



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Accounts Receivable (BAR)

Patch 5 Addendum

**Version 1.7 Patch 5
May 2004**

**Information Technology Support Center
Division of Information Resources
Albuquerque, New Mexico**

TABLE OF CONTENTS

1.0	INTRODUCTION	1
2.0	PATCH 5	5
	2.1 HIPAA Compliant A/R EDI Remark Codes	5
	2.1.1 Post Remark Codes (RMK).....	5
	2.1.2 Remittance Advice Remark Code Inquiry (IRMK)	7
	2.1.3 New Remark Code Transaction Type on Bill Posted Summary	9
	2.2 HIPAA Compliant NCPDP Rej/Pay Codes.....	9
	2.2.1 Post NCPDP Reject/Payment Codes (RX)	10
	2.2.2 New NCPDP Rej/Pay Transaction Type on Bill Posted Summary	12
	2.3 Standard Adjustment Reason Inquiry (IADJ)	13
	2.4 Check Field.....	14
	2.5 Modified ERA Posting.....	14
	2.6 Modified ERA Option	15
3.0	PATCH 4	16
	3.1 HIPAA Standard Adjustment Codes	16
	3.2 Load New Import option (NEW)	16
	3.2.1 New Transport Option	16
	3.2.2 New Warning Message	16
	3.3 Review Postable Claims Option (REV)	17
	3.4 Post ERA Claims (PST)	18
	3.5 Report ERA Claims (RPT)	19
4.0	PATCH 2	21
	4.1 EISS Capability.....	21
	4.1.1 Site Parameters	21
	4.1.2 PSR for the EISS	22
	4.1.3 ASM for the EISS	24
	4.1.4 EISS File Naming Conventions	26
	4.2 Patient Account Statement Menu (PAS)	27
	4.2.1 Setting up TaskMan to Run Patient Statements	30
	4.2.2 Enter/Edit Statement Header Text (SHDR)	31
	4.2.3 Flag Patient Accounts for Statements (FLAG)	32
	4.2.4 Print All Flagged Patients' Account Statements (PRA).....	34
	4.2.5 Print One Flagged Patient's Account Statement (PRO)	34
5.0	PATCH 1	36
	5.1 Period Summary Report (PSR).....	36
	5.2 Age Summary Report (ASM)	41
	5.3 Setting PSR and ASM Parameters	46
6.0	APPENDIX A: IHS HIPAA STANDARD ADJUSTMENT CODES	47
7.0	APPENDIX B: REMITTANCE ADVICE REMARK CODES	59
8.0	APPENDIX C: NCPDP REJ/PAY CODES	88

9.0 CONTACT INFORMATION 95

1.0 Introduction

Please review these changes and add a copy of them to any printed documentation your site may be using for Accounts Receivable v1.7. These changes will be integrated into future versions of the software and user manuals and will no longer be considered an addendum at the time of the next release.

Note: This addendum does not include all changes included in BAR v1.7 patch 1, 2, 3, 4, and 5. To see a list of all changes and fixes included in this patch, please see each patch's respective patch notes file.

Patch 5 of Accounts Receivable version 1.7 contains the following changes:

- Incorporation of HIPAA compliant Remittance Advice Remark Code. This includes the following changes:
 - Creation and population of new A/R EDI REMARK CODES File. This file reflects Remark Codes as of February 2004 Code List Updates as published by wpc-edi.com (Section 7.0)
 - New Transaction Type called "Remark Code" (Section 2.1)
 - Remark Codes are automatically posted during the ERA Post Claims process (Section 2.1)
 - New Post Remark Codes (RMK) option, allowing user to manually post remark codes, if desired (Section 2.1.1)
 - New Posting option called Remittance Advice Remark Code Inquiry (IRMK) allowing user to inquire about individual remark codes (Section 2.1.2)
 - Display Remark Code transactions on Bill Posted Summary (Section 2.1.3)
- Incorporation of HIPAA compliant NCPDP Reject/Payment Codes to RPMS Accounts Receivable. This includes the following changes:
 - Creation of new Transaction Type called "NCPDP REJ/PAY" (Section 2.2)
 - NCPDP Reject/Payment Codes are automatically posted during the ERA Post Claims process (Section 2.2)
 - New Posting option called Post NCPDP Reject/Payment Codes (RX) allowing user to manually post NCPDP Reject/Payment codes if desired (Section 2.2.1)

- Display NCPDP REJ/PAY transactions on Bill Posted Summary (Section 2.2.2)

Note: The NCPDP Reject/Payment Code table is distributed with the Pharmacy POS software. If it is not installed on your system, you will not be able to post manually and NCPDP reject codes on the ERA will come up "NOT MATCHED".

- New Posting Menu option called Standard Adjustment Reason Code Inquiry (IADJ) (Section 2.3)
- Reworded all references of "check" to "chk/EFT #" in regards to ERA Posting and Collection Batch Items (Section 2.4)
- Modified ERA Posting, correcting problems identified through Medicare Part B 835 testing (Section 2.5).
- Modified ERA Posting option: Review Postable Claims now allow check/EFT # to be reviewed more than once (Section 2.6)

Patch 4

- Changes to the Load New Import (NEW) ERA Posting Menu option:
 - New HIPAA 835 V4010 transaction format for electronic remittance advice (ERA) processing. (Section 3.2.1)
 - The system verifies the file being uploaded is a HIPAA 835 V4010 file. If the file is not compliant, you will see an error message and the file will not be loaded. (Section 3.2.2)
 - If the bill found on the ERA file is cancelled in RPMS 3P, the bill will not be matched and cannot be posted electronically.
- To accommodate for files that contain more than Check/EFT Trace Number, the ERA Review, Post, and Report functions have been modified to perform these functions by Check/EFT Trace number rather than the entire file.
- Changes to the Review Postable Claims (REV) ERA Posting Menu option (Section 3.3):
 - The system performs a matching of EFT Check/Trace number from the ERA to the Check # of the RPMS Collection Batch/Item.
 - Once the bills for a Check/EFT Trace number have been reviewed, the check is removed from the selection list.
- Changes to the Post ERA Claims (PST) ERA Posting Menu option (Section 3.4):

- Only Checks/EFT Trace #'s that have been reviewed appear for selection for posting. Therefore, you must review before you post.
- If posting the ERA bill will result in a negative balance on RPMS, the user is notified and asked if the bill should be posted. If you choose not to post the bill, the system does not post the bill and the user is asked to continue the posting process.
- If the site parameter is defined for Rollback, immediately after posting of the Check/EFT Trace is complete, you are asked if rollback should occur at this time. If yes, bills are rolled back to 3P then. If no, the bills are flagged and the user must use ROL to rollback.
- The Report ERA Claims (RPT) ERA Posting Menu option has been completely rewritten for the HIPAA 835 file format. (Section 3.5)
- Transactions created via POST ERA CLAIMS will get flagged with an "e". The "e" is displayed when viewing the bill's history.
- When selecting *R* for rollback during the manual posting process, (PST, ADJ or PST, PAY), the bill will rollback even if it has been previously rolled back.
- Updated Standard Claim Adjustment Reason Codes to accommodate reworded, clearer explanations as defined in the AR Standard Claim Adjustment Reason Codes file.
- HIPAA Standard Adjustment Codes Mapped to RPMS. (Section 6.0)

Patch 3

Please see BAR patch 3 notes file.

Patch 2

This document also contains the Patch 2 addendum information for ease of use. Patch 2 released in August 2003, contained the following changes:

- Enhancements to two reports allowing EISS capability:
 - Period Summary Report (PSR)
 - Age Summary Report (ASM)

When selecting these reports by Allowance Category, all categories, and summary report, a file of the report data will automatically get created on the EISS directory and sent to the ARMS Server where the intranet can find it for web display.

- New menu option: Patient Account Statement (PAS)

This option allows you to flag patient accounts so that you can print a Patient Account statement. This option will allow you to run individual statements or batch of statements using TaskMan.

Patch 1

This document also contains the Patch 1 addendum information for ease of use. Patch 1 released in June 2003, contained the following changes:

- Enhancements of two reports:
 - Period Summary Report (PSR)

This report has been rewritten to use the Transaction file. You may run the report for any date range desired. More detail has been added to the report, allowing better tools for reconciliation. The report has two new sorting criteria and one new report type summary. (Section 5.1)
 - Age Summary Report (ASM)

This report has been expanded to allow sorting by Discharge Service. Also, bill level detail has been added, allowing better tools for reconciliation. The report has two new sorting criteria and one new report type summary. (Section 5.2)

2.0 Patch 5

2.1 HIPAA Compliant A/R EDI Remark Codes

Patch 5 includes the addition of HIPAA compliant Remittance Advice Remark codes to the RPMS Accounts Receivable package. A new A/R EDI Remark Codes file has been created and populated to accommodate these new codes. The file reflects Remark Codes as of the February 2004 Code List Updates as published by wpc-edi.com (refer to Appendix B: Remittance Advice Remark Codes). These Remark Codes are automatically posted to A/R during the ERA Post Claims process. The new codes will be posted as a new Transaction Type called "Remark Code." The new Transaction Type field will hold up to 80 characters of the Remark Code description. To see the full, long description full listing of a Remark Code, use the Remittance Advice Remark Code Inquiry (IRMK) option (Section 2.1.2). Please refer to Appendix B: Remittance Advice Remark Codes to see a complete list of Remark codes.

2.1.1 Post Remark Codes (RMK)

A new posting option called Post Remark Codes has been added, allowing user to manually post remark codes, if desired.

1. To manually post codes, type **RMK** at the "Select Posting Menu Option:" prompt located in the Posting menu.
2. Type your signature code at the "Enter Your Current Signature Code:" prompt.
3. Type the name or number of a batch at the "Select Batch:" prompt, and then type the name of a batch item at the "Select Batch Item:" prompt. If you do not type a valid batch or batch item, the system displays a warning: `A valid collection batch and item was not entered. Continue?.` If you respond by typing **Y**, you will be allowed to type bill number at the "Select A/R BILL/IHS BILL NUMBER:" prompt. If you respond by typing **N**, you will be returned to the Posting menu. If you do not know the bill number, you can press the Return key at a blank "Select A/R Bill/IHS Bill Number:" prompt to enter a patient name at the "Select Patient Name:" prompt, or press the Return key again at a blank "Select Patient Name:" prompt to enter a bill DOS at the "Select Bill DOS:" prompt.
4. Type a remark code at the "Select Remark Code:" prompt.
5. Type any additional remark codes at the "Select Additional Remark Code:" prompt. If you done entering remark codes, press the Return key at a blank "Select Additional Remark Code:" prompt.

```

Select Posting Menu Option: RMK Post Remark Codes

      +-----+
      |                ACCOUNTS RECEIVABLE SYSTEM - VER 1.7                |
      |                Post Remark Codes                                  |
      |                LITTLE BUILDING HEALTH CENTER                      |
      +-----+
User:  USER,DEMO                BUSINESS OFFICE                4-MAR-2004 10:09 AM

Enter your Current Signature Code: ***** SIGNATURE VERIFIED

Select Batch: [RET]
A valid collection batch and item was not entered. Continue? N// Y YES

Select A/R BILL/IHS BILL NUMBER: 113510-AA-2

Select Remark Code: N54 Claim information is inconsistent with pre-
certified/authorized services.

Select Additional Remark Code: [RET]
    
```

Figure 2-1: Using the RMK option (steps 1-5)

6. A summary of the bill and remark code(s) displays (Figure 2-2).

Note: Only if the patient was an inpatient will the “To:” field display, indicating a range of days for the date of service where the “DOS:” field is the first day of service and the “To:” field is the last day of service.

7. Type Y at the “Post these remark codes to this bill?” prompt, if you want to post the codes, otherwise type N to return to step 1.
8. A message indicating the codes are posting displays.
9. Press the Return key at the “Enter Return to Continue:” prompt.
10. You can enter another bill number, patient name, or DOS if you want to continue. If you want to exit, press the Return key at the remaining prompts.

```

BILL #: 113510-96-2                DATE BILLED: MAR 10, 1996
PATIENT: PATIENT,DEMO            AGE OF BILL: 59598 DAYS
CHART: 101772                    BILL STATUS: PENDING

      DOS: MAR 06, 1996                A/R ACCT: AETNA HLTHCARE ASR PROG OF WI
      TO: MAR 07, 1996

*****
N54
Claim information is inconsistent with pre-certified/authorized services.
*****
Post these remark codes to this bill? Y// Y YES

Posting Remark Code N54
    
```

```

Enter RETURN to continue: [RET]

Select A/R BILL/IHS BILL NUMBER: [RET]
Select PATIENT NAME: [RET]
Select Bill DOS: [RET]

```

Figure 2-2: Using the RML option (steps 6-7)

2.1.2 Remittance Advice Remark Code Inquiry (IRMK)

Patch 5 includes a new posting option called Remittance Advice Remark Code Inquiry (IRMK) allowing user to inquire about individual remark codes and see full descriptions of each of the codes. This option only allows you to view one Remark Code at a time. You cannot run a list of multiple codes. To see a complete listing of codes

1. To run a remittance advice remark code inquiry, type **IRMK** at the “Select Posting Menu Option:” prompt located in the Posting menu.
2. A note displays, indicating where you can obtain a hard copy of the Remark Codes file. This display will change depending on what version/patch of A/R your site is currently running.
3. Type the code that you want to view at the “Remittance Advice Remark Code:” prompt.
4. Type the name of an output device at the “Output Device:” prompt.

```

Select Posting Menu Option: IRMK Remittance Advice Remark Code Inquiry

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
+      Remittance Advice Remark Code Inquiry      +
|          LITTLE BUILDING HEALTH CENTER          |
+-----+
User: USER,DEMO          BUSINESS OFFICE          27-FEB-2004 9:22 AM

NOTE: To obtain a complete hardcopy listing of Remittance Advice Remark
Codes, please refer to the User Manual Addendum for A/R V1.7 Patch 5.

Remittance Advice Remark Code: M26

Output DEVICE: HOME// [RET]

```

Figure 2-3: Using the IRMK option

5. A listing of the code displays, showing both the short and long description of the code (Figure 2-4).

Important: If Pharmacy POS is not installed on your system, you will not be able to post manually and NCPDP reject codes on the ERA will come up as “Not Matched.”

If applicable, these NCPDP codes are automatically posted to A/R during the ERA Post Claims process. The new codes will be posted as a new Transaction Type called “NCPDP Rej/Pay.” A new option has been added to accommodate the NCPDP codes: Post NCPDP Reject/Payment Codes (RX). Please refer to Appendix C: NCPDP Rej/Pay Codes for a full list of NCPDP Reject/Payment codes.

2.2.1 Post NCPDP Reject/Payment Codes (RX)

The new posting option called Post NCPDP Reject/Payment Codes allows you to manually post NCPDP Reject/Payment codes, if desired.

1. To manually post these codes, type RX at the “Select Posting Menu Option:” prompt located in the Posting menu.
2. Type your signature code at the “Enter Your Current Signature Code:” prompt.
3. Type the name or number of a batch at the “Select Batch:” prompt, and then type the name of a batch item at the “Select Batch Item:” prompt. If you do not type a valid batch or batch item, the system displays a warning: A valid collection batch and item was not entered. Continue?. If you respond by typing Y, you will be allowed to type bill number at the “Select A/R BILL/IHS BILL NUMBER:” prompt. If you respond by typing N, you will be returned to the Posting menu. If you do not know the bill number, you can press the Return key at a blank “Select A/R Bill/IHS Bill Number:” prompt to enter a patient name at the “Select Patient Name:” prompt, or press the Return key again at a blank “Select Patient Name:” prompt to enter a bill DOS at the “Select Bill DOS:” prompt.
4. Type a remark code at the “Select NCPDP Reject Payment Code:” prompt.
5. Type any NCPDP codes at the “Select Additional Remark Code:” prompt. If you done entering remark codes, press the Return key at a blank “NCPDP Reject Payment Code:” prompt.

```

Select Posting Menu Option: RX Post NCPDP Reject/Payment Codes

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
      |      Post NCPDP Reject/Payment Codes                    |
      |          LITTLE BUILDING HEALTH CENTER                  |
      +-----+
User: USER,DEMO          BUSINESS OFFICE          4-MAR-2004 10:12 AM

Enter your Current Signature Code: ***** SIGNATURE VERIFIED

Select Batch: DEMO HEALTH CENTER-02/26/2004-1 DEMO HEALTH CENTER
-02/26/200          LITTLE BUILDING HEAL
      ==> Total Posted: $ 0.00          ==> Remaining Balance: $ 54326.54

Select Batch Item: 1
      ==> Item Total Posted: $ 0.00          ==> Item Remaining Balance: $ 54326.54

Select Visit Location: LITTLE BUILDING HEALTH CENTER          54326.54
==> Sub-Item Total Posted: $ 0.00 ==> Sub-Item Remaining Balance: $ 54326.54

Select A/R BILL/IHS BILL NUMBER: 113510-96-2

Select NCPDP Reject Payment Code: 21 M/I Patient Gender Code

Select Additional NCPDP Reject Payment Code: 65 Patient Is Not Covered

Select Additional NCPDP Reject Payment Code: 12 M/I Patient Location

Select Additional NCPDP Reject Payment Code: [RET]

```

Figure 2-6: Using the RX option (steps 1-5)

6. A summary of the bill and NCPDP code(s) displays (Figure 2-7).

Note: Only if the patient was an inpatient will the “To:” field display, indicating a range of days for the date of service where the “DOS:” field is the first day of service and the “To:” field is the last day of service.

7. Type Y at the “Post these NCPDP Reject/Payment codes to this bill?” prompt, if you want to post the codes, otherwise type N to return to step 1.
8. A message indicating the codes are posting displays.
9. Press the Return key at the “Enter Return to Continue:” prompt.
10. You can enter another bill number, patient name, or DOS if you want to continue. If you want to exit, press the Return key at the remaining prompts.

```

BILL #: 113510-96-2          DATE BILLED: FEB 2, 1996
PATIENT: PATIENT, DEMO      AGE OF BILL: 59598 DAYS
CHART: 101772              BILL STATUS:

      DOS: MAR 06, 1996      A/R ACCT: AETNA HLTHCARE ASR PROG OF WI
      TO: MAR 07, 1996

*****
10
M/I Patient Gender Code

12
M/I Patient Location

65
Patient Is Not Covered
*****
Post these NCPDP Reject/Payment codes to this bill? Y// Y YES

Posting NCPDP Reject/Payment Code 10
Posting NCPDP Reject/Payment Code 12
Posting NCPDP Reject/Payment Code 65

Enter RETURN to continue: [RET]

Select A/R BILL/IHS BILL NUMBER: [RET]
Select PATIENT NAME: [RET]
Select Bill DOS: [RET]

```

Figure 2-7: Using the RX option (steps 6-7)

2.2.2 New NCPDP Rej/Pay Transaction Type on Bill Posted Summary

The new NCPDP Rej/Pay codes will be posted as a new Transaction Type called "NCPDP Rej/Pay." When running a Bill Posted summary, the NCPDP codes will display in Transaction Type column. For information on how to run a Bill Posted summary, see the A/R v1.7 User manual.


```

Select Posting Menu Option: IADJ Standard Adjustment Reason Inquiry

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
      +          Standard Adjustment Reason Inquiry            +
      |          LITTLE BUILDING HEALTH CENTER                  |
      +-----+
User: USER,DEMO          BUSINESS OFFICE          27-FEB-2004 9:22 AM

NOTE:  For a complete hardcopy listing of Standard Adjustment Reason Codes,
       please refer to the User Manual Addendum for A/R V1.7 Patch 4.

Standard Adjustment Reason Code: 17

Output DEVICE: HOME// [RET]
    
```

Figure 2-9: Using the IADJ option (steps 1-4)

5. A listing of the code displays, showing both the short and full description of the code (Figure 2-10).

```

=====
Standard Adjustment Reason Code Inquiry          FEB 27,2004@09:22   Page 1
=====

STANDARD          SHORT Payment adjusted-requested info not
  CODE: 17          DESC: provided or insufficient/incomplete

      RPMS   4          RPMS   617
CATEGORY: NON PAYMENT  REASON: Pymt Adj Info Incomplete

FULL STANDARD CODE DESCRIPTION:

Payment adjusted because requested information was not provided or was
insufficient/incomplete. Additional information is supplied using the
remittance advice remarks codes whenever appropriate.
    
```

Figure 2-10: Using the IADJ option (step 5)

2.4 Check Field

Patch 5 includes a change in the Check field. All references of "check" are now reworded to "chk/EFT #" in regards to ERA Posting and Collection Batch Items.

2.5 Modified ERA Posting

Posting of the ERA has been modified due to an issue identified with Medicare Part B 835 testing. The system will now review the 835 file received for Claim Date of

Service. If it is not received, it will look for the Line Item Date of Service to post. The modification will apply to all Payers.

2.6 Modified ERA Option

The Review Postable Claims ERA posting option has been modified option allowing check/EFT # to be reviewed more than once.

3.0 Patch 4

3.1 HIPAA Standard Adjustment Codes

Patch 4 includes the new HIPAA complaint IHS HIPAA Standard Adjustment Codes. See Appendix A: IHS HIPAA Standard Adjustment Codes for a full list.

3.2 Load New Import option (NEW)

3.2.1 New Transport Option

To comply with HIPAA guidelines, patch 4 adds a new transport option. When selecting an A/R EDI transport name, you can now select the HIPAA 835 v4010 transport option.

```

+-----+
|                ACCOUNTS RECEIVABLE SYSTEM - VER 1.7                |
|                Load New Import                                     |
|                UNSPECIFIED SERVICE UNIT                           |
+-----+
User: USER,DEMO                BUSINESS OFFICE                17-OCT-2003 9:56 AM

Enter your Current Signature Code:    SIGNATURE VERIFIED

Select A/R EDI TRANSPORT NAME: ??

Choose from:
ACHHHS 835 MODIFIED
AHCCCS
HIPAA 835 v4010
MEDICARE 835 3041.4A
MEDICARE 835 3041.4B

Select A/R EDI TRANSPORT NAME:

```

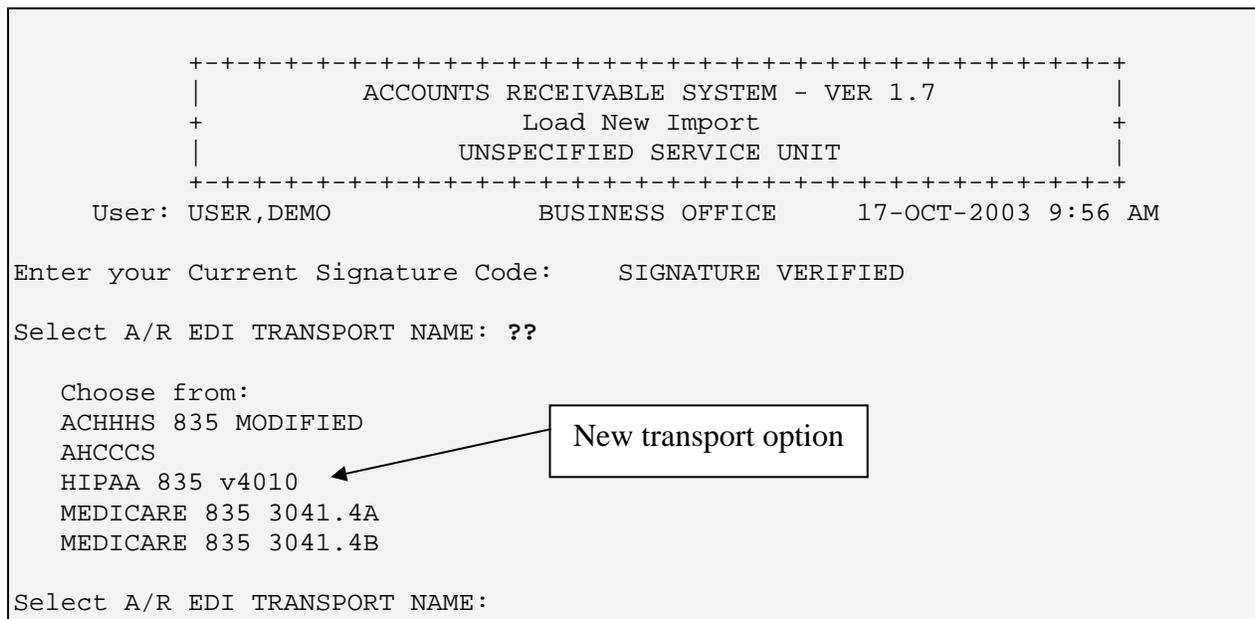


Figure 3-1: New transport

3.2.2 New Warning Message

When using the HIPAA 835 v4010 option, the system will verify if the file you entered is in the correct HIPAA 835 format. If the file is not compliant, you will see an error message (Figure 3-2:) and the file will not be loaded. Also, if the bill found on the ERA file is cancelled in RPMS 3P, the bill will not be matched and cannot be posted electronically.

```
Select A/R EDI TRANSPORT NAME: HIPAA 835 v4010
Enter the directory path for the transport file: /usr3/xxx/xxx/hipaa/
  Replace
  /xxx/xxx/xxxxxx/
File Name : testpsr.txt

File                Directory                Transport
testpsr.txt         /xxx/xxx/xxxxxx/         HIPAA 835 v4010

Do you want to proceed? N// Y YES
Enter RETURN to continue:

The file testpsr.txt in directory /xxx/xxx/xxxxxx/ is not a HIPAA compliant
835 Remittance Advice. It cannot be loaded.
```

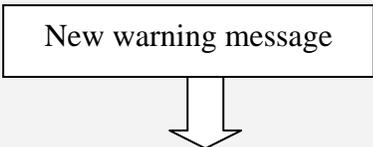


Figure 3-2: New warning message

3.3 Review Postable Claims Option (REV)

This option has been revised to allow for more than one check number to be displayed per remittance advice. Also, the system now matches the EFT Check/Trace number(s) from the ERA to the collection batch/item(s) and displays a message notifying you that there are no matches, a match, or several matches. Once the bills for a Check/EFT Trace number have been reviewed, the check is removed from the selection list.

```

+-----+
|                ACCOUNTS RECEIVABLE SYSTEM - VER 1.7                |
|                Review Postable Claims                              |
|                UNSPECIFIED SERVICE UNIT                            |
+-----+
User: USER,DEMO                BUSINESS OFFICE                20-OCT-2003 12:22 PM

Select file: 1001_ERA_10/01/2003  OKMCD835.txt                CHK: 1501
                                                CHK: 555000

There are 2 check(s) for the file 1001_ERA_10/01/2003

Now matching check/EFT Trace #'s on ERA to Check # of Collection Batch/Item..

Check 1501 does not match any existing batch/items.??

55000 previously match to batch ITSC-MEDICAID-09/29/2003-2 Item: 1
  A/R Acct: NEW MEXICO MEDICAID                for:                1,000.00 Bal: 915.68

Done matching check/EFT Trace # of ERA to check # of collection Batch/Item.

Enter Return to continue: [RET]

1) CHECK #: 555000                BATCH: ITSC-MEDICAID-09/29/2003                ITEM: 1
   A/R ACCOUNT: NEW MEXICO MEDI                BATCHED AMT: 1,000.00 BALANCE: 915.68

Please enter the LINE # of the check you wish to REVIEW: 1//
```

Figure 3-3: Using the REV option

3.4 Post ERA Claims (PST)

This option has been revised to only display checks that have been reviewed using the REV option. Also, if posting the ERA bill will result in a negative balance on RPMS, a new warning message has been added that will ask you if the bill should be posted. If you choose not to post the bill, the system does not post the bill and you are asked to continue the posting process.

A new site parameter dependent prompt has been added, prompting you immediately after posting of the Check/EFT Trace is complete. You are asked if rollback should occur at this time. If yes, bills are rolled back to 3P. If no, the bills are flagged and you must use the ROL option to rollback.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
|          Post ERA Claims                               |
|          UNSPECIFIED SERVICE UNIT                     |
+-----+
User: USER,DEMO          BUSINESS OFFICE          20-OCT-2003 12:42 PM

Select file: 1001_ERA_10/01/2003  OKMCD835.txt  CHK: 1501

1) CHECK #: 1301          BATCH:
   A/R ACCOUNT:          BATCHED AMOUNT: 0.00  BALANCE: 0.00

2) CHECK # 1501          BATCH:          ITEM:
   A/R ACCOUNT:          BATCHED AMOUNT: 0.00  BALANCE: 0.00

3) CHECK # 55500          BATCH: ITSC-MEDICAID-09/29/2003-2  ITEM: 1
   A/R ACCOUNT: NEW MEXICO MEDI  BATCHED AMOUNT: 1,000.00  BALANCE: 915.68

Please enter the LINE # of the check you wish to POST: 3

Do you want to post ERA Claims for Check 5500 now? n// YES
Post 45377a-zzz-99089 will result in a negative balance on the bill.
Post this bill? No// YES

Claim: 45377a <> 45377a-zzz-99089
      Billed: 70.65      Payment: 50.32
      ADJ: 20.32        Pending
                        Clm/Srvc Lacks Info For Adjud

1 Bills posted to AR

Do you want to rollback to 3P the bills that just posted? N// No

Ok, marking for rollback the bills that just posted for check 555000
Please use the ROL option when you're ready to roll them back to 3P

Enter RETURN to continue:
    
```

The screenshot shows the PST option interface. A callout box points to the first two checks, stating: "The system will only display checks that you have reviewed." Another callout box points to the prompt "Post this bill? No// YES", stating: "New negative balance message". A third callout box points to the prompt "Do you want to rollback to 3P the bills that just posted? N// No", stating: "New rollback message".

Figure 3-4: Using the PST option

3.5 Report ERA Claims (RPT)

This report has been totally rewritten for the HIPAA 835 file format.

Generate an ERA Claim Report

1. Type RPT at the “Select ERA Posting Option:” prompt.
2. Type an A/R EDI import name, or the date/time of the import, or the host file name or a check number that corresponds to an import at the “Select file:” prompt. You can also type ?? to select from a list of recently imported files. The system displays a list of lines that you can choose to report on.
3. Type the line number for which you would like a report at the “Please enter the Line # of the check you wish to Report:” prompt.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
+-----+-----+
|                   ERA Posting                          |
+-----+-----+
|                   UNSPECIFIED SERVICE UNIT              |
+-----+-----+
User: TORREZ,JUAN          BUSINESS OFFICE          23-OCT-2003 9:42 AM

NEW   Load New Import
VIEW  View Import Header
REV   Review Postable Claims
PST   Post ERA Claims
RPT   Report ERA Claims

Select ERA Posting Option: RPT

Select file: 1006_ERA_10/16/2003          ACL partb dt1008.txtCHK: 881685516

1) CHECK #: 881685516          BATCH: ** no RPMS match **          ITEM:
   A/R ACCOUNT:                BATCHED AMT:          0.00  BALANCE:          0.00

Please enter the LINE # of the check you wish to REPORT: 1// [RET]

Reports for:          1006_ERA_10/16/2003
                   ACL partb dt1008.txt          CHK: 881685516

```

Figure 3-5: Using the RPT option (steps 1-3)

4. At the “Enter Response:” prompt, type one or more categories you want included in the report by the one-letter code indicated for each as shown in the example (CRXN).
5. Type D (Detailed), B (Brief - one line), or S (Summary - totals only) at the “Select the type of report:” prompt.
6. Type P (Print) or B (Browse) at the “Do you wish to:” prompt.
7. Type the name of a print device at the “Output Device:” prompt.

```

Enter the list of Claim Status(s) you desire to print, and in the sequence to
be printed out.

C - Claim Unmatched      R - Reason Unmatched    N - Not to Post
M - Matched              P - Posted              X - Claim & Reason
Unmatched
A - All Categories
  Example:  CRXN
Enter response: CRXN

Select the type of report: (D/B/S): Summary - Totals Only

  Select one of the following:
    P          PRINT Output
    B          BROWSE Output on Screen
Do you wish to: P// [RET]RINT Output

Output DEVICE: HOME//[RET]
    
```

Figure 3-6: Using the RPT option (steps 4-7)

8. The report is displayed as illustrated in Figure 3-7.

```

          WARNING: Confidential Patient Information, Privacy Act Applies
=====
ELECTRONIC CLAIM REPORT - Summary                OCT 20,2003@13:00   Page 1
FOR FILE NAME: ACL partb dt1008.txt             CHECK/EFT TRACE: 881685516
FOR RPMS FILE: 1006_ERA_10/16/2003 FOR ACL INDIAN HOSPITAL
=====
BATCH: ** No RPMS match **                       ITEM #
=====
MEDICARE PART B                                  MEDICARE PART B
P.O. BOX 1234                                     PH: 8665555708
Anytown, USA 752660156
=====
CLAIM STATUS          BILL COUNT    PAYMENTS    COPAY/DEDUCT    ADJUSTMENTS
-----
CLAIM UNMATCHED      99          2,333.83    589.16          5,985.01
GRAND TOTALS        99          2,333.83    589.16          5,985.01

      ADJUSTMENT Totals:
CLAIM STATUS          BILL COUNT    PAYMENTS    COPAY/DEDUCT    ADJUSTMENTS
-----
          DEDUCTIBLE                6.00
          CO-PAY                    583.16
          NON PAYMENT                5,985.01
                                     =====
                                     6,574.17

          * * E N D   O F   R E P O R T * *

Enter RETURN to continue or '^' to exit:
    
```

Figure 3-7: Sample RPT report

4.0 Patch 2

4.1 EISS Capability

The Executive Information Support System (EISS) is a web-based system that allows authorized users to access specific information regarding finances, travel, etc. This enhancement will allow information from the ASM and PSR reports to pass to EISS when the reports are run under certain criteria.

4.1.1 Site Parameters

In order for the EISS functionality to operate correctly, you must set up four new site parameters through the Site Parameters Edit (SPE) option. The first three items will be automatically populated with data when the Site manager installs the patch. On the EISS (local) path, you will have to find out what path name your local Site manager defined during the installation of this patch. It is recommended that you do not use a public drive to store these files. Once this is defined, follow the instructions in this field.

EISS System: Type the IP address used for sending PSR and ASM Summary data to Web

EISS Username: Type the user name needed to access the remote system receiving the ASM and PSR data.

EISS Password: Type the password needed to access the remote system receiving the ASM and PSR data.

EISS (local) path: Type the directory (path name) on the local system that will hold the ASM and PSR summary data. Since this file holds financial data DO NOT use a public drive to store this file.

1. To access to Site Parameters option, type **SPE** at the “Select Manager Option:” prompt that is located in the Manager menu.
2. Type the name of your site at the “Select A/R Site Parameter/IHS RPMS Site:” prompt.
3. Press the Return key at the “OK? Yes//” prompt to confirm your selection.
4. Follow the prompts as they appear on your screen. Type new parameters at each of the prompts or press the Return key to accept the default response.

```

Select Manager Option: SPE Site Parameter Edit

      +-----+
      |                ACCOUNTS RECEIVABLE SYSTEM - VER 1.7                |
      |                Site Parameter Edit                                |
      |                UNSPECIFIED SERVICE UNIT                            |
      +-----+
User: USER,DEMO                BUSINESS OFFICE                20-AUG-2003 11:20 AM

Select A/R SITE PARAMETER/IHS RPMS SITE: UNSPECIFIED SERVICE UNIT
                                     NM
...OK? Yes// [RET] (Yes)

MULTIPLE 3P EOB LOCATIONS: YES// [RET]
MULTIPLE FISCAL EOB LOCATIONS: YES//[RET]
USABLE: USABLE//[RET]
ACCEPT 3P BILLS: ACCEPT//[RET]
ROLL OVER DURING POSTING: ASK//[RET]
SMALL BALANCE: 5.00//[RET]
Location Type For Reports: BILLING//[RET]
Default Path: /usrx/xxd/duser///[RET]
EISS System: xxx.xxx.xx.x
EISS Username: xxxxxx
EISS Password: xxxxxx
EISS (local) path: /usrx/xxd/duser
Select EDI PAYER: [RET]

Select A/R SITE PARAMETER/IHS RPMS SITE:

```

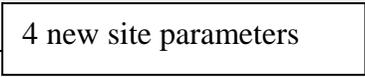


Figure 4-1: Setting the EISS parameters

4.1.2 PSR for the EISS

In order to have the PSR information pass to the EISS, the report must be run choosing specific parameters. The PSR report **MUST** be run choosing the following parameters: All allowance categories, summarized by Allowance category/Bill Entity/Ins Type and the Date Range must be defined as the first and last day of the month.

1. To run the PSR for the EISS, type **PSR** at the “Select Financial Reports Menu Option:” prompt that is located in the Reports menu under Financial reports.
2. Type the name of your location at the “Select Visit Location:” prompt.

```

Select Financial Reports Menu Option: PSR  Period Summary Report

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
      |          Period Summary Report                          |
      |          UNSPECIFIED SERVICE UNIT                      |
      +-----+
User:  USER,DEMO          BUSINESS OFFICE          21-AUG-2003 9:23 AM

NOTE:  This report will contain data for VISIT location(s) regardless of
       BILLING location.

Select Visit LOCATION: UNSPECIFIED SERVICE UNIT          NM

```

Figure 4-2: Running the PSR for the EISS (steps 1 & 2)

3. Type **5** (Allowance Category) at the “Select Criteria for Sorting:” prompt.
4. Press the Return key at the blank “Select Type of Allowance Category to Display:” prompt to select ALL categories.
5. Type **1** (Summarize by Allow Cat/Bill Entity/Ins Type) at the “Select Report Type:” prompt.
6. Type the first day of the month at the “Select Beginning Date:” prompt.
7. Type the last day of the month at the “Select Ending Date:” prompt.
8. Type the name or number of the device to where you want the report printed at the “Device:” prompt.

```

Select one of the following:

1          A/R ACCOUNT
2          CLINIC TYPE
3          VISIT TYPE
4          DISCHARGE SERVICE
5          ALLOWANCE CATEGORY
6          BILLING ENTITY
7          INSURER TYPE

Select criteria for sorting: 5 ALLOWANCE CATEGORY

Select one of the following:

1          MEDICARE
2          MEDICAID
3          PRIVATE INSURANCE (INS TYPES P H F M)
4          CHIP
5          OTHER          (INS TYPES W C N I)

Select TYPE of ALLOWANCE CATEGORY to Display: [RET] ALL

Select one of the following:

```

```

1      Summarize by ALLOW CAT/BILL ENTITY/INS TYPE
2      Summarize by PAYER w/in ALLOW CAT/BILL ENTITY/INS TYPE
3      Summarize by BILL w/in PAYER w/in ALLOW CAT/BILL ENTITY/INS TYPE

Select REPORT TYPE: 1// [RET] Summarize by ALLOW CAT/BILL ENTITY/INS TYPE

===== Entry of TRANSACTION DATE Range =====

Select Beginning Date: 07/01/03 (JUL 01, 2003)
Select Ending Date: 07/31/03 (JUL 31, 2003)

Output DEVICE: HOME// [RET]
    
```

Figure 4-3: Running the PSR for the EISS (steps 3-8)

The system is capable of printing a hard copy for your files as well as sending the electronic file to EISS. Figure 4-4 shows the visual display as well as the message indicating that the data has been passed to EISS.

```

WARNING: Confidential Patient Information, Privacy Act Applies
=====
Period Summary Report for ALL ALLOWANCE CATEGORY(S)AUG 21,2003@09:28 Page 1
with TRANSACTION DATES from 07/01/2003 to 07/31/2003
at UNSPECIFIED SERVICE UNIT Visit location(s) regardless of Billing Location
=====
ALLOWANCE CATEGORY      Billed Amt      Payment      Adjustment      Refund
=====
CHIPS                    788.00          0.00          0.00            0.00
MEDICAID                 1,614.00        412.00        0.00            0.00
MEDICARE                 1,059.00        714.00        345.00          0.00
OTHER                    738.00          492.00        0.00            0.00
PRIVATE INSURANCE       3,406.00        0.00          0.00            0.00
-----
*** VISIT Loc Total     7,605.00        1,618.00      345.00          0.00
=====
***** REPORT Total     7,605.00        1,618.00      345.00          0.00
=====

Please Standby - Copying Data to UNIX File /usrx/dxx/user/BARPSRXXXXXX000000
00000000000000000000000000000000_000000.TXT

Export file /usrx/dxd/user/BARPSRXXXXXX00000000000000000000000000000000_000000.TX
T queued up to be sent to -l user:luser/ 000.000.00.0...
    
```

New message will display

Figure 4-4: Sample of the PSR for the EISS

4.1.3 ASM for the EISS

In order to have the ASM information pass to the EISS, the report must be run choosing specific parameters. The report MUST be run by all allowance categories and summarized by Allowance category.

1. To run the ASM for the EISS, type **ASM** at the “Select Aging Reports Menu Option:” prompt that is located in the Reports menu under Aging reports.

2. Type the name of your location at the “Select Visit Location:” prompt.

```
Select Aging Reports Menu Option: ASM Age Summary Report

+-----+
|                ACCOUNTS RECEIVABLE SYSTEM - VER 1.7                |
|                Age Summary Report                                  |
|                UNSPECIFIED SERVICE UNIT                            |
+-----+
User: USER,DEMO                BUSINESS OFFICE                21-AUG-2003 9:47 AM

NOTE: This report will contain data for the BILLING location you are logged
into. Selecting a Visit Location will allow you to run the report for
a specific VISIT location under this BILLING location.

Select Visit LOCATION: UNSPECIFIED SERVICE UNIT                NM
```

Figure 4-5: Running the ASM for the EISS (steps 1 & 2)

3. Type **5** (Allowance Category) at the “Select Criteria for Sorting:” prompt.
4. Press the Return key at the blank “Select Type of Allowance Category to Display:” prompt to select ALL categories.
5. Type **1** (Summarize by Allow Cat/Bill Entity/Ins Type) at the “Select Report Type:” prompt.
6. Type the name or number of the device to where you want the report printed at the “Device:” prompt.

```
Select one of the following:

1          A/R ACCOUNT
2          CLINIC TYPE
3          VISIT TYPE
4          DISCHARGE SERVICE
5          ALLOWANCE CATEGORY
6          BILLING ENTITY
7          INSURER TYPE

Select criteria for sorting: 5 ALLOWANCE CATEGORY

Select one of the following:

1          MEDICARE
2          MEDICAID
3          PRIVATE INSURANCE (INS TYPES P H F M)
4          CHIP
5          OTHER                (INS TYPES W C N I)

Select TYPE of ALLOWANCE CATEGORY to Display: [RET] ALL

Select one of the following:

1          Summarize by ALLOW CAT/BILL ENTITY/INS TYPE
```


Position	Description
50-53	File Extension (.TXT)

Table 1: EISS file naming convention

4.2 Patient Account Statement Menu (PAS)

This is a new top-level menu option that allows you to print Patient Account statements. You can flag specific patient accounts to receive statements and then print those statements either by a batch or individually. Through TaskMan you can schedule the statements to be run at specific dates and times. The statement contains all the account activity for a given date range. The statements queued to run through TaskMan can then be run using the PRA option.

See Figure 4-8 for a breakdown of each field in the Patient Account statement.

<p>1 Indian Health Service PHS Unspecified Indian Hospital 1234 Main St Anywhere, USA 12345 (555) 555-0123</p>							
<p>2 PATIENT, DELLA P.O.BOX 123 ANYWHERE, USA, 23456</p>				<p>3 STATEMENT PERIOD 08/21/2002 - 08/21/2003</p>			
4	5	6	7	8	9	10	11
DOS	Trans Date	Bill Num	Service Type	Description	Chrg	Credit	Patient Bal
01/01/2001	07/26/2001	44827	IMM	BIL/BIGHO	272.10		272.10
01/01/2001	07/26/2001	44828	IMM	BIL/NEW M	15.00		**
11/28/2001	02/21/2002	44856	GEN	BIL/GREAT	142.20		**
	02/27/2002			BIL/METRO	142.20		**
<p>12 ** SUMMARY by days due**</p>							
0-29 Days	30-59 Days	60-89 Days	90-120+ Days	TOTAL DUE			
\$ 0.00	\$ 0.00	\$ 0.00	\$ 272.10	\$ 272.10			
<p>+++PAYMENT DUE UPON RECEIPT+++</p>							
<p>** Your Insurance has been billed. You may be responsible for all or a portion of the billed amount based on your scheduled benefits. Statement reflects all transactions up to statement date.</p>							
<p>This statement is intended for the above named patient, if you have received this statement in error please notify us immediately.</p>							

Figure 4-8: Breakdown of fields on the patient account statements

1. The statement header shows your site information. The header will be shown on the top of each page of the statement
2. This field shows the patient's information, including name and address. This information will be shown on the top of each page of the statement.
3. This field the dates of service in which a bill has been submitted.
4. **DOS:** The dates of service.
5. **Trans Date:** The transaction dates, or the dates that the noted transaction took place (i.e. payment received)
6. **Bill Number:** The bill number for each of the dates of service.

7. **Service Type:** The abbreviation for each type of service.
8. **Description:** A brief description of each of the transactions (i.e. billed Medicare).
9. **Chrg:** The amount of each of the charges.
10. **Credit:** This field shows the amount of any credit or payment made to the account.
11. **Patient Bal:** The amount that is due from the patient.
12. **Summary by days due:** This section gives a break down of the age of the patient balance portion of the statement.

To access the Patient Account Statement menu, type **PAS** at the “Select A/R Master Menu Option:” prompt.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
+          A/R MASTER MENU                               +
|          UNSPECIFIED SERVICE UNIT                       |
+-----+
User: USER,DEMO          BUSINESS OFFICE          20-AUG-2003 10:22 AM

ACM   Account Management Menu ...
COL   Collection Menu ...
MAN   Manager ...
PAS   Patient Account Statement Menu ...
PST   Posting Menu ...
ROL   Rollback Bills to 3-Party
RPT   Report Menu ...
SVC   Switch Service/Section
UA    User Assistance
UPL   Upload from Third Party Bill File

Select A/R MASTER MENU Option: PAS
    
```

Figure 4-9: Accessing the PAS menu

Sections 4.2.1 through 4.2.5 explain how to use each of the menu options in the Patient Account Statement menu (Figure 4-10).

```

|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
+          Patient Account Statement Menu                 +
|          UNSPECIFIED SERVICE UNIT                       |
+-----+
User: USER,DEMO          BUSINESS OFFICE          20-AUG-2003 10:30 AM

SHDR  Enter/Edit Statement Header Text
FLAG  Flag Patient Accounts for Statements
PRA   Print All Flagged Patients' Account Statements
PRO   Print One Flagged Patient's Account Statement

Select Patient Account Statement Menu Option:
    
```

Figure 4-10: PAS menu options

4.2.1 Setting up TaskMan to Run Patient Statements

To run a batch of the Patient Account statements, you must first schedule the statements to be queued.

1. To schedule the statements, access TaskMan through the IHS Core menu.
2. Type **SCHEDULE** at the “Select TaskMan Management Option:” prompt.
3. Type **BAR ACCOUNT STATEMENT** at the “Select Option to Schedule or Reschedule:” prompt.
4. Type **Y** at the “OK?” prompt.

```

Schedule/Unschedule Options
One-time Option Queue
TaskMan Management Utilities ...
List Tasks
Dequeue Tasks
Requeue Tasks
Delete Tasks
Print Options that are Scheduled to run
Cleanup Task List
Print Options Recommended for Queueing

Select TaskMan Management Option: schedule/Unschedule Options

Select OPTION to schedule or reschedule: bar account STATEMENT      Patient
Account Statement
...OK? Yes//      (Yes)

```

Figure 4-11: Scheduling the Patient Account statements (steps 1-4)

5. The system will open the Edit Option Schedule screen.
6. Use the arrow keys or the Tab key to move between the prompts.
7. Type the date and time you would like the statements run at the “Queued To Run At What Time:” prompt.
8. Type the scheduling frequency for when you would like the statement queued at the “Rescheduling Frequency:” prompt.
9. Type **SAVE** and the press the Return key at the “Command:” prompt
10. Then type **EXIT** and the “Command:” prompt to exit TaskMan.

```

                                Edit Option Schedule

Option Name: BAR ACCOUNT STATEMENT
Menu Text: Patient Account Statement                                TASK ID: 9090
-----

QUEUED TO RUN AT WHAT TIME:  SEP 18,2003@18:00

DEVICE FOR QUEUED JOB OUTPUT:

QUEUED TO RUN ON VOLUME SET:

RESCHEDULING FREQUENCY:  1M(18@18:00)

TASK PARAMETERS:

SPECIAL QUEUEING:

-----

Exit      Save      Next Page      Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:                                     Press <PF1>H for help
Insert
    
```

Figure 4-12: Scheduling the Patient Account statements (steps 5-10)

4.2.2 Enter/Edit Statement Header Text (SHDR)

Use this option to enter or edit the statement header. The header will be displayed at the top of all statements. You will want to include the facility name and address, business office phone number, point of contact, and special messages. The statements will print up to 10 lines of text.

1. To edit or enter the statement header, type **SHDR** at the “Select Patient Account Statement Menu Option:” prompt from the Patient Account Statement menu.

```

|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
+          Patient Account Statement Menu                +
|          UNSPECIFIED SERVICE UNIT                     |
+-----+-----+-----+-----+-----+-----+-----+
User: USER,DEMO          BUSINESS OFFICE          21-AUG-2003 10:07 AM

SHDR  Enter/Edit Statement Header Text
FLAG  Flag Patient Accounts for Statements
PRA   Print All Flagged Patients' Account Statements
PRO   Print One Flagged Patient's Account Statement

Select Patient Account Statement Menu Option:  SHDR
    
```

Figure 4-13: Editing header text (step 1)

2. The system will display the current statement header.
3. Type **Y** at the “Edit?” prompt.
4. The system will open the header in your default text editor. Edit or enter the text as you deem appropriate.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
+          Enter/Edit Statement Header Text              +
|          UNSPECIFIED SERVICE UNIT                      |
+-----+
User: USER,DEMO          BUSINESS OFFICE          21-AUG-2003 10:07 AM

You may enter text that will appear at the top of the account
statements. Typically this will be facility name and address,
business office phone number, point of contact, and special
messages. The statements will print up to 10 lines of text.

TEXT:

                Indian Health Service
                PHS UNSPECIFIED Indian Hospital
                1234 MAIN ST
                ANYWHERE, USA 87000
                (555) 555-1234

Edit? NO// Y YES

==[ WRAP ]==[ INSERT ]===== < TEXT >===== [ <PF1>H=Help ]====
                Indian Health Service
                PHS UNSPECIFIED Indian Hospital
                1234 MAIN ST
                ANYWHERE, USA 87000
                (555) 555-1234

<=====T=====T=====T=====T=====T=====T=====T=====T=====T=====T=====

```

Figure 4-14: Editing header text (steps 2-4)

4.2.3 Flag Patient Accounts for Statements (FLAG)

Use this option to flag for which patients you would like a statement run. This is a one-time option that allows you to chose which patients will receive a statement.

1. To flag patient accounts, type **FLAG** at the “Select Patient Account Statement Menu Option:” prompt.
2. Either type the name or number of patient at the “Select A/R Account/IHS:” prompt, or type **??** to see a list of patients.

3. The system will display a *YES* or *NO* to the right of the patient's name. Yes means the patient is flagged to receive patient statements, while a No means that the patient is not receiving patient statements.
4. Type **YES** or **NO** at the "Pat Acct Stmt:" prompt.
5. You can repeat this process until you have flagged all patients who need to receive statements.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
+          Flag Patient Accounts for Statements          +
|          UNSPECIFIED SERVICE UNIT                      |
+-----+
User: USER,DEMO                BUSINESS OFFICE          21-AUG-2003 10:31 AM

SHDR  Enter/Edit Statement Header Text
FLAG  Flag Patient Accounts for Statements
PRA   Print All Flagged Patients' Account Statements
PRO   Print One Flagged Patient's Account Statement

Select Patient Account Statement Menu Option: FLAG  Flag Patient Accounts for
Statements

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
+          Flag Patient Accounts for Statements          +
|          UNSPECIFIED SERVICE UNIT                      |
+-----+
User: USER,DEMO                BUSINESS OFFICE          21-AUG-2003 10:31 AM

Select A/R ACCOUNTS/IHS: ??

Choose from:
19      PATIENT,DELLA                YES
25      PATIENT,NED S
48      PATIENT,FREDDY                YES
51      PATIENT,CAROLYN
71      PATIENT,ANTHONY J
73      PATIENT,JACOB JOSEPH
88      PATIENT,SHARON                YES
122     PATIENT,LANDREE               NO
126     PATIENT,CARMEN                NO

Select A/R ACCOUNTS/IHS: 19  VALDEZ,DELLA          YES
PAT ACCT STMT: NO
    
```

Figure 4-15: Flagging patient accounts

4.2.4 Print All Flagged Patients' Account Statements (PRA)

Use this option to print the statements that have been queued by TaskMan or reprint those statements already printed through the PRO option.

1. Type **PRA** at the “Select Patient Account Statement Menu Option:” prompt.
2. The system will display all dates and times of the jobs that are ready to print.
3. Type the number of the job you would like to print at the “Enter a Number:” prompt.
4. Type **Y** or **N** at the “Do You Wish to Retain the Run to Print Again Enter Yes or No:” prompt.
5. Type the name of a print device at the “Output Device:” prompt.

```

Select Patient Account Statement Menu Option: PRA Print All Flagged
Patients' Account Statements

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
      +   Print All Flagged Patients' Account Statements   +
      |          UNSPECIFIED SERVICE UNIT                    |
      +-----+
User: USER,DEMO          BUSINESS OFFICE          21-AUG-2003 4:06 PM
Select Account Run time:

1  AUG 18, 2003@12:33:47
2  AUG 18, 2003@18:00:01
3  AUG 21, 2003@10:40:42
4  AUG 21, 2003@10:41:14
5  AUG 21, 2003@10:42:03
Enter a number (1-5): 1
DO YOU WISH TO RETAIN THE RUN TO PRINT AGAIN?
Enter Yes or No: N// Y YES

Output DEVICE: HOME// [RET]

```

Figure 4-16: Printing All Flagged Patients' Account Statements

4.2.5 Print One Flagged Patient's Account Statement (PRO)

Use this option to print a single statement for a patient account that is flagged. The statement that is run through this option is then stored as a job and can be reprinted using the PRA option.

1. Type **PRO** at the “Select Patient Account Statement Menu Option:” prompt.
2. Type the patient name or number at the “Select Patient Account:” prompt. You can also type **??** to see a list of flagged patients.

3. Type the beginning date of the statement at the "Select Beginning Date:" prompt.
4. Type the ending date of the statement at the "Select Ending Date:" prompt.
5. Type the name of a print device at the "Output Device:" prompt.

```

Select Patient Account Statement Menu Option: PRO Print One Flagged Patient's
Account Statement

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
      +   Print One Flagged Patient's Account Statement   +
      |          UNSPECIFIED SERVICE UNIT                    |
      +-----+
User: USER,DEMO                BUSINESS OFFICE        21-AUG-2003 4:23 PM

Select Patient-Account: ??

Choose from:
19          PATIENT,DELLA
48          PATIENT,FREDDY
71          PATIENT,ANTHONY J
88          PATIENT,SHARON

Select Patient-Account: 71 PATIENT,ANTHONY J
Select Beginning Date: T-900 (MAR 04, 2001)
Select Ending Date: T (AUG 21, 2003)

Output DEVICE: HOME// [RET]
    
```

Figure 4-17: Printing One Flagged Patient's Account Statement

5.0 Patch 1

5.1 Period Summary Report (PSR)

This report has been rewritten to use the Transaction file. You may run the report for any date range desired. More detail has been added to the report, allowing better tools for reconciliation. Also, new parameters have been added, providing better report customization. The report can be run using the same parameters as the AGE summary report. Discharge and Insurer Type are two new sorting criteria selections. New summarizing report type by Bill w/in Payer w/in Allowance Category/Billing Entity/Insurer Type when Allowance Category, Billing Entity or Insurer Type is selected as the sorting criteria.

Note: This report will contain data for Visit location(s) regardless of Billing location.

Running the new PSR report

1. Type **PSR** at the “Select Financial Reports Menu Option:” prompt in the Financial Reports menu located in the A/R Reports menu.
2. Type the name of a location at the “Select Location:” prompt or press the Return key at the blank “Select Location:” prompt to select ALL locations. If you enter a location name, you will only be allowed one location.

```

ADA   Advise of Allowance RPT
PSR   Period Summary Report
STA   A/R Statistical Report
TAR   Transaction Report

Select Financial Reports Menu Option: PSR  Period Summary Report

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
      |          Period Summary Report                          |
      |          UNSPECIFIED HEALTH CENTER                      |
      +-----+
User: User, DEMO                BUSINESS OFFICE          4-JUN-2003 10:21 AM

NOTE:  This report will contain data for VISIT location(s) regardless of
       BILLING location.

Select Visit LOCATION: [RET] ALL
    
```

Figure 5-1: Running the new PSR report (steps 1-2)

3. Type the number of one of the options (1-7) at the “Select Criteria for Sorting:” prompt. See Figure 5-2 for a list of your options. Steps 3a-3g provide will information on each of the options.

```

Select one of the following:

1          A/R ACCOUNT
2          CLINIC TYPE
3          VISIT TYPE
4          DISCHARGE SERVICE
5          ALLOWANCE CATEGORY
6          BILLING ENTITY
7          INSURER TYPE

Select criteria for sorting: 6 BILLING ENTITY

```

Figure 5-2: Using the new PSR report (step 4)

- a. If you select 1 (A/R Account), type an A/R account number at the “Select A/R Account:” prompt. If you want to select ALL A/R accounts, press the Return key at a blank “Select A/R Account:” prompt. After typing the first account number, you can type another A/R account number at the “Select Another A/R Account:” prompt. You may also type ?? to see a list of available options.

```

Select criteria for sorting: 1 A/R ACCOUNT

Select A/R Account: ALL// UN-ALLOCATED
Select Another A/R Account: NEW MEXICO BC/BS INC
Select Another A/R Account: [RET]

```

Figure 5-3: Using the new PSR report (step 4a)

- b. If you select 2 (Clinic Type), type a clinic name at the “Select Clinic:” prompt. If you want to select all clinics, press the Return key to accept the default of All. You can type another clinic name at the “Select Another Clinic:” prompt. You may also type ?? to see a list of available options.

```

Select criteria for sorting: 2 CLINIC TYPE

Select Clinic: ALL// CARDIAC          02
Select Another Clinic: Pediatric      20
Select Another Clinic: [RET]

```

Figure 5-4: Using the new PSR report (step 4b)

- c. If you select 3 (Visit Type), type a visit type at the “Select Visit Type:” prompt. You can type another visit type at the “Select Another Visit Type:” prompt. If you want to select all visit types, press the Return key to select the default of ALL. You may also type ?? to see a list of available options.

```
Select criteria for sorting: 3 VISIT TYPE
Select Visit Type: ALL// 2 EPSDT W/O REFERRAL
Select Another Visit Type: 111 INPATIENT
Select Another Visit Type: [RET]
```

Figure 5-5: Using the new PSR report (step 4c)

- d. If you select 4 (Discharge Service), type a discharge service at the “Select Discharge Service:” prompt. You can type another discharge service at the “Select Another Discharge Service:” prompt. If you want to select all discharge services, press the Return key at a blank “Select Discharge Service:” prompt. You may also type ?? to see a list of available options.

```
Select criteria for sorting: 4 DISCHARGE SERVICE
Select Discharge Service: ALL// [RET] ALL
```

Figure 5-6: Using the new PSR report (step 4d)

- e. If you select 5 (Allowance Category), select from the list of options and type the number of an allowance category at the “Select Type of Allowance Category to Display:” prompt. If you want to select all categories, press the Return key at a blank “Select Type of Allowance Category to Display:” prompt.

```
Select criteria for sorting: 5 ALLOWANCE CATEGORY

Select one of the following:

1          MEDICARE
2          MEDICAID
3          PRIVATE INSURANCE (INS TYPES P H F M)
4          CHIP
5          OTHER              (INS TYPES W C N I)

Select TYPE of ALLOWANCE CATEGORY to Display: [RET] ALL
```

Figure 5-7: Using the new PSR report (step 4e)

- f. If you select 6 (Billing Entity), select from the list of options and type the number of billing entity at the “Select Type of Billing Entity to Display:” prompt. If you want to select all categories, press the Return key at a blank “Select Type of Billing Entity to Display:” prompt.

```
Select criteria for sorting: 6 BILLING ENTITY

Select one of the following:

1          MEDICARE
2          MEDICAID
3          PRIVATE INSURANCE
4          NON-BENEFICIARY PATIENTS
```

```

5      BENEFICIARY PATIENTS
6      SPECIFIC A/R ACCOUNT
7      SPECIFIC PATIENT
8      WORKMEN'S COMP
9      PRIVATE + WORKMEN'S COMP
10     CHIP

Select TYPE of BILLING ENTITY to Display: 1  MEDICARE

```

Figure 5-8: Using the new PSR report (step 4f)

- g. If you select 7 (Insurer Type), select from the list of insurer types and type the number of insurer type at the “Select Insurer Type to Display:” prompt. If you want to select all categories, press the Return key at a blank “Select Insurer Type to Display:” prompt.

```

Select criteria for sorting: 7  INSURER TYPE

Select one of the following:

H      HMO
M      MEDICARE SUPPL.
D      MEDICAID FI
R      MEDICARE FI
P      PRIVATE INSURANCE
W      WORKMEN'S COMP
C      CHAMPUS
F      FRATERNAL ORGANIZATION
N      NON-BENEFICIARY (NON-INDIAN)
I      INDIAN PATIENT
K      CHIP (KIDSCARE)

Select INSURER TYPE to Display: [RET] ALL

```

Figure 5-9: Using the new PSR report (step 4g)

4. If you selected the sort criteria of Allowance Category, Billing Entity, or Insurer Type, you will be prompted to select what type of report you would like from a list of options. Type the number of the report type at the “Select Report Type:” prompt.

```

Select one of the following:

1      Summarize by ALLOW CAT/BILL ENTITY/INS TYPE
2      Summarize by PAYER w/in ALLOW CAT/BILL ENTITY/INS TYPE
3      Summarize by BILL w/in PAYER w/in ALLOW CAT/BILL ENTITY/INSTYPE

Select REPORT TYPE: 1// 2 Summarize by PAYER w/in ALLOW CAT/BILL ENTITY/INS
TYPE

```

Figure 5-10: Using the new PSR report (step 5)

5. Type the beginning date you would like to include in your report at the “Select Beginning Date:” prompt.

6. Type the ending date you would like to include in your report at the “Select Ending Date:” prompt.

7. Type the name of an output device at the “Output Device:” prompt.

```

===== Entry of TRANSACTION DATE Range =====
Select Beginning Date: T-365 (JUN 04, 2002)
Select Ending Date: T (JUN 04, 2003)

Output DEVICE: HOME// [RET]
    
```

Figure 5-11: Using the new PSR report (Step 6-8)

8. A report similar to Figure 5-12 will print. The report will vary depending on the criteria you selected.

```

WARNING: Confidential Patient Information, Privacy Act Applies
=====
Period Summary Report for ALL INSURER TYPE(S)      JUN 4,2003@11:14   Page 1
Sorted by PAYER with TRANSACTION DATES from 06/04/2002 to 06/04/2003
at ALL Visit location(s) regardless of Billing Location
=====
INSURER TYPE          Billed Amt          Payment          Adjustment          Refund
=====
*** VISIT Location: UNSPECIFIED HEALTH CENTER

MEDICAID FI
MEDICAID PRESBY              0.00              0.00              39.00              0.00
NEW MEXICO MEDI             344.00            1,184.00           0.00             378.00
-----
** Ins Type Total          344.00            1,184.00           39.00
378.00

PRIVATE INSURANCE
BCBS OF NEW MEX              0.00              25.00              1.49              0.00
LOVELACE HEALTH             106.00              0.00              0.00              0.00
NEW MEXICO BC/B             372.37              4.90              0.00              0.00

WARNING: Confidential Patient Information, Privacy Act Applies
=====
Period Summary Report for ALL INSURER TYPE(S)      JUN 4,2003@11:16   Page 2
Sorted by PAYER with TRANSACTION DATES from 06/04/2002 to 06/04/2003
at ALL Visit location(s) regardless of Billing Location
=====
INSURER TYPE          Billed Amt          Payment          Adjustment          Refund
=====
PRESBYTERIAN HE              96.00              98.00              11.96              0.00
-----
**Ins Type Total          574.37            127.90             13.45              0.00
-----
    
```

***VISIT Loc Total	918.37	1,311.90	52.45	378.00
***** REPORT Total	918.37	1,311.90	52.45	378.00

Figure 5-12: Using the new PSR report (step 9)

5.2 Age Summary Report (ASM)

This report has been expanded to allow sorting by Discharge Service. Also, bill level detail has been added, allowing better tools for reconciliation.

Note: Insurer type abbreviations are listed below:

H	HMO
M	MEDICARE SUPPL
D	MEDICAID FI
R	MEDICARE FI
P	PRIVATE INSURANCE
W	WORKMEN'S COMP
C	CHAMPUS
F	FRATERNAL ORGANIZATION
N	NON-BENEFICIARY (NON-INDIAN)
I	INDIAN PATIENT
K	CHIP (KIDSCARE)

Running the improved ASM report

1. Type **ASM** at the “Select Aging Reports Menu Option:” prompt in the Aging Reports menu located in the A/R reports menu.
2. Type the name of a location at the “Select Visit Location:” prompt. To select ALL locations, press the Return key at a blank “Select Visit Location:” prompt. If you enter a location name, you will only be allowed one location.

```

ADL  Age Day Letter & List
ADT  Age Detail Report
AGE  Age Report
AOI  Age Open Items Report
ASM  Age Summary Report

Select Aging Reports Menu Option: ASM Age Summary Report

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
      |                   Age Summary Report                   |
      |          UNSPECIFIED HEALTH CENTER                     |
      +-----+
User: USER, DEMO                BUSINESS OFFICE        4-JUN-2003 11:30 AM

NOTE: This report will contain data for the BILLING location you are logged
into. Selecting a Visit Location will allow you to run the report for
    
```

a specific VISIT location under this BILLING location.

Select Visit LOCATION: **[RET]** ALL

Figure 5-13: Using the new ASM report (steps 1-2)

3. Type the number of one of the options (1-7) at the “Select Criteria for Sorting:” prompt.

Select one of the following:

- | | |
|---|--------------------|
| 1 | A/R ACCOUNT |
| 2 | CLINIC TYPE |
| 3 | VISIT TYPE |
| 4 | DISCHARGE SERVICE |
| 5 | ALLOWANCE CATEGORY |
| 6 | BILLING ENTITY |
| 7 | INSURER TYPE |

Select criteria for sorting:

Figure 5-14: Using the new ASM report (step 4)

- a. If you select 1 (A/R Account), type a A/R account number at the “Select A/R Account:” prompt. You can type another A/R account number at the “Select Another A/R Account:” prompt. If you want to select all A/R accounts, press the Return key at a blank “Select A/R Account:” prompt. You may also type ?? to see a list of available options.

Select criteria for sorting: **1** A/R ACCOUNT

Select A/R Account: ALL// **2** UNSPECIFIED HEALTH CENTER

Select Another A/R Account: **3** UN-ALLOCATED

Select Another A/R Account: **[RET]**

Figure 5-15: Using the new ASM report (step 4a)

- b. If you select 2 (Clinic Type), type a clinic name at the “Select Clinic:” prompt. You can type another clinic name at the “Select Another Clinic:” prompt. If you want to select all clinics, press the Return key to accept the default of All. You may also type ?? to see a list of available options.

Select criteria for sorting: **2** CLINIC TYPE

Select Clinic: ALL// **CARDIAC** 02

Select Another Clinic: **PEDIATRIC** 20

Select Another Clinic: **[RET]**

Figure 5-16: Using the new ASM report (step 4b)

- c. If you select 3 (Visit Type), type a visit type at the “Select Visit Type:” prompt. You can type another visit type at the “Select Another

Visit Type:” prompt. If you want to select all visit types, press the Return key to select the default of ALL. You may also type ?? to see a list of available options.

```
Select criteria for sorting: 3 VISIT TYPE
Select Visit Type: ALL// [RET] ALL
```

Figure 5-17: Using the new ASM report (step 4c)

- d. If you select 4 (Discharge Service), type a discharge service at the “Select Discharge Service:” prompt. You can type another discharge service at the “Select Another Discharge Service:” prompt. If you want to select all discharge services, press the Return key at a blank “Select Discharge Service:” prompt. You may also type ?? to see a list of available options.

```
Select criteria for sorting: 4 DISCHARGE SERVICE
Select Discharge Service: ALL// OTHER 14
Select Another Discharge Service: Pediatrics 11
Select Another Discharge Service: [RET]
```

Figure 5-18: Using the new ASM report (step 4d)

- e. If you select 5 (Allowance Category), select from the list of options and type the number of an allowance category at the “Select Type of Allowance Category to Display:” prompt. If you want to select all categories, press the Return key at a blank “Select Type of Allowance Category to Display:” prompt.

```
Select criteria for sorting: 5 ALLOWANCE CATEGORY

Select one of the following:

1 MEDICARE
2 MEDICAID
3 PRIVATE INSURANCE (INS TYPES P H F M)
4 CHIP
5 OTHER (INS TYPES W C N I)

Select TYPE of ALLOWANCE CATEGORY to Display:
```

Figure 5-19: Using the new ASM report (step 4e)

- f. If you select 6 (Billing Entity), select from the list of options and type the number of billing entity at the “Select Type of Billing Entity to Display:” prompt. If you want to select all categories, press the Return key at a blank “Select Type of Billing Entity to Display:” prompt.

```
Select criteria for sorting: 6 BILLING ENTITY

Select one of the following:
```

```

1      MEDICARE
2      MEDICAID
3      PRIVATE INSURANCE
4      NON-BENEFICIARY PATIENTS
5      BENEFICIARY PATIENTS
6      SPECIFIC A/R ACCOUNT
7      SPECIFIC PATIENT
8      WORKMEN'S COMP
9      PRIVATE + WORKMEN'S COMP
10     CHIP

```

Select TYPE of BILLING ENTITY to Display:

Figure 5-20: Using the new ASM report (step 4f)

- g. If you select 7 (Insurer Type), select from the list of insurer types and type the number of insurer type at the “Select Insurer Type to Display:” prompt. If you want to select all categories, press the Return key at a blank “Select Insurer Type to Display:” prompt.

Select criteria for sorting: 7 INSURER TYPE

Select one of the following:

```

H      HMO
M      MEDICARE SUPPL.
D      MEDICAID FI
R      MEDICARE FI
P      PRIVATE INSURANCE
W      WORKMEN'S COMP
C      CHAMPUS
F      FRATERNAL ORGANIZATION
N      NON-BENEFICIARY (NON-INDIAN)
I      INDIAN PATIENT
K      CHIP (KIDSCARE)

```

Select INSURER TYPE to Display:

Figure 5-21: Using the new ASM report (step 4g)

4. If you selected the sort criteria of Allowance Category, Billing Entity, or Insurer Type, you will be prompted to select what type of report you would like from a list of options. Type the number of the report type at the “Select Report Type:” prompt.
5. Type the name of an output device at the “Output Device:” prompt.

Select one of the following:

```

1      Summarize by ALLOW CAT/BILL ENTITY/INS TYPE
2      Summarize by PAYER w/in ALLOW CAT/BILL ENTITY/INS TYPE
3      Summarize by BILL w/in PAYER w/in ALLOW CAT/BILL ENTITY/INSTYPE

```

Select REPORT TYPE: 1// 2 Summarize by PAYER w/in ALLOW CAT/BILL ENTITY/INS

```
TYPE
Output DEVICE: HOME//
```

Figure 5-22: Using the new ASM report (steps 5-6)

- A report similar to Figure 5-23 will print. The report will vary depending on the criteria you selected.

WARNING: Confidential Patient Information, Privacy Act Applies						
=====						
Age Summary Report for ALL BILLING SOURCE(S)			JUN 4,2003@12:19		Page 1	
at ALL Visit location(s) under UNSPECIFIED HEALTH CENTER Billing Location						
=====						
BILLING ENTITY	CURRENT	31-60	61-90	91-120	120+	BALANCE
=====						
MEDICAID						
MEDICAID CIMARRON	0.00	0.00	0.00	0.00	6828.56	6828.56
MEDICAID LOVELACE	0.00	0.00	0.00	0.00	4128.52	4128.52
MEDICAID PRESBYTER	0.00	0.00	0.00	0.00	4408.03	4408.03
MONTANA MEDICAID	0.00	0.00	0.00	0.00	172.00	172.00
NEW MEXICO MEDICAI	0.00	378.00	0.00	0.00	53199.12	53577.12

BILL ENTITY TOTAL	0.00	378.00	0.00	0.00	68736.23	69114.23
MEDICARE						
MEDICARE	0.00	0.00	0.00	0.00	12901.73	12901.73

BILL ENTITY TOTAL	0.00	0.00	0.00	0.00	12901.73	12901.73
NON-BENEFICIARY PAT						
WARNING: Confidential Patient Information, Privacy Act Applies						
=====						
Age Summary Report for ALL BILLING SOURCE(S)			JUN 4,2003@12:20		Page 4	
at ALL Visit location(s) under UNSPECIFIED HEALTH CENTER Billing Location						
=====						
BILLING ENTITY	CURRENT	31-60	61-90	91-120	120+	BALANCE
=====						
PRESBYTERIAN HEALT	0.00	0.00	0.00	0.00	2077.26	2077.26
UNITED HEALTH CARE	0.00	0.00	0.00	0.00	442.19	442.19
WEA INSURANCE	0.00	0.00	0.00	0.00	371.64	371.64

BILL ENTITY TOTAL	0.00	0.00	0.00	0.00	54258.64	54258.64
WORKMEN'S COMP						
WORKMEN'S COMP	0.00	0.00	0.00	0.00	114.20	114.20

BILL ENTITY TOTAL	0.00	0.00	0.00	0.00	114.20	114.20
=====						
	0.00	378.00	0.00	0.00	136617.09	136995.09

Figure 5-23: Using the new ASM report (step 7)

5.3 Setting PSR and ASM Parameters

Note: If you want the PSR and ASM to balance, the Location for Reports in A/R SITE PARAMETER must be set to VISIT.

```
Select A/R SITE PARAMETER/IHS RPMS SITE:          DEMO HOSPITAL
MULTIPLE 3P EOB LOCATIONS: YES// [RET]
MULTIPLE FISCAL EOB LOCATIONS: YES//[RET]
USABLE: USABLE//[RET]
ACCEPT 3P BILLS: ACCEPT//[RET]
ROLL OVER DURING POSTING: ASK//[RET]
SMALL BALANCE: 5.00//[RET]
Location Type For Reports: VISIT// or BILLING
```

Figure 5-24: Setting up your site parameters

Based on the site parameter setup, you will see a message when running the following reports.

- Age Detail Report
- Age Summary Report
- Bills Listing Report
- A/R Statistical Report
- Transaction Report

If site parameter is set to BILLING, you will see this message when running the above reports.

Note: This report will contain data for the BILLING location you are logged into. Selecting a Visit Location will allow you to run the report for a specific VISIT location under this BILLING location.

If site parameter is set to VISIT, you will see this message when running the above reports.

Note: This report will contain data for VISIT location(s) regardless of BILLING location.

6.0 Appendix A: IHS HIPAA Standard Adjustment Codes

**Indian Health Service HIPAA
HIPAA Standard Adjustment Codes Mapped to RPMS
Effective A/R v1.7 Patch 4**

HIPAA Standard		RPMS			
Code	Description	Code	Adjustment Category	Code	Adjustment Reason
1	Deductible Amount	13	DEDUCTIBLE	29	Deductible Amount
2	Coinsurance Amount	14	CO-PAY	602	Coinsurance Amount
3	Co-payment Amount	14	CO-PAY	27	Co-Payment Amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	4	NON PAYMENT	604	Code Err Proc Inconst w Mod
5	The procedure code/bill type is inconsistent with the place of service.	4	NON PAYMENT	605	Code Err Proc/BT Inconst w POS
6	The procedure code is inconsistent with the patient's age.	4	NON PAYMENT	606	Code Err Proc Inconst w Pt Age
7	The procedure code is inconsistent with the patient's gender.	4	NON PAYMENT	607	Code Err Proc Inconst w Pt Gdr
8	The procedure code is inconsistent with the provider type.	4	NON PAYMENT	608	Code Err Proc Inconst w ProvTp
9	The diagnosis is inconsistent with the patient's age.	4	NON PAYMENT	609	Code Err DX Inconst w Pt Age
10	The diagnosis is inconsistent with the patient's gender.	4	NON PAYMENT	610	Code Err DX Inconst w Pt Gdr
11	The diagnosis is inconsistent with the procedure.	4	NON PAYMENT	611	Code Err DX Inconst w Procdr
12	The diagnosis is inconsistent with the provider type.	4	NON PAYMENT	612	Code Err DX Inconst w Prov Tp
13	The date of death precedes the date of service.	4	NON PAYMENT	613	Death Precedes Date of Service
14	The date of birth follows the date of service.	4	NON PAYMENT	614	Birth Follows Date of Service

15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	4	NON PAYMENT	615	Pymt Adj Inadeq Auth Number
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	4	NON PAYMENT	616	Clm/Srvc Lacks Info For Adjud
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	4	NON PAYMENT	617	Pymt Adj Info Incomplete
18	Duplicate claim/service.	3	WRITE OFF	135	Duplicate Claim/Service
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	4	NON PAYMENT	619	Clm Denied work related injury
20	Claim denied because this injury/illness is covered by the liability carrier.	4	NON PAYMENT	620	Clm Den Injry Covrd Liab Carr
21	Claim denied because this injury/illness is the liability of the no-fault carrier.	4	NON PAYMENT	621	Clm Den Injry Covrd NoFlt Carr
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	4	NON PAYMENT	622	Pymt Adj Care Covrd Diff Payer
23	Payment adjusted because charges have been paid by another payer.	4	NON PAYMENT	623	Pymt Adj Chrgs Pd by Diff Pyr
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	4	NON PAYMENT	624	Pymt Adj Chrgs Covrd Capit Agr
25	Payment denied. Your Stop loss deductible has not been met.	4	NON PAYMENT	625	Pymt Den StopLoss Ded Not Met
26	Expenses incurred prior to coverage.	4	NON PAYMENT	626	Expnse Incrrd Prior to Coverag
27	Expenses incurred after coverage terminated.	4	NON PAYMENT	627	Expnse Incrrd Aft Cov Termnatd
28	Coverage not in effect at the time the service was provided.	4	NON PAYMENT	628	Coverage Not in Effect on DOS

29	The time limit for filing has expired.	4	NON PAYMENT	134	Time Limit for Filing Expired
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	4	NON PAYMENT	630	Pymt Adj Pt Not Met Requiremts
31	Claim denied as patient cannot be identified as our insured.	4	NON PAYMENT	166	Clm Den Pt Not Identifd Isurd
32	Our records indicate that this dependent is not an eligible dependent as defined.	4	NON PAYMENT	632	Records Indicate Dep Not Elig
33	Claim denied. Insured has no dependent coverage.	4	NON PAYMENT	633	Clm DenInsured No Depend Cove
34	Claim denied. Insured has no coverage for newborns.	4	NON PAYMENT	17	Clm Den Insured no Cov for NB
35	Benefit maximum has been reached.	4	NON PAYMENT	167	Benefit Maximum Reached
36	Balance does not exceed co-payment amount.	4	NON PAYMENT	636	Bal does not Exceed CoPymt Amt
37	Balance does not exceed deductible.	4	NON PAYMENT	637	Bal Does not Exceed Deductible
38	Services not provided or authorized by designated (network) providers.	4	NON PAYMENT	638	Serv Not Auth by Designtd Prov
39	Services denied at the time authorization/pre-certification was requested.	4	NON PAYMENT	639	Srvcs Den At Time Auth Rqsted
40	Charges do not meet qualifications for emergent/urgent care.	4	NON PAYMENT	640	Chrgs DoNotMeet Criteria ER/UC
41	Discount agreed to in Preferred Provider contract.	4	NON PAYMENT	168	Disc Agrmt Pref Prov contract
42	Charges exceed our fee schedule or maximum allowable amount.	4	NON PAYMENT	21	Chrgs Excd Max Allowable Amt
43	Gramm-Rudman reduction.	4	NON PAYMENT	643	Gramm-Rudman Reduction
44	Prompt-pay discount.	4	NON PAYMENT	644	Prompt Pay Discount
45	Charges exceed your contracted/ legislated fee arrangement.	4	NON PAYMENT	645	Chrgs Excd Contract Fee Arrngmt
46	This (these) service(s) is (are) not covered.	4	NON PAYMENT	122	Services Not Covered
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	4	NON PAYMENT	647	Dx not Covered Missing Invalid
48	This (these) procedure(s) is (are) not covered.	4	NON PAYMENT	648	Proc Not Covered

49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.	4	NON PAYMENT	20	Non Cov Srv Routine Exam
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	4	NON PAYMENT	169	Non Cov Srv Not Medically Nec
51	These are non-covered services because this is a pre-existing condition	4	NON PAYMENT	19	NonCov Srv Preexsting Cndition
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	4	NON PAYMENT	178	Prov Not Elig to Prov Serv Bil
53	Services by an immediate relative or a member of the same household are not covered.	4	NON PAYMENT	653	Serv by Mbr of Hshld Not Cover
54	Multiple physicians/assistants are not covered in this case .	4	NON PAYMENT	654	Mult Prov Not Cov in This Case
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.	4	NON PAYMENT	655	Clm Den Proc/Tx Experimental
56	Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.	4	NON PAYMENT	656	Clm Den Proc not Effic by Payer
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	4	NON PAYMENT	657	Pymt Den Info submtd Not Suff
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	4	NON PAYMENT	658	Pymt Adj Tx Prov Invalid POS
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.	4	NON PAYMENT	659	Chrgs Adj Mult Surg Anesth Rul
60	Charges for outpatient services with this proximity to inpatient services are not covered.	4	NON PAYMENT	660	Chrgs Outpt Serv Not Covered

61	Charges adjusted as penalty for failure to obtain second surgical opinion.	4	NON PAYMENT	661	Chrgs Adj Penlty No Secnd Opin
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	15	PENALTY	92	Pymt Den/Reducd No Precrt Auth
63	Correction to a prior claim.	4	NON PAYMENT	663	Correction to Prior Claim
64	Denial reversed per Medical Review.	22	GENERAL INFORMATION	664	Denial Reversed per Med Review
65	Procedure code was incorrect. This payment reflects the correct code.	4	NON PAYMENT	665	ProcCode Incorrect PymtRerCorr
66	Blood Deductible.	13	DEDUCTIBLE	666	Blood Deductible
67	Lifetime reserve days. (Handled in QTY, QTY01=LA)	4	NON PAYMENT	667	Lifetime Reserve Days
68	DRG weight. (Handled in CLP12)	16	GROUPER ALLOWANCE	93	DRG Weight
69	Day outlier amount.	4	NON PAYMENT	669	Day Outlier Amount
70	Cost outlier - Adjustment to compensate for additional costs.	4	NON PAYMENT	670	Cost Outlr Adj to CompAdd Cost
71	Primary Payer amount.	4	NON PAYMENT	165	Primary Payer Amount
72	Coinsurance day. (Handled in QTY, QTY01=CD)	14	CO-PAY	672	Coinsurance Day
73	Administrative days.	4	NON PAYMENT	673	Administrative Days
74	Indirect Medical Education Adjustment.	4	NON PAYMENT	674	Indirect Medical Educ Adj
75	Direct Medical Education Adjustment.	4	NON PAYMENT	675	Direct Medical Educ Adj
76	Disproportionate Share Adjustment.	4	NON PAYMENT	676	Disproportionate Share Adj
77	Covered days. (Handled in QTY, QTY01=CA)	4	NON PAYMENT	677	Covered Days
78	Non-Covered days/Room charge adjustment.	4	NON PAYMENT	678	Non Covered Days/Room Chrg Adj
79	Cost Report days. (Handled in MIA15)	4	NON PAYMENT	679	Cost Report Days
80	Outlier days. (Handled in QTY, QTY01=OU)	4	NON PAYMENT	680	Outlier Days
81	Discharges.	4	NON PAYMENT	681	Discharges
82	PIP days.	4	NON PAYMENT	682	PIP Days
83	Total visits.	4	NON PAYMENT	683	Total Visits
84	Capital Adjustment. (Handled in MIA)	4	NON PAYMENT	684	Capital Adjustment
85	Interest amount.	4	NON PAYMENT	685	Interest Amount
86	Statutory Adjustment.	4	NON PAYMENT	686	Statutory Adjustment
87	Transfer amount.	4	NON PAYMENT	687	Transfer Amount

88	Adjustment amount represents collection against receivable created in prior overpayment.	21	PENDING	688	Adj Amt Rep Rec Prior OvrPymt
89	Professional fees removed from charges.	4	NON PAYMENT	689	Pro Fees Removed From Charges
90	Ingredient cost adjustment.	4	NON PAYMENT	690	Ingredient Cost Adj
91	Dispensing fee adjustment.	3	WRITE OFF	691	Dispensing Fee Adj
92	Claim Paid in full.	22	GENERAL INFORMATION	692	Claim Paid in Full
93	No Claim level Adjustments.	22	GENERAL INFORMATION	693	No Claim Level Adjustments
94	Processed in Excess of charges.	16	GROUPEE ALLOWANCE	694	Processed in Excess of Charges
95	Benefits adjusted. Plan procedures not followed.	4	NON PAYMENT	695	Ben Adj Plan Proc Not Followed
96	Non-covered charge(s).	4	NON PAYMENT	696	Non-covered Charge(s)
97	Payment is included in the allowance for another service/procedure.	4	NON PAYMENT	697	Pymt IncludeAllow for Diff Srv
98	The hospital must file the Medicare claim for this inpatient non-physician service.	21	PENDING	698	Hosp Must File Medicare Claim
99	Medicare Secondary Payer Adjustment Amount.	4	NON PAYMENT	699	MSP Adjustment Amount
100	Payment made to patient/insured/responsible party.	4	NON PAYMENT	23	Pymt Made to Pt/Insrd/Rsp Prty
101	Predetermination: anticipated payment upon completion of services or claim adjudication.	21	PENDING	701	Predetermined Antcptd Pymt
102	Major Medical Adjustment.	4	NON PAYMENT	702	Major Medical Adjustment
103	Provider promotional discount (e.g., Senior citizen discount).	4	NON PAYMENT	703	Provider Promotional Discount
104	Managed care withholding.	4	NON PAYMENT	704	Managed Care Withholding
105	Tax withholding.	4	NON PAYMENT	705	Tax Withholding
106	Patient payment option/election not in effect.	4	NON PAYMENT	706	Pt Pymt Optn/Elect Not inEffct
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.	4	NON PAYMENT	707	Clm Den Reltd Srv Not Identifd
108	Payment reduced because rent/purchase guidelines were not met.	4	NON PAYMENT	708	Pymt Reduce-Guidelines Not Met
109	Claim not covered by this payer/contractor. You must send the claim to the correct	4	NON PAYMENT	709	Clm not Covered by Payer

	payer/contractor.				
110	Billing date predates service date.	4	NON PAYMENT	710	Billing Date Precedes DOS
111	Not covered unless the provider accepts assignment.	4	NON PAYMENT	711	Not Cov Unlss Prov Acpts Asnmt
112	Payment adjusted as not furnished directly to the patient and/or not documented.	4	NON PAYMENT	180	Pymt Adj Not Furn or Prov toPT
113	Payment denied because service/procedure was provided outside the United States or as a result of war.	4	NON PAYMENT	713	Pymt Den Srv Prov Outside US
114	Procedure/product not approved by the Food and Drug Administration.	4	NON PAYMENT	714	Proc/Src Not approved by FDA
115	Payment adjusted as procedure postponed or canceled.	4	NON PAYMENT	715	Pymt Adj Proc Postponed Cancel
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.	4	NON PAYMENT	716	Pyt Den Adv Indmn Ntc NotCmply
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.	4	NON PAYMENT	717	Pymt Adj Transp Covrd CloseFac
118	Charges reduced for ESRD network support.	4	NON PAYMENT	718	Charges Redcd for ESRD Support
119	Benefit maximum for this time period has been reached.	4	NON PAYMENT	719	Max Benefits for Time Period
120	Patient is covered by a managed care plan.	4	NON PAYMENT	720	Pt Cov'd by Managed Care Plan
121	Indemnification adjustment.	4	NON PAYMENT	721	Indemnification Adjustment
122	Psychiatric reduction.	4	NON PAYMENT	722	Psychiatric Reduction
123	Payer refund due to overpayment.	22	GENERAL INFORMATION	723	Payer Refund Due to Overpymt
124	Payer refund amount - not our patient.	22	GENERAL INFORMATION	724	Payer Refund Amt - Not Our Pt
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	4	NON PAYMENT	725	Pymt Adj Due to Billing Errors
126	Deductible -- Major Medical	13	DEDUCTIBLE	726	Deductible - Major Medical
127	Coinsurance -- Major Medical	14	CO-PAY	727	Coinsurance - Major Medical

128	Newborn's services are covered in the mother's Allowance.	4	NON PAYMENT	728	NB Srvc Cov'd in Mothers Allow
129	Payment denied - Prior processing information appears incorrect.	4	NON PAYMENT	164	Pymt Den Prior Info Incorrect
130	Claim submission fee.	4	NON PAYMENT	141	Pymt/Red for Req charges/taxes
131	Claim specific negotiated discount.	4	NON PAYMENT	731	Clm Specific Negotiated Disct
132	Prearranged demonstration project adjustment.	4	NON PAYMENT	732	Pre-Arranged Demo Proj Adj
133	The disposition of this claim/service is pending further review.	21	PENDING	733	Claim Pending Further Review
134	Technical fees removed from charges.	4	NON PAYMENT	734	Tech Fees Removed From Charges
135	Claim denied. Interim bills cannot be processed.	4	NON PAYMENT	735	Clm Den Intrm bill Cannot Proc
136	Claim Adjusted. Plan procedures of a prior payer were not followed.	4	NON PAYMENT	736	Clm Adj Plan Proc Prior Payer
137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.	4	NON PAYMENT	730	Claim Submission Fee
138	Claim/service denied. Appeal procedures not followed or time limits not met.	4	NON PAYMENT	738	Clm Den Appeal Proc Not Follow
139	Contracted funding agreement - Subscriber is employed by the provider of services.	4	NON PAYMENT	739	Contracted funding Agreement
140	Patient/Insured health identification number and name do not match.	4	NON PAYMENT	740	Pt ID# & Name do not match
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	4	NON PAYMENT	125	Clm Adj Spans Elig/Inelig Date
142	Claim adjusted by the monthly Medicaid patient liability amount.	4	NON PAYMENT	742	Clm Adj Mnth Medcd Pt Liab Amt
143	Portion of payment deferred.	21	PENDING	743	Portion of Payment Deferred
144	Incentive adjustment, e.g. preferred product/service.	4	NON PAYMENT	744	Incentive Adjustment
145	Premium payment withholding	21	PENDING	745	Premium Pmt Withholding
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	4	NON PAYMENT	746	Pmt Den DX Invalid for DOS
147	Provider contracted/negotiated rate expired or not on file.	4	NON PAYMENT	747	Prv Rate Expired/Not on file

148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.	4	NON PAYMENT	748	Clm/Srv Rej Info Incomplete
149	Lifetime benefit maximum has been reached for this service/benefit category.	4	NON PAYMENT	749	Lifetime Ben Max for Srv/Ben
150	Payment adjusted because the payer deems the information submitted does not support this level of service.	4	NON PAYMENT	750	PayAdj No Info for Lgthof Svc
151	Payment adjusted because the payer deems the information submitted does not support this many svcs.	4	NON PAYMENT	751	PayAdj No Info for Lgth of Svc
152	Payment adjusted because the payer deems the information submitted does not support this length of service.	4	NON PAYMENT	752	PayAdj No Info for Dosage
153	Payment adjusted because the payer deems the information submitted does not support this dosage.	4	NON PAYMENT	753	PayAdj No Info for Days Supply
154	Payment adjusted because the payer deems the information submitted does not support this day's supply.	4	NON PAYMENT	754	PayAdj No Info for Lvl of Svc
155	This claim is denied because the patient refused the service/procedure	4	NON PAYMENT	755	Clm DEn Pt Refused Srv/Proc
156	Flexible spending account payments.	22	GENERAL INFORMATION	756	Flex Spending Accts Payable
157	Payment denied/reduced because service/procedure was provided as a result of an act of war.	4	NON PAYMENT	757	Pmt Den/Red Result Act of War
158	Payment denied/reduced because service/procedure was provided outside the United States.	4	NON PAYMENT	758	Pmt Den/Red Outside US
159	Payment denied/reduced because service/procedure was provided as a result of terrorism.	4	NON PAYMENT	759	Pmt Den/Red Result of Terrorsrm
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion.	4	NON PAYMENT	760	Pmt Den/Red Activity Ben Excl
A0	Patient refund amount.	19	REFUND	800	Patient Refund Amount
A1	Claim denied charges.	4	NON PAYMENT	801	Claim Denied Charges
A2	Contractual adjustment.	4	NON PAYMENT	802	Contractual Adjustment

A3	Medicare Secondary Payer liability met.	4	NON PAYMENT	803	MSP Liability Met
A4	Medicare Claim PPS Capital Day Outlier Amount.	4	NON PAYMENT	804	Medicare Claim PPS Day Outlier
A5	Medicare Claim PPS Capital Cost Outlier Amount.	4	NON PAYMENT	805	Medicare Claim PPS CostOutlier
A6	Prior hospitalization or 30 day transfer requirement not met.	4	NON PAYMENT	806	PriorHosp 30day transf not met
A7	Presumptive Payment Adjustment	4	NON PAYMENT	807	Presumptive pymt adjustment
A8	Claim denied; ungroupable DRG	4	NON PAYMENT	808	Clm Den Ungroupable DRG
B1	Non-covered visits.	4	NON PAYMENT	851	Non-Covered Visits
B2	Covered visits.	4	NON PAYMENT	852	Covered Visits
B3	Covered charges.	4	NON PAYMENT	853	Covered Charges
B4	Late filing penalty.	15	PENALTY	854	Late Filing Penalty
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	4	NON PAYMENT	855	Pymt Adj Guidelines Not Met
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.	4	NON PAYMENT	856	Pymt Adj Due to Type of Prvder
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	4	NON PAYMENT	857	Prov Not Certified for Proc
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	4	NON PAYMENT	858	Clm Not Covd Altrnt Serv Avail
B9	Services not covered because the patient is enrolled in a Hospice.	4	NON PAYMENT	859	Srvc Not Covd Pt Enrll Hospice
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.	4	NON PAYMENT	860	Amt Reduced Portion of Proc pd
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	4	NON PAYMENT	861	Clm transfer to proper payer
B12	Services not documented in patients'	4	NON PAYMENT	862	Service not documented in MR

	medical records.				
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	4	NON PAYMENT	863	Payment made in prev payment
B14	Payment denied because only one visit or consultation per physician per day is covered.	4	NON PAYMENT	864	Pymt Den 1 Vt Per Prov Per Day
B15	Payment adjusted because this procedure/service is not paid separately.	4	NON PAYMENT	865	Pymt Adj Proc Not Pd Separate
B16	Payment adjusted because `New Patient' qualifications were not met.	4	NON PAYMENT	866	PymtAdj New Pt Qualifn Not Met
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.	4	NON PAYMENT	867	Adj Not Prescr by MD,RX Incmpl
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.	4	NON PAYMENT	868	Pymt Den Proc Code/Mod Invalid
B19	Claim/service adjusted because of the finding of a Review Organization.	4	NON PAYMENT	869	Clm Adj Post Rev Org Finding
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.	4	NON PAYMENT	870	PymtAdj Proc Prtly by DiffProv
B21	The charges were reduced because the service/care was partially furnished by another physician.	4	NON PAYMENT	871	ChrgRdc Proc Prtly by DiffProv
B22	This payment is adjused based on the diagnosis.	4	NON PAYMENT	872	Pymt Adj Based on Diagnosis
B23	Payment denied because this provider has failed an aspect of a proficiency testing program.	4	NON PAYMENT	873	Pymt Den Prov Fail Profcy Test
D1	Claim/service denied. Level of subluxation is missing or inadequate.	4	NON PAYMENT	901	Clm Den Level of Sublxtn Inadq
D2	Claim lacks the name, strength, or dosage of the drug furnished.	4	NON PAYMENT	902	Claim lacks Drug Information

D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.	4	NON PAYMENT	903	ClmDen Info on Pt Eqpmt Missng
D4	Claim/service does not indicate the period of time for which this will be needed.	4	NON PAYMENT	904	Clm Does Not Show Time Period
D5	Claim/service denied. Claim lacks individual lab codes included in the test.	4	NON PAYMENT	905	Clm Den Lacks Indvdl Lab Codes
D6	Claim/service denied. Claim did not include patient's medical record for the service.	4	NON PAYMENT	906	Clm Den Did Not Includ MR Copy
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit.	4	NON PAYMENT	907	Clm Den Lacks Date of RecVisit
D8	Claim/service denied. Claim lacks indicator that 'x-ray is available for review.'	4	NON PAYMENT	908	ClmDen Lacks Indctr Xray Avlbl
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.	4	NON PAYMENT	909	ClmDen Lacks Inv Crtfy LnsCost
D10	Claim/service denied. Completed physician financial relationship form not on file.	4	NON PAYMENT	910	Clm DEn MD FinRel Form NotFile
D11	Claim lacks completed pacemaker registration form.	4	NON PAYMENT	911	Clm Lacks Compl Pcmkr Reg Form
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.	4	NON PAYMENT	912	Clm Den No Idtfr Who Did DxTst
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.	4	NON PAYMENT	913	Clm Den Ordrr MD Has Fin Intrst
D14	Claim lacks indication that plan of treatment is on file.	4	NON PAYMENT	914	Clm Lacks Tx Plan on File
D15	Claim lacks indication that service was supervised or evaluated by a physician.	4	NON PAYMENT	915	ClmLacks Indctn Srv Sprvs byMD
W1	Workers Compensation State Fee Schedule Adjustment	3	WRITE OFF	15	Wrkrs comp State Fee Sched Adj

7.0 Appendix B: Remittance Advice Remark Codes

Indian Health Service Remittance Advice Remark Codes A/R V1.7 Patch 5 March 3, 2004

(includes February 2004 Code List Updates)

Code	Short Description	Long Description
M1	X-ray not taken within the past 12 months or near enough to start of treatment	X-ray not taken within the past 12 months or near enough to the start of treatment.
M2	Not paid separately when the patient is an inpatient.	Not paid separately when the patient is an inpatient.
M3	Equipment is the same or similar to equipment already being used.	Equipment is the same or similar to equipment already being used.
M4	This is the last monthly installment payment for this durable medical equipment.	This is the last monthly installment payment for this durable medical equipment.
M5	Mo rental pymt can't til earlier: 15th of 1st mo or mo equipmnt not needed	Month rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.
M6	You furnish & srvc item til pt doesnt need it, we pay mntnce/srvc evry 6 mo per.	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing fore very 6 month period after the end of the 15th paid rental month or the end of the warranty period.
M7	No rental pymt after item purchased or after total rental pymt = purchase price	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.
M8	We don't take bloodgas tst res when tst condcted by medsuplr or while pat on Oxy	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.
M9	10th rental must, offer patient choice to purchase	This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.
M10	Equipment purchases limited to 1st or 10th month of medical necessity	Equipment purchases are limited to the first or the tenth month of medical necessity.
M11	DME, orthotics & prosthetics must be billed to DME who srvc pat's zip code	DME, orthotics and prosthetics must be billed to the DME carrier who services the patient's zip code.
M12	Diagnostic tests by phys must indicate if purchased srvc included on claim	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.
M13	Only one initial visit is covered per specialty per medical group.	Only one initial visit is covered per specialty per medical group.
M14	No separat pymt for injctn admin dng off vst, nopymt for off vst ifonly injctn	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.
M15	Separately billd srvc/tst bundled components same prcdr. Separate pymt not allwd	Separately billed services/tests have been bundled as they are considered components of the same

M16	Please see the letter or bulletin of (date) for further information.	procedure. Separate payment is not allowed. Please see the letter or bulletin of (date) for further information.
M17	Payment approved as you didn't/couldn't know not normally covered for patient	Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.
M18	Certain srvc's approved home use, Hosp and SNF are not considered patient's home	Certain services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home.
M19	Missing/incomplete/invalid oxygen certification/re-certification.	Missing/incomplete/invalid oxygen certification/re-certification.
M20	Missing/incomplete/invalid HCPCS.	Missing/incomplete/invalid HCPCS.
M21	Missing/incomplete/invalid place of residence for srvc/item provided in a home	Missing/incomplete/invalid place of residence for this service/item provided in a home.
M22	Missing/incomplete/invalid number of miles traveled.	Missing/incomplete/invalid number of miles traveled.
M23	Invoice needed for the cost of the material or contrast agent.	Invoice needed for the cost of the material or contrast agent.
M24	Missing/incomplete/invalid number of doses per vial.	Missing/incomplete/invalid number of doses per vial.
M25	Payment adjusted, info furnished does not substantiate this level of service	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
M26	Pymt adjusted, info not substantiate level of srvc, refund pat w/in 30 days	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the

service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request review at any time within 120 days of the date of this notice. However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days. The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Please contact this office if you have any questions about this notice.

M27 Pat relieved of liability of pymt. Provider liable for charges including coins.

The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she

		does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal. You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 120 days of the date of this notice (or, for a medical insurance review, within 120 days of the date of this notice). You may make the request through any Social Security office or through this office.
M28	Not qualify for pymt under Part B when Part A coverage exhausted/not available	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
M29	Missing/incomplete/invalid operative report.	Missing/incomplete/invalid operative report.
M30	Missing/incomplete/invalid pathology report.	Missing/incomplete/invalid pathology report.
M31	Missing/incomplete/invalid radiology report.	Missing/incomplete/invalid radiology report.
M32	Conditional payment pending decision on this service by patient's primary payer	This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.
M33	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.
M34	Claim lacks the CLIA certification number.	Claim lacks the CLIA certification number.
M35	Missing/incomplete/invalid pre-operative photos or visual field results.	Missing/incomplete/invalid pre-operative photos or visual field results.
M36	11th rental mo, we can't pay until you indicate patient offered purchase option	This is the 11th rental month. We cannot pay for this until you indicate that the patient has been given the option of changing the rental to a purchase.
M37	Service not covered when the patient is under age 35.	Service not covered when the patient is under age 35.
M38	Pt liable chrgs,informd in writing prior srvc provided we wouldn't pay, pt agrd	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.
M39	Pat not liable pymt,noncoverage notice provided pat not comply program requirmnt	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.
M40	Claim must be assigned and must be filed by the practitioner's employer.	Claim must be assigned and must be filed by the practitioner's employer.
M41	We do not pay for this as the patient has no legal obligation to pay for this.	We do not pay for this as the patient has no legal obligation to pay for this.
M42	The medical necessity form must be personally signed by the attending physician.	The medical necessity form must be personally signed by the attending physician.
M43	Pymt for srvc previously made to you/another prvdr by diff carrier/intermediary	Payment for this service previously issued to you or another provider by another

M44	Missing/incomplete/invalid condition code.	carrier/intermediary. Missing/incomplete/invalid condition code.
M45	Missing/incomplete/invalid occurrence codes or dates.	Missing/incomplete/invalid occurrence codes or dates.
M46	Missing/incomplete/invalid occurrence span code or dates.	Missing/incomplete/invalid occurrence span code or dates.
M47	Missing/incomplete/invalid internal or document control number.	Missing/incomplete/invalid internal or document control number.
M48	Pymt for srvcs rendered to hosp inpat made to hosp, req pymt from hosp, not pat	Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.
M49	Missing/incomplete/invalid value code(s) or amount(s).	Missing/incomplete/invalid value code(s) or amount(s).
M50	Missing/incomplete/invalid revenue code(s).	Missing/incomplete/invalid revenue code(s).
M51	Missing/incomplete/invalid procedure code(s) and/or dates.	Missing/incomplete/invalid procedure code(s) and/or dates.
M52	Missing/incomplete/invalid "from" date(s) of service.	Missing/incomplete/invalid "from" date(s) of service.
M53	Missing/incomplete/invalid days or units of service.	Missing/incomplete/invalid days or units of service.
M54	Missing/incomplete/invalid total charges.	Missing/incomplete/invalid total charges.
M55	Not pay self-admin anti-emetic drugs not admin w/covered oral anti-cancer drug	We do not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug.
M56	Missing/incomplete/invalid payer identifier.	Missing/incomplete/invalid payer identifier.
M57	Missing/incomplete/invalid provider identifier.	Missing/incomplete/invalid provider identifier.
M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
M59	Missing/incomplete/invalid "to" date(s) of service.	Missing/incomplete/invalid "to" date(s) of service.
M60	Missing/incomplete/invalid Certificate of Medical Necessity.	Missing/incomplete/invalid Certificate of Medical Necessity.
M61	We can't pay for this, approval period for FDA clinical trial has expired	We cannot pay for this as the approval period for the FDA clinical trial has expired.
M62	Missing/incomplete/invalid treatment authorization code.	Missing/incomplete/invalid treatment authorization code.
M63	We do not pay for more than one of these on the same day.	We do not pay for more than one of these on the same day.
M64	Missing/incomplete/invalid other diagnosis.	Missing/incomplete/invalid other diagnosis.
M65	1 interpreting phys chrg per claim allowed when purch diagnostic test indicated	One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each interpreting physician.
M66	recrds show diagnostic tst subjct price limits billed&proc submt incld prof comp	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.
M67	Missing/incomplete/invalid other procedure	Missing/incomplete/invalid other procedure code(s)

M68	code(s) and/or date(s). Missing/incomplete/invalid attnd/order/render/supvsr/refer phys id.	and/or date(s). Missing/incomplete/invalid attending, attending, ordering, rendering, supervising or referring physician identification.
M69	Paid at reg rate, you didn't submit justifying documentation for mod proc code	Paid at the regular rate as you did not submit documentation to justify the modified procedure code.
M70	NDC code submitted was translated to HCPCS for processing, cont sumbitting NDC	NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.
M71	Total payment reduced due to overlap of tests billed.	Total payment reduced due to overlap of tests billed.
M72	Did not enter full 8-digit date (MM/DD/CCYY).	Did not enter full 8-digit date (MM/DD/CCYY).
M73	HPSA bonus only paid on prof comp of srvc. Rebill as separate prof and tech comp	The HPSA bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components. Use the HPSA modifier on the professional component only.
M74	This service does not qualify for a HPSA bonus payment.	This service does not qualify for a HPSA bonus payment.
M75	Allwd amt adj. Mult automated multichannel tst perfrmd sameday combined for pymt	Allowed amount adjusted. Multiple automated multichannel tests performed on the same day combined for payment.
M76	Missing/incomplete/invalid diagnosis or condition.	Missing/incomplete/invalid diagnosis or condition.
M77	Missing/incomplete/invalid place of service.	Missing/incomplete/invalid place of service.
M78	Missing/incomplete/invalid HCPCS modifier.	Missing/incomplete/invalid HCPCS modifier.
M79	Missing/incomplete/invalid charge.	Missing/incomplete/invalid charge.
M80	Not covr'd when performed during same sess'n/date as prev processed srvc for pat	Not covered when performed during the same session/date as a previously processed service for the patient.
M81	You are required to code to the highest level of specificity	You are required to code to the highest level of specificity.
M82	Service is not covered when patient is under age 50.	Service is not covered when patient is under age 50.
M83	Service is not covered unless the patient is classified as at high risk.	Service is not covered unless the patient is classified as at high risk.
M84	Medical code sets used must be the codes in effect at the time of service	Medical code sets used must be the codes in effect at the time of service.
M85	Subjected to review of physician evaluation and management services.	Subjected to review of physician evaluation and management services.
M86	Service denied, payment already for same/similar procedure w/in set time frame	Service denied because payment already made for same/similar procedure within set time frame.
M87	Claim/service(s) subjected to CFO-CAP prepayment review.	Claim/service(s) subjected to CFO-CAP prepayment review.
M88	We cannot pay for lab tests unless billed by the lab that did the work.	We cannot pay for laboratory tests unless billed by the laboratory that did the work.
M89	Not covered more than once under age 40.	Not covered more than once under age 40.
M90	Not covered more than once in a 12 month period.	Not covered more than once in a 12 month period.
M91	Lab procedures w/different CLIA cert numbers must be billed on separate claims.	Lab procedures with different CLIA certification numbers must be billed on separate claims.
M92	Services subjected to review under the Home	Services subjected to review under the Home

M93	Health Medical Review Initiative. Info suppld suprts break in therapy. New capped rentl per w/delivery of equip	Health Medical Review Initiative. Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.
M94	Info suppld doesn't supprt break in therapy. New capped rentl period won't begin	Information supplied does not support a break in therapy. A new capped rental period will not begin.
M95	Services subjected to Home Health Initiative medical review/cost report audit.	Services subjected to Home Health Initiative medical review/cost report audit.
M96	Tech comp of service furnished to inpatient may only be billed by that inpat fac	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.
M97	Not pd to practitioner when provided to pat in POS.Pymt incl in reimburse to fac	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
M98	Begin using Universal Product Number, soon payment denied if no/wrong UPN	Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.
M99	Missing/incomplete/invalid Universal Product Number/Serial Number.	Missing/incomplete/invalid Universal Product Number/Serial Number.
M100	We don't pay oral anti-emetic not admin immed w/in 48 hrs of admin covrd chemo	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
M101	Begin using G1-G5 mod w/this HCPCS. Soon deny payment if billed w/out G1-G5 mod	Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.
M102	Service not performed on equipment approved by the FDA for this purpose.	Service not performed on equipment approved by the FDA for this purpose.
M103	Info supprt brk in ther/info on rec not supprt need/pmt reduc/new capd rent per	Information supplied supports a break in therapy. However, the medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.
M104	Info suppld supports break in therapy. New capped rentl period w/deliv of equip	Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service.
M105	Info not suprt brk in ther/infoonrec not suprt need/pmt rdc/nonew capd rent per	Information supplied does not support a break in therapy. The medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.
M106	Info suppld not support break in therapy/New capped rental period will not begin	Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.

M107	Pymt reduced as 90-day rolling average hematocrit for ESRD patient exceeds 36.5%	Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.
M108	Missing/incomplete/invalid prov ident for prov who interpreted diagnostic test	Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.
M109	We provide bundled pymt for teleconsultation. Send 25% pymt to refer practitioner	We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring practitioner.
M110	Missing/incomplete/invalid prov ident for prov interpret srvc purchased from	Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.
M111	We don't pay chiropractic manipulative treatment when patient refuses x-ray taken	We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken.
M112	Apprvd amt based on max allowance for item under DMEPOS Competitive Bidding Demo	The approved amount is based on the maximum allowance for this item under the DMEPOS Competitive Bidding Demonstration.
M113	Pat use srvc prior curnt rnd DMEPOS Competitive Bid Demo/aprvd amt allw prior rnd	Our records indicate that this patient began using this service(s) prior to the current round of the DMEPOS Competitive Bidding Demonstration. Therefore, the approved amount is based on the allowance in effect prior to this round of bidding for this item.
M114	Srvc processed accordance rules & guidelines under Competitive Bid Demo Project	This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may phone 1-888-289-0710.
M115	This item denied when provided to this patient by a non-demonstration supplier	This item is denied when provided to this patient by a non-demonstration supplier.
M116	Paid under Competitive Bid Demo. Proj ending, future srvc may not be paid	Paid under the Competitive Bidding Demonstration project. Project is ending, and future services may not be paid under this project.
M117	Not covered unless submitted via electronic claim.	Not covered unless submitted via electronic claim.
M118	Letter to follow containing further information.	Letter to follow containing further information.
M119	Missing/incomplete/invalid National Drug Code (NDC).	Missing/incomplete/invalid National Drug Code (NDC).
M120	Miss/incmplt/invld provid subst phys srvc reciprocal billing/locum tenens arngmt	Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement.
M121	We pay for this service only when performed with a covered cryosurgical ablation	We pay for this service only when performed with a covered cryosurgical ablation.
M122	Missing/incomplete/invalid level of subluxation.	Missing/incomplete/invalid level of subluxation.
M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
M124	Missing/incomplete/invalid indication whether patient owns equip req part/supply	Missing/incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.
M125	Missing/incomplete/invalid info on period time service/supply/equipment needed	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.

M126	Missing/incomplete/invalid individual lab codes included in the test.	Missing/incomplete/invalid individual lab codes included in the test.
M127	Missing/incomplete/invalid patient medical record for this service.	Missing/incomplete/invalid patient medical record for this service.
M128	Missing/incomplete/invalid date of the patient's last physician visit.	Missing/incomplete/invalid date of the patient's last physician visit.
M129	Missing/incomplete/invalid indicator of x-ray availability for review.	Missing/incomplete/invalid indicator of x-ray availability for review.
M130	Missing/incomplete/invalid invoice/stmnt cert cost lens, less disc/type lens use	Missing/incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
M131	Missing/incomplete/invalid physician financial relationship form.	Missing/incomplete/invalid physician financial relationship form.
M132	Missing/incomplete/invalid pacemaker registration form.	Missing/incomplete/invalid pacemaker registration form.
M133	Claim not identify who performed purchased diagnostic test or amount charged	Claim did not identify who performed the purchased diagnostic test or the amount you were charged for the test.
M134	Performed by a facility/supplier in which the provider has a financial interest.	Performed by a facility/supplier in which the provider has a financial interest.
M135	Missing/incomplete/invalid plan of treatment.	Missing/incomplete/invalid plan of treatment.
M136	Missing/incomplete/invalid indication service supervised/valuated by physician	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.
M137	Part B coinsurance under a demonstration project.	Part B coinsurance under a demonstration project.
M138	Pat id demo partcpnt/not enrld demo time srvc render. Cvrq limit demo partcpnts	Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.
M139	Denied services exceed the coverage limit for the demonstration.	Denied services exceed the coverage limit for the demonstration.
M140	Srvc not cvrd til after pat 50 birthday, ie, no cvrg prior day after 50 birthday	Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday
M141	Missing/incomplete/invalid physician certified plan of care.	Missing/incomplete/invalid physician certified plan of care.
M142	Miss/incomplete/invalid American Diabetes Association Certificate of Recognition	Missing/incomplete/invalid American Diabetes Association Certificate of Recognition.
M143	We have no record you are licensed to dispensed drugs in the State where located	We have no record that you are licensed to dispensed drugs in the State where located.
M144	Pre-/post-operative care payment included in allowance for the surgery/procedure	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
MA01	If not agree aprvd srvc, appeal. One who not do 1st clm rev. Write w/in 120 day	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late. An institutional provider, e.g., hospital, Skilled Nursing Facility (SNF), Home Health Agency (HHA) or

MA02	If not agree detrmnation,right to appeal.Write w/in 120 dy.Dec by QIO w/in 60 dy	<p>hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.

If your carrier issues telephone review decisions, a professional provider should phone the carrier's office for a telephone review if the criteria for a telephone review are met.</p> <p>If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within120 days of the date of this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60days.

An institutional provider, e.g., hospital, Skilled Nursing Facility (SNF), Home Health Agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF non-certified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section N1879 of the Social Security Act, and the patient chooses not to appeal.</p>
MA03	If not agree w/approved amt & \$100 or more in dispute, ask hearing w/in 6 months	<p>If you do not agree with the approved amounts and \$100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within six months of the date of this notice. To meet the \$100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision. An institutional provider, e.g., hospital, Skilled Nursing Facility (SNF), Home Health Agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act , and the patient chooses not to appeal.</p>

MA04	2ndry pymt not consdrd w/out id/pymt info from primry. Info not report/illegible	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
MA05	Incorrect admission date patient status or type of bill entry on claim.	Incorrect admission date patient status or type of bill entry on claim.
MA06	Missing/incomplete/invalid beginning and/or ending date(s).	Missing/incomplete/invalid beginning and/or ending date(s).
MA07	The claim information has also been forwarded to Medicaid for review.	The claim information has also been forwarded to Medicaid for review.
MA08	Also sbmt clm pat oth ins poss pmt supl ben.We not fwd/supl cvrg not Medigap/MCR	You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.
MA09	Claim submitted unassgn but processed assgn. You agrd accept assignmt all claims	Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.
MA10	Patient's payment in excess amount owed. You must refund overpayment to patient	The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.
MA11	Pmt conditional.If no-fault/liability/WorkComp/VA/grp plan cvrg, rfd may due us	Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources.
MA12	Not estblsh right under the law to bill srvc furnish by person furnish this srvc	You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).
MA13	May be subject penalties if bill patient amounts not reported w/PR group code.	You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
MA14	Pat mbr emplyr-sponsrd hlthpln.Srvc outside pln not cvrd.Pmt this clm not notifd	Patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.
MA15	Claim separated expedite handling. Receive separate notice for oth srvc report	Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.
MA16	The patient is covered by the Black Lung Program. Send this claim to them	The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828,Lanham-Seabrook MD 20703.
MA17	Prim pyr&pd prim rate.Contct pat oth ins to rfd excess pd due erroneous prim pmt	We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.
MA18	Claim info fwd pat suppl ins. Send any ques	The claim information is also being forwarded to

	regarding supplemental ben to them	the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
MA19	Inf notsent Medigap.Incrrect/invld info sbmt on ins.Vfy inf sbmt 2ndry clm direct	Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.
MA20	SNF not cvrd care primary urethral catheter for convenience/control incontinence	Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.
MA21	SSA records indicate mismatch with name and sex.	SSA records indicate mismatch with name and sex.
MA22	Payment of less than \$1.00 suppressed.	Payment of less than \$1.00 suppressed.
MA23	Demand bill approved as result of medical review.	Demand bill approved as result of medical review.
MA24	ChristianScienceSanitarium/SkilledNursingFacility (SNF) bill same benefit period	Christian Science Sanitarium/ Skilled Nursing Facility (SNF) bill in the same benefit period.
MA25	Patient may not elect change hospice provider more than once in a benefit period	A patient may not elect to change a hospice provider more than once in a benefit period.
MA26	Our records indicate that you were previously informed of this rule.	Our records indicate that you were previously informed of this rule.
MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	Missing/incomplete/invalid entitlement number or name shown on the claim.
MA28	Rcpt notice by phys/suplr not acctpt assgn is info only & they not party determin	Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.
MA29	Missing/incomplete/invalid provider name, city, state, or zip code.	Missing/incomplete/invalid provider name, city, state, or zip code.
MA30	Missing/incomplete/invalid type of bill.	Missing/incomplete/invalid type of bill.
MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	Missing/incomplete/invalid beginning and ending dates of the period billed.
MA32	Missing/incomplete/invalid number of covered days during the billing period.	Missing/incomplete/invalid number of covered days during the billing period.
MA33	Missing/incomplete/invalid noncovered days during the billing period.	Missing/incomplete/invalid noncovered days during the billing period.
MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.	Missing/incomplete/invalid number of coinsurance days during the billing period.
MA35	Missing/incomplete/invalid number of lifetime reserve days.	Missing/incomplete/invalid number of lifetime reserve days.
MA36	Missing/incomplete/invalid patient name.	Missing/incomplete/invalid patient name.
MA37	Missing/incomplete/invalid patient's address.	Missing/incomplete/invalid patient's address.
MA38	Missing/incomplete/invalid birth date.	Missing/incomplete/invalid birth date.
MA39	Missing/incomplete/invalid gender.	Missing/incomplete/invalid gender.
MA40	Missing/incomplete/invalid admission date.	Missing/incomplete/invalid admission date.
MA41	Missing/incomplete/invalid admission type.	Missing/incomplete/invalid admission type.
MA42	Missing/incomplete/invalid admission source.	Missing/incomplete/invalid admission source.
MA43	Missing/incomplete/invalid patient status.	Missing/incomplete/invalid patient status.

MA44	No appeal rights. Adjudicative decision based on law.	No appeal rights. Adjudicative decision based on law.
MA45	As previously advised, portion/all of payment is being held in a special account	As previously advised, a portion or all of your payment is being held in a special account.
MA46	New info considered/addtln pmt can't issd. Please review info listed for expln	The new information was considered, however, additional payment cannot be issued. Please review the information listed for the explanation.
MA47	Records show opted out MCR, agree w/patient not bill MCR. We can't pay. Pat resp	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.
MA48	Missing/incomplete/invalid name or address of responsible party or primary payer	Missing/incomplete/invalid name or address of responsible party or primary payer.
MA49	Miss/incmplt/invld prov id home hlth agcy/hosp phys perf care pln ovrsght srvc	Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.
MA50	Miss/incmplt/invld Investigational Device Exemption # FDA-apprvd clin trial srvc	Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
MA51	Missing/incomplete/invalid CLIA cert # for lab service billed by phys office lab	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
MA52	Missing/incomplete/invalid date.	Missing/incomplete/invalid date.
MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project Id	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.
MA54	Physician certification or election consent for hospice care not received timely	Physician certification or election consent for hospice care not received timely.
MA55	Not cvrd pat recd med hlth care svc,auto revoke recv relig non-med hlth care svc	Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
MA56	Opted out MCR, agree w/pat not bill MCR. Can't pay. Pat resp limiting chrg amt	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
MA57	Pat submitd written request revoke election religious non-med health care srvc	Patient submitted written request to revoke his/her election for religious non-medical health care services.
MA58	Missing/incomplete/invalid release of information indicator.	Missing/incomplete/invalid release of information indicator.
MA59	Pat ovrpd. Rfnd pat w/in 30 days the diff between pymnt and pat responsibility	The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/he rpayment and the total amount shown as patient responsibility on this notice.
MA60	Missing/incomplete/invalid patient relationship to insured.	Missing/incomplete/invalid patient relationship to insured.
MA61	Missing/incomplete/invalid social security # or	Missing/incomplete/invalid social security number

MA62	health insurance claim number Telephone review decision.	or health insurance claim number. Telephone review decision.
MA63	Missing/incomplete/invalid principal diagnosis.	Missing/incomplete/invalid principal diagnosis.
MA64	We should be 3rd payer. Can't process til recvd pymt info from 1st & 2nd payers	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
MA65	Missing/incomplete/invalid admitting diagnosis.	Missing/incomplete/invalid admitting diagnosis.
MA66	Missing/incomplete/invalid principal procedure code or date.	Missing/incomplete/invalid principal procedure code or date.
MA67	Correction to a prior claim.	Correction to a prior claim.
MA68	Not x-over claim, 2nd ins info incomplete. Supply complt info/use PLANID of ins	We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim.
MA69	Missing/incomplete/invalid remarks.	Missing/incomplete/invalid remarks.
MA70	Missing/incomplete/invalid provider representative signature.	Missing/incomplete/invalid provider representative signature.
MA71	Missing/incomplete/invalid provider representative signature date.	Missing/incomplete/invalid provider representative signature date.
MA72	Pat ovrrpd assigned srvcs. Rfnd pat w/in 30 days the diff between pymt & pat resp	The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice.
MA73	Info remit assoc w/MCR demo. No pmt issd fee- for-srvc MCR pat elect managed care	Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.
MA74	Payment replaces earlier payment that was either lost, damaged or returned	This payment replaces an earlier payment for this claim that was either lost, damaged or returned.
MA75	Missing/incomplete/invalid patient or authorized representative signature.	Missing/incomplete/invalid patient or authorized representative signature.
MA76	Missing/incomplete/invld prov id HHA/hospice phys perform care pln ovrsight srvcs	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.
MA77	Pat ovrrpd. Rfnd pat w/in 30 days diff betwn pat pmt less prev pyr pmt & pat resp	The patient overpaid you. You must issue the patient a refund within 30 days for the difference between the patient's payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice.
MA78	Patient overpaid. Refund patient w/in 30 days diff between allowed amt & pat pmt	The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.
MA79	Billed in excess of interim rate.	Billed in excess of interim rate.
MA80	Info notice. Pmt issd hosp by intermediary for srvc this encnter under demo proj	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
MA81	Missing/incomplete/invalid provider/supplier	Missing/incomplete/invalid provider/supplier

MA82	signature. Miss/incmplt/invalid prov/suplr billing #/id or billing nam,addr,city,st,zip,ph #	signature. Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.
MA83	Not indicate whether 1st or 2nd pyr. Refer item 11 of HCFA-1500 instr for assist	Did not indicate whether we are the primary or secondary payer. Refer to Item 11 in the HCFA- 1500 instructions for assistance.
MA84	Pat id participant Nat'l Emphysema Treatment Trial but pat not participnt/apprvd	Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.
MA85	Oth primry pyr; you not complete/enter accurate ins plan/grp/progrm name or id #	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.
MA86	Missing/incomplete/invalid group or policy # of insured for the primary coverage	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.
MA87	Missing/incomplete/invalid insured's name for the primary payer.	Missing/incomplete/invalid insured's name for the primary payer.
MA88	Missing/incomplete/invalid insured's address and/or phone # for primary payer	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.
MA89	Missing/incomplete/invalid patient's relationship to insured for primary payer	Missing/incomplete/invalid patient's relationship to the insured for the primary payer.
MA90	Missing/incomplete/invalid employment status code for the primary insured.	Missing/incomplete/invalid employment status code for the primary insured.
MA91	This determination is the result of the appeal you filed.	This determination is the result of the appeal you filed.
MA92	Missing/incomplete/invalid plan information for other insurance.	Missing/incomplete/invalid plan information for other insurance.
MA93	Non-PIP (Periodic Interim Payment) claim.	Non-PIP (Periodic Interim Payment) claim.
MA94	"Attending phys not hospice employee" not on clm cert render phys not emply hosp	Did not enter the statement "Attending physician not hospice employee" on the claim to certify that the rendering physician is not an employee of the hospice. Refer to item 19 on the HCFA-1500.
MA95	De-activate and refer to M51.	De-activate and refer to M51.
MA96	Claim rejected. Coded MCR Managed Care Demo but pat not enrld MCR mangd care pln	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number.	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number.
MA98	Claim Rejectd. Not correct MCR Managed Care Demo contract # for this beneficiary	Claim Rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.
MA99	Missing/incomplete/invalid Medigap information.	Missing/incomplete/invalid Medigap information.
MA100	Missing/incomplete/invalid date of current illness, injury or pregnancy.	Missing/incomplete/invalid date of current illness, injury or pregnancy.
MA101	A SNF responsible payment of outside prov who furnish srvcs/supls to residents	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.

MA102	Missng/incmplt/invlid name/prov id rendering/referring/ordering/supervising prov	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.
MA103	Hemophilia Add On.	Hemophilia Add On.
MA104	Missing/incomplete/invalid date pat last seen or provider id of attending phys	Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.
MA105	Missing/incomplete/invalid provider number for this place of service.	Missing/incomplete/invalid provider number for this place of service.
MA106	PIP (Periodic Interim Payment) claim.	PIP (Periodic Interim Payment) claim.
MA107	Paper claim contains more than three separate data items in field 19.	Paper claim contains more than three separate data items in field 19.
MA108	Paper claim contains more than one data item in field 23.	Paper claim contains more than one data item in field 23.
MA109	Claim processed in accordance with ambulatory surgical guidelines.	Claim processed in accordance with ambulatory surgical guidelines.
MA110	Miss/incmplt/invlid info if diagnostic performd outside entity/no purchasd tests	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.
MA111	Missing/incomplete/invalid purchase price of test/performing lab's name & addr	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.
MA112	Missing/incomplete/invalid group practice information.	Missing/incomplete/invalid group practice information.
MA113	Incmlpt/invlid TIN submttd per IRS.Not process.May not bill pat pnding corrcct TIN	Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.
MA114	Missing/incomplete/invalid information on where the services were furnished.	Missing/incomplete/invalid information on where the services were furnished.
MA115	Missing/incomplete/invalid physical location where services rendered in a HPSA	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).
MA116	Stmt "Homebound" not on claim validate lab srvc performed at home/in institutn	Did not complete the statement "Homebound" on the claim to validate whether laboratory services were performed at home or in an institution.
MA117	This claim has been assessed a \$1.00 user fee.	This claim has been assessed a \$1.00 user fee.
MA118	Coins/deduct amts apply for srvc/suppls furn MCR-elig vet thru VA. No MCR pmt	Coinsurance and/or deductible amounts apply to a claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. No Medicare payment issued.
MA119	Provider level adjustment for late claim filing applies to this claim.	Provider level adjustment for late claim filing applies to this claim.
MA120	Missing/incomplete/invalid CLIA certification number.	Missing/incomplete/invalid CLIA certification number.
MA121	Missing/incomplete/invalid date the x-ray was	Missing/incomplete/invalid date the x-ray was

	performed.	performed.
MA122	Missing/incomplete/invalid initial date actual treatment occurred.	Missing/incomplete/invalid initial date actual treatment occurred.
MA123	Center not selected participate in study, therefore, we cannot pay for services	Your center was not selected to participate in this study, therefore, we cannot pay for these services.
MA124	Processed for IME only.	Processed for IME only.
MA125	Per legislation governing this program, payment constitutes payment in full.	Per legislation governing this program, payment constitutes payment in full.
MA126	Pancreas transplant not covered unless kidney transplant performed.	Pancreas transplant not covered unless kidney transplant performed.
MA127	Reserved for future use.	Reserved for future use.
MA128	Missing/incomplete/invalid six-digit FDA approved, identification number.	Missing/incomplete/invalid six-digit FDA approved, identification number.
MA129	This provider was not certified for this procedure on this date of service.	This provider was not certified for this procedure on this date of service.
MA130	Incmlpt/invld info,no appeal rights afforded.Submt new clm w/ complt/corct info	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
MA131	Phys already paid in conjunction w/demo clm. Have phys withdraw clm & rfnd pmt	Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.
MA132	Adjustment to the pre-demonstration rate.	Adjustment to the pre-demonstration rate.
MA133	Claim overlaps inpatient stay. Rebill only services rendered outside inpat stay	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
MA134	Missing/incomplete/invalid provider number of facility where patient resides	Missing/incomplete/invalid provider number of the facility where the patient resides.
N1	May appeal this decision in writing. Instruction incld contract/plan benefit doc	You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
N2	allowance made accordance most appropriate course of treatment provision of plan	This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.
N3	Missing/incomplete/invalid consent form.	Missing/incomplete/invalid consent form.
N4	Missing/incomplete/invalid prior insurance carrier EOB.	Missing/incomplete/invalid prior insurance carrier EOB.
N5	EOB received from previous payer. Claim not on file.	EOB received from previous payer. Claim not on file.
N6	FEHB law(U.S.C. 8904(b)),can't pay more for cvrd care than MCR allwd if A/B cvrg	Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B.
N7	Processing claim/service included consideration under Major Medical provisions	Processing of this claim/service has included consideration under Major Medical provisions.
N8	X-over clm deny by prev pyr&complt dat not fwd.Resubmt to pyr to provd adjud dat	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.
N9	Adjustment represents the estimated amount the primary payer may have paid.	Adjustment represents the estimated amount the primary payer may have paid.
N10	Clm/svc adj on findings rev org/prof	Claim/service adjusted based on the findings of a

	conslt/manual adjudicatn/med or dentl advsr	review organization/professional consult/manual adjudication/medical or dental advisor.
N11	Denial reversed because of medical review.	Denial reversed because of medical review.
N12	Pol prov cvrg suppl MCR. Mbr not MCR B,mbr resp pmt of chrg would be cvrd by MCR	Policy provides coverage supplemental to Medicare. As member does not appear to be enrolled in Medicare Part B, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.
N13	Payment based on professional/technical component modifier(s).	Payment based on professional/technical component modifier(s).
N14	Payment based on contractual amt or agreemet, fee schedule, or max allowable amt	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
N15	Services for a newborn must be billed separately.	Services for a newborn must be billed separately.
N16	Family/member Out-of-Pocket maximum met. Payment based on a higher percentage.	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.
N17	Per admission deductible.	Per admission deductible.
N18	Payment based on the Medicare allowed amount.	Payment based on the Medicare allowed amount.
N19	Procedure code incidental to primary procedure.	Procedure code incidental to primary procedure.
N20	Service not payable with other service rendered on the same date.	Service not payable with other service rendered on the same date.
N21	Range of dates separated onto single lines.	Range of dates separated onto single lines.
N22	Procedure code added/changed as it more accurately describes services rendered	This procedure code was added/changed because it more accurately describes the services rendered.
N23	Pat liability maybe affectd due coord of ben w/oth carriers/max benefit provision	Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.
N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.
N25	Co contractd by ben plan prov admin clm pmt svc only,not assume finan risk/oblig	This company has been contracted by your benefit plan to provide administrative claims payment services only. This company does not assume financial risk or obligation with respect to claims processed on behalf of your benefit plan.
N26	Missing/incomplete/invalid itemized bill.	Missing/incomplete/invalid itemized bill.
N27	Missing/incomplete/invalid treatment number.	Missing/incomplete/invalid treatment number.
N28	Consent form requirements not fulfilled.	Consent form requirements not fulfilled.
N29	Missing/incomplete/invalid documentation/orders/notes/summary/report/invoice.	Missing/incomplete/invalid documentation/orders/notes/summary/report/invoice.
N30	Patient ineligible for this service.	Patient ineligible for this service.
N31	Missing/incomplete/invalid prescribing/referring/attending provider license num	Missing/incomplete/invalid prescribing/referring/attending provider license number.
N32	Claim must be submitted by the provider who rendered the service.	Claim must be submitted by the provider who rendered the service.
N33	No record of health check prior to initiation of treatment.	No record of health check prior to initiation of treatment.
N34	Incorrect claim form for this service.	Incorrect claim form for this service.
N35	Program integrity/utilization review decision.	Program integrity/utilization review decision.
N36	Claim must meet primary payer processing requirements before we considr payment	Claim must meet primary payer's processing requirements before we can consider payment.
N37	Missing/incomplete/invalid tooth number/letter.	Missing/incomplete/invalid tooth number/letter.

N38	Missing/incomplete/invalid place of service.	Missing/incomplete/invalid place of service.
N39	Procedure code is not compatible with tooth number/letter.	Procedure code is not compatible with tooth number/letter.
N40	Missing/incomplete/invalid x-ray.	Missing/incomplete/invalid x-ray.
N41	Authorization request denied.	Authorization request denied.
N42	No record of mental health assessment.	No record of mental health assessment.
N43	Bed hold or leave days exceeded	Bed hold or leave days exceeded.
N44	Pyr share reg surchrg/assessmts/allwncs/hlth care-relatd tx pd directly reg auth	Payer's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority.
N45	Payment based on authorized amount.	Payment based on authorized amount.
N46	Missing/incomplete/invalid admission hour.	Missing/incomplete/invalid admission hour.
N47	Claim conflicts with another inpatient stay.	Claim conflicts with another inpatient stay.
N48	Claim information not agree with information received from oth insurance carrier	Claim information does not agree with information received from other insurance carrier.
N49	Court ordered coverage information needs validation.	Court ordered coverage information needs validation.
N50	Missing/incomplete/invalid discharge information.	Missing/incomplete/invalid discharge information.
N51	Electronic interchange agreement not on file for provider/submitter.	Electronic interchange agreement not on file for provider/submitter.
N52	Patient not enrolled in billing provider's managed care plan on date of service	Patient not enrolled in the billing provider's managed care plan on the date of service.
N53	Missing/incomplete/invalid point of pick-up address.	Missing/incomplete/invalid point of pick-up address.
N54	Claim information is inconsistent with pre-certified/authorized services.	Claim information is inconsistent with pre-certified/authorized services.
N55	Procedures for billing group/referring/performing providers were not followed	Procedures for billing with group/referring/performing providers were not followed.
N56	Procedure code billd not correct/valid for services billd/date of service billd	Procedure code billed is not correct/valid for the services billed or the date of service billed.
N57	Missing/incomplete/invalid prescribing/dispensed date.	Missing/incomplete/invalid prescribing/dispensed date.
N58	Missing/incomplete/invalid patient liability amount.	Missing/incomplete/invalid patient liability amount.
N59	Please refer to provider manual for additional program and provider information	Please refer to your provider manual for additional program and provider information.
N60	A valid NDC is required for payment of drug claims effective October 02.	A valid NDC is required for payment of drug claims effective October 02.
N61	Rebill services on separate claims.	Rebill services on separate claims.
N62	Inpatient admission spans multiple rate periods. Resubmit separate claims.	Inpatient admission spans multiple rate periods. Resubmit separate claims.
N63	Rebill services on separate claim lines.	Rebill services on separate claim lines.
N64	The "from" and "to" dates must be different.	The "from" and "to" dates must be different.
N65	Procedure code/rate count not determined/on file, for date of service/provider	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
N66	Missing/incomplete/invalid documentation.	Missing/incomplete/invalid documentation.
N67	Prof provider srvc not paid separately. Included in fac pmt under demo project	Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if

		you furnished these services in another location on the date of the patient's admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.
N68	Prior payment cancelled, subsequently notified patient covered by a demo project	Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for your payment. Prior payment made to you by the patient or another insurer for this claim must be refunded to the payer within 30 days.
N69	PPS code changed by claims processing system. Insufficient visits or therapies.	PPS (Prospective Payment System) code changed by claims processing system. Insufficient visits or therapies.
N70	Home health consolidated billing and payment applies.	Home health consolidated billing and payment applies.
N71	unassigned claim drug/bio/clin diagnostic lab/ambulance srvc processed assigned	Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims.
N72	PPS code changed by medical reviewers. Not supported by clinical records	PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical records.
N73	A SNF resp pmt outside prov who furnish srvc/supls under arrangemnt to resident	A Skilled Nursing Facility is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.
N74	Resubmt w/multiple claims, each claim cvrg srvc provided only 1 calendar month	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
N75	Missing/incomplete/invalid tooth surface information.	Missing/incomplete/invalid tooth surface information.
N76	Missing/incomplete/invalid number of riders.	Missing/incomplete/invalid number of riders.
N77	Missing/incomplete/invalid designated provider number.	Missing/incomplete/invalid designated provider number.
N78	Necessary components of child and teen checkup (EPSDT) were not completed.	The necessary components of the child and teen checkup (EPSDT) were not completed.
N79	Service billed is not compatible with patient location information.	Service billed is not compatible with patient location information.
N80	Missing/incomplete/invalid prenatal screening information.	Missing/incomplete/invalid prenatal screening information.
N81	Procedure billed is not compatible with tooth surface code.	Procedure billed is not compatible with tooth surface code.
N82	Prov must acct ins pmt as pmt in full 3rd party pyr contrct says full reimburse	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.
N83	No appeal right. Adjudicative decision based	No appeal rights. Adjudicative decision based on

N84	provisions of demonstration project Further installment payments forthcoming.	the provisions of a demonstration project. Further installment payments forthcoming.
N85	Final installment payment.	Final installment payment.
N86	Fail trial pelvic muscle exer traing req biofdbck traing trt urinary incnt cvrd	A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered.
N87	Home use of biofeedback therapy is not covered.	Home use of biofeedback therapy is not covered.
N88	Payment conditional. An HHA episode care notice has been filed for this patient	This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care.
N89	Payment info forwarded more one other payer, but only one identified on remit	Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
N90	Covered only when performed by the attending physician.	Covered only when performed by the attending physician.
N91	Services not included in the appeal review.	Services not included in the appeal review.
N92	This facility is not certified for digital mammography.	This facility is not certified for digital mammography.
N93	Sep claim required each place of service. Srvcs multiple site not billd same clm	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.
N94	Claim/Service denied more specific taxonomy code required for adjudication	Claim/Service denied because a more specific taxonomy code is required for adjudication.
N95	This provider type/provider specialty may not bill this service.	This provider type/provider specialty may not bill this service.
N96	Pat refractory conven'l ther & approp surg candidate implantation w/anesth occur	Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and bean appropriate surgical candidate such that implantation with anesthesia can occur.
N97	Strss incnt/urnry obstr/spec neuro dis assoc w/2ndry manif above 3 indicatn excl	Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement)which are associated with secondary manifestations of the above three indications are excluded.
N98	Patient must have successful test stimulation to support subsequent implantation	Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement through test stimulation. Improvement is measured through voiding diaries.
N99	Pat must demo adeq abilty void diary data clin reslt implant proc properly eval	Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.

N100	PPS (Prospect Payment System) code corrected during adjudication.	PPS (Prospect Payment System) code corrected during adjudication.
N101	Add'l info need to process claim. Please resubmit w/id # provider where service	Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters "HSP" and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.
N102	Denied w/out reviewing med rec, requested rec not received or received timely	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.
N103	Social Security rec say pat prisoner at time of srvc. Pat liable hlth care cost	Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.
N104	Not payable under claims jurisdiction area. Id correct MCR contractor thru CMS	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.hhs.gov .
N105	This is a misdirected claim/service for an RRB beneficiary.	This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.
N106	Payment for services to SNF inpatients can only be made to the SNF.	Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.
N107	Services to SNF inpatient must be inpat claim. Can't bill separately as output	Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.
N108	Missing/incomplete/invalid upgrade information.	
N109	This claim chosen for complex review & denied after reviewing medical records.	This claim was chosen for complex review and was denied after reviewing the medical records.
N110	This facility is not certified for film mammography.	This facility is not certified for film mammography.
N111	No appeal right except duplicate claim/service issue.	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
N112	This claim is excluded from your electronic remittance advice.	This claim is excluded from your electronic remittance advice.
N113	Only one initial visit is covered per physician, group practice or provider.	Only one initial visit is covered per physician, group practice or provider.

N114	Dur transition Ambulance Fee Schedule, pmt basd lessr of blended amt/submt chrg	During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.
N115	This decision was based on a local medical review policy (LMRP).	This decision was based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LMRP.
N116	Pmt conditional, srvc provided in home, possible pat undr home hlth episode care	This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.
N117	This service is paid only once in a patient's lifetime.	This service is paid only once in a patient's lifetime.
N118	This service is not paid if billed more than once every 28 days.	This service is not paid if billed more than once every 28 days.
N119	Svc not pd if billd once evry 28 days, & pat 5/more consec days in any inpat/SNF	This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or Skilled/nursing Facility (SNF) within those 28 days.
N120	Payment subject home health prospective pymt sys partial episode pymt adjustment	Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.
N121	No cvrg itms/srvcs provided this type practitioner for pat in covered SNF stay	No coverage for items or services provided by this type of practitioner for patients in a covered Skilled Nursing Facility (SNF) stay.
N122	Mammography add-on code cannot be billed by itself.	Mammography add-on code cannot be billed by itself.
N123	This split service & represents portion of units from originally submitted srvc	This is a split service and represents a portion of the units from the originally submitted service.
N124	Pmt denied. Info not substantiate need for this more extensive service/item	Payment has been denied for the/made only for a less extensive servie/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.

N125	Payment denied, information not substantiate need for more extensive service/itm	<p>Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases: -If you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/item; or -If you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay. If an exception applies to you, or you believe the carrier was wrong in denying payment, you should request review of this determination by the carrier within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30-days, you may delay refunding to the beneficiary until you receive the results of the review. If the review determination is favorable to you, you do not have to make any refund. If the review is unfavorable, you must make the refund within 15 days of receiving the unfavorable review decision. You may request review of the determination at any time within 120 days of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he or she maybe entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days. The requirements for refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office.</p>
N126	Social Security Records indicate that this individual has been deported.	Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who

N127	This is misdirected claim/service for United Mine Workers of America beneficiary	have been deported. This is a misdirected claim/service for a United Mine Workers of America beneficiary. Submit paper claims to: UMWA Health and Retirement Funds, PO Box 389, Ephraim, UT 84627-0361. Call Envoy at 1-800-215-4730 for information on electronic claims submission.
N128	This amount represents the prior to coverage portion of the allowance.	This amount represents the prior to coverage portion of the allowance.
N129	This amount represents the dollar amount not eligible due to the patient's age.	This amount represents the dollar amount not eligible due to the patient's age.
N130	Consult plan benefit documents for information about restrictions this service.	Consult plan benefit documents for information about restrictions for this service.
N131	Total payments under multiple contracts cannot exceed allowance for this service	Total payments under multiple contracts cannot exceed the allowance for this service.
N132	Pmt will cease for srvc's this US Gov't debarred/excl'd prov after 30 day grace per	Payments will cease for services rendered by this US Government debarred or excluded provider after the 30 day grace period as previously notified.
N133	Services for predetermination & services requesting payment processed separately	Services for predetermination and services requesting payment are being processed separately.
N134	Represents scheduled pymt for service. If treatment discont'd, contact Cust Srv	This represents your scheduled payment for this service. If treatment has been discontinued, please contact Customer Service.
N135	Record fees are patient's responsibility and limited to the specified co-payment	Record fees are the patient's responsibility and limited to the specified co-payment.
N136	To obtain info on process to file appeal in AZ, call Depart's Consumr Assist Off	To obtain information on the process to file an appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548.
N137	You may file appeal w/our Company/file complaint w/Commissioner in Maryland	You, the provider, acting on the Member's behalf, may file an appeal with our Company. You, the provider, on the Member's behalf, may file a complaint with the Commissioner in the state of Maryland without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The Commissioner's address: Commissioner Steven B. Larsen, Maryland Insurance Administration, 525 St. Paul Place, Baltimore, MD 21202 - (410) 468-2000.
N138	If disagree Dentl Advisor opinion&add'l info relative, submt radiographs 2nd rev	In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.
N139	Code of Fed Reg, Ch 32, Sect 199.13 non-participat prov not approp appealing prty	Under the Code of Federal Regulations, Chapter 32, Section 199.13 non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her

N140	Not authorized OCONUS provider, not considered an appropriate appealing party.	representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter. You have not been designated as an authorized OCONUS provider therefore are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90days from the date of this letter.
N141	Patient not reside long-term care facility during all/part service dates billed	The patient was not residing in a long-term care facility during all or part of the service dates billed.
N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	The original claim was denied. Resubmit a new claim, not a replacement claim.
N143	The patient not in hospice program during all or part of service dates billed	The patient was not in a hospice program during all or part of the service dates billed.
N144	The rate changed during the dates of service billed.	The rate changed during the dates of service billed.
N145	Missing/incomplete/invalid provider identifier for this place of service.	Missing/incomplete/invalid provider identifier for this place of service.
N146	Missing/incomplete/invalid/not approved screening document.	Missing/incomplete/invalid/not approved screening document.
N147	Long term care case mix/per diem rate not determined,pat ID # miss/incmplt/invid	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.
N148	Missing/incomplete/invalid date of last menstrual period.	Missing/incomplete/invalid date of last menstrual period.
N149	Rebill all applicable services on a single claim.	Rebill all applicable services on a single claim.
N150	Missing/incomplete/invalid model number.	Missing/incomplete/invalid model number.
N151	phone contact services not paid til face-to-face contact requirement met	Telephone contact services will not be paid until the face-to-face contact requirement has been met.
N152	Missing/incomplete/invalid replacement claim information.	Missing/incomplete/invalid replacement claim information.
N153	Missing/incomplete/invalid room and board rate.	Missing/incomplete/invalid room and board rate.
N154	This payment was delayed for correction of provider's mailing address.	This payment was delayed for correction of provider's mailing address.
N155	Our records not indicate oth ins on file. submit oth ins info for our records	Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.
N156	Patient responsible difference between approved treatment & elective treatment	The patient is responsible for the difference between the approved treatment and the elective treatment.
N157	Transportation to/from this destination is not covered.	Transportation to/from this destination is not covered.
N158	Transportation in a vehicle other than an	Transportation in a vehicle other than an

N159	ambulance is not covered. Payment denied/reduced, mileage not covered when patient not in the ambulance	ambulance is not covered. Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.
N160	Patient choose option before pymt made for procedure/equipment/supply/service	The patient must choose an option before a payment can be made for this procedure/equipment/supply/service.
N161	This drug/service/supply is covered only when the associated service is covered	This drug/service/supply is covered only when the associated service is covered.
N162	Alert. Claim paid, but billed test/specialty not included Lab Certification	This is an alert. Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Your failure to correct the laboratory certification information wil result in a denial of payment in the near future.
N163	Medical record does not support code billed per the code definition.	Medical record does not support code billed per the code definition.
N164	Transportation to/from this destination is not covered.	Transportation to/from this destination is not covered.
N165	Transportation in a vehicle other than an ambulance is not covered.	Transportation in a vehicle other than an ambulance is not covered.
N166	Payment denied/reduced, mileage not covered when patient not in the ambulance	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.
N167	Charges exceed the post-transplant coverage limit.	Charges exceed the post-transplant coverage limit.
N168	Patient choose option before payment for procedure/equipment/supply/service.	The patient must choose an option before a payment can be made for this procedure/equipment/supply/service.
N169	This drug/service/supply is covered only when the associated service is covered.	This drug/service/supply is covered only when the associated service is covered.
N170	A new/revised/renewed certificate of medical necessity is needed.	A new/revised/renewed certificate of medical necessity is needed.
N171	Payment for repair/replacement is not covered or has exceeded the purchase price	Payment for repair or replacement is not covered or has exceeded the purchase price.
N172	Patient not liable denied/adjusted charge for receiving any updated service/item	The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.
N173	No qualifying hospital stay dates were provided for this episode of care.	No qualifying hospital stay dates were provided for this episode of care.
N174	Not cvrd srvc/proc/equip/bed, pat liability limited amts in adj under group "PR"	This is not a covered service/procedure/equipment/bed, however patient liability is limited to amounts shown in the adjustments under group "PR".
N175	Missing/incomplete/invalid Review Organization Approval.	Missing/incomplete/invalid Review Organization Approval.
N176	Srvcs provided aboard ship cvrd only when United States registry & in US waters	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.
N177	Not sent to patient's other insurer. They indicated no add'l payment can be made	We did not send this claim to patient's other insurer. They have indicated no additional payment can be made.
N178	Missing/invalid/incomplete pre-operative photos or visual field results.	Missing/invalid/incomplete pre-operative photos or visual field results.
N179	Add'l information requested from member.	Additional information has been requested from

	Charges be reconsidered upon receipt	the member. The charges will be reconsidered upon receipt of that information.
N180	This item/service not meet criteria for the category under which it was billed	This item or service does not meet the criteria for the category under which it was billed.
N181	Add'l info req another prov involved in care. Chrsgs be reconsidered upon receipt	Additional information has been requested from another provider involved in the care of this member. The charges will be reconsidered upon receipt of that information.
N182	This claim/service must be billed according to the schedule for this plan.	This claim/service must be billed according to the schedule for this plan.
N183	Predetermination advisory msg, when service submitted, add'l documents required	This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits.
N184	Rebill technical and professional components separately.	Rebill technical and professional components separately.
N185	Do not resubmit this claim/service.	Do not resubmit this claim/service.
N186	NAS required for this service. Contact the nearest MTF for assistance.	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.
N187	May request review follow receipt notice, follow instr contract/plan benefit doc	You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
N188	The approved level of care does not match the procedure code submitted.	The approved level of care does not match the procedure code submitted.
N189	Service has been paid as a one-time exception to the plan's benefit restrictions	This service has been paid as a one-time exception to the plan's benefit restrictions.
N190	Missing/incomplete/invalid contract indicator.	Missing/incomplete/invalid contract indicator.
N191	The provider must update insurance information directly with payer.	The provider must update insurance information directly with payer.
N192	Patient is a Medicaid/Qualified Medicare Beneficiary.	Patient is a Medicaid/Qualified Medicare Beneficiary.
N193	Specific federal/state/local program may cover service through another payer	Specific federal/state/local program may cover this service through another payer.
N194	Technical component not paid if provider does not own the equipment used.	Technical component not paid if provider does not own the equipment used.
N195	The technical component must be billed separately.	The technical component must be billed separately.
N196	Patient eligible to apply for other coverage which may be primary.	Patient eligible to apply for other coverage which may be primary.
N197	The subscriber must update insurance information directly with payer.	The subscriber must update insurance information directly with payer.
N198	Rendering provider must be affiliated with the pay-to provider.	Rendering provider must be affiliated with the pay-to provider.
N199	Additional payment approved based on payer-initiated review/audit.	Additional payment approved based on payer-initiated review/audit.
N200	The professional component must be billed separately.	The professional component must be billed separately.
N201	Mental hlth fac resp pmt of outside providers of services/supplies to residents	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.
N202	Additional information/explanation will be sent	Additional information/explanation will be sent

N203	separately Missing/incomplete/invalid anesthesia time/units	separately Missing/incomplete/invalid anesthesia time/units
N204	Srvcs under review possible pre-existing condition. Send med rec for prior 12 mo	Services under review for possible pre-existing condition. Send medical records for prior 12 months
N205	Information provided was illegible	Information provided was illegible
N206	The supporting documentation does not match the claim	The supporting documentation does not match the claim
N207	Missing/incomplete/invalid birth weight	Missing/incomplete/invalid birth weight
N208	Missing/incomplete/invalid DRG code	Missing/incomplete/invalid DRG code
N209	Missing/invalid/incomplete taxpayer identification number (TIN)	Missing/invalid/incomplete taxpayer identification number (TIN)
N210	You may appeal this decision	You may appeal this decision
N211	You may not appeal this decision	You may not appeal this decision
N212	Charges processed under a Point of Service benefit	Charges processed under a Point of Service benefit

8.0 Appendix C: NCPDP Rej/Pay Codes

Indian Health Service NCPDP Reject/Payment Codes (from Pharmacy POS) 24-Feb-04

Code	Description
1	M/I Bin
2	M/I Version Number
3	M/I Transaction Code
4	M/I Processor Control Number
5	M/I Pharmacy Number
6	M/I Group Number
7	M/I Cardholder ID Number
8	M/I Person Code
9	M/I Birth Date
10	M/I Patient Gender Code
11	M/I Patient Relationship Code
12	M/I Patient Location
13	M/I Other Coverage Code
14	M/I Eligibility Clarification Code
15	M/I Date of Service
16	M/I Prescription/Service Reference Number
17	M/I Fill Number
18	M/I METRIC QUANTITY
19	M/I Days Supply
20	M/I Compound Code
21	M/I Product/Service ID
22	M/I Dispense As Written(DAW)/Product Selection Code
23	M/I Ingredient Cost Submitted
24	M/I SALES TAX
25	M/I Prescriber ID
26	M/I Unit of Measure
27	(FUTURE USE)
28	M/I Date Prescription Written
29	M/I Number Refills Authorized
30	M/I P.A./M.C. CODE AND NUMBER
31	(FUTURE USE)
32	M/I Level of Service
33	M/I Prescription Origin Code
34	M/I Submission Clarification Code
35	M/I Primary Care Provider ID
36	M/I CLINIC ID
37	(FUTURE USE)
38	M/I Basis of Cost
39	M/I Diagnosis Code
40	Pharmacy Not Contracted With Plan on Date of Service

41	Submit Bill To Other Processor Or Primary Payer
42	(FUTURE USE)
43	(FUTURE USE)
44	(FUTURE USE)
45	(FUTURE USE)
46	(FUTURE USE)
47	(FUTURE USE)
48	(FUTURE USE)
49	(FUTURE USE)
50	Non-Matched Pharmacy Number
51	Non-Matched Group ID
52	Non-Matched Cardholder ID
53	Non-Matched Person Code
54	Non-Matched Product/Service ID Number
55	Non-Matched Product Package Size
56	Non-Matched Prescriber ID
57	NON-MATCHED P.A./M.C. NUMBER
58	Non-Matched Primary Prescriber
59	NON-MATCHED CLINIC ID
60	Product/Service Not Covered For Patient Age
61	Product/Service Not Covered For Patient Gender
62	Patient/Card Holder ID Name Mismatch
63	Institutionalized Patient Product/Service ID Not Covered
64	Claim Submitted Does Not Match Prior Authorization
65	Patient Is Not Covered
66	Patient Age Exceeds Maximum Age
67	Filled Before Coverage Effective
68	Filled After Coverage Expired
69	Filled After Coverage Terminated
70	Product/Service Not Covered
71	Prescriber Is Not Covered
72	Primary Prescriber Is Not Covered
73	Refills Are Not Covered
74	Other Carrier Payment Meets Or Exceeds Payable
75	Prior Authorization Required
76	Plan Limitations Exceeded
77	Discontinued Product/Service ID Number
78	Cost Exceeds Maximum
79	Refill Too Soon
80	Drug-Diagnosis Mismatch
81	Claim Too Old
82	Claim Is Post-Dated
83	Duplicate Paid/Captured Claim
84	Claim Has Not Been Paid/Captured
85	Claim Not Processed
86	Submit Manual Reversal
87	Reversal Not Processed
88	DUR Reject Error
89	Rejected Claim Fees Paid
90	Host Hung Up

91	Host Response Error
92	System Unavailable/Host Unavailable
93	PLANNED UNAVAILABLE
94	INVALID MESSAGE
95	Time Out
96	Scheduled Downtime
97	Payor Unavailable
98	Connection To Payer Is Down
99	Host Processing Error
CA	M/I Patient First Name
CB	M/I Patient Last Name
CC	M/I Cardholder First Name
CD	M/I Cardholder Last Name
CE	M/I Home Plan
CF	M/I Employer Name
CG	M/I Employer Street Address
CH	M/I Employer City Address
CI	M/I Employer State/Province Address
CJ	M/I Employer Zip Postal Zone
CK	M/I Employer Phone Number
CL	M/I Employer Contact Name
CM	M/I Patient Street Address
CN	M/I Patient City Address
CO	M/I Patient State/Province Address
CP	M/I Patient Zip/Postal Zone
CQ	M/I Patient Phone Number
CR	M/I Carrier ID
CT	PATIENT SOCIAL SECURITY NUMBER
DP	M/I DRUG TYPE OVERRIDE
DR	M/I Prescriber Last Name
DQ	M/I Usual and Customary Charge
DS	M/I POSTAGE AMOUNT CLAIMED
DT	M/I Unit Dost Indicator
DU	M/I Gross Amount Due
DV	M/I Other Payer Amount Paid
DW	M/I BASIS OF DAYS SUPPLY DETERMINATION
DX	M/I Patient Paid Amount Submitted
DY	M/I Date of Injury
DZ	M/I Claim/Reference ID
E1	M/I Product/Service ID Qualifier
E2	ALTERNATE PRODUCT CODE
E3	M/I Incentive Amount Submitted
E4	M/I Reason For Service Code
E5	M/I Professional Service Code
E6	M/I Result of Service Code
E7	M/I Quantity Dispensed
E8	M/I Other Payer Date
M1	Patient Not Covered In This Aid Category
M2	Recipient Locked In
M3	Host PA/MC Error

M4	Prescription/Service Reference Number/Time Limit Exceeded
M5	Requires Manual Claim
M6	Host Eligibility Error
M7	Host Drug File Error
M8	Host Provider File Error
MZ	Error Overflow
1C	M/I Smoker/Non-Smoker Code
1E	M/I Prescriber Location Code
2C	M/I Pregnancy Indicator
2E	M/I Primary Care Provider ID Qualifier
3A	M/I Request Type
3B	M/I Request Period Date-Begin
3C	M/I Request Period Date-End
3D	M/I Basis of Request
3E	M/I Authorized Representative First Name
3F	M/I Authorized Representative Last Name
3G	M/I Authorized Representative Street Address
3H	M/I Authorized Representative City Address
3J	M/I Authorized Representative State/Province Address
3K	M/I Authorized Representative Zip/Postal Zone
3M	M/I Prescriber Phone Number
3N	M/I Prior Authorized Number Assigned
3P	M/I Authorization Number
3R	Prior Authorization Not Required
3S	M/I Prior Authorization Supporting Documentation
3T	Active Prior Auth Exists Resubmit At Expiration of Prior Auth
3W	Prior Authorization in Process
3X	Authorization Number Not Found
3Y	Prior Authorization Denied
4C	M/I Coordination of Benefits/Other Payments Count
4E	M/I Primary Care Provider Last Name
5C	M/I Other Payer Coverage Type
5E	M/I Other Payer Reject Count
6C	M/I Other Payer ID Qualifier
6E	M/I Other Payer Reject Code
7C	M/I Other Payer ID
7E	M/I DUR/PPS Code Counter
8C	M/I Facility ID
8E	M/I DUR/PPS Level of Effort
AA	Patient Spenddown Not Met
AB	Date Written Is After Date Filled
AC	Product Not Covered Non-Participating Manufacturer
AD	Billing Provider Not Eligible To Bill This Claim Type
AE	QMB (Qualified Medicare Beneficiary)-Bill Medicare
AF	Patient Enrolled Under Managed Care
AG	Days Supply Limitation For Product/Service
AH	Unit Dose Packaging Only Payable For Nursing Home Recipients
AJ	Generic Drug Required
AK	M/I Software Vendor/Certification ID
AM	M/I Segment Identification

A9	M/I Transaction Count
BE	M/I Professional Service Fee Submitted
B2	M/I Service Provider ID Qualifier
CW	M/I Alternate ID
CX	M/I Patient ID Qualifier
CY	M/I Patient ID
CZ	M/I Employer ID
DC	M/I Dispensing Fee Submitted
DN	M/I Basis of Cost Determination
EA	M/I Originally Prescribed Product/Service Code
EB	M/I Originally Prescribed Quantity
EC	M/I Compound Ingredient Component Count
ED	M/I Compound Ingredient Quantity
EE	M/I Compound Ingredient Drug Cost
EF	M/I Compound Dosage Form Description Code
EG	M/I Compound Dispensing Unit Form Indicator
EH	M/I Compound Route of Administration
EJ	M/I Originally Prescribed Product/Service ID Qualifier
EK	M/I Scheduled Prescription ID Number
EM	M/I Prescription/Service Reference Number Qualifier
EN	M/I Associated Prescription/Service REference Number
Ep	M/I Associated Prescription/Service Date
ER	M/I Procedure Modifier Code
ET	M/I Quantity Prescribed
EU	M/I Prior Authorization Type Code
EV	M/I Prior Authorization Number Submitted
EW	M/I Intermediary Authorzation Type ID
EX	M/I Intermediary Authorization ID
EY	M/I Provider ID Qualifier
EZ	M/I Prescriber ID Qualifier
E9	M/I Provider ID
FO	M/I Plan ID
GE	M/I Percentage Sales Tax Amount Submitted
HA	M/I Flat Sales Tax Amount Submitted
HB	M/I Other Payer Amount Paid Count
HC	M/I Other Payer Amount Paid Qualifier
HD	M/I Dispensing Status
HE	M/I Percentage Sales Tax Rate Submitted
HF	M/I Quantity Intended To Be Dispensed
HG	M/I Days Supply Intended To Be Dispensed
H1	M/I Measurement Time
H2	M/I Measurement Dimension
H3	M/I Measurement Unit
H4	M/I Measurement Value
H5	M/I Primary Care Provider Location Code
H6	M/I DUR Co-Agent Id
H7	M/I Other Amount Claimed Submitted Count
H8	M/I Other Amount Claimed Submtited Qualifier
H9	M/I Other Amount Claimed Submitted
JE	M/I Percentage Sales TAx Basis Submitted

J9	M/I DUR Co-Agent ID Qualifier
KE	M/I Coupon Type
ME	M/I Coupon Number
NE	M/I Coupon Value Amount
NN	Transaction Rejected At Switch Or Intermediary
PA	PA Exhausted/Not Renewable
PB	Invalid Transaction Count For This Transaction Code
PC	M/I Claim Segment
PD	M/I Clinical Segment
PE	M/I COB/Other Payments Segment
PF	M/I Compound Segment
PG	M/I Coupon Segment
PH	M/I DUR/PPS Segment
PJ	M/I Insurance Segment
PK	M/I Patient Segment
PM	M/I Pharmacy Provider Segment
PN	M/I Prescriber Segment
PP	M/I Pricing Segment
PR	M/I Prior Authorization Segment
PS	M/I Transaction Header Segment
PT	M/I Workers' Compensation Segment
PV	Non-Matched Associated Prescription/Service Date
PW	Non-Matched Employer ID
PX	Non-Matched Other Payer ID
PY	Non-Matched Unit Form/Route of Administration
PZ	Non-Matched Unit Of Measure To Product/Service ID
P1	Associated Prescription/Service Reference Number Not Found
P2	Clinical Information Counter Out Of Sequence
P3	Compound Ingrid Component Count Does Not Match Number of Repetitions
P4	COB/Other Payments Count Does Not Match Number of Repetitions
P5	Coupon Expired
P6	Date of Service Prior To Date Of Birth
P7	Diagnosis Code Count Does Not Match Number Of Repetitions
P8	DUR/PPS Code Counter Out of Sequence
P9	Field Is Non-Repeatable
RA	PA Reversal Out Of Order
RB	Multiple Partial Not Allowed
RC	Different Drug Entity Between Partial & Completion
RD	Mismatched Cardholder/Group ID-Partial To Completion
RE	M/I Compound Product ID Qualifier
RF	Improper Order of 'Dispensing Status' Code on Partial Fill Transaction
RG	M/I Associated Prescription/Service Ref Num on Completion Transaction
RH	M/I Associated Prescription/Service Date on Completion Transaction
RJ	Associated Partial Fill Transaction Not on File
RK	Partial Fill Transaction Not Supported
RM	Completion Trans Not Permitted W/ Same 'Date of Service' Partl Trans
RN	Plan Limits Exceeded On Intended Partial Fill Values
RP	Out Of Sequence 'P' Reversal on Partial Fill Transaction
RS	M/I Associated Prescription/Service Date on Partial Transaction
RT	M/I Associated Prescription/Service Ref Number on Partial Trans

RU	Mandatory Elements Must Occur Befr Optional Data Elements In Segment
R1	Other Amount Claimed Submitted Count Does Not Match # of Repetitions
R2	Other Payer Reject Count Does Not Match Number Of Repetitions
R3	Procedure Modifier Code Count Does Match Number Of Repetitions
R4	Procedure Modifier Code Invalid For Product/Service ID
R5	Product/Service ID Must Be Zero When Product/Service ID Qual Equals 06
R6	Product/Service Not Appropriate For This Location
R7	Repeating Segment Not Allowed In Same Transaction
R8	Syntax Error
R9	Value In Gross Amount Due Does Not Follow Pricing Formulae
SE	M/I Procedure Modifier Code Count
TE	M/I Compound Product ID
UE	M/I Compound Ingredient Basis Of Cost Determination
VE	M/I Diagnosis Code Count
WE	M/I Diagnosis Code Qualifier
XE	M/I Clinical Information Counter
ZE	M/I Measurement Date

9.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the ITSC Help Desk by:

Phone: (505) 248-4371 or
(888) 830-7280

Fax: (505) 248-4363

Web: <http://www.rpms.ihs.gov/TechSupp.asp>

Email: ITSCHelp@mail.ihs.gov