RMD Bulletin

Knowledge is power…

OHC Claim Adjustment Reason Code

CARC 38 Terminated January 2013

On October 2011, in compliance with Short-Doyle/Medi-Cal Phase II billing requirements, the Integrated System (IS) was enhanced to include specific adjudication information received from other third party payers on Medi-Cal claims for clients who have another payer in addition to Medi-Cal. This enhancement only allows providers to enter the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant adjustment codes and payment information they receive on claims, however, third party payers such as private insurance or Medicare do not always send back HIPAA compliant adjustment codes when claims are submitted to them non-electronic (paper).

When providers submit non-electronic (paper) claims to third party payers, those payers will send an Explanation of Benefits (EOB) letting the provider know whether the claims have been approved or denied. Typically, when a payer denies a claim, that payer explains why the claim was denied using a code that is unique to that payer. In addition, if the payer only pays a portion of the claim, they will send an adjustment code explaining why they didn't pay the entire amount. Because this information is not returned to the provider electronically, payers are not required to use HIPAA compliant codes. At the same time, providers are required to send HIPAA compliant adjustments on their Medi-Cal claims and only HIPAA compliant adjustments appear on the drop down list in the IS.

Previously, Revenue Management Division (RMD) instructed providers to use HIPAA compliant Claim Adjustment Reason Codes (CARC) when balance billing to Medi-Cal and provided a crosswalk linking non-compliant response codes to HIPAA compliant CARC for use on claims that are balanced billed to Medi-Cal. One of the CARC codes on the crosswalk, 38 – Services not provided or authorized by designated (network/primary care) providers, is no longer valid on claims adjudicated on or after January 1, 2013. This means that third party payers are not allowed to use CARC 38 when adjusting (i.e., not paying all or part of) your claim after January 1, 2013. It also means that this code should not be sent on claims for services rendered on or after this date. Two new, more specific codes have been added that can be used in place of the deactivated code: 242 – Services not provided by network/primary care providers – and 243 – Services not authorized by network/primary care providers.

Attached to this Bulletin is an updated version of the OHC Crosswalk. It has been revised to include new suggestions for what to use in place of the deactivated CARC 38.

For detailed instructions on using the attached crosswalk, please refer to RMD Bulletin NGA 11-039, OHC Adjustment Code Crosswalk.

We're here to help you…

If you have any questions or require further information, please do not hesitate to contact RMD at (213) 480-3444 or RevenueManagement@dmh.lacounty.gov.

OTHER HEALTH COVERAGE ADJUSTMENT CODE CROSSWALK (Updated 01/28/2013)

Paper Claim Responses ONLY

Insurance Company Name	Denial Reason Code	Description	HIPAA Compliant Claim Adjustment Reason Code	Claim Adjustment Reason Code Description
Aetna	01	Member has no coverage	B1	Non-covered visits
	001	Non-participating provider services paid as referred at the lesser of billed charges or the 80th percentile of Ingenix	242	Services not provided by network/primary care providers.
	01	Member has no coverage	200	Expenses incurred during lapse in coverage
	002	The member is responsible for the reported copayment/coinsurance amount.	2	Coinsurance Amount
	004	Paid as billed		
	005	The payment ------- applicable interest incurred	225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)
Affiliated Physicians IPA	189	Not otherwise classified or unlisted procedure code CPT/HCPCS was billed when there is a specific procedure code for this procedure service	189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service
Affordable Benefit Administrators Inc.	A9	No Benefits Allowable -Non PPO Provider	242	Services not provided by network/primary care providers.
AHS Childrens Hospital Los Angeles	DCB	Uphold service not covered benefit	B1	Non-covered visits
Altamed Health Services Corporation	DCB	Uphold service not covered benefit	B1	Non-covered visits
Anthem	01	This is a duplicate claim	18	Duplicate claim/service
	01	Your evidence of coverage does not provide benefits for this type of service	204	This service/equipment/drug is not covered under the patient's current benefit plan
	02	The service is denied because the service billed is not covered separately and is considered part of the member's primary procedure	49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam
	03	This is the amount in excess of the allowed expense for a non-participating provider	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
	04	This balance is the member's coinsurance responsibility	2	Coinsurance Amount
	05	Your evidence of coverage does not provide benefits for this type of service	204	This service/equipment/drug is not covered under the patient's current benefit plan
	No Code	CPT/HCPCS code H2011 is used for state Medicaid agencies only	189	Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service
Blue Cross of California	1	This procedure number was changed to conform with the description of service reported.	186	Level of care change adjustment
	2	Services from this type of provider are not a benefit of the subscriber's health plan	204	This service/equipment/drug is not covered under the patient's current benefit plan
	6	The patient did not have active coverage on this date of service	200	Expense incurred during lapse in coverage

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Insurance Company Name	Denial Reason Code	Description	HIPAA Compliant Claim Adjustment Reason Code	Claim Adjustment Reason Code Description
Blue Shield of California	1	Service is not a benefit of the subscriber's contract	204	This service/equipment/drug is not covered under the patient's current benefit plan
	2	Services from this type of provider are not a benefit of the subscriber's health plan	170	Payment is denied when performed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 service Payment Information REF), if present.
	2	The charge for this service cannot be processed as submitted. We do not use this code for claim processing nor is there a provider contract defining its use. Please resubmit the claim using a current CPT-4, ADA, non- temporary HCPCS or Revenue Code that completely describes the actual services provided.	189	Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service
	2	Patient is not eligible for coverage under the subscriber's contract	B1	Non-covered visits
	3	Patient had no coverage for the above date of service	200	Expense incurred during lapse in coverage
	5	Coverage does not include benefits for conditions existing prior	204	This service/equipment/drug is not covered under the patient's current benefit plan
	6	The patient did not have active coverage on this date of service	200	Expense incurred during lapse in coverage
	4 (B13)	Services were previously processed under claim number:_____	18	Duplicate claim/service.
Cigna Behavioral Health of California	A003	Copayment	3	Co-payment amount
	A018	These services exceed the authorization.	198	Precertification/authorization exceeded
	A121	Interest payable	225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)
CMS Centers for Medicare & Medicaid Services	No Code	Denial from Medicare - If you are **not** interested in becoming a Medicare provider and are submitting claims for denial only, please let this letter serve as a letter of denial from Medicare for the beneficiary for the following services:	242	Services not provided by network/primary care providers.
College Health IPA	D58	CPT Code not covered during In Patient confinement	189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service
	D59	Only one initial evaluation allowed per inpatient confinement	198	Precertification/authorization exceeded
Department of Veterans Affairs	CE-52303 =(MOD)	When the same service is reported two or more times without an appropriate modifier to indicate repeat services, the second procedure and any subsequent procedures are likely to be rejected by most carriers as duplicate line items.	18	Duplicate claim/service
	CE-53070 =(CPT)	This service is not valid for Medicare/Medigap business purposes. Medicare/Medigap uses another CPT code for the reporting of, and payment for, this service. If this procedure code was authorized pay it, if not reject the line item.	189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service

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Insurance Company Name	Denial Reason Code	Description	HIPAA Compliant Claim Adjustment Reason Code	Claim Adjustment Reason Code Description
HealthCare Partners Provider Network	ADJB	Contracted or Non-contracted provider's claim adjudicated based on HealthCare Partners', Federal or State regulatory claims processing guidelines, contract agreement, Medicare rates or HCP Usual and Customary fee schedule	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability)
	ADJC	Contracted provider's claim adjudicated based on HealthCare Partners', Federal or State regulatory claims processing guidelines and contract agreement and/or fee schedule	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability)
	ADJNC	Non-contracted provider's claim adjudicated based on HCP Federal or State regulatory claims processing guidelines, Medicare rates, Letter of Agreement or HCP Usual and Customary fee schedule	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability)
	ARC	Provider disputes and member appeals adjudicated based on HCP, Federal or State regulatory claims processing guidelines, contract agreement, Medicare rates, or HCP Usual and Customary fee schedule	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability)
	AUDT	Claim adjusted due to internal audit performed for coding integrity according to the National Correct Coding Initiative (NCCI)	236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative
	AUTH	Service was not authorized or exceeded the authorized limit	243	Services not authorized by network/primary care providers.
	BEN	Service is not covered by the member's benefit plan or has exceeded benefit limits	204	This service/equipment/drug is not covered under the patient's current benefit plan
	CC	Claim adjusted due to GMIS ClaimCheck coding integrity audit	B5	Coverage/program guidelines were not met or were exceeded.
	COB	Another insurer or carrier has primary responsibility for this service	22	This care may be covered by another payer per coordination of benefits
	DUP	Procedure has been previously processed on a separate claim	18	Duplicate claim/service.
	ELG	Service denied because patient is not enrolled with HCP and Health Plan on service date	200	Expenses incurred during lapse in coverage
	ER	Emergency room criteria not met based upon available information	40	Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
	FCR	Claim adjusted due to previous overpayment	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.
	FWD	Health Plan or other party financially responsible for claim under Division of Responsibility (DOR) terms or as a result of the patient's eligibility (not an HCP member at date of service)	22	This care may be covered by another payer per coordination of benefits.

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Insurance Company Name	Denial Reason Code	Description	HIPAA Compliant Claim Adjustment Reason Code	Claim Adjustment Reason Code Description
HealthCare Partners Provider Network	INCCD	Missing/Incomplete/Invalid procedure, diagnosis or other code	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
	INCCL	Missing/Incomplete/Invalid claim form	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
	INCDOC	Missing/Incomplete/Invalid claim attachments	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
	INCDT	Admission Date is Missing/Incomplete/Invalid service, admit, discharge or other date	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
	INCLOC	Missing/Incomplete/Invalid place of service or other location	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
	INCMISC	Missing/Incomplete/Invalid data on claim	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
	INCPR	Missing/Incomplete/Invalid provider information	226	Information requested from the Billing/Rendering Provider was not provided or was Insufficient/Incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)
	INCPT	Missing/Incomplete/Invalid patient information	31	Patient cannot be identified as our insured
	RPCAI	Adjustment due to Repricing by CAI	216	Based on findings of a review organization
	RPMUL	Adjustment due to Repricing by Multiplan	216	Based on findings of a review organization
	RPNHB	Adjustment due to Repricing by NHBC	216	Based on findings of a review organization
Kaiser Permanente	236	Adjusted to correct contract payment rate	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability)
	294	Claim adjusted - Initial decision overturned	129	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
	CI	Coinsurance	2	Coinsurance Amount
	CO	Copay	3	Co-payment amount
	DE	Deductible	1	Deductible Amount
	INT	Interest Rate	225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)
	IQ	The member is a Medi-Cal Program enrollee and is not responsible for these charges	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
	PI	The claim is denied. It will be reopened when the requested provider information is received	226	Information requested from the Billing/Rendering Provider was not provided or was Insufficient/Incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)

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Kaiser Permanente	RU	The claim is denied. The procedure or services performed were not ordered or authorized by a Kaiser Permanente physician	243	Services not authorized by network/primary care providers.
	SO	These services were incurred after termination of coverage	27	Expenses incurred after coverage terminated
	U23	This procedure is normally included in the cost of the primary procedure	49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam
MHN Services	GQ	Medicare doesn't allow service. MHN development effort exhausted	226	Information requested from Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
	NQ	Duplicate claim, service(s) currently in review with U.M.	18	Duplicate claim/service.
PacifiCare Behavioral Health	0	No valid authorization for date(s) of service	242	Services not provided by network/primary care providers.
	1	Reviewed-Services Previously Denied	193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
SAG - PHP	AC	Provider return completed W9 W/next claim	226	Information requested from the Billing/Rendering Provider was not provided or was Insufficient/Incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT)
	GL	Not a covered service	B1	Non-covered visits
	IS	Please validate DX, Service Code or Member ID	11	The diagnosis is inconsistent with the procedure
Self-Insured Schools of California	1	This amount exceeds the allowed expense and is the member's responsibility to pay	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability)
TriCare	18	Provider not TriCare authorized for this service	243	Services not authorized by network/primary care providers.
	135	Provider is not TriCare authorized. Requested provider certification information not received.	243	Services not authorized by network/primary care providers.
United Behavioral Health	B05	Your plan does not cover this expense	B1	Non-covered visits
United Food and Commercial Workers Unions and Food Employers Benefit Fund	711	Non- Contracting Provider; Service not authorized by EMAP Network No benefit payable per plan section 1201	243	Services not authorized by network/primary care providers.

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Insurance Company Name	Denial Reason Code	Description	HIPAA Compliant Claim Adjustment Reason Code	Claim Adjustment Reason Code Description
United Healthcare	#	Payment of benefits has been made in accordance with the terms of the managed care system	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability)
	AX	Charges cannot be considered because no units were billed, units billed exceed maximum and/or are unsupported by the submitted documentation, or the service was billed more frequently than permitted by this code	B5	Coverage/program guidelines were not met or were exceeded.
	IX	This physician or Health Care provider is not a network provider, but has accepted a reduction in charges on this claim	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability)
	O9	The number of units reported exceeds either the typical frequency per day, therefore, the number of units that exceed the typical frequency per day are not being considered. If the provider has additional documentation, please send it to us for consideration. A single rental payment covers a full calendar month for durable medical equipment, orthotics and prosthetics and is allowed once per calendar month for twelve continuous months after which they are considered purchased. The additional units for the rental of this item have been denied as exceeding these limits.	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
	U	The number of units reported exceeds either the typical frequency per day, or the frequency within the global period, or the monthly rental of this item allowed under the provider's agreement. The allowed unit(s) will be processed on new services line(s).	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
USBHPC	07	Claim filed after time limit. Provider can request reconsideration by sending a detailed activity report showing the original filing date	29	The time limit for filing has expired
	0209	Not eligible charge	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
	0289	Claim filed after time limit.	29	The time limit for filing has expired
	0305	Requires notification	197	Precertification/authorization/notification absent.
ValueOptions Inc	GL	Not a covered service	B1	Non-covered visits

Note: Code 38 terminated on 01/2013. Code 242 and 243 were added.