APPROVED

UHIN STANDARDS COMMITTEE

Transparency Denial Standard

Version 1.5

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General

The UHIN Transparency Denial Standard version 1.5 is compatible with state requirements set forth in the Utah Code Annotated 31A-22-613.5(a).

Purpose

To establish performance measures that report the number and cost of an insurer's denied health claims and to provide guidance pertaining to the reporting method and timeline to the Utah Insurance Department. Information derived from the data will be shared as public record for display on the Utah Insurance Department's websites (insurance.utah.gov and healthrates.utah.gov).

Applicability

This standard applies to all health benefit plans issued or renewed on or after January 1, 2015 or otherwise defined by Utah Administrative Insurance Rule R590-271 (Data Reporting for Consumer Quality Comparison), which can be found at https://rules.utah.gov/publicat/code/r590/r590-271.htm.

This standard or rule may not apply to ERISA-governed plans or self-insured plans as defined by the Utah Insurance Department rule. Please consult with your legal department and the Utah Insurance Department for applicability.

Basic Concepts

- **Claim**: An invoice or bill submitted to a payer for one or more medical services.
- **Claims Paid**: Claims reported in a Remittance Advice.
- **Denial**: A reportable status of claim/service that has been accepted for processing and is not paid. This includes paper and electronic claims.
- **Member Responsibility**: The amount that the member is responsible to pay for the services that were rendered.
- **Provider Responsibility**: The amount that the provider is required to write off and may or may not bill the member.
- **Reject**: An electronic claim that is not accepted by a payer for processing due to data errors.
- **Reporting Period**: Yearly for regular submissions of all claims adjudicated as of the end of the calendar year.
- **Service Line**: The line item detail charge that makes up a claim. This is the unit of measurement for reporting the information.
- **SFTP**: Secure File Transfer Protocol

Detail

This standard includes the following:

- The format in which a payer will provide the data to the Utah Insurance Department will be in a report form. Please see the Transparency Standards Reporting Worksheet for Denials.
- A list of Claim Adjustment Reason Codes (CARCs) which identify the denied services to be reported. See Appendix A.
- As an exception, when claims are adjudicated at a claim level, they should be reported at a claim level (e.g. Per Diem, DRG).
- Reporting is not required on claims where the carrier is not the primary payer.
- Performance Measure for the reporting period (percentage and cost of claims denied[1]):
    - Member
        - Total count of denied services to member
        - Total cost of denied services to member

[1] Denial percentages are based on submitted billed charges to the payer. Member percentage and provider percentage should equal 100 percent of denied services.

        - Member's percentage of denied services and associated average cost can be calculated using the following formula: Total denied services to member divided by total billed services
    - Provider
        - Total count of denied services to provider
        - Total cost of denied services to provider
        - Provider's percentage of denied services and associated average cost can be calculated using the following formula: Total denied services to provider divided by total billed services
    - Totals
        - Total count of denied services
        - Total count of billed services
        - Total cost of denied services
        - Total cost of billed services
        - Total percentage of denied services and associated average cost can be calculated using the following formula: Total denied services divided by total billed services
- Reporting timelines and submission times:
    - Annual submissions are due to the Utah Insurance Department on or before April 1 of the succeeding calendar year. All received will be posted to the Utah Insurance Department website (https://healthrates.utah.gov) on April 1st.
    - Reported totals will be based on a full year's data, January 1 – December 31st.
    - Report the claims based on paid (remittance) date.
    - All data is reported at the company level for Utah business.
- Always report the final status of any claim that is adjusted. Do not report all the iterations of adjustments.
- Denied service where a contract does not exist between a health plan and a provider are reported as a member denied services.
- Denied services where a contract does exist between a health plan and a provider are reported as a provider denied service.
- The primary denial reason is used for reporting purposes when there are multiple denial reasons on the same line. This may require payers to develop a hierarchy/prioritization for reporting purposes to determine the primary denial.

The report excludes all claims that are rejected before entering your adjudication system. For example:

- Billing Errors
- Duplicate Claim
- Eligibility
- Incorrect payer
- Invalid Provider ID
- Non-compliant HIPAA Transactions
- Secondary Insurance

The report includes major medical policies which may cover certain dental, pharmacy, and vision services. The report excludes dental, pharmacy, vision only policies and government program claims (i.e. Medicare, Medicare Advantage Plan, Medicare Part D, CHIP and Medicaid).

Implementation

General Considerations

- This information will be used by the public to compare Health Insurers and Health Benefit Plans.
- The data submission will be sent to UHIN; there are several connectivity methods available for the submissions. Payers are encouraged to contact UHIN for connectivity methods. Please call UHIN Customer Service at 1-877-693-3071 (toll free).
- The Department recognizes that the Claim Adjustment Reason Codes are updated each trimester and may impact reporting. Payers should report the CARC codes that are valid as of the date of service being denied.
- The CARC codes used in this Standard will be reviewed yearly in November for changes, additions, and deletions in the report. Adopted/Deleted CARCs are effective for data collection in the following calendar year.
- Frequently Asked Questions for Transparency Reporting – document is available at https://standards.uhin.org/.

Senders

- Senders should contact UHIN for questions and concerns with the Standard, submission, and connectivity. Contact UHIN Customer Service at 1-877-693-3071 (toll free).
- Senders should contact Utah Insurance Department for questions and concerns regarding reporting acceptance. Contact Daron Funn at dfunn@utah.gov, or 801-538-3824.
- If CARCs are kept outside of payers' claim processing systems, a CARC crosswalk may be used for reporting purposes.

Receivers

The Utah Insurance Department is responsible for maintaining and receiving reports.

History

	Original	V1.1	V1.2
ORIGINATION DATE	1/2010	1/11/2012	9/16/2014
APPROVAL DATE	5/18/2011	5/30/2012	5/6/2015
EFFECTIVE DATE	6/18/2011	6/30/2012	6/6/2015

	V1.3	V1.4	V1.5
ORIGINATION DATE	11/30/2016	10/16/2017	11/26/2018
APPROVAL DATE	12/30/2016	2/7/2018	1/2/2019
EFFECTIVE DATE	2/28/2017	3/7/2018	2/2/2019

Appendix A

2018 Reporting Claim Adjustment Reason Codes (CARC)

Included Code value	Description	Use Date
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
29	The time limit for filing has expired.	Start: 01/01/1995
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. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 01/01/1995
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. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 01/01/1995
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 01/01/1995
51	These are non-covered services because this is a pre-existing condition. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 01/01/1995
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. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 01/01/1995
55	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 01/01/1995

56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 01/01/1995
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 01/01/1995
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 01/01/1995
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
61	Adjusted for failure to obtain second surgical opinion. Notes: The description effective date was inadvertently published as 3/1/2016 on 7/1/2016. That has been corrected to 1/1/2017.	Start: 01/01/1995
95	Plan procedures not followed.	Start: 01/01/1995
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.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 01/01/1995
108	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
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

117	Transportation is only covered to the closest facility that can provide the necessary care.	Start: 01/01/1995
119	Benefit maximum for this time period or occurrence has been reached.	Start: 01/01/1995
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
136	Failure to follow prior payer's coverage rules. (Use only with Group Code OA)	Start: 10/31/1998
138	Appeal procedures not followed or time limits not met.	Start: 06/30/1999 Stop: 05/01/2018
139	Contracted funding agreement - Subscriber is employed by the provider of services. Use only with Group Code CO.	Start: 06/30/1999
140	Patient/Insured health identification number and name do not match.	Start: 06/30/1999
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
150	Payer deems the information submitted does not support this level of service.	Start: 10/31/2002
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	Start: 10/31/2002
152	Payer deems the information submitted does not support this length of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 10/31/2002
153	Payer deems the information submitted does not support this dosage.	Start: 10/31/2002

154	Payer deems the information submitted does not support this day's supply.	Start: 10/31/2002
155	Patient refused the service/procedure.	Start: 06/30/2003
157	Service/procedure was provided as a result of an act of war.	Start: 09/30/2003
158	Service/procedure was provided outside of the United States.	Start: 09/30/2003
159	Service/procedure was provided as a result of terrorism.	Start: 09/30/2003
160	Injury/illness was the result of an activity that is a benefit exclusion.	Start: 09/30/2003
163	Attachment/other documentation referenced on the claim was not received.	Start: 06/30/2004
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	Start: 06/30/2004
165	Referral absent or exceeded.	Start: 10/31/2004 Stop: 05/01/2018
167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 06/30/2005
170	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 06/30/2005
171	Payment is denied when performed/billed by this type of provider in this type of facility. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 06/30/2005
173	Service/equipment was not prescribed by a physician.	Start: 06/30/2005
174	Service was not prescribed prior to delivery.	Start: 06/30/2005
175	Prescription is incomplete.	Start: 06/30/2005
176	Prescription is not current.	Start: 06/30/2005

177	Patient has not met the required eligibility requirements.	Start: 06/30/2005
178	Patient has not met the required spend down requirements.	Start: 06/30/2005
179	Patient has not met the required waiting requirements. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 06/30/2005
180	Patient has not met the required residency requirements.	Start: 06/30/2005
181	Procedure code was invalid on the date of service.	Start: 06/30/2005
182	Procedure modifier was invalid on the date of service.	Start: 06/30/2005
183	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 06/30/2005
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 06/30/2005
185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 06/30/2005
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
192	Non standard adjustment code from paper remittance. Usage: 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

193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	Start: 02/28/2006
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	Start: 02/28/2006
197	Precertification/authorization/notification/pre-treatment absent.	Start: 10/31/2006
198	Precertification/notification/authorization/pre-treatment exceeded.	Start: 10/31/2006
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	Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR) 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.) *Notes: Not for use by Workers' Compensation payers; use code P3 instead.*	Start: 10/31/2006
202	Non-covered personal comfort or convenience services.	Start: 02/28/2007
203	Discontinued or reduced service.	Start: 02/28/2007
204	This service/equipment/drug is not covered under the patient’s current benefit plan	Start: 02/28/2007
210	Payment adjusted because pre-certification/authorization not received in a timely fashion	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
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

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
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
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
231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 07/01/2009
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
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
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
240	The diagnosis is inconsistent with the patient's birth weight. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 06/03/2012
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	Start: 06/03/2012

243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	Start: 06/03/2012
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
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
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
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). *Notes: To be used after the first month of the grace period.*	Start: 11/01/2013
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
261	The procedure or service is inconsistent with the patient's history.	Start: 06/01/2014
269	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 03/01/2015
272	Coverage/program guidelines were not met.	Start: 11/01/2015
273	Coverage/program guidelines were exceeded.	Start: 11/01/2015

296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.	Start: 07/01/2018
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: 1/1/1995
A6	Prior hospitalization or 30 day transfer requirement not met.	Start: 1/1/1995
A8	Ungroupable DRG.	Start: 1/1/1995
B1	Non-covered visits.	Start: 1/1/1995
B5	Coverage/program guidelines were not met or were exceeded.	Start: 1/1/1995
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	Start: 01/01/1995
B8	Alternative services were available, and should have been utilized. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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 patient's medical records.	Start: 01/01/1995
B14	Only one visit or consultation per physician per day is covered.	Start: 01/01/1995
B16	'New Patient' qualifications were not met.	Start: 01/01/1995

B20	Procedure/service was partially or fully furnished by another provider.	Start: 01/01/1995
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	Start: 01/01/1995

***Note**: Group Codes “CO”, “OA” and “PI” should be reported as provider responsibility in this report.