HIPAA - ASC X12N

Outbound EDI 835 Electronic Remittance Advice Transaction

HIPAA Transaction
Companion Guide
Refers to the X12N Implementation Guide
ANSI Version 4010 X091A1

Version 1.0

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1 Introduction

1.1 Document Purpose

Companion Documents

Companion Documents are available to external entities (health plans, program contractors, providers, third party processors, and billing services) to clarify the information on HIPAA-compliant electronic interfaces with Passport Health Plan.

HIPAA Overview

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. They also address the security and privacy of health data. The intent of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of electronic data interchange standards in health care.

The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were not imposed arbitrarily but were developed by processes that included significant public and private sector input.

Covered entities are required to accept HIPAA Transactions in the standard format in which they are sent and must not delay a transaction or adversely affect an entity that wants to conduct the transactions electronically. Both Passport and its providers are HIPAA covered entities.

Document Objective

This Companion Document provides information about the 835 Claims Remittance Advice Transaction that is specific to Passport and Passport trading partners. For this transaction, the document describes the ways in which claim submitters receive information from Passport.

Intended Users

Companion Documents are intended for the technical staff of the Passport trading partners that are responsible for electronic transaction/file exchanges.

Relationship to HIPAA Implementation Guides

Companion documents supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This document describes the Passport environment and interchange conventions for 835

Claims Remittance Advice Transactions. It also provides specific information on the fields and values required for transactions sent to Passport.

Companion Documents are intended to supplement rather than replace the standard HIPAA Implementation Guide for each transaction set. Information in these documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

Disclaimer

This Companion Document is intended to be a technical document describing the specific technical and procedural requirements for interfaces between Passport and its trading partners. It does not supersede either health plan contracts or the specific procedure manuals for various operational processes. If there is conflict between this document and either the health plan contracts or operational procedure manuals, the contract or procedure manual will prevail.

Substantial effort has been taken to minimize conflicts or errors; however, Passport, AmeriHealth Mercy Health Plan and/or their employees will not be liable or responsible for any errors or expenses resulting from the use of information in this document. If you believe there is an error in the document, please notify Passport immediately.

1.2 Contents of this Companion Document

Introduction

Section 1 provides general information on Companion Documents and HIPAA and outlines the information to be included in the remainder of the document.

Transaction Overview

Section 2 provides an overview of the transactions included in this Companion Document including information on:

- The purpose of the transaction(s)
- The standard Implementation Guide for the transaction(s)
- Replaced and impacted Passport files and processes
- Transmission schedules

Technical Infrastructure

Section 3 provides a brief statement of the technical interface required for trading partners to communicate with Passport via electronic transactions. Readers are referred to either WebMD's (http://www.webenvoy.com) or HDX's (http://www.hdx.com) documentation for additional reference.

Transaction Standards

Section 4 provides information relating to the transactions included in this Companion Document including:

- General HIPAA transaction standards
- Testing criteria and procedures
- Data interchange conventions applicable to the transactions
- Procedures for acknowledgment transactions
- Procedures for handling rejected transmissions and transactions

Transaction Specifications

Section 5 provides more specific information relating to the transaction included in this Companion Document including:

- A statement of the purpose of transaction specifications for electronic interchanges between Passport and other HIPAA covered entities.
- Detailed Specifications that show how Passport populates the data elements in the 835 Claim Remittance Advice Transaction when Passport uses transaction data elements in ways that are not fully described by information in a HIPAA Implementation Guide.

2. 835 Claim Remittance Advice Transaction

2.1 Transaction Overview

Claim Remittance Advice Transaction

The HIPAA Implementation Guide for the 835 Health Care Claim Payment/Advice Transaction describes the transaction's "business use and definition" in the following way:

> The 835 is intended to meet the particular needs of the health care industry for the payment of claims and transfer of remittance information. The 835 can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice from a health care payer to a health care provider, either directly or through a DFI [Depository Financial Institution].

The 835 Transaction (sometimes called the Claims Remittance Advice or Claims RA Transaction in the remainder of this document) is a claims payment reporting transaction. It tells claim submitters the results of payer adjudication at the claim and service line levels.

The 835 Claim Remittance Advice does not report on claims that have not yet been processed or have been pended by the Passport claims adjudication process. In the HIPAA environment, submitters can obtain the statuses of all their claims, including claims that have not yet completed adjudication, with Passport's website (http://www.passporthealthplan.com).

The 835 RA Transactions and 837 Claim Transactions are closely linked. Although data on 835 Transactions comes from the claim adjudication database and the Passport Financial System, much of it is derived from information on incoming 837s and paper claims, with the addition of Payment Amounts, Adjustment Reason Codes, and Remark Codes generated by the adjudication process. Any change from a billed amount to a paid amount at a claim or service line level is called an adjustment in HIPAA nomenclature and is reported on the 835 with an Adjustment Reason Code and an Adjustment Amount.

Adjustment Reason Codes occur at institutional and professional claim service line levels. In addition, the 835 Transaction supports HIPAA compliant Remark Codes at both levels. Remarks Codes are not directly associated with changes from billed to payment amounts but are used to provide additional information about claim and service line errors.

Lengthy and detailed mapping documents show the relationships between the Passport Reason and Edit/Result Codes that appear on the Remittance Advice and the Adjustment Reason and Remark Codes on the 835 Transaction. Passport continues to generate pre-HIPAA Reason and Edit/Result Codes and to translate them to HIPAA compliant Adjustment Reason and Remark Codes. The mapping documents are the basis for this translation.

Processes Replaced or Impacted

The primary process affected by the 835 Claim Remittance Advice Transaction is the creation and transmission of the claim remittance advice. The email electronic remittance process that was available to select providers prior to the implementation of HIPAA will be eliminated but those providers interested in continuing to receive the RA information electronically may register with WebMD or HDX to receive the 835.

2.2 835 Claim Remittance Advice Transaction

Standard Implementation Guide

The standard Implementation Guide for the 835 Claim Remittance Advice Transaction is the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 Transaction Set Implementation Guide for the Health Care Claim Payment/Advice and all approved Addenda. Versions of the 835 Implementation Guide and Addenda adopted by Passport and other covered entities and used in preparation of this document are:

- ASC X12N 835 (004010X091)
- ASC X12N 835 (004010X091A1) (Addenda)

Related Transactions

HIPAA-mandated 837 Claim Transactions provide some of the claim data that Passport returns to claim submitters on 835 Remittance Advice Transactions.

Transmission Schedules

Passport sends 835 Remittance Advice Transactions to WebMD or HDX, for providers that have requested receipt of the 835 transaction and tested through either WebMD or HDX, following the check run batch for claims payment.

3. Technical Infrastructure and Procedures

3.1 Passport Data Center Communications Requirements

Passport will transmit the 835 Remittance Advice to WebMD or HDX via ftp. The files are encrypted before transmission using PGP encryption and a previously assigned key.

Providers will connect to WebMD or HDX, or arrange for their clearinghouse to connect to WebMD or HDX, to receive their 835 transactions.

4. Transaction Standards

4.1 General Information

HIPAA Requirements

HIPAA standards are specified in the Implementation Guide for each mandated transaction and modified by authorized Addenda.

An overview of requirements specific to the 835 Transaction can be found in Section 2, Data Overview, of the 835 Implementation Guide. The Data Overview Section contains information related to:

- Format and content of interchanges and functional groups
- Format and content of the header, detailer and trailer segments specific to the transaction
- Code sets and values authorized for use in the transaction
- Allowed exceptions to specific transaction requirements

Size of Transmissions/ Batches

Transmission sizes are limited based on two factors:

- The number of segments recommended by HIPAA Implementation Guides and imposed by lengths of control fields within transactions
- WebMD or HDX file transfer limitations

Recommended HIPAA standards for the maximum file size of each transaction are specified in the appropriate Implementation Guide or its authorized Addendum. The 835 Implementation Guide recommends a maximum of 10,000 CLP (Claim Payment) Segments per transaction.

Other Standards

Balancing Financial Data

The 835 Implementation Guide discusses balancing within the 835 Transaction by presenting it in three hierarchical levels:

- Service Line
- Claim
- 835 Transaction

At the outpatient/professional service line level, balancing is between the amounts charged for the service, any line-level adjustment made to the charged amount, and the service line payment amount. The 835 Implementation Guide translates these requirements into specific data elements that carry Charged Amounts, Adjustment Amounts, and Paid Amounts. Each Paid Amount must always be equal to the Charged Amount minus the Adjustment Amount.

At the transaction level, the Total Payment Amounts for all claims in a transaction must equal the sum of all claim-level Payment Amounts plus or minus PLB Segment for overpayments.

For all levels of balancing, positive Adjustment Amounts are subtracted from amounts charged by the provider to create Payment Amounts. Negative Adjustment Amounts, should they occur, are negative to Passport and are added to the amounts charged by the provider.

Remittance Tracking

The Trace Number (Element TRN02) and the Payer Identification Number (Element TRN03) in the 835 Transaction's Reassociation Trace Number (TRN) Segment reassociate the remittance advice data in the 835 Transaction with the payment sent separately. For Passport, TRN02 is the Payment Number of the check written for provider payment by the Passport Financial System.

Claims and Service Lines

As used by Passport, the structure of the 835 Transaction defines institutional and professional at the service line level. Each CLP Claim Payment Segment on the 835 Transaction represents an adjudicated payment or denial.

4.2 Testing Procedures

Providers should contact, or have their vendor contact, WebMD or HDX to test provider receipt of 835 transactions.

4.3 Data Interchange Conventions

Overview of Data Interchange

When transmitting 835 Transactions to providers, Passport follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or "outer envelopes". All 835 Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures, has fixed fields of a fixed length. Blank fields cannot be left out.

Interchange Specifications Table

Definitions of table columns follow:

Loop ID

> The Implementation Guide's identifier for a data loop within a transaction. "NA" is always used in this situation because the segments in outer envelopes have segments and elements but not loops.

Segment ID

> The Implementation Guide's identifier for a data segment.

Element ID

> The Implementation Guide's identifier for a data element within a segment.

Element Name

> A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition/Length

> How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this column after element definitions.

Valid Values

The valid values from the Implementation Guide that are used by Passport.

Definition/Format

Definitions of valid values used by Passport and additional information about Passport data element requirements.

<table>
<tr><th colspan="7">ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS</th></tr>
<tr><th>Loop ID</th><th>Seg ID</th><th>Element ID</th><th>Element Name</th><th>Element Definition/Length</th><th>Valid Values</th><th>Definition/Format</th></tr>
<tr><td colspan="7">ISA INTERCHANGE HEADER</td></tr>
<tr><td>NA</td><td>ISA</td><td>ISA01</td><td>AUTHORIZATION INFORMATION QUALIFIER</td><td>Code to identify the type of information in the Authorization Information Element/2 Characters</td><td>00</td><td>No Authorization Information Present</td></tr>
<tr><td>NA</td><td>ISA</td><td>ISA02</td><td>AUTHORIZATION INFORMATION</td><td>Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier/10 characters</td><td></td><td>Leave field blank - not used by Passport.</td></tr>
<tr><td>NA</td><td>ISA</td><td>ISA03</td><td>SECURITY INFORMATION QUALIFIER</td><td>Code to identify the type of information in the Security Information/2 characters</td><td>00</td><td>No Security Information present</td></tr>
<tr><td>NA</td><td>ISA</td><td>ISA04</td><td>SECURITY INFORMATION</td><td>This field is used for identifying the security information about the interchange sender and the data in the interchange; the type of information is set by the Security Information Qualifier/10 characters</td><td></td><td>Leave field blank - not used by Passport.</td></tr>
<tr><td>NA</td><td>ISA</td><td>ISA05</td><td>INTERCHANGE ID QUALIFIER</td><td>Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters</td><td>ZZ</td><td>Mutually Defined</td></tr>
<tr><td>NA</td><td>ISA</td><td>ISA06</td><td>INTERCHANGE SENDER ID</td><td>Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element/15 characters</td><td></td><td><table><tr><th>Plan Name</th><th>LOB Code</th><th>Payer Identifier</th></tr><tr><td>Passport Health Plan</td><td>1300</td><td>61129</td></tr></table></td></tr>
<tr><td>NA</td><td>ISA</td><td>ISA07</td><td>INTERCHANGE ID QUALIFIER</td><td>Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters</td><td>ZZ</td><td>Mutually Defined</td></tr>
</table>

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
NA	ISA	ISA08	INTERCHANGE RECEIVER ID	Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them/15 characters		WebMD or HDX identifier.
NA	ISA	ISA09	INTERCHANGE DATE	Date of the interchange/6 characters		The Interchange Date in YYMMDD format
NA	ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 characters		The Interchange Time in HHMM format
NA	ISA	ISA11	INTERCHANGE CONTROL STANDARDS	Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer/1 character	U	U.S. EDI Community of ASC X12, TDCC, and UCS
IDENTIFIER						
NA	ISA	ISA12	INTERCHANGE CONTROL VERSION NUMBER	This version number covers the interchange control segments/5 characters	00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedure Review Board through October 1997
NA	ISA	ISA13	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		The Interchange Control Number. ISA13 must be identical to the control number in associated Interchange Trailer field IEA02.
NA	ISA	ISA14	ACKNOWLEDGEMENT REQUESTED	Code sent by the sender to request an Interchange Acknowledgement (TA1)/1 character	0	No Acknowledgement Requested Passport does not request or expect TA1 Interchange Acknowledgement Segments from its trading partners.
NA	ISA	ISA15	USAGE INDICATOR	Code to indicate whether data enclosed is test, production or information/1 character	P or T	Production Data or Test Data

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
NA	ISA	ISA16	COMPONENT ELEMENT SEPARATOR	The delimiter value used to separate components of composite data elements/1 character		A "colon" (:)(the symbol above the semicolon on most keyboards) is the value used by Passport for component separation. Segment and element level delimiters are defined by usage in the ISA Segment and do not require separate ISA elements to identify them. Delimiter values, by definition, cannot be used as data, even within free-form messages. The following separator or delimiter values are used by Passport on outgoing transactions: Segment Delimiter - "~' (tilde - hexadecimal value X"7E") Element Delimiter - "*' (asterisk)Composite Component Delimiter (ISA16) – “>” (default).
IEA INTERCHANGE TRAILER IEA IEA01						
NA	IEA	IEA01	NUMBER OF INCLUDED FUNCTIONAL GROUPS	A count of the number of functional groups included in an interchange/5 characters		The number of functional groups of transactions in the interchange
NA	IEA	IEA02	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		A control number identical to the header-level Interchange Control Number in ISA13.

GS/GE FUNCTIONAL GROUP ENVELOPE TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Value**	**Definition/Format**	**Source**
GS FUNCTIONAL GROUP HEADER							
NA	GS	GS01	FUNCTIONAL IDENTIFIER CODE	Code identifying a group of application related transaction sets	HP	Health Care Claim Payment/Advice (835)	HIPAA Code Set
NA	GS	GS02	APPLICATION SENDER'S CODE	Code identifying party sending transmission; codes agreed to by trading partners		Passport repeats the Sender Identifier used in the ISA Segment.	Transmission sender
NA	GS	GS03	APPLICATION RECEIVER'S CODE	Codes identifying party receiving transmission. Codes agreed to by trading partners		Passport repeats the Receiver Identifier used in the ISA Segment.	Transmission sender
NA	GS	GS04	DATE	The functional group creation date.		Date expressed as CCYYMMDD	Transmission sender
NA	GS	GS05	TIME	The functional group creation time.		Time on a 24-hour clock in HHMM format.	Transmission sender
NA	GS	GS06	GROUP CONTROL NUMBER	A control number for the functional group of transactions.		Assigned number originated and maintained by the sender	Transaction sender
NA	GS	GS07	RESPONSIBLE AGENCY CODE	Code used in conjunction with Element GS08 to identify the issuer of the standard	"X"	Accredited Standards Committee X12	HIPAA Code Set
NA	GS	GS08	VERSION / RELEASE / INDUSTRY IDENTIFIER CODE	Code that identifies the version of the transaction(s) in the functional group	004010X091A1 Passport uses Addenda versions of all HIPAA Transactions. This Version Number incorporates the	HIPAA Code Set	

GS/GE FUNCTIONAL GROUP ENVELOPE TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Value**	**Definition/Format**	**Source**
					final Addenda.		
GE FUNCTIONAL GROUP TRAILER							
NA	GE	GE01	NUMBER OF TRANSACTION SETS INCLUDED	The number of transactions in the functional group ended by this trailer segment			Transmission sender
NA	GE	GE02	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		This number must match the control number in GS06.	Transmission sender

4.4 Acknowledgment Procedures

Overview of Electronic Acknowledgment Processes

Passport accepts and processes 997 Functional Acknowledgement Transactions from WebMD and HDX. The 997s from WebMD and HDX serve as either acknowledgements or as notifications of syntactical problems with the 835s transmitted from Passport. Discrepancies are possible, due to variations in sender and receiver edits. A similar interchange will occur between WebMD or HDX and the individual provider.

5. Transaction Specifications

5.1 About Transaction Specifications

Purpose

Transaction Specifications document the codes that Passport allows between trading partners and specify the type and format of the information included in data elements. In some cases, these values are subsets of the data element values listed or referenced in Implementation Guides. In others, they are specific to Passport requirements.

For example, in the Receiver Identification Segment (REF) of a transaction in the Implementation Guide, Element REF02 is defined as an alphanumeric identification element that is between 1 and 30 characters long. In the Transaction Specifications, REF02 is defined as the Receivers ISA ID. The length and format of the field are based on the characteristics of the Receivers ISA ID rather than on the variable field size defined for the transaction by the Implementation Guide.

Relationship to HIPAA Implementation Guides

Transaction Specifications supplement information in the Implementation Guides for each HIPAA Transaction with additional information specific to the trading partners using the transaction.

The information in the Transaction Specifications is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.

- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

5.2 835 Claims Remittance Advice Transaction Specifications

Overview

The purpose of these Transaction Specifications is to identify the data elements used in the 835 Claims Remittance Advice Transaction so that providers and other entities that receive 835 Transactions from Passport will be able to understand and process transaction data. The 835 Transaction does not include or accompany claim payments. Rather, it serves as a detailed remittance advice that shows payments, adjustments, and denials for each claim submitted by providers that choose to receive 835s.

The Passport Financial System implements company policy by generating weekly checks to providers paid on a fee-for-service basis. To be consistent with this payment policy, the company generates 835 Transactions on a weekly basis. Each 835 includes identification, medical, and financial data on paid and denied claims adjudicated during the previous week. Pended claims and claims received but not yet processed by Passport are not included. Claim replacements and voids are reported using the existing non-electronic process.

The following entities can receive 835 Transactions from Passport:

- Authorized fee-for-service providers that submit claims to Passport
- Provider groups that serve as billing providers for individual physicians or other practitioners
- Billing agents that transmit claims and collect receivables for fee-for-service providers

Three special considerations that affect the Passport 835 Transactions are discussed in further detail. They are:

- Claim Adjudication Codes
- Billing and Servicing Providers
- Provider Level Adjustments

Claim Adjudication Codes

The most important data variations between the current Passport Claims Remittance Advice and the 835 Transaction are in the code sets that tell claim submitters the results of each claim’s

adjudication. On its pre-HIPAA RAs, Passport relied on several code sets to inform submitters of claims and service lines that are paid, denied, pended, and not yet processed.

Detailed mappings between Passport and HIPAA claim adjustment codes are included in this document (see Appendix 1). These mappings are used in code set translation. They only apply to Passport codes for which there are appropriate and reasonable translations. The following categories of Passport Edit/Result and Claim Reason Codes have been excluded from the code set mappings:

- Passport Codes for pended and not-yet-processed claims and service lines

  The 835 RA is a financial transaction that supports only adjudicated (paid or denied) claims and service lines.

- Passport Codes for voids

  Although the 835 Transaction supports replacements and voids, it does not have detailed Adjustment Reason or Remark Code to explain them. They are identified through the non-electronic process.

- Passport Codes that cannot be reasonably translated

Both Passport and HIPAA Code Sets have some values that do not have equivalent values so one code may be mapped to many.

On the HIPAA code set side, there are also three code sets that describe the results of claim adjudication: Adjustment Group Code, Adjustment Reason Code, and Remark Code. Adjustment Group and Adjustment Reason Codes explain the differences between Charged Amounts and Paid Amounts at both claim and service line levels. For the 835, adjustments are variations between Charged and Paid Amounts that result from claim adjudication.

High-level Adjustment Group Codes, and Adjustment Reason Codes that are more specific, are associated with an Adjustment Amount on the 835 Transaction. Remark Codes have no direct relationship to dollar amounts, although many Remark Codes provide further explanation of the Adjustment Reason codes by explaining why a claim or service line is adjusted or denied.

There are major differences between the Passport and the HIPAA compliant code sets used to explain the results of claim adjudication. The following distinctions are especially important:

- Passport pays most claims based on Allowed Amounts determined by the claim adjudication process independently of provider charges. The only connection between charges and payments is that Passport does not pay more than the Charged Amount even if the Passport Allowed Amount is greater.
- Passport will only send service line level adjustments.
- Few Passport and HIPAA code set values have solid, unambiguous matches at the same level of detail. This is true both because Passport codes are more detailed and specific than HIPAA codes and because they frequently cover different situations.

In light of these considerations, Passport has adopted a three-step approach to population of Adjustment Group, Adjustment Reason, and Remark Codes on 835 Transactions.

Step 1: Determine whether a service line needs a CAS (Claim or Service Line Adjustment) Segment with an Adjustment Group Code, Adjustment Reason Code, and Adjustment Amount.

When the Payment Amount for a claim or line is different from the Charged Amount, a CAS Segment is required. When the amounts are equal, the CAS Segment with its adjustment codes is not needed.

In theory, a Remark Code can occur without a CAS Segment for a claim or service line. In practice, this seldom happens because most Remark Codes explain reasons for denials or cut-backs that generate adjustment codes and Adjustment Amounts.

Step 2: If Charged and Payment Amounts for an institutional claim or professional service line are different, Adjustment Group and Adjustment Reason Codes are required on the 835 Transaction, along with an Adjustment Amount.

Adjustment code combinations are based on two factors. The first factor is the status categories that are assigned to institutional claims and professional service lines by the claim adjudication process:

- Original Paid Claims or Service Lines
- Denied Claims or Service Lines

The second factor in adjustment code assignment is the reason for the adjustment. The following adjustment types (in addition to provider level adjustments that are not claim specific) are accommodated:

- Share of Cost Amounts paid by the patient
- Amounts paid by other health care carriers
- Amounts previously paid by Passport
- Pricing adjustments - reductions in Payment Amounts from Charged Amounts due to use of Passport Allowed Amounts in payment

Adjustment Group and Adjustment Reason Codes and messages used by Passport on the 835 Transaction are shown in the chart on the next page.

Step 3: Translate Passport Code Sets.

The third step involves translation of Passport Reason and Edit/Result Codes to HIPAA Remark Codes on the 835 Transaction. Further translations of Passport codes to Adjustment Group and Reason Codes are not attempted.

Remark Codes populate LQ (Health Care Remark Codes) Segments when generated at the service line level.

Adjustment Type	835 Adjustment Group	835 Adjustment Reason
Share of Cost	PR - Patient Responsibility	2 - Coinsurance Amount
Other Carrier	OA - Other Adjustment	23 - Payment adjusted because another payer has paid charges.
Prior Passport Payment	OA - Other Adjustment	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.
Pricing	PI - Payer Initiated	A2 - Contractual Adjustment
Share of Cost	CR - Correction and Reversals	2 - Coinsurance Amount
Other Carrier	CR - Correction and Reversals	23 - Payment adjusted because another payer has paid charges.
Prior Passport Payment	CR - Correction and Reversals	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.
Pricing	CR - Correction and Reversals	A2 - Contractual Adjustment
Pricing	PI - Payer Initiated	A1 - Claim denied charges

All of these conditions can occur at service line levels.

Billing and Servicing Providers

Passport has two kinds of situations involving Billing and Servicing or Rendering Providers that require recognition in the 835 Transaction. They are:

- Rendering Providers with multiple locations – the Rendering Provider is also the Billing Provider.

  In this situation, the provider's Passport ID Number, without a Location Code suffix, appears as the Billing Provider (Loop 1000B/Element REF02 in the Payee Additional Identifier REF Segment). The Provider IDs for the various locations appear, with Location suffixes, as service providers (Loop 2000/Element TS301and Loop 2100/Element NM109 in the Rendering Provider Name NM1 Segment).

- Provider Groups and Billing Agents – the Rendering Provider and Billing Provider are different.

  In this situation, Passport assigns Provider IDs to the group or billing agent. The group or billing agent appears on the 835 as a Billing Providers Provider (Loop 1000B/Element REF02 in the Payee Additional Identifier REF Segment) without a Location Code. Members of the group have different Passport Provider IDs. They appear as Rendering Providers (Loop 2000/Element TS301and Loop 2100/Element NM109 in the Rendering Provider Name NM1 Segment) with Location Codes.

If a rendering provider with multiple locations is a member of a billing group, the group is the billing provider on the 835 and each location is a different rendering provider.

Provider Level Adjustments

In addition to supporting financial adjustments (changes from charged to paid amounts) at claim and service line levels, the 835 Transaction's PLB Provider Adjustment Segment allows claim payers to notify billing providers of payments and withholds that are not claim specific. Passport uses the provider level adjustment feature:

- To report non-claim specific payments to (and withholds from) billing providers. A reduction to prior advanced payments is an example of what can be handled by this segment.
- To offset negative payment amounts to billing providers when the total provider payment balance on the 835 is negative. This function is needed because the Passport Financial System does not issue negative payments.

Payments to and withholds from billing providers that are not specific to claims are included in transaction level balancing along with claim based payments. They have PLB03 Adjustment Reason Codes of "AM" (Applied to Borrower's Account).

Transaction Specifications Table

The 835 Claims Remittance Advice Transaction Specifications for individual data elements are shown in the table beginning on the next page. This table contains information on all fields included in Passport's 835 Claims Remittance Advice. Definitions of table columns follow:

Loop ID

The Implementation Guide's identifier for a data loop within a transaction.

Segment ID

This is the Implementation Guide's identifier for a data segment within a loop.

Element ID

This is the Implementation Guide's identifier for a data element within a segment.

Element Name

The data element name is found in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition

How the data element is defined in the Implementation Guide.

Valid Values

Passport uses the valid values from the Implementation Guide.

Definition/Format

Definitions of valid values used by Passport and additional information about Passport data element requirements.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
NA	ST	ST01	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	835	Transaction Set Number
NA	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set		This number is unique within a functional group of similar transactions. The value of this element is the same as that of the SE02 element at the end of the transaction.
NA	BPR	BPR01	Transaction Handling Code	This code designates whether and how the money and remittance information will be processed	I	Remittance Information Only (the capital letter “I”)
NA	BPR	BPR02	Total Actual Provider Amount	The total payment for this batch or transaction		The Total Payment Amount on the 835 Transaction. This is the amount of the weekly check to the billing provider. The Passport translator verifies that it balances to sums of 835 Transaction payment totals at service provider, claim, and service line levels. When the Billing Provider that receives the transaction (REF02 within the transaction header) and the Rendering Provider (Loop 2100, Element NM109) are the same, balancing is for a single 835 provider/receiver. This has two decimal places.
NA	BPR	BPR03	Credit or Debit Flag Code	Code indicating whether amount is a credit or debit	C	Credit Negative dollar amounts are made with the Credit Flag by assigning a negative value to BPR02.
NA	BPR	BPR04	Payment Method Code	Code identifying the method for the movement of payment instructions	CHK	Passport makes claim payments primarily by check.
NA	BPR	BPR16	Check Issue or EFT Effective Date	Date the check was issued or the electronic funds transfer (EFT) effective date		Date that the check was issued or that Passport intends the transaction to be settled in CCYYMMDD format.
NA	TRN	TRN01	Trace Type Code	Code identifying the type of reassociation which needs to be performed	1	Current Transaction Trace Numbers

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
NA	TRN	TRN02	Check or EFT Trace Number	Check number or Electronic Funds Transfer (EFT) number that is unique within the sender/receiver relationship		Check Number
NA	TRN	TRN03	Originating Company Identifier	A unique identifier designating the company originating the transaction		Number “1” concatenated with tax id for originating LOB for 835 Passport – 611294407
NA	REF	REF01	Receiver Identification Qualifier		EV	
NA	REF	REF02	Receiver Identification			Immediate destination value.
1000A	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PR	Payer Identification
1000A	N1	N102	Payer Name	Name identifying the organization remitting the payment	Passport Health Plan	Name of organization making the payment.
1000A	N3	N301	Payer Address Line	Address line for the payer's address	200 Stevens Drive	
1000A	N4	N401	Payer City Name	The city name of the payer's address	Philadelphia	
1000A	N4	N402	Payer State Code	State postal code of the payer's address	PA	
1000A	N4	N403	Payer Postal Zone or ZIP Code	The postal zone code of the payer's address	19113	
1000B	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PE	Payee

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
1000B	N1	N102	Information Receiver Last or Organization Name	The name of the organization or last name of the individual that expects to receive information or is receiving information		Payee Name
1000B	N1	N103	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	The payee's Federal Taxpayer's ID Number
1000B	N1	N104	Payee Identifier	Number identifying the organization receiving the payment		Payee's Tax ID Number
1000B	N3	N301	Payee Address Line	The payee's address line		Payee's Street Address Line 1
1000B	N3	N302	Payee Address Line	The payee's address line		Payee's Street Address Line 2
1000B	N4	N401	Payee City Name	The City Name of the payee's address		Payee's City
1000B	N4	N402	Payee State Code	The State Postal Code of the payee's address		Payee's State
1000B	N4	N403	Payee Postal Zone or ZIP Code	The Zip Code of the payee's address		Payee's Zip Code
1000B	REF	REF01	Ref Identification Qualifier	Payee Additional Information Qualifier	PQ	Payee Identification Qualifier
1000B	REF	REF02	Ref Identification	Payee Additional Information		Payee ID
2000	LX	LX01	Assigned Number	Number assigned for differentiation within a transaction set	1	The single-element LX Segment is especially needed when the 835 Transaction has multiple 2000 Header Number Loops for different rendering providers. This can happen when the 835 is sent to a provider group or billing agent that includes multiple rendering providers and/or facilities within it. If the payee identified in Payee Identification Loop 1000B is the same as the Service or Rendering Provider and the provider has only a single

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
						Location, there is only one 2000 Loop.
2100	CLP	CLP01	Patient Control Number	Patient's unique alpha-numeric identification number for this claim assigned by the provider to facilitate retrieval of individual case records and posting of payment		The Loop 2100 CLP Claim Payment Information Segment begins data on each individual claim for a service provider within the 835 Transaction. This element carries the Patient Control Number assigned by the provider, whether received on 837 Transactions or paper claims. CLP01 is zero if no Patient Control Number is present.
2100	CLP	CLP02	Claim Status Code	Code specifying the status of a claim submitted by the provider to the payer for processing		Default to Tertiary Payer – code 3
2100	CLP	CLP03	Total Claim Charge Amount	The sum of all charges included within this claim		The Total Charged Amount for the claim. This amount includes Share of Cost payments by the patient and amounts paid by other carriers before Passport.
2100	CLP	CLP04	Claim Payment Amount	Net provider reimbursement amount for this claim (includes all payments to the provider)		The Passport Total Net Paid Amount for the claim.
2100	CLP	CLP06	Claim Filing Indicator Code	Code identifying type of claim or expected adjudication process	MC	Medicaid
2100	CLP	CLP07	Payer Claim Control Number	A number assigned by the payer to identify a claim The number is usually referred to as an Internal Control Number (ICN), Claim Control Number (CCN) or a Document Control Number (DCN)		The 14-character Claim Reference Number (CRN) assigned by Passport.
2100	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	CO	For contractual obligation
2100	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	85	For interest amount

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		Claim Interest Amount
2100	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	OA	For other adjustment
2100	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	B13	For previous paid amount
2100	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		Prior paid amount
2100	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	QC	Patient
2100	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	
2100	NM1	NM103	Patient Last Name	The last name of the individual to whom the services were provided		
2100	NM1	NM104	Patient First Name	The first name of the individual to whom the services were provided		
2100	NM1	NM105	Patient Middle Name	The middle name of the individual to whom the services were provided		
2100	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	MI	
2100	NM1	NM109	Identification Code	Used for Identification Code		
2100	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	82	Produce this segment if Payee Tax ID not equal to Provider ID (where Billing Provider is a Group)
2100	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	2	

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100	NM1	NM103	Rendering Provider Last or Organization Name	The last name or organization of the provider who performed the service		
2100	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code		"FI" if 9 digit id, else "SL"
2100	NM1	NM109	Rendering Provider Identifier	The identifier assigned by the payer to the provider who performed the service		
2110	SVC	SVC01-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID	HC	
2110	SVC	SVC01-2	Procedure Code	Code identifying the procedure, product or service		
2110	SVC	SVC01-3	Procedure Modifier	Procedure Modifier		
2110	SVC	SVC01-7	Description	Description		
2110	SVC	SVC02	Line Item Charge Amount	Charges related to this service		
2110	SVC	SVC03	Line Item Provider Payment Amount	The actual amount paid to the provider for this service line		
2110	SVC	SVC04	National Uniform Billing Committee Revenue Code	Code values from the National Uniform Billing Committee Revenue Codes		
2110	DTM	DTM01	Date Time Qualifier	Code specifying the type of date or time or both date and time	150	From Date of Service
2110	DTM	DTM02	Service Date	Date of service, such as the start date of the service, the end date of the service, or the single day date of		The Service Begin Date in CCYYMMDD format.

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
				the service		
2110	DTM	DTM01	Date Time Qualifier	Code specifying the type of date or time or both date and time	151	To Date of Service
2110	DTM	DTM02	Service Date	Date of service, such as the start date of the service, the end date of the service, or the single day date of the service		The Service End Date in CCYYMMDD format.
2110	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	OA	For Other Adjustment. Default claim adjustment group
2110	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	96	For Non-covered charges
2110	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		This calculated amount is the value not paid on the claim based on the charge amount. Value = (procedure charge – amount paid)
2110	AMT	AMT01	Amount Qualifier Code	Code to qualify amount	B6	Service supplemental amount
2110	AMT	AMT02	Service Supplemental Amount	Additional amount or charge associated with the service		
2110	LQ	LQ01	Code List Qualifier Code	Code identifying a specific industry code list	HE	Health Care Remark Codes; see implementation guide for complete code list.
2110	LQ	LQ02	Remark Code	Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list		See Appendix for Crosswalk of Local Explanation Codes To HIPAA Remark Codes.
NA	PLB	PLB01	Provider Identifier	Number assigned by the payer, regulatory authority, or other authorized body or agency to		

835 CLAIMS REMITTANCE ADVICE TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
				identify the provider		
NA	PLB	PLB02	Fiscal Period Date	Last day of provider's fiscal year through date of the bill		Last day of the Provider's Fiscal Year. If date is not known, use December 31 of the current year. Format CCYYMMDD.
NA	PLB	PLB03-1	Adjustment Reason Code	Code that indicates the reason for the adjustment	CS	For adjustment
NA	PLB	PLB03-2	Provider Adjustment Identifier	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		Patient Account Number
NA	PLB	PLB04	Amount	Amount		Current claims recovery amount.
NA	SE	SE01	Transaction Segment Count	A tally of all segments between the ST and the SE segments including the ST and SE segments		Count of all segments between the ST and SE Segments, including the ST and SE Segments. Format is numeric from 1 to 10 digits.
NA	SE	SE02	Transaction Set Control Number	The unique identification number within a transaction set		Number unique within a functional group of 835 Transactions. This number is the same number that is in data element ST02.

APPENDIX 1: Explanation Codes

Explanation Code ID	Explanation Code Description	Health Care Remark Code (LQ02)	Health Care Remark Code Description
040	Referral/Pre-auth Violation	M62	Missing/incomplete/invalid treatment authorization
042	Claim Level Interest Clean Date Override	MA67	Correction to a prior claim.
043	UM Pre-auth Denial	N35	Program integrity/utilization review decision.
044	UM Referral Denial	N35	Program integrity/utilization review decision.
047	Earliest Agreement Override	N144	The rate changed during the dates of service bille
048	ASC Multiple Procedures Reductions Taken	N14	Payment based on a contractual amount or agreement
049	ASC Default Category Reductions Taken	N14	Payment based on a contractual amount or agreement
050	Provider Payment Adjustment	N14	Payment based on a contractual amount or agreement
051	Provider Surcharge Amount	N44	Payer’s share of regulatory surcharges, assessment
053	Extra Contractual Override	N14	Payment based on a contractual amount or agreement
054	Services Denied.Contact Delegated Entity	M41	We do not pay for this as the patient has no legal
055	Benefit allowable for Medicare primary	N14	Payment based on a contractual amount or agreement
201	Interest is being recouped.	MA67	Correction to a prior claim.
318	Claim sent to Home Plan	N193	Specific federal/state/local program may cover thi
AAR	Reduced For Automatic Recovery	MA67	Correction to a prior claim.
CDD	Definite Duplicate Claim	M86	Service denied because payment already made for sa

CG0	Tier not found, Category not covered	M41	We do not pay for this as the patient has no legal
CG1	Rule not set, Category not covered	M41	We do not pay for this as the patient has no legal
CG2	Covered Amount > Category Allow Amt	M41	We do not pay for this as the patient has no legal
CG3	Cov Amount > Ctgy Allow Amount + Hist	M41	We do not pay for this as the patient has no legal
CG4	Covered Ctr > Category Allow Ctr	M41	We do not pay for this as the patient has no legal
CG5	Cov Ctr > Ctgy Allow Ctr + Hist	M41	We do not pay for this as the patient has no legal
COB	Pd Limit Accum Altered by COB Adjustment	N130	Consult plan benefit documents for information abo
CVX	Coverage Exclusion	N35	Program integrity/utilization review decision.
D21	Submit Ortho Tx date	M58	Missing/incomplete/invalid claim information. Res
D22	Submit x-ray(s) for procedure	M127	Missing/incomplete/invalid patient medical record
DIS	Agreement Discount Off Charges	N14	Payment based on a contractual amount or agreement
DP0	Member age exceeds procedure norm	M67	Missing/incomplete/invalid other procedure code(s)
DP1	Dental procedure not valid for teeth	M41	We do not pay for this as the patient has no legal
DP2	Covered Amount > Procedure Allow Amt	M41	We do not pay for this as the patient has no legal
DP3	Cov Amt>Proc Allow Amt+Hist or Curr Clm	M41	We do not pay for this as the patient has no legal
DP4	Covered Ctr > Procedure Allow Ctr	M41	We do not pay for this as the patient has no legal
DP5	Cov Ctr>Proc Allow Ctr+Hist or Curr Clm	N130	Consult plan benefit documents for information abo
EXR	External Referral Received	N45	Payment based on authorized amount.
F50	Clm Adj - Third Party Denied/Ben Exhaust	N130	Consult plan benefit documents for information abo
GLB	Disallow--global case	N14	Payment based on a contractual amount or agreement
GLD	Global Case Rate Override	N14	Payment based on a contractual amount or agreement
I02	Illegible Records Submitted	M127	Missing/incomplete/invalid patient medical record
I04	Correct NDC Code Required	M58	Missing/incomplete/invalid claim information. Res
I05	Invalid/Inapp/Del Code, Mod or Desc	N56	Procedure code billed is not correct/valid for the
I06	Itemized Bill/DOS/Charges/Invoice Req	M58	Missing/incomplete/invalid claim information. Res

I07	Invalid/Inapp/Del Code, Mod, or Desc	N56	Procedure code billed is not correct/valid for the
I08	Diagnosis inv/missing/del 4th or 5th	M64	Missing/incomplete/invalid other diagnosis.
I10	E Code Cannot Be Used As Primary DX	M64	Missing/incomplete/invalid other diagnosis.
I11	EOB from primary carrier required	N4	Missing/incomplete/invalid prior insurance carrier
I12	Claim without Phys name or number	M58	Missing/incomplete/invalid claim information. Res
I13	EOB/attachments illegible/incomplete	M58	Missing/incomplete/invalid claim information. Res
I14	Invalid/missing Revenue Code	N56	Procedure code billed is not correct/valid for the
I38	Need Newborn Member Number	N30	Patient ineligible for this service.
I48	Resub Primary Carrier/Appeal Process	N4	Missing/incomplete/invalid prior insurance carrier
I68	Invalid place of service for procedure	M77	Missing/incomplete/invalid place of service.
I73	EPSDT Form was Incomplete	N4	Missing/incomplete/invalid prior insurance carrier
I99	MAID Missing or Invalid	M58	Missing/incomplete/invalid claim information. Res
IAA	ITS LIL allowable amount	N14	Payment based on a contractual amount or agreement
IAC	ITS LIL co-pay amount	N135	Record fees are the patient's responsibility and l
IAD	ITS LIL deductible	N17	Per admission deductible.
IAN	ITS LIL coinsurance amount	MA118	Coinsurance and/or deductible amounts apply to a c
IAX	ITS LIL disallow amount	M41	We do not pay for this as the patient has no legal
IN	Inlier Pricing	N45	Payment based on authorized amount.
ISS	Invalid Sex For Service Rendered	MA39	Missing/incomplete/invalid gender.
L01	Stat adj for letter sent	N10	Claim/service adjusted based on the findings of a
LS2	Stoploss Based on Charge	N14	Payment based on a contractual amount or agreement
M98	Total Amt Still Under Consideration	M58	Missing/incomplete/invalid claim information. Res
M99	Provider Payment Adjustment	N14	Payment based on a contractual amount or agreement
MLN	Please submit primary dx	M58	Missing/incomplete/invalid claim information. Res
MRC	Miscellaneous Recovery	MA67	Correction to a prior claim.

MSD	Multiple Same Day Surgery Reductions	N14	Payment based on a contractual amount or agreement
N01	Subset Procedure Disallow	N19	Procedure code incidental to primary procedure.
N02	Redundant Procedure Disallow	N19	Procedure code incidental to primary procedure.
N03	Secondary Procedure Disallow	N19	Procedure code incidental to primary procedure.
N04	Follow-Up Service Disallow	N19	Procedure code incidental to primary procedure.
N05	Same Day Procedure Disallow	N19	Procedure code incidental to primary procedure.
N06	Assistant Surgeon Disallow	M41	We do not pay for this as the patient has no legal
N09	Cosmetic Procedure Disallow	N35	Program integrity/utilization review decision.
N10	Investigation Disallow	N35	Program integrity/utilization review decision.
N11	Outdated Procedure Disallow	N56	Procedure code billed is not correct/valid for the
N13	Invalid Procedure Disallow	N56	Procedure code billed is not correct/valid for the
N14	Invalid Gender for Procedure	MA39	Missing/incomplete/invalid gender.
N15	Age exceeds normal range for procedure	M67	Missing/incomplete/invalid other procedure code(s)
N16	Age exceeds extreme range for procedure	M67	Missing/incomplete/invalid other procedure code(s)
N17	Invalid place of service for procedure	M77	Missing/incomplete/invalid place of service.
N19	Invalid Diagnosis for Procedure	N56	Procedure code billed is not correct/valid for the
N25	Charges were combined into primary proc	N19	Procedure code incidental to primary procedure.
OAS	Patient Over Allowable Age for Service	M67	Missing/incomplete/invalid other procedure code(s)
OUT	Outlier Pricing	N14	Payment based on a contractual amount or agreement
PAA	Exceeds Per Case Rate	N14	Payment based on a contractual amount or agreement
PAC	Exceeds Per Case Rate	N14	Payment based on a contractual amount or agreement
PAI	Exceeds All Inclusive P/D Rate	N14	Payment based on a contractual amount or agreement
PAK	Exceeds Per Diem Rate	N14	Payment based on a contractual amount or agreement
PAL	Exceeds Per Diem/Per Case Rate	N14	Payment based on a contractual amount or agreement
PAP	Exceeds Per Diem Rate	N14	Payment based on a contractual amount or agreement

PAR	Exceeds the Per Diem/Per Case Rate	N14	Payment based on a contractual amount or agreement
PBA	Benefits Based on Admission Date	N45	Payment based on authorized amount.
PBB	Admission Date Benefit Calc Bypassed	N45	Payment based on authorized amount.
PBM	Major Medical Benefits Applied	MA67	Correction to a prior claim.
PCD	Service Pricing Disallow	M41	We do not pay for this as the patient has no legal
PCO	PCA Pend Override	N14	Payment based on a contractual amount or agreement
PDA	Agreement Straight Discount	N14	Payment based on a contractual amount or agreement
PDC	Agreement Discount	N14	Payment based on a contractual amount or agreement
PDD	Discount Based on Default for Charges	N14	Payment based on a contractual amount or agreement
PDP	Agreement Discount from Charges	N14	Payment based on a contractual amount or agreement
PE0	Exceeds the DRG Outlier	N14	Payment based on a contractual amount or agreement
PEN	Reduction Based On Service Penalty	M62	Missing/incomplete/invalid treatment authorization
PEO	Exceeds the DRG Outlier	N14	Payment based on a contractual amount or agreement
PFC	Exceeds Profile R&C Rate	N14	Payment based on a contractual amount or agreement
PFS	Exceeds Profile Scheduled Amount	N14	Payment based on a contractual amount or agreement
PFU	Exceeds Profile Anesthesia Rate	N14	Payment based on a contractual amount or agreement
PFV	Exceeds the Profile RVU x CVF	N14	Payment based on a contractual amount or agreement
PFW	Exceeds the Profile Anesthesia Rate	N14	Payment based on a contractual amount or agreement
PGA	Exceeds DRG Amount	N14	Payment based on a contractual amount or agreement
PGD	Exceeds the DRG Outlier Discount	N14	Payment based on a contractual amount or agreement
PGE	Exceeds DRG Rate	N14	Payment based on a contractual amount or agreement
PGO	Exceeds the DRG Outlier Aggregate	N14	Payment based on a contractual amount or agreement
PGP	Exceeds the DRG Outlier Per Diem	N14	Payment based on a contractual amount or agreement
PGR	Exceeds DRG Rate x WT	N14	Payment based on a contractual amount or agreement
PL	Payment Level Override	N14	Payment based on a contractual amount or agreement

PLA	Average Daily Charges Stoploss Met	N14	Payment based on a contractual amount or agreement
PLC	Medicare Limiting Charge Applied	N9	Adjustment represents the estimated amount the pri
PLE	Encounter Units applied for this service	N45	Payment based on authorized amount.
PLO	Other Party Liability Disallow Override	MA18	The claim information is also being forwarded to t
PLP	Percent Threshold Stoploss Met	N14	Payment based on a contractual amount or agreement
PLT	Stoploss	N17	Per admission deductible.
PMX	Maximum Provision	N130	Consult plan benefit documents for information abo
PPC	Exceeds the APC rate	N14	Payment based on a contractual amount or agreement
PS	Exceeds Service Amount	N14	Payment based on a contractual amount or agreement
PS0	Not a Covered Service	N35	Program integrity/utilization review decision.
PS1	Exceeds the maximum allowable	N14	Payment based on a contractual amount or agreement
PS2	Exceeds the maximum number of units	N130	Consult plan benefit documents for information abo
PSB	Exceeds RBRVS Rate	N14	Payment based on a contractual amount or agreement
PSC	Exceeds the R&C Rate	N14	Payment based on a contractual amount or agreement
PSM	Exceeds the MDR Anesthesia Rate	N14	Payment based on a contractual amount or agreement
PSR	Exceeds Rate Entered	N14	Payment based on a contractual amount or agreement
PSS	Exceeds the Scheduled Rate	N14	Payment based on a contractual amount or agreement
PSU	Exceeds the Anesthesia Rate	N14	Payment based on a contractual amount or agreement
PSV	Exceeds the RVU x CVF Rate	N14	Payment based on a contractual amount or agreement
PSW	Exceeds the Anesthesia Rate (Round Up)	N14	Payment based on a contractual amount or agreement
PTR	Procedure Tiers Calculation Applied	N14	Payment based on a contractual amount or agreement
Q02	Claim Processed to Wrong Provider	MA67	Correction to a prior claim.
Q03	Recovering Duplicate Payment	MA67	Correction to a prior claim.
Q05	Incorrect Quantity	M123	Missing/incomplete/invalid name, strength, or dosa
Q06	Incorrect Procedure Code Entered	M58	Missing/incomplete/invalid claim information. Res

Q07	Incorrect Payment for Non-Covered Serv	M41	We do not pay for this as the patient has no legal
Q08	Incorrect Date of Service	M58	Missing/incomplete/invalid claim information. Res
Q09	Incorrect Secondary Liability	N4	Missing/incomplete/invalid prior insurance carrier
Q10	Incorrect Contract Amount Prev Paid	MA67	Correction to a prior claim.
Q11	Claim Previously Processed Incorrectly	MA67	Correction to a prior claim.
Q12	Duplicate Claim Prev Denied Appropriate	M86	Service denied because payment already made for sa
Q13	Incorrect Place of Service	M58	Missing/incomplete/invalid claim information. Res
Q14	Valid Authorization on File	N45	Payment based on authorized amount.
Q15	Valid EOB on File	N45	Payment based on authorized amount.
Q16	Additional Charges Considered	MA67	Correction to a prior claim.
Q17	Administrative Overturn	N10	Claim/service adjusted based on the findings of a
Q18	Other Insurance not Effective on DOS	N14	Payment based on a contractual amount or agreement
Q19	Claim is not a Duplicate	N14	Payment based on a contractual amount or agreement
Q20	Service not Covered by Other Insurance	N4	Missing/incomplete/invalid prior insurance carrier
Q21	Provider Adjustment	N14	Payment based on a contractual amount or agreement
Q22	Claim was Submitted Timely	N14	Payment based on a contractual amount or agreement
Q23	Authorization Updated	N45	Payment based on authorized amount.
Q24	Incorrect Diagnosis Code Entered	M64	Missing/incomplete/invalid other diagnosis.
Q26	Retro Benefit Change Former PE Member	N14	Payment based on a contractual amount or agreement
Q27	Valid Referral On File	N45	Payment based on authorized amount.
Q28	Member's Eligibility Updated	N14	Payment based on a contractual amount or agreement
Q99	Adjusting Historical Claim	MA67	Correction to a prior claim.
R00	Payment Included in Other Billed Service	N19	Procedure code incidental to primary procedure.
R01	No Precert/Authorization	M62	Missing/incomplete/invalid treatment authorization
R02	Included in other billed charges	N19	Procedure code incidental to primary procedure.

R07	Received after Timely Filing Limit	MA119	Provider level adjustment for late claim filing ap
R08	Diagnosis inv/missing/del 4th or 5th	M64	Missing/incomplete/invalid other diagnosis.
R10	Not Enrolled on Date of Service	N30	Patient ineligible for this service.
R15	Subset/Incidental procedure disallow	N19	Procedure code incidental to primary procedure.
R19	DSH Days Awaiting PRO Review	M58	Missing/incomplete/invalid claim information. Res
R21	Dates and/or Services outside of Auth	M62	Missing/incomplete/invalid treatment authorization
R22	Authorization Expired	M62	Missing/incomplete/invalid treatment authorization
R23	Additional Services Require Authorizatio	M62	Missing/incomplete/invalid treatment authorization
R26	Service Not Covered For PE Member	N35	Program integrity/utilization review decision.
R27	No PCP Required for PE Member	N14	Payment based on a contractual amount or agreement
R29	Beyond Adjustment Period	MA119	Provider level adjustment for late claim filing ap
R30	Adjustment to Previous Payment	MA67	Correction to a prior claim.
R34	Assistant Surgeon Payment	N14	Payment based on a contractual amount or agreement
R35	Authorization Denied for this DOS	N35	Program integrity/utilization review decision.
R36	Capitated Service	N14	Payment based on a contractual amount or agreement
R37	Combined Payment - Mother and Baby	N14	Payment based on a contractual amount or agreement
R38	Contracted Fee	N14	Payment based on a contractual amount or agreement
R39	Dup Claim Prev Paid at Correct Rate/Cap	M86	Service denied because payment already made for sa
R40	Dup Clm - Orig Still under Investigation	M58	Missing/incomplete/invalid claim information. Res
R42	DRG Payment	N14	Payment based on a contractual amount or agreement
R43	Interim Bill Payment	N14	Payment based on a contractual amount or agreement
R44	Multiple Surgical Reduction	N14	Payment based on a contractual amount or agreement
R45	Complete Medical Records Required	M58	Missing/incomplete/invalid claim information. Res
R46	Over Maximum Procedure/Benefit Limit	N130	Consult plan benefit documents for information abo
R47	Paymt reflects COB, if $0, max liab met	N9	Adjustment represents the estimated amount the pri

R49	Previous Payments = to Purchase Price	N14	Payment based on a contractual amount or agreement
R50	Same Procedure Paid to Different Provide	M86	Service denied because payment already made for sa
R51	Service Not Covered	N35	Program integrity/utilization review decision.
R53	Services were not Provided	N29	Missing/incomplete/invalid documentation/orders/no
R54	Disproportionate Share Day Submit to MA	N193	Specific federal/state/local program may cover thi
R55	Billed Info Reflects Lower Degree Acuity	N14	Payment based on a contractual amount or agreement
R56	Administrative Approval	N10	Claim/service adjusted based on the findings of a
R59	Referral Expired	M62	Missing/incomplete/invalid treatment authorization
R60	Dates and/or Services Outside Referral	M62	Missing/incomplete/invalid treatment authorization
R61	No PCP Referral	N54	Claim information is inconsistent with pre-certifi
R63	EPSDT Pay Adj- 5 /12 year old screening	N14	Payment based on a contractual amount or agreement
R64	Interim Bill 1st Cycle Payment	N14	Payment based on a contractual amount or agreement
R65	Interim Bill 2nd Cycle Payment	N14	Payment based on a contractual amount or agreement
R66	Interim Bill Final Cycle Payment	N14	Payment based on a contractual amount or agreement
R67	Discrep with Level of Care - Appeal Requ	N29	Missing/incomplete/invalid documentation/orders/no
R70	EPSDT Screening didn't Comply with Sched	N35	Program integrity/utilization review decision.
R71	Dup Previously Submitted EPSDT Screening	M86	Service denied because payment already made for sa
R72	Provider was Not Member's PCP	M41	We do not pay for this as the patient has no legal
R73	Member's Sex Not Valid For Procedure	MA39	Missing/incomplete/invalid gender.
R74	All Req'd Tests Not Done during Screen	N29	Missing/incomplete/invalid documentation/orders/no
R77	Member's Age Not Valid For Procedure	M67	Missing/incomplete/invalid other procedure code(s)
R78	DCBS Claim Payment	N14	Payment based on a contractual amount or agreement
R79	Special Project - Adjustment - EPSDT	N14	Payment based on a contractual amount or agreement
R80	Carrier of Service - Block Vision	N193	Specific federal/state/local program may cover thi
R81	Chrgs Considered included in Inpat Admis	N19	Procedure code incidental to primary procedure.

R84	Resub W/ Individual Provider Name/Number	M58	Missing/incomplete/invalid claim information. Res
R85	Late Penalty Interest Payment	N14	Payment based on a contractual amount or agreement
R86	Invalid/Missing Revenue Code on Claim	N56	Procedure code billed is not correct/valid for the
R88	Code - updated	N22	This procedure code was added/changed because it m
R89	Authorization on File for Technical Comp	N45	Payment based on authorized amount.
R90	Replacement Code to Assure Contract Pymt	N22	This procedure code was added/changed because it m
R91	Inappropriate Coding for Contract/Agree	MA129	This provider was not certified for this procedure
R92	Retro Eligibility	N14	Payment based on a contractual amount or agreement
R94	Prov # Submitted via EDI Incorrect/Termd	N144	The rate changed during the dates of service bille
R95	Claim without Physician Name or Number	M58	Missing/incomplete/invalid claim information. Res
R96	EOB/attachments illegible/incomplete	M58	Missing/incomplete/invalid claim information. Res
R97	DOS Cannot be Greater than Received Date	N29	Missing/incomplete/invalid documentation/orders/no
R98	Provider Billed Incorrect Diagnosis Code	M64	Missing/incomplete/invalid other diagnosis.
R99	Primary Insurance recouped and adjusted	N9	Adjustment represents the estimated amount the pri
RD2	Duplicate Claim Line Denial	M86	Service denied because payment already made for sa
RDP	Duplicate Claim Line Denial	M86	Service denied because payment already made for sa
RWD	Risk Withhold Disallow	N14	Payment based on a contractual amount or agreement
S10	Date req. after Subgroup Termination	N30	Patient ineligible for this service.
S11	Date Req. Prior to Group Effective Date	N30	Patient ineligible for this service.
S12	Date Req prior to Subscriber Orig Eff Dt	N30	Patient ineligible for this service.
S13	All Enroll events are Future	N30	Patient ineligible for this service.
S14	Date requested prior to plan-entry date	N30	Patient ineligible for this service.
S1A	No eligibility found	N30	Patient ineligible for this service.
S1B	Plan not found	N30	Patient ineligible for this service.
S1C	Plan not effective on date requested	N30	Patient ineligible for this service.

S2	Date requested < Subscriber's Birth Date	N30	Patient ineligible for this service.
S20	Date req. prior to Member Orig. Eff Date	N30	Patient ineligible for this service.
S21	Date req. prior to Group Effective Date	N30	Patient ineligible for this service.
S22	Date req. prior to subgroup orig eff dt.	N30	Patient ineligible for this service.
S23	Date req. Prior to Subscriber Eff Dt.	N30	Patient ineligible for this service.
S24	Part A or B not active for member	N9	Adjustment represents the estimated amount the pri
S25	Enrollment on hold status	M58	Missing/incomplete/invalid claim information. Res
S3	Date requested < Member's Birth Date	N30	Patient ineligible for this service.
S4	Eligibility spans multiple plans	N30	Patient ineligible for this service.
S6	Member is over dependent age limit	N30	Patient ineligible for this service.
S7	Subscriber is over subscriber age limit	N30	Patient ineligible for this service.
S8	Spouse is over the spouse age limit	N30	Patient ineligible for this service.
S9	Date requested after Group term date	N30	Patient ineligible for this service.
SB	Subscriber & Spouse only enrolled.	N30	Patient ineligible for this service.
SC	Subscriber Only enrolled.	N30	Patient ineligible for this service.
SD	Subscriber & Dependent Child(ren) enroll	N30	Patient ineligible for this service.
SE	Spouse and dependents only	N30	Patient ineligible for this service.
SF	Spouse only coverage	N30	Patient ineligible for this service.
SG	Dependents only enrolled	N30	Patient ineligible for this service.
SL	Retired - No benefits	N30	Patient ineligible for this service.
SM	Deceased Member	N30	Patient ineligible for this service.
SN	Non-eligible member	N30	Patient ineligible for this service.
SO	Termination - ineligible	N30	Patient ineligible for this service.
SP	Termination - Non payment of premium	N30	Patient ineligible for this service.
SPD	Supplemental Discount	N14	Payment based on a contractual amount or agreement

SQ	Termination - Divorce	N30	Patient ineligible for this service.
SS	Separation - Member	N30	Patient ineligible for this service.
ST	Termination	N30	Patient ineligible for this service.
SW	Termination - COBRA	N30	Patient ineligible for this service.
TF0	Submitted after plan filing limit	MA119	Provider level adjustment for late claim filing ap
TF1	Submitted After Provider's Filing Limit	MA119	Provider level adjustment for late claim filing ap
TR0	Tier not found, Service not covered	N35	Program integrity/utilization review decision.
TR1	Rule not set, Service not covered	N35	Program integrity/utilization review decision.
TR2	Covered Amount > Service Allow Amt	M41	We do not pay for this as the patient has no legal
TR3	Covered Amount > Srv allow + rel hist am	M41	We do not pay for this as the patient has no legal
TR4	Covered Ctr > Service Allow Ctr	M41	We do not pay for this as the patient has no legal
TR5	Covered Counter > Srv Allow Ctr+rel hist	M41	We do not pay for this as the patient has no legal
TR6	COB Subtraction Method Disallow	N9	Adjustment represents the estimated amount the pri
UAS	Patient Under Age For Service Rendered	M67	Missing/incomplete/invalid other procedure code(s)
UD	Utilization Management Disallow	N35	Program integrity/utilization review decision.
UED	Utilization Edit Denial	N35	Program integrity/utilization review decision.
UM0	Services Disallowed by UM	N35	Program integrity/utilization review decision.
UM1	Units exceed UM authorization	M62	Missing/incomplete/invalid treatment authorization
UM2	Units reduced by UM authorization	M62	Missing/incomplete/invalid treatment authorization
UM3	Pended Status, Zero Units	M58	Missing/incomplete/invalid claim information. Res
UM4	Pended Status, Zero Units	M58	Missing/incomplete/invalid claim information. Res
X00	Payment Included in Other Billed Service	N19	Procedure code incidental to primary procedure.
X01	No Precert/Authorization	M62	Missing/incomplete/invalid treatment authorization
X02	Illegible records submitted	M127	Missing/incomplete/invalid patient medical record
X03	Not the Member's PCP	M41	We do not pay for this as the patient has no legal

X04	Correct NDC Code required	M58	Missing/incomplete/invalid claim information. Res
X05	Invalid/Inapp/Del Code, Mod or Desc	N56	Procedure code billed is not correct/valid for the
X06	Itemized Bill/DOS/Charges/Invoice Requi	M58	Missing/incomplete/invalid claim information. Res
X07	Received after Timely Filing Limit	MA119	Provider level adjustment for late claim filing ap
X08	Diagnosis inv/missing/del 4th or 5th	M64	Missing/incomplete/invalid other diagnosis.
X10	Not Enrolled on Date of Service	N30	Patient ineligible for this service.
X11	EOB from primary carrier required	N4	Missing/incomplete/invalid prior insurance carrier
X12	Motor Vehicle Accident - Auto Primary	MA18	The claim information is also being forwarded to t
X13	Workers Comp Primary Carrier	MA18	The claim information is also being forwarded to t
X17	Missing/Illegible Value Code or Amount	N56	Procedure code billed is not correct/valid for the
X18	No Referral	M62	Missing/incomplete/invalid treatment authorization
X19	DSH Days Awaiting PRO Review	M58	Missing/incomplete/invalid claim information. Res
X20	Incomplete EPSDT screen Form	M58	Missing/incomplete/invalid claim information. Res
X21	Dates and/or Services outside of Auth	M62	Missing/incomplete/invalid treatment authorization
X22	Authorization Expired	M62	Missing/incomplete/invalid treatment authorization
X23	Additional Services Require Authorizatio	M62	Missing/incomplete/invalid treatment authorization
X26	Service Not Covered For PE Member	N35	Program integrity/utilization review decision.
X29	Beyond Adjustment Period	MA119	Provider level adjustment for late claim filing ap
X32	Appeal - Denial Upheld	N10	Claim/service adjusted based on the findings of a
X33	Appeal - Orig Claim Pymt Upheld	N10	Claim/service adjusted based on the findings of a
X35	Authorization Denied for this DOS	N35	Program integrity/utilization review decision.
X36	Capitated Service	N14	Payment based on a contractual amount or agreement
X38	Need Newborn Member Number	N30	Patient ineligible for this service.
X39	Dup Claim Prev Paid at Correct Rate/Cap	M86	Service denied because payment already made for sa
X40	Dup Clm - Orig Still Under Investigation	M58	Missing/incomplete/invalid claim information. Res

X45	Complete medical records required	M127	Missing/incomplete/invalid patient medical record
X46	Over Maximum Procedure/Benefit Limit	N130	Consult plan benefit documents for information abo
X49	Previous Payments = to Purchase Price	N14	Payment based on a contractual amount or agreement
X50	Same Procedure Paid to Different Prov	M86	Service denied because payment already made for sa
X51	Service Not Covered	N35	Program integrity/utilization review decision.
X53	Services were not Provided	N29	Missing/incomplete/invalid documentation/orders/no
X54	Not Eligible for Total Component Payment	N13	Payment based on professional/technical component
X58	Recovery Forwarded to State per Contract	MA67	Correction to a prior claim.
X59	Referral Expired	M62	Missing/incomplete/invalid treatment authorization
X60	Dates and/or Services outside Referral	M62	Missing/incomplete/invalid treatment authorization
X61	No PCP Referral	N54	Claim information is inconsistent with pre-certifi
X62	Invalid or Missing DRG	N208	Missing/incomplete/invalid DRG code
X67	Discrep with Level of Care - Appeal Requ	N29	Missing/incomplete/invalid documentation/orders/no
X68	Invalid or Zero Units Submitted	M58	Missing/incomplete/invalid claim information. Res
X69	Attending Phys ID/Name Missing/Invalid	M58	Missing/incomplete/invalid claim information. Res
X70	EPSDT Screening didn't Comply with sched	N35	Program integrity/utilization review decision.
X71	Dup Previously Submitted EPSDT Screening	M86	Service denied because payment already made for sa
X72	Provider was Not Member's PCP	M41	We do not pay for this as the patient has no legal
X73	EPSDT Form was Incomplete	M58	Missing/incomplete/invalid claim information. Res
X74	All Req'd Tests Not Done during Screen	N29	Missing/incomplete/invalid documentation/orders/no
X77	Incorrect Provider/TIN ID # Submitted	M58	Missing/incomplete/invalid claim information. Res
X79	Special Project - Adjustment - EPSDT	N14	Payment based on a contractual amount or agreement
X81	Chrgs Considered included in Inpat Admis	N19	Procedure code incidental to primary procedure.
X83	Mother's Bill not Received; Refile	M58	Missing/incomplete/invalid claim information. Res
X84	Resub W/ Individual Provider Name/Number	M58	Missing/incomplete/invalid claim information. Res

X86	Invalid/missing revenue code	N56	Procedure code billed is not correct/valid for the
X89	Modifier is Invalid or Inapprop. W/ Proc	N184	Rebill technical and professional components separ
X90	UB Line Item Dates of Services Required	M58	Missing/incomplete/invalid claim information. Res
X91	Inappropriate Coding for Contract/Agreem	MA129	This provider was not certified for this procedure
X94	Prov # Submitted via EDI Incorrect/Termd	N144	The rate changed during the dates of service bille
X95	Claim without Physician Name or Number	M58	Missing/incomplete/invalid claim information. Res
X96	EOB/attachments illegible/incomplete	M58	Missing/incomplete/invalid claim information. Res
X97	DOS Cannot be Greater than Received Date	N29	Missing/incomplete/invalid documentation/orders/no
X98	Inappropriate Coding for Contract/Agree	MA129	This provider was not certified for this procedure
Z00	Withhold amount previously paid	M86	Service denied because payment already made for sa
Z01	Medicaid Fee-for-Service	N193	Specific federal/state/local program may cover thi
Z02	Carrier of Service - PCN	N193	Specific federal/state/local program may cover thi
Z06	Carrier of Service - AmeriHealth Inc.	N193	Specific federal/state/local program may cover thi
Z14	Carrier of Service - AmeriHealth, Inc.	N193	Specific federal/state/local program may cover thi
Z24	Carrier of Service - Block Vision	N193	Specific federal/state/local program may cover thi
Z31	Submit to Doral Dental	N193	Specific federal/state/local program may cover thi
Z37	Medicaid Fee-for-Service	N193	Specific federal/state/local program may cover thi
Z38	Missing/Illegible Procedure/Revenue Code	N56	Procedure code billed is not correct/valid for the
Z41	Missing/Illegible ICD-9 procedure code	N56	Procedure code billed is not correct/valid for the
Z47	Submit to Medicaid Fee-For-Service	N193	Specific federal/state/local program may cover thi
Z48	Resub Primary Carrier/Appeals Process	N4	Missing/incomplete/invalid prior insurance carrier
Z51	Service Not Covered for PE Member	N35	Program integrity/utilization review decision.
Z52	Service Not Covered For KCHIP 3 Member	N35	Program integrity/utilization review decision.
Z53	Submit to Appropriate Transport. Broker	N193	Specific federal/state/local program may cover thi
Z54	Inappr. Claim Form for Prof Services	MA129	This provider was not certified for this procedure

Z55	Service Performed Inv. for POS Submitted	M58	Missing/incomplete/invalid claim information. Res
Z56	Duplicate EPSDT screening	M86	Service denied because payment already made for sa
Z92	Invalid or Missing Place of Service	M77	Missing/incomplete/invalid place of service.
Z94	Submit services to Medicaid FFS Service	N193	Specific federal/state/local program may cover thi
Z95	Invalid/Innap/del code, mod or desc	N56	Procedure code billed is not correct/valid for the
Z99	Code Not payable for Provider Specialty	N95	This provider type/provider specialty may not bill