UHIN STANDARDS COMMITTEE
Transparency Denial Standard
Version 1.2

The UHIN Transparency Denial Standard version 1.1 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 Health Insurance Exchange (Avenue H) and on the Utah Insurance Department's websites (insurance.utah.gov and healthrates.utah.gov).

Applicability[1]: 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 rule* can be found at (ADD LINK ONCE MADE AVAILABLE BY UID).

Definitions:

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

Details: 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. Use the Transparency Denial Standard Reporting Worksheet available at:

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

http://www.uhin.org/system/files/documents/Transparency%20Denial%20Standard%20Reporting%20Worksheet%20v1%2020110125_0.xls

- 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.
  - **Member**
    - Total count of denied services to member
    - Total cost of denied services to member
      - 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

  Denial percentages are based on submitted billed charges to the payer. Member percentage and provider percentage should equal 100 percent of denied 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.
  - 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:
- Duplicate claim
- Eligibility
- Invalid Provider ID
- Non-compliant HIPAA transactions

The report excludes dental, pharmacy, vision and government program claims (i.e. Medicare, Medicare Advantage Plan, CHIP and Medicaid). Other lines of business should be reported.

Implementation Considerations

- **General:**
  - 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 the UHIN Helpdesk at 1-877-693-3071 (toll free) or 801-466-7705 Option 9.
  - The Department recognizes that the Claim Adjustment Reason Codes are updated 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 adds and deletes in the report. Adopted/Deleted CARCs are effective for data collection in the following calendar year.
- **Senders:**
  - Senders should contact UHIN for questions and concerns with the Standards for submission and connectivity.
  - Senders should contact Utah Insurance Department for questions and concerns regarding reporting acceptance, to Jordan Tolman at jmtolman@utah.gov, or (801)538-3861.
  - If CARCs are kept outside of payers' claim processing systems, a CARC crosswalk may be used for reporting purposes.
- **Receiver:**
  - The Utah Insurance Department is responsible for maintaining and receiving reports.

Implementation Date: The implementation date of this Standard will be Month Day, 2015. First reporting is due April 1, 2016.

	Original	V1.1	V1.2	V1.3
ORIGINATION DATE	01/2010	01/11/2012	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	

* A = Amendment

Appendix A

Claim Adjustment Reason Codes (CARC)

Transparency - CARC code guidelines for denial reporting.

I Include the CARC in Transparency reporting.

E Exclude the CARC from Transparency reporting.

	Code	Description	Effective	Modified	Obsolete	Notes
E	1	Deductible Amount	1/1/1995			
E	2	Coinsurance Amount	1/1/1995			
E	3	Co-payment Amount	1/1/1995			
I	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		

I	9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	13	The date of death precedes the date of service.	1/1/1995			
I	14	The date of birth follows the date of service.	1/1/1995			
I	15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	1/1/1995	9/30/2007		
I	16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	11/1/2013		
E	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	1/1/1995	6/2/2013		
I	19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	1/1/1995	9/30/2007		
I	20	This injury/illness is covered by the liability carrier.	1/1/1995	9/30/2007		
I	21	This injury/illness is the liability of the no-fault carrier.	1/1/1995	9/30/2007		

I	22	This care may be covered by another payer per coordination of benefits.	1/1/1995	9/30/2007			
E	23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with group code OA)	1/1/1995	9/30/2012			
E	24	Charges are covered under a capitation agreement/managed care plan.	1/1/1995	9/30/2007			
I	26	Expenses incurred prior to coverage.	1/1/1995				
I	27	Expenses incurred after coverage terminated.	1/1/1995				
I	29	The time limit for filing has expired.	1/1/1995				
I	31	Patient cannot be identified as our insured.	1/1/1995	9/30/2007			
I	32	Our records indicate that this dependent is not an eligible dependent as defined.	1/1/1995				
I	33	Insured has no dependent coverage.	1/1/1995	9/30/2007			
I	34	Insured has no coverage for newborns.	1/1/1995	9/30/2007			
I	39	Services denied at the time authorization/pre-certification was requested.	1/1/1995				
I	40	Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009			
E	44	Prompt-pay discount.	1/1/1995				
E	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability).	1/1/1995	7/1/2013			
I	49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	11/1/2013			

I	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	53	Services by an immediate relative or a member of the same household are not covered.	1/1/1995			
I	54	Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	55	Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	1/1/1995	6/1/2008		
I	61	Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		

E	69	Day outlier amount.	1/1/1995			
E	70	Cost outlier - Adjustment to compensate for additional costs.	1/1/1995	6/30/2001		
E	74	Indirect Medical Education Adjustment.	1/1/1995			
E	75	Direct Medical Education Adjustment.	1/1/1995			
E	76	Disproportionate Share Adjustment.	1/1/1995			
E	78	Non-Covered days/Room charge adjustment.	1/1/1995			
I	85	Patient Interest Adjustment (Use Only Group code PR)	1/1/1995	7/9/2007		Only use when the payment of interest is the responsibility of the patient.
I	89	Professional fees removed from charges.	1/1/1995			
E	90	Ingredient cost adjustment. Note: To be used for pharmaceuticals only.	1/1/1995	7/1/2009		
I	91	Dispensing fee adjustment.	1/1/1995			
I	94	Processed in Excess of charges.	1/1/1995			
I	95	Plan procedures not followed.	1/1/1995	9/30/2007		
I	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
E	100	Payment made to patient/insured/responsible party/employer.	1/1/1995	1/27/2008		
E	101	Predetermination: anticipated payment upon completion of services or claim adjudication.	1/1/1995	2/28/1999		
E	102	Major Medical Adjustment.	1/1/1995			
E	103	Provider promotional discount (e.g., Senior citizen discount).	1/1/1995	6/30/2001		
E	104	Managed care withholding.	1/1/1995			

E	105	Tax withholding.	1/1/1995			
E	106	Patient payment option/election not in effect.	1/1/1995			
I	107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	109	Claim/service not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	1/1/1995	1/29/2012		
I	110	Billing date predates service date.	1/1/1995			
I	111	Not covered unless the provider accepts assignment.	1/1/1995			
I	112	Service not furnished directly to the patient and/or not documented.	1/1/1995	9/30/2007		
I	114	Procedure/product not approved by the Food and Drug Administration.	1/1/1995			
I	115	Procedure postponed, canceled, or delayed.	1/1/1995	9/30/2007		
E	116	The advance indemnification notice signed by the patient did not comply with requirements.	1/1/1995	9/30/2007		
I	117	Transportation is only covered to the closest facility that can provide the necessary care.	1/1/1995	9/30/2007		
E	118	ESRD network support adjustment.	1/1/1995	9/30/2007		
I	119	Benefit maximum for this time period or occurrence has been reached.	1/1/1995	2/29/2004		
E	121	Indemnification adjustment - compensation for outstanding member responsibility.	1/1/1995	9/30/2007		
E	122	Psychiatric reduction.	1/1/1995			
I	128	Newborn's services are covered in the mother's Allowance.	2/28/1997			

I	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.)	2/28/1997	1/30/2011		
I	130	Claim submission fee.	2/28/1997	6/30/2001		
E	131	Claim specific negotiated discount.	2/28/1997			
E	132	Prearranged demonstration project adjustment.	2/28/1997			
I	133	The disposition of this claim/service is pending further review. (Use only with Group Code OA). This change effective 11/01/2014: The disposition of this service line is pending further review. (Use only with Group Code OA). NOTE: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	7/1/2014	9/28/2014		
I	134	Technical fees removed from charges.	10/31/1998			
I	135	Interim bills cannot be processed.	10/31/1998	9/30/2007		
I	136	Failure to follow prior payer's coverage rules. (Use Group Code OA).	10/31/1998	7/1/2013		
E	137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.	2/28/1999	9/30/2007		
I	138	Appeal procedures not followed or time limits not met.	6/30/1999	9/30/2007		
I	139	Contracted funding agreement - Subscriber is employed by the provider of services.	6/30/1999			
I	140	Patient/Insured health identification number and name do not match.	6/30/1999			
I	141	Claim spans eligible and ineligible periods of coverage.	6/30/1999	9/30/2007		
E	142	Monthly Medicaid patient liability amount.	6/30/2000	9/30/2007		
E	143	Portion of payment deferred.	2/28/2001			
E	144	Incentive adjustment, e.g. preferred product/service.	6/30/2001			
I	146	Diagnosis was invalid for the date(s) of service reported.	6/30/2002	9/30/2007		
I	147	Provider contracted/negotiated rate expired or not on file.	6/30/2002			

I	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.)	6/30/2002	9/20/2009		
I	149	Lifetime benefit maximum has been reached for this service/benefit category.	10/31/2002			
I	150	Payer deems the information submitted does not support this level of service.	10/31/2002	9/30/2007		
I	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	10/31/2002	1/27/2008		
I	152	Payer deems the information submitted does not support this length of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	10/31/2002	7/10/2010		
I	153	Payer deems the information submitted does not support this dosage.	10/31/2002	9/30/2007		
I	154	Payer deems the information submitted does not support this day's supply.	10/31/2002	9/30/2007		
I	155	Patient refused the service/procedure.	6/30/2003	9/30/2007		
I	157	Service/procedure was provided as a result of an act of war.	9/30/2003	9/30/2007		
I	158	Service/procedure was provided outside of the United States.	9/30/2003	9/30/2007		
I	159	Service/procedure was provided as a result of terrorism.	9/30/2003	9/30/2007		
I	160	Injury/illness was the result of an activity that is a benefit exclusion.	9/30/2003	9/30/2007		
E	161	Provider performance bonus	2/29/2004			
I	163	Attachment/other documentation referenced on the claim was not received.	6/30/2004	6/2/2013		
I	164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	6/30/2004	6/2/2013		
I	165	Referral absent or exceeded.	10/31/2004	9/30/2007		
E	166	These services were submitted after this payers responsibility for processing claims under this plan ended.	2/28/2005			

I	167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6/30/2005	7/1/2010		
E	168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.	6/30/2005	9/30/2007		
E	169	Alternate benefit has been provided.	6/30/2005	9/30/2007		
I	170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6/30/2005	9/20/2009		
I	171	Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6/30/2005	9/20/2009		
E	172	Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6/30/2005	9/20/2009		
I	173	Service/equipment was not prescribed by a physician.	6/30/2005	7/1/2013		
I	174	Service was not prescribed prior to delivery.	6/30/2005	9/30/2007		
I	175	Prescription is incomplete.	6/30/2005	9/30/2007		
I	176	Prescription is not current.	6/30/2005	9/30/2007		
I	177	Patient has not met the required eligibility requirements.	6/30/2005	9/30/2007		
I	178	Patient has not met the required spend down requirements.	6/30/2005	9/30/2007		
I	179	Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6/30/2005	9/20/2009		
I	180	Patient has not met the required residency requirements.	6/30/2005	9/30/2007		
I	181	Procedure code was invalid on the date of service.	6/30/2005	9/30/2007		
I	182	Procedure modifier was invalid on the date of service.	6/30/2005	9/30/2007		

I	183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6/30/2005	9/20/2009		
I	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6/30/2005	9/20/2009		
I	185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6/30/2005	9/20/2009		
E	186	Level of care change adjustment.	6/30/2005	9/30/2007		
E	187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)	6/30/2005	1/25/2009		
I	188	This product/procedure is only covered when used according to FDA recommendations.	6/30/2005			
I	189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	6/30/2005			
I	190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	10/31/2005			
I	192	Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.	10/31/2005	9/30/2007		
I	193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	2/28/2006	1/27/2008		

I	194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	2/28/2006	9/30/2007		
E	195	Refund issued to an erroneous priority payer for this claim/service.	2/28/2006	9/30/2007		
I	197	Precertification/authorization/notification absent.	10/31/2006	9/30/2007		
I	198	Precertification/authorization exceeded.	10/31/2006	9/30/2007		
I	199	Revenue code and Procedure code do not match.	10/31/2006			
I	200	Expenses incurred during lapse in coverage	10/31/2006			
I	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 or either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	10/31/2006	9/28/2014		Not for use by Worker's Compensation payers; use code P3 instead.
I	202	Non-covered personal comfort or convenience services.	2/28/2007	9/30/2007		
I	203	Discontinued or reduced service.	2/28/2007	9/30/2007		
I	204	This service/equipment/drug is not covered under the patient's current benefit plan	2/28/2007			
E	205	Pharmacy discount card processing fee	7/9/2007			
E	206	National Provider Identifier - missing.	7/9/2007	9/30/2007		
E	207	National Provider identifier - Invalid format	7/9/2007	6/1/2008		
E	208	National Provider Identifier - Not matched.	7/9/2007	9/30/2007		
E	209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)	7/9/2007	7/1/2013		
I	210	Payment adjusted because pre-certification/authorization not received in a timely fashion	7/9/2007			
E	211	National Drug Codes (NDC) not eligible for rebate, are not covered.	7/9/2007			
E	212	Administrative surcharges are not covered	11/5/2007			

I	213	Non-compliance with the physician self referral prohibition legislation or payer policy.	1/27/2008			
I	215	Based on subrogation of a third party settlement	1/27/2008			
I	216	Based on the findings of a review organization	1/27/2008			
E	219	Based on extent of injury. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	1/27/2008	10/17/2010		
E	222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6/1/2008	9/20/2009		
E	223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.	6/1/2008			
E	224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.	6/1/2008			
E	225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)	6/1/2008			
I	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.)	9/21/2008	7/1/2013		

I	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.)	9/21/2008	9/20/2009		
I	228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	9/21/2008			
E	229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer’s cost avoidance policy allows providers to bypass claim submission to a prior payer. Use only with Group Code PR.	1/25/2009	7/1/2013		
I	231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2009	9/20/2009		
E	232	Institutional Transfer Amount. Note - Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.	11/1/2009			
I	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	1/24/2010			
I	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.)	1/24/2010			
E	235	Sales Tax	6/6/2010			
I	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.	1/30/2011	7/1/2013		

E	237	Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	6/5/2011			
I	238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	3/1/2012	7/1/2013		
E	239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	3/1/2012	1/29/2012		
I	240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6/3/2012			
E	241	Low Income Subsidy (LIS) Co-payment Amount	6/3/2012			
I	242	Services not provided by network/primary care providers.	6/3/2012	6/2/2013		This code replaces deactivated code 38
I	243	Services not authorized by network/primary care providers.	6/3/2012	6/2/2013		This code replaces deactivated code 38
E	245	Provider performance program withhold.	9/30/2012			
E	246	This non-payable code is for required reporting only.	9/30/2012			
E	247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.	9/30/2012			For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care ACT (PPACA).
E	248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.	9/30/2012			For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care ACT (PPACA).
E	249	This claim has been identified as a readmission. (Use only with Group Code CO)	9/30/2012			
I	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	9/30/2012	6/1/2014		

		Reason Code, or Remittance Advice Remark Code that is not an ALERT).				
I	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).	9/30/2012	6/1/2014		
I	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).	9/30/2012	6/2/2013		
E	253	Sequestration - reduction in federal payment	6/2/2013	11/1/2013		
E	254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	6/2/2013			
I	256	Service not payable per managed care contract.	6/2/2013			
I	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)	11/1/2013	6/1/2014		To be used after the first month of the grace period.
I	258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	11/1/2013			
E	259	Additional payment for Dental/Vision service utilization.	1/26/2014			
E	260	Processed under Medicaid ACA Enhanced Fee Schedule	1/26/2014			
I	261	The procedure or service is inconsistent with the patient's history.	6/1/2014			
E	262	Adjustment for delivery cost. Note: To be used for pharmaceuticals only.	11/1/2014			
E	263	Adjustment for shipping cost. Note: To be used for pharmaceuticals only.	11/1/2014			
E	264	Adjustment for postage cost. Note: To be used for pharmaceuticals only.	11/1/2014			

E	265	Adjustment for administrative cost. Note: To be used for pharmaceuticals only.	11/1/2014			
E	266	Adjustment for compound preparation cost. Note: To be used for pharmaceuticals only.	11/1/2014			
E	267	Claim/service spans multiple months. Rebill as separate claim/service.	11/1/2014			
E	268	The Claim spans two calendar years. Please resubmit one claim per calendar year.	11/1/2014			
E	A0	Patient refund amount.	1/1/1995			
I	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.)	1/1/1995	9/20/2009		
E	A5	Medicare Claim PPS Capital Cost Outlier Amount.	1/1/1995			
I	A6	Prior hospitalization or 30 day transfer requirement not met.	1/1/1995			
E	A7	Presumptive Payment Adjustment	1/1/1995			Stop: 7/1/2015
I	A8	Ungroupable DRG.	1/1/1995	9/30/2007		
I	B1	Non-covered visits.	1/1/1995			
E	B4	Late filing penalty.	1/1/1995			
I	B5	Coverage/program guidelines were not met or were exceeded.	1/1/1995	9/30/2007		
I	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	B8	Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
E	B9	Patient is enrolled in a Hospice.	1/1/1995	9/30/2007		
E	B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	1/1/1995			

I	B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	1/1/1995			
I	B12	Services not documented in patients' medical records.	1/1/1995			
E	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	1/1/1995			
I	B14	Only one visit or consultation per physician per day is covered.	1/1/1995	9/30/2007		
I	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1/1/1995	9/20/2009		
I	B16	'New Patient' qualifications were not met.	1/1/1995	9/30/2007		
I	B20	Procedure/service was partially or fully furnished by another provider.	1/1/1995	9/30/2007		
E	B22	This payment is adjusted based on the diagnosis.	1/1/1995	2/28/2001		
I	B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	1/1/1995	9/30/2007		
E	P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.	11/1/2013			This code replaces deactivated code 162
E	P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	11/1/2013			This code replaces deactivated code 191
E	P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside	11/1/2013			This code replaces deactivated code 201

		arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR)				
E	P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	11/1/2013			This code replaces deactivated code 214
E	P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.	11/1/2013			This code replaces deactivated code 217
E	P6	Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.	11/1/2013			This code replaces deactivated code 218
E	P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.	11/1/2013			This code replaces deactivated code 220
E	P8	Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used	11/1/2013			This code replaces deactivated code 221

		for Property and Casualty only. This code replaces deactivated code				
E	P9	No available or correlating CPT/HCPCS code to describe This code replaces deactivated code e this service. To be used for Property and Casualty only.	11/1/2013			This code replaces deactivated code 230
E	P10	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only.	11/1/2013			This code replaces deactivated code 244
E	P11	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA)	11/1/2013			This code replaces deactivated code 255
E	P12	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	11/1/2013			This code replaces deactivated code W1
E	P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	11/1/2013			This code replaces deactivated code W2
E	P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	11/1/2013			This code replaces deactivated code W3
E	P15	Workers' Compensation Medical Treatment Guideline Adjustment.	11/1/2013			This code replaces

		To be used for Workers' Compensation only.				deactivated code W4
E	P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA)	11/1/2013			This code replaces deactivated code W5
E	P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only.	11/1/2013			This code replaces deactivated code W6
E	P18	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only.	11/1/2013			This code replaces deactivated code W7
E	P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.	11/1/2013			This code replaces deactivated code W8
E	P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.	11/1/2013			This code replaces deactivated code W9
E	P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	11/1/2013			This code replaces deactivated code Y1
E	P22	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service	11/1/2013			This code replaces deactivated code Y2

		Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.				
E	P23	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	11/1/2013			This code replaces deactivated code Y3

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