Start: 01/01/1995
365	Is service the result of an accident? Start: 01/01/1995
366	Is injury due to auto accident? Start: 01/01/1995
374	Is prescribed lenses a result of cataract surgery? Start: 01/01/1995
375	Was refraction performed? Start: 01/01/1995
380	CRNA supervision/medical direction. Start: 01/01/1995 | Last Modified: 10/17/2010
382	Did provider authorize generic or brand name dispensing? Start: 01/01/1995
383	Nerve block use (surgery vs. pain management) Start: 01/01/1995 | Last Modified: 10/17/2010
384	Is prosthesis/crown/inlay placement an initial placement or a replacement? Start: 01/01/1995
385	Is appliance upper or lower arch & is appliance fixed or removable? Start: 01/01/1995

386	Orthodontic Treatment/Purpose Indicator Start: 01/01/1995 | Last Modified: 10/17/2010
387	Date patient last examined by entity. Note: This code requires use of an Entity Code. Start: 02/28/1997 | Last Modified: 02/11/2010
388	Date post-operative care assumed Start: 02/28/1997
389	Date post-operative care relinquished Start: 02/28/1997
390	Date of most recent medical event necessitating service(s) Start: 02/28/1997
391	Date(s) dialysis conducted Start: 02/28/1997
394	Date(s) of most recent hospitalization related to service Start: 02/28/1997
395	Date entity signed certification/recertification Note: This code requires use of an Entity Code. Start: 02/28/1997 | Last Modified: 02/11/2010
396	Date home dialysis began Start: 02/28/1997
397	Date of onset/exacerbation of illness/condition Start: 02/28/1997
398	Visual field test results Start: 02/28/1997
400	Claim is out of balance Start: 02/28/1997
401	Source of payment is not valid Start: 02/28/1997
402	Amount must be greater than zero. Note: At least one other status code is required to identify which amount element is in error. Start: 02/28/1997 | Last Modified: 09/20/2009
403	Entity referral notes/orders/prescription Start: 02/28/1997
406	Brief medical history as related to service(s) Start: 02/28/1997
407	Complications/mitigating circumstances Start: 02/28/1997
408	Initial certification Start: 02/28/1997
409	Medication logs/records (including medication therapy) Start: 02/28/1997
414	Necessity for concurrent care (more than one physician treating the patient) Start: 02/28/1997 | Last Modified: 10/17/2010
417	Prior testing, including result(s) and date(s) as related to service(s) Start: 02/28/1997
419	Individual test(s) comprising the panel and the charges for each test Start: 02/28/1997

420	Name, dosage and medical justification of contrast material used for radiology procedure Start: 02/28/1997
428	Reason for transport by ambulance Start: 02/28/1997
430	Nearest appropriate facility Start: 02/28/1997
431	Patient's condition/functional status at time of service. Start: 02/28/1997 | Last Modified: 10/17/2010
432	Date benefits exhausted Start: 02/28/1997
433	Copy of patient revocation of hospice benefits Start: 02/28/1997
434	Reasons for more than one transfer per entitlement period Start: 02/28/1997
435	Notice of Admission Start: 02/28/1997
441	Entity professional qualification for service(s) Start: 02/28/1997
442	Modalities of service Start: 02/28/1997
443	Initial evaluation report Start: 02/28/1997
449	Projected date to discontinue service(s) Start: 02/28/1997
450	Awaiting spend down determination Start: 02/28/1997
451	Preoperative and post-operative diagnosis Start: 02/28/1997
452	Total visits in total number of hours/day and total number of hours/week Start: 02/28/1997
453	Procedure Code Modifier(s) for Service(s) Rendered Start: 02/28/1997
454	Procedure code for services rendered. Start: 02/28/1997
455	Revenue code for services rendered. Start: 02/28/1997
456	Covered Day(s) Start: 02/28/1997
457	Non-Covered Day(s) Start: 02/28/1997
458	Coinsurance Day(s) Start: 02/28/1997
459	Lifetime Reserve Day(s) Start: 02/28/1997

460	NUBC Condition Code(s) Start: 02/28/1997
464	Payer Assigned Claim Control Number Start: 02/28/1997 | Last Modified: 10/31/2004
465	Principal Procedure Code for Service(s) Rendered Start: 02/28/1997
466	Entity's Original Signature. Note: This code requires use of an Entity Code. Start: 02/28/1997 | Last Modified: 01/30/2011
467	Entity Signature Date. Note: This code requires use of an Entity Code. Start: 02/28/1997 | Last Modified: 02/11/2010
468	Patient Signature Source Start: 02/28/1997
469	Purchase Service Charge Start: 02/28/1997
470	Was service purchased from another entity? Note: This code requires use of an Entity Code. Start: 02/28/1997 | Last Modified: 02/11/2010
471	Were services related to an emergency? Start: 02/28/1997
472	Ambulance Run Sheet Start: 02/28/1997
473	Missing or invalid lab indicator Start: 06/30/1998
474	Procedure code and patient gender mismatch Start: 06/30/1998 | Last Modified: 02/29/2000
475	Procedure code not valid for patient age Start: 06/30/1998 | Last Modified: 02/29/2000
476	Missing or invalid units of service Start: 06/30/1998
477	Diagnosis code pointer is missing or invalid Start: 06/30/1998
478	Claim submitter's identifier Start: 06/30/1998 | Last Modified: 01/24/2010
479	Other Carrier payer ID is missing or invalid Start: 06/30/1998
480	Entity's claim filing indicator. Note: This code requires use of an Entity Code. Start: 06/30/1998 | Last Modified: 06/06/2010
481	Claim/submission format is invalid. Start: 10/31/1998
483	Maximum coverage amount met or exceeded for benefit period. Start: 06/30/1999
484	Business Application Currently Not Available Start: 02/29/2000
485	More information available than can be returned in real time mode. Narrow your current search criteria. Start: 02/28/2001

486	Principal Procedure Date Start: 10/31/2001 | Last Modified: 07/01/2009
487	Claim not found, claim should have been submitted to/through 'entity'. Note: This code requires use of an Entity Code. Start: 02/28/2002 | Last Modified: 02/11/2010
488	Diagnosis code(s) for the services rendered. Start: 06/30/2002
489	Attachment Control Number Start: 10/31/2002
490	Other Procedure Code for Service(s) Rendered Start: 02/28/2003
491	Entity not eligible for encounter submission. Note: This code requires use of an Entity Code. Start: 02/28/2003 | Last Modified: 02/11/2010
492	Other Procedure Date Start: 02/28/2003
493	Version/Release/Industry ID code not currently supported by information holder Start: 02/28/2003
494	Real-Time requests not supported by the information holder, resubmit as batch request Start: 02/28/2003
495	Requests for re-adjudication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and re-submit. Start: 10/31/2003
496	Submitter not approved for electronic claim submissions on behalf of this entity. Note: This code requires use of an Entity Code. Start: 02/29/2004 | Last Modified: 02/11/2010
497	Sales tax not paid Start: 06/30/2004
498	Maximum leave days exhausted Start: 06/30/2004
499	No rate on file with the payer for this service for this entity Note: This code requires use of an Entity Code. Start: 06/30/2004 | Last Modified: 02/11/2010
500	Entity's Postal/Zip Code. Note: This code requires use of an Entity Code. Start: 06/30/2004 | Last Modified: 02/11/2010
501	Entity's State/Province. Note: This code requires use of an Entity Code. Start: 06/30/2004 | Last Modified: 02/11/2010
502	Entity's City. Note: This code requires use of an Entity Code. Start: 06/30/2004 | Last Modified: 02/11/2010
503	Entity's Street Address. Note: This code requires use of an Entity Code. Start: 06/30/2004 | Last Modified: 02/11/2010
504	Entity's Last Name. Note: This code requires use of an Entity Code. Start: 06/30/2004 | Last Modified: 02/11/2010
505	Entity's First Name. Note: This code requires use of an Entity Code. Start: 06/30/2004 | Last Modified: 02/11/2010
506	Entity is changing processor/clearinghouse. This claim must be submitted to the new processor/clearinghouse. Note: This code requires use of an Entity Code. Start: 06/30/2004 | Last Modified: 02/11/2010
507	HCPCS Start: 10/31/2004

508	ICD9 Note: At least one other status code is required to identify the related procedure code or diagnosis code. Start: 10/31/2004 | Last Modified: 07/01/2009
509	External Cause of Injury Code (E-code). Start: 10/31/2004 | Last Modified: 01/30/2011
510	Future date. Note: At least one other status code is required to identify the data element in error. Start: 10/31/2004 | Last Modified: 09/20/2009
511	Invalid character. Note: At least one other status code is required to identify the data element in error. Start: 10/31/2004 | Last Modified: 09/20/2009
512	Length invalid for receiver's application system. Note: At least one other status code is required to identify the data element in error. Start: 10/31/2004 | Last Modified: 09/20/2009
513	HIPPS Rate Code for services Rendered Start: 10/31/2004
514	Entity's Middle Name Note: This code requires use of an Entity Code. Start: 10/31/2004 | Last Modified: 01/30/2011
515	Managed Care review Start: 10/31/2004
516	Other Entity's Adjudication or Payment/Remittance Date. Note: An Entity code is required to identify the Other Payer Entity, i.e. primary, secondary. Start: 10/31/2004 | Last Modified: 11/29/2009
517	Adjusted Repriced Claim Reference Number Start: 10/31/2004
518	Adjusted Repriced Line item Reference Number Start: 10/31/2004
519	Adjustment Amount Start: 10/31/2004
520	Adjustment Quantity Start: 10/31/2004
521	Adjustment Reason Code Start: 10/31/2004
522	Anesthesia Modifying Units Start: 10/31/2004
523	Anesthesia Unit Count Start: 10/31/2004
524	Arterial Blood Gas Quantity Start: 10/31/2004
525	Begin Therapy Date Start: 10/31/2004
526	Bundled or Unbundled Line Number Start: 10/31/2004
527	Certification Condition Indicator Start: 10/31/2004
528	Certification Period Projected Visit Count Start: 10/31/2004
529	Certification Revision Date Start: 10/31/2004

530	Claim Adjustment Indicator Start: 10/31/2004
531	Claim Disproportinate Share Amount Start: 10/31/2004
532	Claim DRG Amount Start: 10/31/2004
533	Claim DRG Outlier Amount Start: 10/31/2004
534	Claim ESRD Payment Amount Start: 10/31/2004
535	Claim Frequency Code Start: 10/31/2004
536	Claim Indirect Teaching Amount Start: 10/31/2004
537	Claim MSP Pass-through Amount Start: 10/31/2004
538	Claim or Encounter Identifier Start: 10/31/2004
539	Claim PPS Capital Amount Start: 10/31/2004
540	Claim PPS Capital Outlier Amount Start: 10/31/2004
541	Claim Submission Reason Code Start: 10/31/2004
542	Claim Total Denied Charge Amount Start: 10/31/2004
543	Clearinghouse or Value Added Network Trace Start: 10/31/2004
544	Clinical Laboratory Improvement Amendment Start: 10/31/2004
545	Contract Amount Start: 10/31/2004
546	Contract Code Start: 10/31/2004
547	Contract Percentage Start: 10/31/2004
548	Contract Type Code Start: 10/31/2004
549	Contract Version Identifier Start: 10/31/2004
550	Coordination of Benefits Code Start: 10/31/2004
551	Coordination of Benefits Total Submitted Charge Start: 10/31/2004

552	Cost Report Day Count Start: 10/31/2004
553	Covered Amount Start: 10/31/2004
554	Date Claim Paid Start: 10/31/2004
555	Delay Reason Code Start: 10/31/2004
556	Demonstration Project Identifier Start: 10/31/2004
557	Diagnosis Date Start: 10/31/2004
558	Discount Amount Start: 10/31/2004
559	Document Control Identifier Start: 10/31/2004
560	Entity's Additional/Secondary Identifier. Note: This code requires use of an Entity Code. Start: 10/31/2004 | Last Modified: 02/11/2010
561	Entity's Contact Name. Note: This code requires use of an Entity Code. Start: 10/31/2004 | Last Modified: 02/11/2010
562	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code. Start: 10/31/2004 | Last Modified: 02/11/2010
563	Entity's Tax Amount. Note: This code requires use of an Entity Code. Start: 10/31/2004 | Last Modified: 02/11/2010
564	EPSDT Indicator Start: 10/31/2004
565	Estimated Claim Due Amount Start: 10/31/2004
566	Exception Code Start: 10/31/2004
567	Facility Code Qualifier Start: 10/31/2004
568	Family Planning Indicator Start: 10/31/2004
569	Fixed Format Information Start: 10/31/2004
571	Frequency Count Start: 10/31/2004
572	Frequency Period Start: 10/31/2004
573	Functional Limitation Code Start: 10/31/2004
574	HCPCS Payable Amount Home Health Start: 10/31/2004

575	Homebound Indicator Start: 10/31/2004
576	Immunization Batch Number Start: 10/31/2004
577	Industry Code Start: 10/31/2004
578	Insurance Type Code Start: 10/31/2004
579	Investigational Device Exemption Identifier Start: 10/31/2004
580	Last Certification Date Start: 10/31/2004
581	Last Worked Date Start: 10/31/2004
582	Lifetime Psychiatric Days Count Start: 10/31/2004
583	Line Item Charge Amount Start: 10/31/2004
584	Line Item Control Number Start: 10/31/2004
585	Denied Charge or Non-covered Charge Start: 10/31/2004 | Last Modified: 07/09/2007
586	Line Note Text Start: 10/31/2004
587	Measurement Reference Identification Code Start: 10/31/2004
588	Medical Record Number Start: 10/31/2004
589	Provider Accept Assignment Code Start: 10/31/2004 | Last Modified: 10/17/2010
590	Medicare Coverage Indicator Start: 10/31/2004
591	Medicare Paid at 100% Amount Start: 10/31/2004
592	Medicare Paid at 80% Amount Start: 10/31/2004
593	Medicare Section 4081 Indicator Start: 10/31/2004
594	Mental Status Code Start: 10/31/2004
595	Monthly Treatment Count Start: 10/31/2004
596	Non-covered Charge Amount Start: 10/31/2004

597	Non-payable Professional Component Amount Start: 10/31/2004
598	Non-payable Professional Component Billed Amount Start: 10/31/2004
599	Note Reference Code Start: 10/31/2004
600	Oxygen Saturation Qty Start: 10/31/2004
601	Oxygen Test Condition Code Start: 10/31/2004
602	Oxygen Test Date Start: 10/31/2004
603	Old Capital Amount Start: 10/31/2004
604	Originator Application Transaction Identifier Start: 10/31/2004
605	Orthodontic Treatment Months Count Start: 10/31/2004
606	Paid From Part A Medicare Trust Fund Amount Start: 10/31/2004
607	Paid From Part B Medicare Trust Fund Amount Start: 10/31/2004
608	Paid Service Unit Count Start: 10/31/2004
609	Participation Agreement Start: 10/31/2004
610	Patient Discharge Facility Type Code Start: 10/31/2004
611	Peer Review Authorization Number Start: 10/31/2004
612	Per Day Limit Amount Start: 10/31/2004
613	Physician Contact Date Start: 10/31/2004
614	Physician Order Date Start: 10/31/2004
615	Policy Compliance Code Start: 10/31/2004
616	Policy Name Start: 10/31/2004
617	Postage Claimed Amount Start: 10/31/2004
618	PPS-Capital DSH DRG Amount Start: 10/31/2004

619	PPS-Capital Exception Amount Start: 10/31/2004
620	PPS-Capital FSP DRG Amount Start: 10/31/2004
621	PPS-Capital HSP DRG Amount Start: 10/31/2004
622	PPS-Capital IME Amount Start: 10/31/2004
623	PPS-Operating Federal Specific DRG Amount Start: 10/31/2004
624	PPS-Operating Hospital Specific DRG Amount Start: 10/31/2004
625	Predetermination of Benefits Identifier Start: 10/31/2004
626	Pregnancy Indicator Start: 10/31/2004
627	Pre-Tax Claim Amount Start: 10/31/2004
628	Pricing Methodology Start: 10/31/2004
629	Property Casualty Claim Number Start: 10/31/2004
630	Referring CLIA Number Start: 10/31/2004
631	Reimbursement Rate Start: 10/31/2004
632	Reject Reason Code Start: 10/31/2004
633	Related Causes Code (Accident, auto accident, employment) Start: 10/31/2004 | Last Modified: 10/17/2010
634	Remark Code Start: 10/31/2004
635	Repriced Ambulatory Patient Group Code Start: 10/31/2004
636	Repriced Line Item Reference Number Start: 10/31/2004
637	Repriced Saving Amount Start: 10/31/2004
638	Repricing Per Diem or Flat Rate Amount Start: 10/31/2004
639	Responsibility Amount Start: 10/31/2004
640	Sales Tax Amount Start: 10/31/2004

642	Service Authorization Exception Code Start: 10/31/2004
643	Service Line Paid Amount Start: 10/31/2004
644	Service Line Rate Start: 10/31/2004
645	Service Tax Amount Start: 10/31/2004
646	Ship, Delivery or Calendar Pattern Code Start: 10/31/2004
647	Shipped Date Start: 10/31/2004
648	Similar Illness or Symptom Date Start: 10/31/2004
649	Skilled Nursing Facility Indicator Start: 10/31/2004
650	Special Program Indicator Start: 10/31/2004
651	State Industrial Accident Provider Number Start: 10/31/2004
652	Terms Discount Percentage Start: 10/31/2004
653	Test Performed Date Start: 10/31/2004
654	Total Denied Charge Amount Start: 10/31/2004
655	Total Medicare Paid Amount Start: 10/31/2004
656	Total Visits Projected This Certification Count Start: 10/31/2004
657	Total Visits Rendered Count Start: 10/31/2004
658	Treatment Code Start: 10/31/2004
659	Unit or Basis for Measurement Code Start: 10/31/2004
660	Universal Product Number Start: 10/31/2004
661	Visits Prior to Recertification Date Count CR702 Start: 10/31/2004
662	X-ray Availability Indicator Start: 10/31/2004
663	Entity's Group Name. Note: This code requires use of an Entity Code. Start: 10/31/2004 | Last Modified: 02/11/2010

664	Orthodontic Banding Date Start: 10/31/2004
665	Surgery Date Start: 10/31/2004
666	Surgical Procedure Code Start: 10/31/2004
667	Real-Time requests not supported by the information holder, do not resubmit Start: 02/28/2005
668	Missing Endodontics treatment history and prognosis Start: 06/30/2005
669	Dental service narrative needed. Start: 10/31/2005
670	Funds applied from a consumer spending account such as consumer directed/driven health plan (CDHP), Health savings account (H S A) and or other similar accounts Start: 06/30/2006 | Last Modified: 02/28/2007
671	Funds may be available from a consumer spending account such as consumer directed/driven health plan (CDHP), Health savings account (H S A) and or other similar accounts Start: 06/30/2006 | Last Modified: 02/28/2007
672	Other Payer's payment information is out of balance Start: 10/31/2006
673	Patient Reason for Visit Start: 10/31/2006
674	Authorization exceeded Start: 10/31/2006
675	Facility admission through discharge dates Start: 10/31/2006
676	Entity possibly compensated by facility. Note: This code requires use of an Entity Code. Start: 10/31/2006 | Last Modified: 02/11/2010
677	Entity not affiliated. Note: This code requires use of an Entity Code. Start: 10/31/2006 | Last Modified: 02/11/2010
678	Revenue code and patient gender mismatch Start: 10/31/2006
679	Submit newborn services on mother's claim Start: 10/31/2006
680	Entity's Country. Note: This code requires use of an Entity Code. Start: 10/31/2006 | Last Modified: 02/11/2010
681	Claim currency not supported Start: 10/31/2006
682	Cosmetic procedure Start: 02/28/2007
683	Awaiting Associated Hospital Claims Start: 02/28/2007
684	Rejected. Syntax error noted for this claim/service/inquiry. See Functional or Implementation Acknowledgement for details. (Note: Only for use to reject claims or status requests in transactions that were 'accepted with errors' on a 997 or 999 Acknowledgement.) Start: 11/05/2007

685	Claim could not complete adjudication in real time. Claim will continue processing in a batch mode. Do not resubmit. Start: 01/27/2008
686	The claim/ encounter has completed the adjudication cycle and the entire claim has been voided Start: 01/27/2008
687	Claim estimation can not be completed in real time. Do not resubmit. Start: 01/27/2008
688	Present on Admission Indicator for reported diagnosis code(s). Start: 01/27/2008
689	Entity was unable to respond within the expected time frame. Note: This code requires use of an Entity Code. Start: 06/01/2008 | Last Modified: 02/11/2010
690	Multiple claims or estimate requests cannot be processed in real time. Start: 06/01/2008
691	Multiple claim status requests cannot be processed in real time. Start: 06/01/2008
692	Contracted funding agreement-Subscriber is employed by the provider of services Start: 09/21/2008
693	Amount must be greater than or equal to zero. Note: At least one other status code is required to identify which amount element is in error. Start: 01/25/2009
694	Amount must not be equal to zero. Note: At least one other status code is required to identify which amount element is in error. Start: 01/25/2009
695	Entity's Country Subdivision Code. Note: This code requires use of an Entity Code. Start: 01/25/2009 | Last Modified: 02/11/2010
696	Claim Adjustment Group Code. Start: 01/25/2009
697	Invalid Decimal Precision. Note: At least one other status code is required to identify the data element in error. Start: 07/01/2009
698	Form Type Identification Start: 07/01/2009
699	Question/Response from Supporting Documentation Form Start: 07/01/2009
700	ICD10. Note: At least one other status code is required to identify the related procedure code or diagnosis code. Start: 07/01/2009
701	Initial Treatment Date Start: 07/01/2009
702	Repriced Claim Reference Number Start: 11/01/2009
703	Advanced Billing Concepts (ABC) code Start: 01/24/2010
704	Claim Note Text Start: 01/24/2010
705	Repriced Allowed Amount Start: 01/24/2010
706	Repriced Approved Amount Start: 01/24/2010

707	Repriced Approved Ambulatory Patient Group Amount Start: 01/24/2010
708	Repriced Approved Revenue Code Start: 01/24/2010
709	Repriced Approved Service Unit Count Start: 01/24/2010
710	Line Adjudication Information. Note: At least one other status code is required to identify the data element in error. Start: 01/24/2010
711	Stretcher purpose Start: 01/24/2010
712	Obstetric Additional Units Start: 01/24/2010
713	Patient Condition Description Start: 01/24/2010
714	Care Plan Oversight Number Start: 01/24/2010
715	Acute Manifestation Date Start: 01/24/2010
716	Repriced Approved DRG Code Start: 01/24/2010
717	This claim has been split for processing. Start: 01/24/2010
718	Claim/service not submitted within the required timeframe (timely filing). Start: 01/24/2010
719	NUBC Occurrence Code(s) Start: 01/24/2010
720	NUBC Occurrence Code Date(s) Start: 01/24/2010
721	NUBC Occurrence Span Code(s) Start: 01/24/2010
722	NUBC Occurrence Span Code Date(s) Start: 01/24/2010
723	Drug days supply Start: 01/24/2010
724	Drug dosage Start: 01/24/2010
725	NUBC Value Code(s) Start: 01/24/2010
726	NUBC Value Code Amount(s) Start: 01/24/2010
727	Accident date Start: 01/24/2010
728	Accident state Start: 01/24/2010

729	Accident description Start: 01/24/2010
730	Accident cause Start: 01/24/2010
731	Measurement value/test result Start: 01/24/2010
732	Information submitted inconsistent with billing guidelines. Note: At least one other status code is required to identify the inconsistent information. Start: 01/24/2010
733	Prefix for entity's contract/member number. Start: 01/24/2010
734	Verifying premium payment Start: 06/06/2010
735	This service/claim is included in the allowance for another service or claim. Start: 06/06/2010
736	A related or qualifying service/claim has not been received/adjudicated. Start: 06/06/2010
737	Current Dental Terminology (CDT) Code Start: 06/06/2010
738	Home Infusion EDI Coalition (HEIC) Product/Service Code Start: 06/06/2010
739	Jurisdiction Specific Procedure or Supply Code Start: 06/06/2010
740	Drop-Off Location Start: 06/06/2010
741	Entity must be a person. Note: This code requires use of an Entity Code. Start: 06/06/2010
742	Payer Responsibility Sequence Number Code Start: 06/06/2010
743	Entity's credential/enrollment information. Note: This code requires use of an Entity Code. Start: 10/17/2010
744	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error. Start: 10/17/2010
745	Identifier Qualifier Note: At least one other status code is required to identify the specific identifier qualifier in error. Start: 10/17/2010
746	Duplicate Submission Note: use only at the information receiver level in the Health Care Claim Acknowledgement transaction. Start: 10/17/2010
747	Hospice Employee Indicator Start: 10/17/2010
748	Corrected Data Note: Requires a second status code to identify the corrected data. Start: 10/17/2010
749	Date of Injury/Illness Start: 10/17/2010
750	Auto Accident State or Province Code Start: 10/17/2010 | Last Modified: 01/30/2011

751	Ambulance Pick-up State or Province Code Start: 10/17/2010 | Last Modified: 01/30/2011
752	Ambulance Drop-off State or Province Code Start: 10/17/2010 | Last Modified: 01/30/2011
753	Co-pay status code. Start: 01/30/2011
754	Entity Name Suffix. Note: This code requires the use of an Entity Code. Start: 01/30/2011
755	Entity's primary identifier. Note: This code requires the use of an Entity Code. Start: 01/30/2011
756	Entity's Received Date. Note: This code requires the use of an Entity Code. Start: 01/30/2011
757	Last seen date. Start: 01/30/2011
758	Repriced approved HCPCS code. Start: 01/30/2011
759	Round trip purpose description. Start: 01/30/2011
760	Tooth status code. Start: 01/30/2011
761	Entity's referral number. Note: This code requires the use of an Entity Code. Start: 01/30/2011
762	Locum Tenens Provider Identifier. Code must be used with Entity Code 82 – Rendering Provider Start: 01/20/2013
763	Ambulance Pickup ZipCode Start: 01/20/2013
764	Professional charges are non covered. Start: 06/02/2013
765	Institutional charges are non covered. Start: 06/02/2013
766	Services were performed during a Health Insurance Exchange (HIX) premium payment grace period. Start: 11/01/2013
767	Qualifications for emergent/urgent care Start: 01/26/2014
768	Service date outside the accidental injury coverage period. Start: 01/26/2014
769	DME Repair or Maintenance Start: 06/01/2014

Section 3: Evaluation

Data-driven monitoring and evaluation of third-party payer performance is important to the successful management of the payer relationship. Each of the agencies used reports and data metrics to monitor compliance with the contract as well as the revenue generated from third-party payers. These reports also identified opportunities to increase third-party revenue.

This section will present the following tools and resources related to the evaluation process:

Data and Reporting

- **ADPH Production Report** – A summary report that compares actual performance to budget projections, as well as billed and paid visits. Three measures are used to assess possible areas of lost revenue:
  - *Percent of Billed Visit to Actual Visits*
  - *Percent of Paid Visits to Actual Visits*
  - *Percent of Paid Visits to Billed Visits*

  Based on trends identified in this report, ADPH developed goals and benchmarks, as well as areas to implement improvement projects. Sample entries are included for "Site 1" to provide examples of the type of information housed in this document.
- **PPHeartland Payer Mix Budget to Actual Report** – The agency examines performance quarterly by comparing each health center's actual performance to the budget projections set at the beginning of the year. The indicators in this report include:
  - *Units* – the number of patient visits completed at the site.
  - *Average Charge per Unit* – the average charge for each visit.
  - *Payer Mix* – Visits by each payer category as a percentage of all visits to the health center.
  - *Adjustment Percentage* – The portion of the total charge amount that was reduced due to contractual allowances, per payer type.
  - *Collection Percentage* – The percentage of claims within a payer type that were successfully collected by the agency.

  The analysis is stratified by clinician and non-clinician services. The report also delineates performance by services and supplies. Sample entries are included for "Original Budget Projections" to provide examples of the type of information housed in this document.

Maximizing Revenue Opportunities

- **PPMNS Clinician Coding Chart Audit** – A tool to assess appropriate documentation and coding in a patient's health record. The coding manager compares the code assigned by the clinician to the correct code as determined by the audit.
- **PPMNS New Clinician Coding Training Agenda** – Each clinician receives a coding and documentation training by the coding manager to ensure the agency is meeting the agreed-upon expectations of third-party payers and not jeopardizing reimbursements. This agenda is intended for training new clinicians on the agency's processes, ideally conducted by a staff member appropriately trained in medical coding.

3.a.1 ADPH Production Report

See companion Case Study, page 15

County	Budgeted Units	Actual Units	Billed Units	Paid Units	% Billed of Actual	% Paid of Actual	% Paid of Billed
SITE 1	2004	2346	1672	1572	71%	67%	94%
SITE 2							
SITE 3							
SITE 4							
SITE 5							
SITE 6							
SITE 7							
SITE 8							
SITE 9							
SITE 10							
SITE 11							
SITE 12							
SITE 13							
SITE 14							
SITE 15							
SITE 16							
SITE 17							
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SITE 29							
SITE 30							
SITE 31							
SITE 32							
SITE 33							
SITE 34							
SITE 35							
SITE 36							
SITE 37							
SITE 38							
SITE 39							
SITE 40							
SITE 41							
SITE 42							
SITE 43							
SITE 44							
SITE 45							
SITE 46							
	0	0	0	0	0	0	0

3.a.2 PPHeartland Payer Mix Budget to Actual Report

See companion Case Study, page 15

First Quarter

Original Budget Predictions

	First Quarter Units	Avg Charge per Unit	Payer Mix	Adjustment %	Collection %
Clinician					
Waiver			30%	45%	99%
Medicaid			19%	38%	98%
Commerial			26%	30%	98%
Self-Pay			25%	60%	61%
Non-Clinician					
Waiver				45%	99%
Medicaid				43%	98%
Commerial				38%	98%
Self-Pay				31%	61%
Supply					
Waiver			41%	38%	99%
Medicaid			12%	44%	98%
Commerial			10%	31%	98%
RX			19%	44%	80%
Self-Pay			18%	49%	61%

Actual

	First Quarter Units	Avg Charge per Unit	Payer Mix	Adjustment %	Collection %
Clinician					
Waiver					
Medicaid					
Commerial					
Self-Pay					
Non-Clinician					
Waiver					
Medicaid					
Commerial					
Self-Pay					
Supply					
Waiver					
Medicaid					
Commerial					
RX					
Self-Pay					

3.b.1 PPMNS Clinician Coding Chart Audit

See companion Case Study, page 16

Date Reviewed: _____ Clinician: _____

Date of Service: _____ Chart #: _____

Chief Complaint/Reason for Visit:

New Patient ☐ Service(s) Selected: _____

Established Patient ☐ Service(s) Supported: _____

History

History Present Illness (HPI)		Review of Systems (ROS)				Past Family Social History (PFSH)	
Location	☐	Constitutional	☐	Endocrine	☐	Past Medical	☐
Quality	☐	Eyes	☐	Neurologic	☐	Family Hx	☐
Severity	☐	ENT	☐	Heme/Lymph	☐	Social Hx	☐
Duration	☐	Respiratory	☐	Musculoskeletal	☐		
Timing	☐	Cardiovascular	☐	Psychiatric	☐		
Context	☐	Gastrointestinal	☐	Allergic/Immuno	☐	Established Patient	
Mod/factor	☐	Genitourinary	☐	All others negative	☐	*Pertinent (1 of 3)* *Complete (2 of 3)*	
Assoc S/Sx	☐	Integumenaty	☐	Unable to obtain	☐		
Brief (1-3) Extended (4 or more)		Problem Pertinent (1) Extended (2-9) Complete (10 or more)				New Patient *Complete (3 of 3)*	

History Total/Level - must have all elements in column to meet level

Problem Focused (PF)		Exp Problem Focused (EPF)		Detailed		Comprehensive	
Chief Complaint	☐	Chief Complaint	☐	Chief Complaint	☐	Chief Complaint	☐
Brief HPI	☐	Brief HPI	☐	Extended HPI	☐	Extended HPI	☐
		Problem Pertinent ROS	☐	Extended ROS	☐	Complete ROS	☐
				Pertinent PFSH	☐	Complete PFSH	☐

Exam '95 Guidelines

Body Areas		Organ Systems				Preventative Exam (PHE)		
Head	☐	Constitutional	☐	Musculoskeletal	☐	(Includes a comprehensive history, exam, and counseling)		
Neck	☐	Eyes	☐	Integumentary	☐			
Chest	☐	ENT, Mouth	☐	Neurological	☐	New Patient	99384 12-17 yrs	☐
Abdomen	☐	Respiratory	☐	Psychiatric	☐		99385 18-39 yrs	☐
Genitalia	☐	Cardiovascular	☐	Heme/Lymph/Imm	☐		99386 40-64 yrs	☐
Back	☐	Gastrointestinal	☐					
Each Extremity	☐	Genitourinary	☐					

Exam Level				Established Patient		
					99394 12-17 yrs	☐
Problem Focused (1 body area/organ system)	☐	**Detailed** (5-7 body areas/organ systems)	☐		99395 18-39 yrs	☐
Expanded Problem Focused (2-4 body areas/organ systems)	☐	**Comprehensive** (8+ organ systems only)	☐		99396 40-64 yrs	☐

Number of Diagnoses

Diagnosis	Points	Score
Self limited/minor problem; stable, improved, worse (max 2)	1	
Established problem; stable, improved	1	
Established problem; worsening	2	
New problem; no additional work-up planned (max 1)	3	
New problem; additional work-up planned	4	
	Total	

Amount of Complexity and Data

Complexity and Data	Points	Score
Review/order of clinical lab test	1	
Review/order tests in radiology section of CPT	1	
Review/order tests in medicine section of CPT	1	
Discussion of test results with performing physicians	1	
Independent review of image, tracing, or specimen	2	
Decision to obtain old records/history from someone other than the patient	1	
Review and summarize old records/obtain history from someone other than the patient	2	
	Total	

Table of Risk

Risk	Presenting Problem	Diagnostic Procedure(s) Ordered	Managament Options
Minimal	• One self-limited or minor problem, e.g. cold, insect bite, tinea corp.	• Lab test required • Venipuncture • Chest X-ray • EKG/EEG • Urinalysis • Ultrasound	• Rest • Elastic bandages • Gargle • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g. well-controlled hypertension, non-insulin dependent diabetes	• Physiologic tests under stress, e.g. pulm function test • Non-cardio imaging studies with contrasts, e.g. barium • Superficial needle biopsies • Clinical lab test requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • IV fluids without additives
Moderate	• One or more chronic illnesses with mild exacerbation or progression. • Two or more stable chronic illnesses. • Undiagnosed new problem with uncertain prognosis, e.g. lump in breast • Acute illness with systemic symptoms, e.g. pneumonitis • Acute complicated injury, e.g. injury with brief loss of consciousness	• Physiologic test under stress, e.g. cardiac stress test, fetal contraction tes, MRI for brain tumor. • Diagnostic endoscopies without identified risk factors. • Deep needle or incisional biopsy. • Cardiovascular imaging studies with contrast and no identified risk factors, e.g. arteriogram. • Obtained fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis.	• Minor surgery with identified risk factors. • Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors. • Prescription drug management. • IV fluids with additive. • Closed treatment of fracture or dislocation without manipulation.
High	• One or more chronic illness with sever exacerbation, progression, or side effects of treatment. • Acute or chronic illness or injuries that may pose a threat to life or bodily function, e.g. psychiatric illness with potential threat to self or others, abrupt change in neurological status e.g. seizure, TIA.	• Cardiovascular imaging studies with contrast with identified risk factors. • Cardiac electrophysiological tests. • Diagnostic endoscopies with identified risk factors. • Discography.	• Elective major surgery (open percutaneous or endoscopic) with identified risk factors. • Emergency major sugery. • Parenteral control substances. • Drug therapy requiring intensive monitoring for toxicity.

Medical Decision Making (MDM) Totals

	(2 of 3 must meet or exceed)				Total
Diagnosis	1	2	3	4 or more	**History:**
Data	1	2	3	4 or more	**Exam:**
Risk	Minimal	Low	Moderate	High	**MDM:**
Level	**Straightforward**	**Low Complexity**	**Mod. Complexity**	**High Complexity**	**BBT:**
					Level:

Billing Based on Time (BBT):_____ Total visit time: _____ Total counseling time: _____

3.b.2 PPMNS New Clinician Coding Training Agenda

See companion Case Study, page 16

Training Agenda

- Introduction
- Importance of documentation
- Diagnosis coding
- Who is responsible?
  - As stated in [AGENCY NAME] policy, clinicians are solely responsible for:
    - Selecting the appropriate level of office visit, procedure, and supply code(s)
    - Selecting the most specific diagnosis code(s) for the services they provide
    - For completing the encounter form accordingly
- Evaluation and management documentation guidelines (office visits)
  - New vs. established patient
  - Determine the level of services
    - History
    - Exam
    - Medical decision-making
  - Review examples
  - Billing based on time
- Filling out a charge ticket
- Q & A
- Wrap up

About NFPRHA

Founded in 1971 and located in Washington, DC, the National Family Planning & Reproductive Health Association (NFPRHA) is a 501(c)3 non-profit membership organization representing the broad spectrum of family planning administrators and providers who serve the nation's low-income, under-insured, and uninsured women and men.

As the only national membership organization in the United States dedicated to increasing family planning access, NFPRHA is committed to advocacy, education, and training for its members. NFPRHA works to help ensure access to voluntary, comprehensive, and culturally sensitive sexual and reproductive health care services and supplies, and to support reproductive freedom for all.

To that end, NFPRHA seeks to maximize the opportunities for protecting and expanding access to family planning services for vulnerable populations by advocating for programs and resources that enhance both the medical services provided through and infrastructure of the publicly funded safety net.

Furthermore, NFPRHA prepares its membership for changes in the health care economy by providing policy and operational analyses to help its members consider and execute strategies for adapting to evolving economic and policy climates, and by convening administrators and clinicians to share experiences and best practices that help enhance quality and service delivery.

National
Family Planning
& Reproductive Health Association

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